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NHS Gloucestershire

Gloucestershire Integrated Care Board Meeting

To be held at 2.15pm to 4.30pm on Wednesday 25th September 2024
Committee Room, Ground Floor, Shire Hall, Westgate Street, Gloucester, GL1 2TG

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	2.15 – 2.17pm	**Welcome and Apologies** *Welcome: Nina Phillipidis* *Apologies:*	Information	**Chair**
2.	2.17 – 2.19pm	**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.	2.19 – 2.20pm	**Minutes of the meeting held 31st July 2024**	Approval	**Chair**
4.	2.20 – 2.30pm	**Action Log & Matters Arising** • **HPV Information**	Discussion	**Chair**
		Business Items		
5.	2.30 – 2.40pm	**Questions from Members of the Public**	Discussion	**Chair**
6.	2.40 – 3.00pm	**Patient Story – Bowel Cancer Screening Patient Interview**	Discussion	**Kalpna Mistry / Rebecca Smith**
7.	3.00- 3.30pm	**Clinical Programme Group – Cancer**	Discussion	**Rebecca Smith Sadaf Haque**
8.	3.30 – 3.40pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	3.40 - 3.50pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	3.50 – 4.10pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Ellen Rule Tracey Cox Marie Crofts Cath Leech**
11.	4.10 – 4.30	**One Plan for all Children & Young People in Gloucestershire 2024-30 (and appendices)**	Discussion	**Ann James Beth Bennett-Britton**
		Information items		
12.1	4.30 – 4.35pm	**Chair's verbal & ARAC report from the Audit Committee** held on 5th September 2024 and approved minutes from 24th June 2024	Information	**Julie Soutter & Karen Clements**
12.2		**Chair's verbal report on the Primary Care & Direct Commissioning Committee** held on 8th August 2024		**Ayesha Janjua**
12.3		**Chair's verbal report on the System Quality Committee** held 7th August 2024 and approved minutes from 5th June 2024		**Prof Jane Cummings**
12.4		**Chair's verbal report on the Resources Committee** held 5th September 2024 & approved minutes from 4th July 2024		**Ayesha Janjua**
13.	4.35pm	**Any Other Business**		**Chair**

Time and date of the next meeting

The next Board meeting will be held on Wednesday 27th November 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)

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Gloucestershire Integrated Care Public Board Meeting

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

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

Members Present:		
Dame Gill Morgan	GM	Chair, NHS Gloucestershire ICB
Mary Hutton	MH	Chief Executive Officer, 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
Ellen Rule	ER	Deputy CEO & Director of Strategy and Transformation, NHS Gloucestershire ICB
Dr Jo Bayley	JB	Chief Executive, GDOC Ltd.
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
Kevin McNamara	KM	Chief Executive Officer, Gloucestershire Hospitals NHS Foundation Trust
Marie Crofts	MCr	Chief Nursing Officer, NHS Gloucestershire ICB
Siobhan Farmer	SF	Director of Public Health, Gloucestershire County Council
Tracey Cox	TC	Director of People, Culture & Engagement, NHS Gloucestershire ICB
Participants Present:		
Ann James	AJ	Executive Director of Children's Services,
Benedict Leigh	BL	Director of Integration, NHS Gloucestershire ICB and Gloucestershire County Council
Carole Alloway-Martin	CAM	Cabinet Member, Adult Social Care Commissioning, GCC and Chair of the 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
Martin Holloway	MHo	Senior Independent Director and Non-Executive Director of SWAST
Mark Walkingshaw	MW	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Dr Olesya Atkinson	OA	GP & PCN Representative
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire ICB
Becky Parish (Item 6)	BP	Associate Director of Patient & Public Engagement
Kerry O'Hara (Item 6)	KOH	ICS Programme Director for Clinical Programmes, GICB
Dr Christian Hamilton (Item 7)	CH	Associate Director of Elective Care, NHS Gloucestershire ICB

1.	**Welcome and Apologies**	
1.1	The Chair welcomed members present. Apologies were received from Jo Coast and Sarah Scott.	
1.2	The meeting was declared to be quorate.	

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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) Jo Bayley, Douglas Blair and Graham Russell declared Conflicts of Interest in relation to the Development of Health Services in Lydney, Forest of Dean request for approval (Item 13) and therefore would leave the meeting when this item was discussed and a decision made.	
3.	**Minutes of the Public Board meeting held on 29th May 2024 and Extraordinary Board meeting held on 26th June 2024.**	
3.1	The minutes from the Public Board meeting held on the 29th May 2024 were approved as an accurate record of the meeting. The minutes from the Extraordinary Board meeting held on 26th June 2024 were approved as an accurate record of the meeting.	
3.2	The Chair informed the Board that a formal letter had been received from the Regional Office of NHS England just prior to the meeting today, to inform the Board that having scrutinised NHS Gloucestershire ICB, they were content that the statutory delivery requirements placed on the Board were being met.	
3.3	The Regional Office had also asked the Health and Wellbeing Board for a review on the progress of NHS Gloucestershire ICB and how the two parties worked together. Again, there had been a very positive view from the Health and Wellbeing Board on how well integrated working had progressed. The letter from Regional Office would be published with the Annual Report and Accounts in order that this could be in the public domain.	
4.	**Action Log and Matters Arising**	
4.1	It was agreed by members of the Board that items being forward planned for specific meetings should be kept on the Action Log until those meetings had taken place, so as not to lose line of sight. The System Quality Committee had been requested to look at a number of important specific quality issues and the Chair felt that a public Board meeting could be devoted to these topics, demonstrating the importance of quality.	
	31/01/24 Action 20: P2 beds/EoL. SQC to bring back a report on P2 beds/EoL to a future Board meeting. **Action Open.**	
	31/01/24 Action 21: LMNS membership and functionality. The regional CNO would be advising the ICB CNO on this matter. **Action Open.**	
	31/01/24 Action 22: Migrant Health Report. A report on Migrant Health would be submitted to the November Board meeting. **Action to remain Open.**	
	27/03/2024 Action 23: Social Prescribing/CEO Report. Creative Health Consortium has been a scheduled topic for a patient story in Autumn 2024. **Action to remain Open.**	

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	27/03/2024 Action 24: Interim Procurement Strategy. The ToR will be reviewed and any changes will be reported and agreed by the Audit Committee at its next meeting and submitted to a subsequent ICB Board meeting for approval **Action to remain Open.**	
	29/05/2024 Action 25: Contaminated Blood Inquiry Report. To be placed on a future public Board agenda. **Action Open.**	
	29/05/2024 Action 26: Countess of Chester case. To be placed on a future public Board agenda. **Action Open.**	
	29/05/2024 Action 27: Dying Matters Report. To be discussed by the System Quality Committee and reported back to the Board at a future meeting. **Action Open.**	
	29/05/2024 Action 28: Dental Access: HG to update the Board at a future meeting to evidence ongoing progress around dental access. **Action Open.**	
	29/05/2024 Action 29: BP to send a short summary of how pharmacists had recently helped patients to Board members. This document had since been sent to Board members. **Action to be Closed.**	
	29/05/2024 Action 30: Working as One/Newton Programme. Representatives to be invited to a future Board meeting with an update on outstanding issues for system partners. **Action Open.**	
	29/05/2024 Action 31: BAF and CRR. TC and JS to bring the Board Assurance Framework and Corporate Risk Register to the October Board Development session.	
	29/05/2024 Action 32: Hospital Mortality Rates. AR to bring a Hospital Mortality Rates report to a future Board meeting. **Action Open.**	
	29/05/2024 Action 33: System Resources Committee ToR. RB to alter the phrasing to reflect that JS would be a member of the System Resources Committee as an ex-officio role in the revised Terms of Reference prior to the document being sent out to Board members. This was subsequently actioned in July 2024 and uploaded to ICB website for information for Board members**. Action to be Closed.**	
5.	**<u>Questions from members of the public</u>**	
5.1	Questions from members of the public were read out, together with full responses from the ICB Board which are included in a log on the ICB public website, as below. The responses would be sent directly to those who had asked the questions. Any actions arising from the questions would be brought back to a future Board meeting. ICB Board Questions and Answers 2024 **Question One:** "What does NHS Gloucestershire Integrated Care Board consider the challenges and opportunities of live video recording of their meetings in public. What would/could NHS Gloucestershire Integrated Care Board see as the benefits and risks in undertaking this live video recording, in line with the Gloucestershire County Council on site facilities for doing so? What does NHS Gloucestershire Integrated Care Board see as further assurance and reassurance this videoing would/could have, and this live videoing being	

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	placed on the One Gloucestershire web site, and could/would give around further increased openness and transparency to the public?" **Question Two:** "What assurance and re assurance does NHS Gloucestershire Integrated Care Board seek, and have, to their grant giving, procurement, commissioning, and monitoring practices to Voluntary and Community Sector/ Voluntary and Community Sector Social Enterprise organisations are in line, or not, with the Nolan Principles (Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership)? What open and transparent measure(s) does NHS Gloucestershire Integrated Care Board have in place to demonstrate this is consistently happening? **Question Three:** "What assurance and re assurance does NHS Gloucestershire Integrated Care Board have that they are meeting the health and social care needs of the Kurdish community in the county. What robust measures are in place to evidence this is the case, under the categories of access, experience and outcomes?"	
6.	**Patient Story – Case Study on Community Diagnostic Centre (CDC)**	
6.1	BP outlined a case study from Gloucestershire Hospitals NHS Foundation Trust and the Patient Experience Team relating to an individual's experience of the new Community Diagnostic Centre (CDC) at Quayside House in Gloucester. This was linked to the Planned Care Recovery (item 7). BP informed the Board that her colleague KOH had been heavily involved with the project and would be engaging in discussion following the patient story.	
6.2	BP explained how the patient Abdullah (pseudonym), a 48-year-old male, lived in Gloucester City, did not drive and was currently unable to work due to an ongoing heart condition, which necessitated regular visits to both acute and primary care. He was also awaiting urology surgery. English was not his first language, and he was at greater risk of experiencing health inequalities.	
6.3	Abdullah received an Echo Physiology appointment in Spring 2024 at the new Community Diagnostic Centre. He had been able to walk to his appointment easily and knew where it was, as his GP surgery was in the same location. The entrance had been a little tricky to locate and signage had not been great, but Abdullah had found the centre to be welcoming, bright and clean, and the environment calmer and quieter than those in the main hospitals.	
6.4	Abdullah was very pleased with the care and service he received at the CDC and he wanted to have more of his appointments at this venue, due to the fact he was able to walk there and his appointment was received quickly after being requested. He felt that by not having to catch a bus and pay for the fare, he experienced less stress and anxiety, two factors he was trying to manage due to his health condition. He was very grateful for the close proximity of the CDC. This had been a very positive story and the Patient Experience Team would be keeping in touch with Abdullah in the future.	
6.5	KOH explained that signage had been improved since opening the CDC; the lift was now fully functional and the front doors were now opening properly which would definitely help to improve patient experience in accessing the CDC. KOH recognised that the multi-organisational team working together had been reactive to issues as they had arisen, resulting in a much better patient experience for those using the CDC.	

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6.6	The Chair thanked all those involved for making really tangible differences to the community in some of the more deprived areas of the city and for all the hard work that had gone into bringing this new CDC to fruition.	
6.7	DB pointed out a slight discrepancy in the paper on the last page, which BP confirmed would be rectified. It was evident that staff had not found the CDC easy to locate compared to patients and hoped that with improvements made, everybody would be able to locate it.	
6.8	BP concurred that staff and patients had found it more difficult to locate in the initial months following the opening of the CDC. BP notified members that enquiries from members of the public had significantly reduced over the last few months and since the story had been collected. BP had found that most people now know how to access the CDC. KOH also observed that parking for staff was offsite, having only been agreed with GCC a week before opening, whereas patient parking was onsite, so this was probably a factor. The experience-based design survey would be repeated twice a year, monitoring some of the changes to see whether they were having positive impacts on people's experiences of the CDC.	
6.9	KM recognised the efforts made from multi-organisational working in bringing the CDC online and credited KOH with the work that she had done in driving that forward. The Chair commented that this was a wonderful asset for the community, demonstrating what relatively small amounts of capital could do to transform patient experience, and urged members of the Board to visit if they could.	
7.	**Planned Care and Recovery Update**	
7.1	This presentation was delivered by CH and MW, with Alexandra Matthews, Divisional Director of Operations (Surgery) at GHFT unable to attend but who had input into the presentation, for which the Chair requested she be thanked for, upon her return. CH had also involved other staff from GHFT in the production of the presentation which had been circulated prior to the meeting.	
7.2	The presentation provided an overview of the elective care recovery programme following the pandemic, with details of what had worked well, latest performance, actions underway as well as the scale of the ongoing challenge and risks to delivery.	
7.3	MW highlighted that the system was working in partnership with acute and community colleagues and primary care referrers. The ICB also had a strong relationship with independent sector providers who had been making significant contributions during the period of recovery, along with out of county providers.	
7.4	MW explained that there was a window of opportunity in terms of the availability of the Elective Recovery Fund (ERF) for work achieved above the 2019/2020 levels. Ambitious targets had been set this year to over-achieve in order to bring additional income into Gloucestershire.	
7.5	CH noted that recovery in Gloucestershire had been very good to date in comparison to other national and regional systems. However, there were still some very long waiting lists; Gloucestershire's had increased the least as a percentage in the South West due to some innovative ideas adopted during the pandemic.	
7.6	Staff had been recruited with customer care skills who had proactively contacted patients on the waiting list and answered specific questions about their specialty specific conditions. • At that point, around 20% of people had no longer required their appointment following that conversation.	

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	• Patients who had felt their condition had significantly deteriorated had been upgraded and were seen sooner. This resulted in keeping the waiting list as live and as accurate and prioritised people into the right order. • Cancer work and urgent work was maintained throughout the pandemic. • National software was introduced to reduce face to face appointments. • Independent sector providers such as the Winfield Hospital helped with the use of their facilities and that continued and many people with long waits were still referred to the Trust to support the reduction in the waiting lists. CH was pleased to report that the Winfield had been, and still was, exemplary in their collaborative working with the NHS. • A very advanced Advice & Guidance service was in place for GPs; the relationships between GPs and Consultants had been crucial in order to support patients who were unable to access hospital care during the pandemic. • TrakCare in Gloucestershire had enabled the management of waiting lists at a detailed level, whereas other areas had taken a long time to reach the same advanced stage. CH and colleagues at GHFT had started the work together which was still ongoing to this day.	
7.7	The target for 65 week waits was to get to zero by September 2024 with expectations to realise that target shortly after September. CH stated that 10-15% of time was being spent managing people on lists rather than treating them to be removed from the waiting lists. The aim was to get back to treating people in real time as opposed to holding them for long periods of time.	
7.8	CH informed the Board that there was 125% more elective activity in value weighted terms being achieved now than in 2019/2020 and the system was currently at 117% ERF with independent sector colleagues also contributing. Out of country providers were not performing as well for Gloucestershire patients as they were for their own systems, possibly due to a coding issue, with further investigation needed.	
7.9	CH informed the Board that generally women waited longer for an outpatient appointment than men in almost every specialty by about 5-6 weeks. It could be the case that women with childcare/elderly relatives issues had to rearrange appointments in line with their family commitments, but CH considered that women were not treated differently. It was noted that people with caring responsibilities could be offered a greater choice of appointments. The highest slots that were DNA'd were on a Monday morning, and more work needed to be undertaken on understanding which cohorts of people DNA'd the most and the reason for this, so that more varied options could be offered to them.	
7.10	CH explained that there were many digital tools available to patients to help them to manage appointments and the right ones needed to be chosen to maximise impact. New drug and surgical treatments were always emerging and it was advisable to be cognisant of those in order to pre-empt possible future costs to the system.	
7.11	There were a range of transformation programmes which CH explained, with a great many opportunities around Artificial Intelligence (AI) which were becoming more mainstream with a number of NHS trusts taking on robotic automation to take on administrative tasks, thus ultimately saving time and money. Community facilities needed to be kept maximised and invested in, enabling some procedures to be taken out of main hospitals and offering people the chance to have access to treatment closer to home.	
7.12	A new Day Surgery Unit had recently opened in Cheltenham General Hospital (CGH), which was supported by two theatres designed for high throughput with theatres, recovery	

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	and the unit itself all co-located, which had already made a significant difference. CH explained how other efficiencies were being made around appointments and clinics.	
7.13	The patient portal had recently gone live, which was a two way tool enabling patients to cancel appointments; unfortunately, appointments would not be able to be re-booked on this system but this facility would available in time. The early adoption of robotic Aquablation would be putting Gloucestershire ahead of the rest of the South West, as treating patients had begun in April 2024.	
7.14	There were some significant risks and challenges to recovery plans which included: • Further junior doctor industrial action • General practice collective action • Staff recruitment, retention and burnout • Provider Selection Regime (PSR).	
7.15	The Chair and KM agreed that this was a hugely positive result of all the hard work that had been undertaken. KM stated that there were still aspirations to reduce waiting lists still further. It was hoped that junior doctors would soon reach pay agreements, but estates maintenance backlogs meant that recovery needed to be pushed harder as it had a disproportionate impact from the ageing estate. Any new funding from the Government would need to be quickly deployed into services, so as not to erode the first couple of months of the year where waiting lists could be immediately tackled. There was a good appetite to do more and this reflected the teamwork that had taken place across Gloucestershire, enabling an improving position.	
7.16	The Chair queried whether community hospitals could offer the system more. DB commented there were ongoing conversations about maintaining efficiency across the patch in terms of the physical estate, looking at what could be used and whether that availability could be used more creatively.	
7.17	KC offered personal thanks for everything that had been done during the pandemic, whereby certain protocols adopted had helped her own health pathway at that particular time. KC was interested in women waiting longer for appointments and other countries had found some evidence that part of this was due to symptom severity being underestimated in women compared to men; this also applied to patients from ethnic minority groups. KC wanted to know if the ICB should be concerned about this or whether there was confidence that there was a level playing field.	
7.18	ER stated that it would be interesting to have a gender breakdown of people who were referred for urgent or routine appointments as this would highlight the point being made. The Chair thought this was something that could be examined by the Health Innovation Network (HIN) (formerly known as Academic Health Science Network - AHSN), as this was relevant on a bigger scale. CH confirmed he could look at the hospital data but the question related predominantly to primary care presentation, as to whether women tended not to express the severity of their symptoms. There could be a dataset within the primary care systems that might help identify if women were not describing symptoms similarly to that of men (albeit some would be gender specific symptoms). The Chair observed that it would be good to get a literature review which could give some answers to this in the future.	
7.19	JB reflected on the benefits of having strong working relationships across the system at the time of the pandemic which had been of benefit to the county. JB stated that the use of secondary care referral forms by primary care should be asking the right questions to detect pathology in women. JB spoke about women not accessing services in a timely way and experiencing worse outcomes due to childcare responsibilities. If this were the	

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	case then scrutiny would be needed around how the system was interacting with them as this was indirect discrimination. The Chair thought that data needed to be examined along with the much bigger societal issues and questions about what could be done locally.	
7.20	TC asked CH whether any work had been undertaken on people presenting in A&E waiting for treatment, which related to efficacy in waiting list management and targeting decision-making in different ways. CH responded that some work had been carried out and it was revealed that cardiology, unsurprisingly, was the specialty that rose to the top. A long wait for a cardiovascular patient would inevitably result in a patient visit to A&E at some point.	
7.21	AR responded that patients knowing they can still speak with him whilst working in the ICB had reduced the number of patients that he needed to see in clinics. Regarding cohorting, AR tried to make sure that the patients presenting would be seen by him and the other people would be called when he could do this. AR explained that before 9.30 patients would have to pay to attend clinics if coming by bus if they had a free bus pass. AR had tackled this by saying to patients to come when they wanted and they would be seen. If elderly people had a bus pass, then they could be moved to later appointments. CH responded that it would be good if a more flexible approach to attending appointments could be established for patients and this would contribute to a reduction in DNAs.	
7.22	AJa had noticed the decrease in uptake of cervical screening for women and there were issues emerging, which disproportionately affected women's' access to services and outcomes. AJa felt that the benchmarking in the presentation had been very positive and the "where next" question was really looking at technical efficiency in pathways along with allocative efficiency. It would be good to look at alternatives and interventions to some surgeries and wondered if this was something to be addressed further.	
7.23	CH replied that there was variation across Gloucestershire and indeed, standardisation was difficult across the county. CH stated that E-prescribing would make a beneficial difference to clinicians, and other obvious things to examine were, filling clinics, filling lists, ensuring the IT systems worked for people and not against them and getting the basics right.	
7.24	The Chair referenced under-treatment and over-treatment which was something the Resources Committee would be looking informally at to try to understand separately, the outcomes for men and women. The Chair thought it would be useful for CH to be involved in this session.	
7.25	KM referenced where things were going next and said that proper job planning to ensure direct clinical care was prioritised would ensure that as much clinical time as possible was being devoted to patient contact. KM commented that the Federated Data platform had been of huge benefit for Trusts who had deployed this, reducing waiting lists by an average of 6%. KM felt relatively optimistic that more progress could be made, although there would be some things that the NHS could not legitimately do around waiting list expectations, given the current stringent financial resources.	
7.26	The Chair referred to a major piece of work being undertaken around the interface between secondary and primary care, partly related to GP collective action. When this work was ready, it would be brought back to a future Board for a longer discussion due to interface issues being very important. The Chair wished this to be noted although it was not for discussion today. **Action: Interface discussion between primary and secondary to be tabled for a future Board Development meeting, date to be confirmed.**	**CG**

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	***Resolution**: The Board noted the content of the Planned Care and Recovery presentation for information.*	
8.	**Chief Executive Officer Report**	
8.1	MH highlighted the following areas from the Report: • New NHS Oversight and Assessment Framework • ICS Engagement Improvement Framework • CQC - major review on Maternity Services • GP Collective Action • Fit and Proper Person Test – ICB Board Members • General election implications for Health and Social Care based on the Labour Party Manifesto. The Chair informed members that a full and independent investigation of the NHS, to uncover the extent of the issues facing the nation's health service had been commissioned by the new health and social care secretary, Rt Hon Wes Streeting, with this work being led by the Right Honourable Professor Lord Ara Darzi, who was calling for evidence for his review. The Chair invited members to feedback any evidence into the report, to take the opportunity to do so. Findings would be fed into government's 10-year plan to radically reform the NHS. The Chair noted that the interim report on the Care Quality Commission (CQC) had been rather critical of their interface with the service. The full report would be brought back to the Board when it became available. **Action: Interim Report regarding the CQC to be brought back to a future Board meeting.**	**MCr**
	***Resolution**: The Board noted the content of the Chief Executive Officer Report.*	
9.	**Board Assurance Framework (BAF)**	
9.1	TC informed the Board that as a consequence of the most recent review of the BAF, there were only two risks that had changed in ratings, the first being BAF risk number 4 (Quality Risk) which had increased slightly. This risk related predominantly to some of the concerns around maternity services with assurance that related to visibility around Urgent Care together with parity in other areas where there were known challenges across the system.	
9.2	BAF risk number 7 (Recovery Risk) which related to productivity and growing demands. The increase in the rating for this risk was self-explanatory given the context of the ICB's discussion on planned care and recovery as well as the financial challenges facing the system. The quality of the narrative for the BAF had been improved together with some of the descriptions of the actions. The BAF continued to be a work in progress and would be revisited in the autumn for a longer and more detailed session at the October Board Development session.	
9.3	JS informed members that there would be an Audit Committee meeting in September and there was also a meeting in the diary to look at testing the BAF to examine the identification of risks and to ensure that there were no gaps in governance processes. This would feed into the Board session with the Audit Committee continuing to look at this. A deep dive into the Integration Directorate Risks would be taking place at the September Audit Committee, where risks, controls and assurances would be examined.	
	***Resolution**: The Board members noted the content of the Board Assurance Framework.*	

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10.	**Integrated Finance, Performance, Quality & Workforce Report (IPR)**	
10.1	MW updated on Performance: • The new Government had committed to further and faster progress on the reduction of waits for care and treatment, including adding 40k appointments across the NHS each week. Further guidance was awaited on this. • NHSE in the South West had been conducting a review of performance reporting from ICBs, to ensure that risk reporting covered all the comprehensive requirements. The ICB had ensured better linking to the detail within the metrics with the narrative contained in the main body of the report. Each month three areas of focus would be included in the reporting in order to demonstrate this. • Positive progress had been made with NHS 111 with the number of abandoned calls reducing. Performance indicators had seen significant improvements over the last month and the hope was that momentum would be maintained during handover to the new provider. • The 2023/2024 ERF target had been met and the position at M3 for 2024/2025 was on track to meet the first quarter target (just under 120% of value weighted activity against 2019/2020). • Levels of activity and demands in Primary Care remained a concern together with the potential impact of collective action. However, just under 80% of respondents from the GP survey had rated their overall experience of General Practice as having been good, which compared very well to the national position. • Ambulance handover and response times were still a concern and specific actions were being taken by teams across the system to try to maintain stability albeit there were still significant pressures. • Cervical screening uptake had reduced in certain parts of the county and engagement events had been taking place within communities where there had been a drop in uptake, which had started to yield positive results. • Long waits would still continue to be an area of focus with additional activity having been commissioned from various providers; this was expected to make a significant contribution. The system was now moving into the next phase of recovery for elective waits. • Members were asked to note the Outcome Measures Dashboard which was summarised in the Report.	
10.2	TC updated on workforce: • At the last People Committee meeting held on 8th July 2024, a Systemwide Apprenticeship Strategy was approved along with an Advanced Care Practice Strategy. A deep dive was conducted into the current position on workforce numbers for those areas. There was a risk to the ICB in declining numbers compared to the previous year due to financial constraints resulting in less flexibility in budgets This risk was consistent with some of the trends that were being seen in other systems. • Good progress was being made on the agency cap requirements and both providers were well within the 3.2% target YTD, so vacancy control measures and work being undertaken at a regional level was beginning to realise a significant impact. • Gloucestershire Health & Care NHS Foundation Trust (GHC) had launched a Proud to Care website (a link was available in the papers) to highlight training and career pathways for health and social care staff. This was a really useful tool for the system which TC recommended members to view.	

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	• Skills for Care had now published a Social Care Workforce Strategy which described a challenge of 540k additional care workers required nationally by 2040. The format of the plan was very similar to the Long-Term Workforce Plan which had a focus on three key themes (Attract and Retain, Train, Transform). A more detailed examination of the recommendations in the Report would be conducted at the next People Committee in August.	
10.3	MCr updated on Quality: • Maternity Services were still under Enhanced Surveillance and the Quality Improvement Group continued, with MCr as Chair and attended by KM. There had been a good deal of progress with seven Quality Improvement Groups within the organisation with good oversight from Obstetrics and Midwifery. • A review had been commissioned from the CSU for the Local Maternity and Neonatal System (LMNS); a workshop was well attended last week with views on what was going well and not so well. • The Collaborative Commissioning Hub (CCH) delivered quarterly reports on Pharmacy, Optometry and Dentistry (POD) and there had been no concerns from the Quarter 1 report. Work continued with other ICBs in terms of oversight and scrutiny as well as the types of reports that were needed for assurance purposes. • A meeting with GPs and partners took place around Quality Alerts to try to improve procedures around initiating a response for an immediate patient safety concern, and how themes, near misses and information was processed. This was a work in progress and an opportunity to learn and collate information from patient safety events.	
10.4	The Chair queried cervical cytology activity levels and asked whether this would decrease because of the vaccine impact. MW responded that the vaccine was having a significant impact in reducing instances of disease. **Action: SF to request an update from the regional lead on the impact of the vaccine, to be shared under Matters Arising at the next Board meeting on 25th September 2024, if available.**	**SF**
10.5	CL updated on Finance: • The M3 report was based on the plan submitted on 12th June 2024 to NHSE – the Board was briefed at the end of May 2024 on that plan. The YTD position was showing a variance within GHC due to the phasing and timings of savings, which would be resolved over the coming months. • There was a larger variance of £1.9m within GHFT due to the pay run rate and some non-pay run rates. The nursing run rate was also significantly reducing and controls had made a difference. The pay overspend for nursing was likely to be non-recurrent. The non-pay run rates were still being investigated and updates would follow when more was known. • There were quite significant risks around delivery of savings and unidentified savings. It was hoped that these would be identified by August 2024, with delivery plans in place. Actions were underway for high-risk plans to turn these into delivery plans over the next few weeks this would enable a more robust assessment of the financial position, after some intensive work over the next few weeks. • Two new significant NICE Technology Appraisals (TA) were in progress and the consultation finished a few weeks ago, with results awaited. Refusal to licence a newly developed dementia drug would result in NICE decisions being delayed until 2025/2026 and was also a risk to the system. The planned underspend for this year was £2m,which was planned to be used in 2025/26 .	

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	***Resolution*: The Board noted the content of the Integrated Finance, Performance, Quality and Workforce Report.**	
11.	**2024/2025 Capital Budget**	
11.1	NHSE had announced that systems submitting a balanced revenue plan would receive additional capital, which resulted in the GICB receiving an additional £7.46m which had been prioritised by the system. The system had planned for disposals totalling £4m in 2024/2025, with mitigations underway where risks were emerging. Following review of the current and 2025/26 plans, the system had built in a planned underspend in 2024/2025 to be used in next year. There were still significant challenges around backlog maintenance that would arise during the year. The risks were described in the paper circulated prior to the meeting.	
11.2	It was observed that central monies were not cash backed and there would be risks and concerns around this, throughout the rest of the year. Cash for each organisation was reported on, and the risks associated with the capital plans had been recognised in terms of the capital that would be made available to the system. The Chair stressed that questions should be asked if capital was to be offered, particularly if it were not to be cash backed.	
	***Resolution*: The ICB Board members approved the updated 2024/2025 Capital Plan noting the significant risks that the organisations within the ICS were holding and managing on an ongoing basis.**	
12.	**2024/2025 Revenue Budget**	
12.1.	The ICS had submitted a balanced financial plan on the 12th June 2024. The plan included a high level of savings for all organisations for the system including a stretch target of £15m in order to attain a breakeven plan as a system. This had increased the risk within the financial plan and there was still some work to do in order to identify all of those savings, although progress was being made. The risks were described in the paper.	
12.2	MH stated that there was currently a good deal of focus on financial challenges and a plan was needed to identify the £15m of savings by the end of August and care would be needed to work this through. Urgent Care and the Working as One programme would be areas of focus to look at benefits realisation. A significant programme of work was already underway, but work was now needed to bring things to a conclusion and to examine what would come into the financial plan and how outcomes could be delivered. The Chair thanked all those involved who had worked very hard to bring this work together.	
	Resolution*: The ICB Board members:** • ***Approved the 2024/2025 updated revenue budget, noting the ongoing work to reduce the inherent risks within the system and each organisation's plans. • ***Supported the measures required to deliver the proposed budget and improve the overall financial sustainability of the system and ICB.***	
13.	**Development of Health Services in Lydney, Forest of Dean**	
13.1	NB: Jo Bayley, Douglas Blair and Graham Russell had declared Conflicts of Interest on this item at the beginning of the meeting, so were present for the discussion, but were not present in the room whilst voting for the final proposal took place.	

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13.2	ER explained this paper required the Board to approve the proposed way forward for Urgent Care services for the Forest of Dean, as set out in the options appraisal paper. The paper set out several areas that related to the development of health services in the Lydney area of the Forest of Dean. This included 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. It was noted that the group of papers included an engagement report, produced in 2021, which had not yet been shared in public until now. This had been due in part to competing priorities during the Covid-19 pandemic, and the considerable delays in securing the way forward for the capital scheme for the Lydney Health Centre.	
13.3	Following the most recent engagement exercise, ER informed members that the public had cited various transport concerns and anxieties about the ever-growing population in Lydney. ER stated that it had been very clear that the people of Lydney wanted a service in the town and it was important today to make that very clear to members of the Board. This was examined from every angle to examine the possibility of being able to deliver this. It had been made clear to members of the public who had attended the engagement exercise, that various criteria would be examined in order to consider the viability from a quality, financial, practicality and strategic point of view.	
13.4	A conclusion was reached that Option 2 was the only viable one which could be taken forward, to deliver all MIU provision from the new community hospital in Cinderford. MH and ER had attended the Forest Health Forum to share that this would be the recommendation to the Board today. It was thought important to talk to local people directly who had taken part in the engagement exercise. There had been acknowledgement and appreciation for the in-depth work that had been undertaken, and although not all the people agreed with the decision made, it had been understood.	
13.5	ER felt that the system should be proud of what had been delivered in the Forest of Dean; the full infrastructure plan originally envisaged back in 2016/2017 was to deliver a new hospital and three new health centres, giving a really robust infrastructure for the Forest of Dean district. There was full commitment to developing Health and Wellbeing services which was a clear priority for the Health Forum. The Town Council had included this within their Strategic Development Plan. A local Urgent Care offer had been committed to, including a range of services; • Pharmacy First • Minor Injuries Unit • Rapid Response • Frailty • Integrated Neighbourhood Teams • A co-located Out of Hours service.	

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	The proposed way forward would ensure that the most efficient use would be made of the new community hospital in the Forest of Dean.	
13.6	JS noted that the additional engagement had taken place in 2021 and ER and MH had attended the Health Forum very recently. There had been a gap of three years between receiving the initial feedback and now and JS asked whether there had been any ongoing dialogue in that three year period.	
13.7	ER confirmed that dialogue had taken place and both ER and MH had been regular visitors to the Health Forum where fair challenge had taken place about the length of time taken. The pandemic had been responsible for some of this together with rising building costs and getting the capital scheme secured for the building of the Lydney Health Centre, which had taken considerably longer than envisaged. At the point where this was agreed, the options appraisal was completed.	
13.8	JS asked about the Lydney Primary Care Centre which would be expected to open in Spring 2026 and wondered at the level of confidence around mitigation and management of the level of risks of delivery and also the capital, given the very tight capital plan.	
13.9	MH explained that the project was being led by third party developers due to the shortage of capital and would not come onto the ICB's balance sheet. The agreement had been put in place so unless something untoward were to have an impact on the business case then there was confidence that this would go through.	
13.10	AJa commented that this was one of the most comprehensive options appraisals she had seen and that it was positive. She referenced feedback, which had stated quite clearly that there were worries around the gap between the Cinderford services coming on stream and the GP practices closing and the lack of information in between. AJa wondered what was being planned and whether anything different had been said around assurances and information.	
13.11	ER responded that as some time had now elapsed and the new hospital was now open, the feedback had been acted upon and communications had been improved around the transition. Information for local residents had been acted upon but had been pre-empted by the new hospital having been opened. Pleasingly, ER informed members that feedback on the new hospital had been very positive.	
13.12	JCu recognised the amount of detail having gone into the options appraisal with thought and scrutiny applied to the various options. JCu asked whether there was any evidence of local people being able to access the new hospital and whether some of the concerns that people had initially raised, were being mitigated.	
13.13	ER stated that it was too early to do any actual analysis of the footfall but a number of key stakeholders had been to the new hospital for the opening event, which was attended by the Princess Royal, HRH Princess Anne. A number of people who had taken part in the engagement exercise had been there, with ER having sat with some of them in the new Minor Injuries reception. ER explained that although she could not speak for people, once something had become tangible, there had been an air of excitement and pride in what was a fantastic facility. This would of course not entirely mitigate some of the concerns about travel distances, or people wanting another facility, but there had certainly been some positive comments from some of the stakeholders around supporting the hospital	

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	and being "our hospital for the Forest for the future" which had been really good to hear. It was noted that flows and footfall would be monitored going forward.	
13.14	JCu referenced the amount of diagnostic services that were available and any impact that had and how this had fed into the thinking. ER commented that there had been a positive approach to consolidating services into one hospital from the original two as it had been a struggle to staff the x-ray departments at both the old hospitals and it was a regular occurrence that the departments were often closed due to low footfall.	
13.15	ER herself had experienced this herself, having to make multiple visits between the two hospitals for x-rays and triages for an injury. Consolidation of the services onto one site meant that there were excellent diagnostic facilities and that had resulted in the delivery of a consistent offer from the one new hospital. This had certainly been part of the thinking as historically, records had shown closure of one or other of the old hospitals at particular times.	
13.16	KM queried how close we would be getting to meeting Minor Injury Unit (MIU) national specifications and what the expectations would be. ER reported that there was national guidance around Urgent Treatment Centres that had been in existence for some time now and many areas in the country had moved away from MIUs towards Urgent Treatment Centres (UTCs). The decision was taken not to implement an UTC partly due to medical cover cost implications and primary care implications. Some of the UTC specification was to compensate in areas that did not have such strong primary care as Gloucestershire. It could be the case that a move towards some aspects of that could be taken up, particularly with regard to the diagnostic offer. A gap analysis was recently completed between the MIU offer and the UTC specification, which ER confirmed that she would be happy to share if that were to be of interest to people. If a strategic decision was taken to move towards the UTC model across the county, the ICB would be compromised around delivery on a number of sites, particularly on the smaller sites.	
13.17	The Chair thought a future conversation about local facilities for community hospitals, the best use of facilities and optimising them would be needed but this work would take some time to do and would require proper reflective thought.	
13.18	The Chair commented that transport was right at the heart of the challenges that people faced, particularly in rural communities such as the Forest of Dean and in other places. The Chair asked whether there were opportunities with the partnerships that the ICB had locally, through the relationships with the County Council, District Council and voluntary sector to do something creatively to support people without access to a car.	
13.19	ER explained that Caroline Smith from the Patient Engagement Team had joined the local Transport Forum at the local District Council in the Forest of Dean and all the travel analysis had been fed into this work, which resulted in some modification of bus routes to accommodate the new hospital location. Car ownership was considerably higher in the Forest of Dean than that of many other districts and there were also community transport options being offered by Voluntary, Community and Social Enterprises (VCSE). Urgent Care at Home would be provided by visiting GPs via the Out of Hours service or through the South Western Ambulance Service (SWAST).	
	***Resolution**: The Board:*	

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	1. ***Agreed to proceed with Option 2, to maintain the Forest of Dean Minor Injuries Unit at Cinderford Hospital, which would be delivering a Minor Injuries service for the Forest of Dean District. The ICB would not further progress with developing a local offer in Lydney but had acknowledged all the issues associated with that recommendation;*** 2. ***Noted the new proposed practice development for the Lydney area, which was the next stage in developing the infrastructure for services delivery in the Forest of Dean;*** 3. ***Discussed and had given 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.***	
	Action by ER: To inform the Health Forum in the Forest of Dean of the formal decision of the Board as soon as possible so that they knew, understood and were assured that their concerns had been considered, even though on this occasion, a different decision had been taken by the Board.	
14.	**Committee Updates**	
14.1	**Chair's verbal report from the Audit Committee held on 24th June 2024**	
14.1.1	The meeting had been predominantly focused on the end of year items; the Annual Report, External and Internal Audits and Risk Management which had all been satisfactory and rated Green for assurance. A good discussion was held around risk management and the members heard from the People, Culture and Engagement team on their approach to risk management. The Counter Fraud Annual Report was also covered.	
14.2	**Chair's verbal report on the Primary Care & Direct Commissioning Committee meeting held on 6th June 2024 and approved minutes from 4th February 2024**	
14.2.1	The business case had been approved for the Lydney Health Centre with assurance from the developer on the call. Standard Operating Procedures (SOP) were looked at for practice boundary changes in order to help develop a standard process for these. Tier 2 oral surgery and next steps for procurement were discussed. A SOP for practices requiring financial assistance and the standard process for these was discussed.	
14.3	**Chair's verbal report on the System Quality Committee meeting held on 3rd June 2024 and approved minutes from 3rd April 2024**	
14.3.1	JS covered the meeting on 3rd June as JCu was on leave. A number of items were discussed at the meeting and would be coming back to the Board in due course. Maternity was discussed and would also be revisited. The BAF 4 quality risk on the BAF was updated to reflect partner risks on quality. The quality dashboards for the Acute Trust and GHC were being reviewed. There was a new style Primary Care report which continued to be under development. The End of Life report was still awaited and was not yet complete but would be brought back in due course. The Research Audit and Evaluation Strategy was approved with another report due to be submitted to the System Quality Committee. The Intellectual Property Rights (IPR) policy was approved as well as the Maternity and Neonatal Advocate policy.	

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14.4	**<u>Chair's verbal report on the Resources Committee meeting held June 2024 and approved minutes from 2nd May 2024</u>**	
14.4.1	The May meeting discussed the Strategic Outcomes Framework and the meeting in June discussed the System Resources deep dive workshop taking place in September. The approach for benefits realisation was discussed to ensure that this was a really robust programme and piece of work across the system.	
14.5	**<u>Chair's verbal report on the People Committee held 18th July 2024 and approved minutes from 16th May 2024</u>**	
14.5.1	The July meeting had been uplifting with some great papers with a focus on the work going on around engaging the local community, particularly school leavers in employment. There was some really positive work on T Levels and Apprenticeships with great progress. An inspiring video, *We Want You* had been made in partnership with Cleeve School to help school leavers understand the potential job opportunities across health and social care, which had been made in a clever and engaging way. There had been a discussion around actions of ED&I, specifically on bullying and harassment and whether actions being taken were adequate in the light of the "Too Hot To Handle" report with a separate meeting to follow that up in more detail.	
15.	**<u>Any Other Business</u>**	
	There were no items of any other business to discuss.	
	The meeting concluded at 16.30pm.	

Time and date of next meeting

The next Board meeting will be held on Wednesday 25th September 2024 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)

Agenda Item 4

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

No.	Date Raised	Reference	Owner	Action	Due	Updates	Status
20	31/01/2024	**Min 8.18 P2 beds/EoL/Dying Matters**	**SQC**	SQC to bring back a report on P2 beds/EoL to a future Board meeting.	**November 2024**	**March 2024:** EoL was explained by ER with a number of actions having been undertaken. - see Item 4 in March mins). The Chair recommended that the EoL report when completed should be sent to DE and IB after being presented to the Quality Committee. **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.** **July 2024:** Remains open until presented at Board. **September 2024:** End of Life Care Report and final evaluation is to be reported to System Quality Committee in October. This will then be reported through the SQC minutes in November and discussed in November ICB Board within the agenda. **Action Open.**	**Open**
21	31/01/2024	**Min 10.12 LMNS membership and functionality**	**MCr**	The Chair raised membership of the LMNS noting that new people had joined the ICB and asked that consideration be given if the right people were included and whether more challenge could be built in. This was important to help KM and MC to accomplish future requirements.	**May 2024**	**March 2024** update: The review of the LMNS Board is currently underway following a meeting and advice from the SW perinatal team on 4th March. MC will confirm at the May Board that this had taken place. **May 2024:** Following the further unannounced inspection of maternity services in March 2024 the CNO established a Quality improvement Group as part of the National Quality Board framework of surveillance, to focus . on the top 5/10 priorities including CQC "Must Do" actions and immediate concerns. The review of the LMNS is part of this process but has not yet been completed. **July 2024:** The regional CNO is advising the ICB CNO on this. **Action Open.** **September 2024:**	**Open**
22	31/01/2024	**Min 11.2.1 Migrant Health Report**	**Primary Care Team**	Primary Care Team to bring a detailed report on Migrant Health to a future Board meeting.	**January 2025**	**May 2024:** A detailed paper from the Primary Care Team will be submitted to the September ICB Board on Migrant Health. **July 2024:** A detailed paper from the Primary Care Team will be submitted to the September ICB Board on Migrant Health. **September 2024**: This is to be presented to the SQC in December 2024 and will be brought back to Board in January 2025. **Action Open.**	**Open**

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23	27/03/2024	**Min 8.1 Social Prescribing, CEO report**	**Tracey Cox**	Creative Health Consortium to be placed on a future Agenda for discussion around a Patient Story.	**TBC**	This topic is on the list of patient stories for the Autumn 2024. **July 2024:** Creative Health Consortium is a topic for a patient story in Autumn 2024. To remain open until presented **September 2024:** This is to still be arranged. **Action Open.**	**Open**
24	27/03/2024	**Min 13.2 Interim Procurement Strategy**	**Julie Soutter & Christina Gradowski**	Procurement Strategy - Julie Soutter and CGi to examine the incorporation of procurement items into the Audit Committee ToR. A flowchart to demonstrate where CSU fitted in would also be helpful.	**January 2025**	The ToR will be reviewed, and any changes will be reported and agreed by the Audit Committee in July to submit if required to the ICB Board in September . **July 2024:** Terms of Reference are on the Audit Committee agenda in September. To be brought to Board in September **September 2024:** Updates were made to the TOR and presented in September to the Audit Committee. To go back to the December 2024 Audit Committee with the final version to be presented at the January 2025 ICB Board. **Action Open.**	**Open**
25	29/05/2024	**Min 1.5 - Contaminated Blood Inquiry Report**	**Ryan Brunsdon**	Contaminated Blood Inquiry Report to be placed on a future Board agenda.	**November 2024**	**July 2024:** To be incorporated the Quality Topics item. To remain open until presented. **September 2024:** This item will be covered within the ICB Board away day on 20th November 2024. **Action Open.**	**Open**
26	29/05/2024	**Min 1.6 Countess of Chester case**	**Ryan Brunsdon**	Countess of Chester case to be placed on a future Board agenda.	**November 2024**	**July 2024:** To be incorporated the Quality Topics item. To remain open until presented. **September 2024:** This item will be covered within the ICB Board away day on 20th November 2024. **Action Open.**	**Open**
28	29/05/2024	**Min 7.9 - Dental Access**	**Helen Goodey**	HG to update the Board at a future meeting to evidence ongoing progress around dental access.	**November 2024**	**July 2024:** HG to update the Board at a future meeting to evidence ongoing progress around dental access **September 2024:** This item will be covered within the Chief Executive Report in the November Board. **Action Open**	**Open**
30	29/05/2024	**Min 8.5 Newton Europe Group**	**Ellen Rule**	Working as One/Newton Programme representatives to be invited to a future Board meeting with an update on outstanding issues for system partners.	**September 2024**	**July 2024**: Representatives to be invited to a future Board meeting with an update on outstanding issues for system partners. **Action Open**. **September 2024:** This item was covered during the Working As One Workshop on 25th September. **Action Closed**	**To be Closed**
31	/0 5/ 20	**Min 9.5 - BAF and CRR**	**Tracey Cox & Julie**	TC and JS to bring the Board Assurance Framework and Corporate	**October 2024**	**July 2024:** Planned for October Board Dev Session. Action Open.	**Open**

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			Soutter	Risk Register to a future Board Development session.		September 2024: The BAF and Risk discussion has been planned for the October 2024 Board Development session. **Action Open**	
32	**29/05/2024**	**Min 10.13 - Hospital Mortality Rates report**	**Dr Raghu**	AR to bring a Hospital Mortality Rates report to a future Board meeting.	**TBC**	**July 2024:** AR to bring a Hospital Mortality Rates report to a future Board meeting. **Action Open.** **September 2024:** This item will be covered within the Chief Executive Report in the November Board and reported through the System Quality Committee. **Action Open**	**Open**
34	**31/07/2024**	**Min 7.25 - Interface discussion - secondary and primary care**	**Christina Gradowski**	Interface discussion to be tabled for a future Board Development meeting, date to be confirmed.	**Autumn / winter 2024**	**September 2024:** Interface discussion between primary and secondary are to be tabled for a future Board Development meeting, date to be confirmed.	**Open**
35	**31/07/2024**	**Min 8.1 - CQC Interim Report**	**Marie Crofts**	Interim Report regarding the CQC to be brought back to a future Board meeting. Date to be confirmed.	**November 2024**	**September 2024:** This item will be covered within the Chief Executive Report in the November Board. **Action Open**	**Open**
36	**31/07/2024**	**Min 10.4 - HPV information**	**Siobhan Farmer**	SF to give some further information on the Human Papillomavirus (HPV) vaccine under Matters Arising at the next Board meeting on 25th September 2024.	**September 2024**	**September 2024:** An update will be provided under matters arising. **Action to be closed.**	**To be Closed**
37	**31/07/2024**	**Min 13 - Decision on Lydney Health Services**	**Ellen Rule**	ER to inform the Health Forum in the Forest of Dean of the formal decision of the Board as soon as possible so that they knew, understood, and were assured that their concerns had been considered, even though on this occasion, a different decision had been taken by the Board.	**September 2024**	**September 2024:** The outcome of the decision regarding the Forest of Dean was shared along with the appropriate section of the minutes. **Action closed.**	**To be Closed**

Cancer

Sadaf Haque, Cancer Lead NHS Gloucestershire
Becca Smith, Associate Director Clinical Programmes

25 September 2024

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Part of the One Gloucestershire Integrated Care System (ICS)

Cancer Services across Gloucestershire

- 32,627 suspected cancer referrals from primary care to GHFT 23/24
- 4961 first treatments for cancer at GHFT in 23/24
- 25,498 Systemic Anti-Cancer treatments delivered at GHFT in 2023
- 4405 people used our cancer rehabilitation service at GHC in 23/24
- 11,823 people in Gloucestershire were living with or beyond a cancer diagnosis in 2021

- The majority of cancer diagnoses are in those 65 and over
- The population of over 65s is due to increase by 52.5% in Gloucestershire between 2018-2043
  - Expect approx. 38.5% increase in cancer diagnoses in over 65s between 2023 and 2043

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Context

National expectations

- 75% earlier diagnosis by 2028 (stage 1 and 2)
- 77% faster diagnosis - diagnosed/given an all clear within 28 days of referral
- 75% treatment within 62 days of referral
- Personalised care for all

- Our Integrated Care Strategy is built around 3 pillars, reflecting our commitment to prevention and community / neighbourhood-based care. This presentation describes our collective contribution to improving cancer services across these three pillars.

1. Making Gloucestershire a better place for the future	2. Transforming what we do	3. Improving health and care services today
1. Support more people to be diagnosed earlier for cancer 2. Improve the number of eligible patients attending invitation for cancer screening 3. Raise awareness of cancer signs and symptoms though public engagement events	1. Empowering people to live well and self-manage conditions 2. Improving access to our services for all communities 3. Reduce the number of patients diagnosed with cancer following an emergency admission	1. Maintain high numbers of people being diagnosed/given an all clear within 28 days of referral 2. Increase the number of people receiving treatment within 62 days of referral 3. Deliver quality follow up and surveillance (for potential reoccurrence and management of treatment related side effects)

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1. Making Gloucestershire a better place in future

1.1 Support more people to be diagnosed earlier for cancer (cancers diagnosed at stages 1-2)

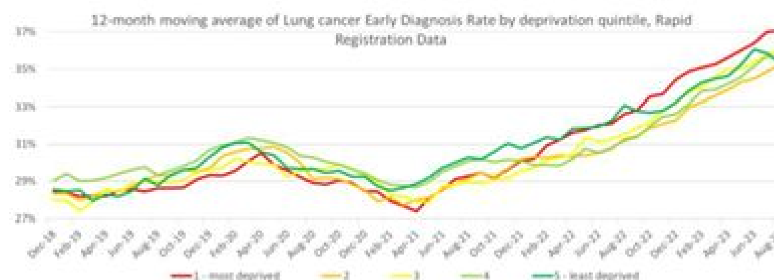
53.1% patients diagnosed with cancer at stage 1 and 2 in Gloucestershire compared to 55.2% nationally (23/24). Our worst performance is in lung, oesophageal and haematology

We are supporting improvement by:

- Supporting GPs – education on signs and symptoms with clear referral criteria
  - funding and support for locally led improvement projects targeted at local needs
- Improving rates of attendance at liver and inflammatory bowel disease surveillance using a patient navigator to understand why patients don't attend and to provide bespoke support
- Testing innovations in oesophageal cancer such as a sponge that can be swallowed to collect samples
- Implementing genomic testing so that people and their families at high risk can have frequent checks
- Improving public knowledge of cancer signs and symptoms and preventative skin care

- Rolling out targeted lung health checks (TLHC)
  - This new screening program offers people with a history of smoking a scan to detect cancer before symptoms appear
  - Over 80% cancers diagnosed at stages 1 and 2 so far in Somerset, Wiltshire and Bristol
  - Diagnoses other diseases such as emphysema and heart disease

TLHC is reversing health inequity



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1. Making Gloucestershire a better place in future

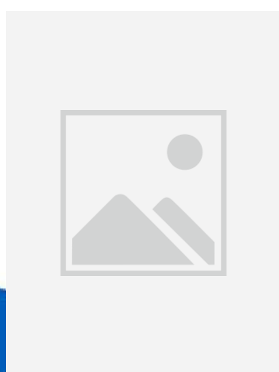
1.2 Improve the number of eligible patients attending invitation for cancer screening

Of the eligible Gloucestershire population there is 76.4% uptake of bowel screening (target 60%), 71.6% uptake of breast screening (target 70%) and 73.1% uptake cervical screening for 25-49s and 77.4% uptake of cervical screening for 50-64s (target 80%). All have increased over the last 2 years.

Deprivation, is a large driver of poor bowel and cervical screening uptake, this is especially true in cervical screening in the younger 25-29 cohort where screening uptake is 28.5% lower in the most deprived population than the least deprived.

We are supporting improvement by:

- Running a campaign of engagement events and comms materials, examples include:
- Cervical Screening talk with Afghan refugees including info on HPV vaccine
- Bowel screening bus tour of our most deprived communities
- Bowel Screening Film with 10 languages launched 10th May 2024
- Breast screeners talk at Friendship Café with Indian women
- Bowel screening advice with Nepalese soldiers at Imjin Bks – Increase from 29% to 89% in 12 months



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1. Making Gloucestershire a better place in future

1.3 Raise awareness of cancer signs and symptoms though public engagement events

Approximately 1 in 5 people delay visiting their GP with symptoms that could indicate cancer

To improve peoples' awareness of signs and symptoms we are:

- Delivering a campaign of awareness events – county wide and with local communities
- Delivering a campaign of communications via multiple media types
- Working with communities to design services more accessible to them
- Working with patients and public to jointly design every project we do and every service we develop

- Recently we have delivered:
  - Skin cancer awareness at a farmers market
  - Bowel cancer awareness in our most deprived areas and at Imjin Bks with Nepalese soldiers
  - Breast cancer awareness with Afghan Refugees, African Caribbean, Indian and Inner City Glos communities
  - Funded primary care to run awareness sessions relevant to their local population e.g TWNS Prostate Facebook Live, Hadwen Health & WellBeing Event, Rosebank Cancer Awareness Day.
  - Had a stand at Festivals of the World Event

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2. Transforming what we do

2.1 Empowering people to live well and self-manage conditions

Cancer survival has doubled in the last 50 years, in 2021 there were 11,823 people living with, or beyond, cancer in Gloucestershire

We are supporting improvement by:

- Working with communities – increasing awareness of our services including local support groups, voluntary sector offers
- Running advice and awareness sessions with the Macmillan hub and local services
- Developing a package of advice for returning to the workplace to support employers and employees
- Piloting supported self management for people living with cancer using digital platforms
- Piloting a late effects service for those with long term impacts of radiotherapy treatment
- Expanding rehabilitation service, Macmillan Next Steps, running sessions at community centers, gyms and GP practices all over the county

- Piloting a prehabilitation service
  - Dieticians, pyschologists and physiotherapists
  - Reduced post-op complications
  - Reduced admissions, emergency presentations and calls to the emergency helpline
  - Increased days alive out of hospital

Patient feedback for late effects service

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2. Transforming what we do

2.2 Improving access to our services for all communities

We know that many factors about our services and communities influence how easy it is for a person to visit us. These factors ultimately make it more likely for some groups of people to be diagnosed late with cancer

We are supporting improvement by:

- Using population health data to prioritise groups with poor cancer outcomes and deliver a targeted approach
- Co-designing all projects, evaluations and business cases with service users, relatives and carers
- Using HEAT tool when evaluating services to ensure consideration of multiple dimensions of Health Inequalities
- Implementing changes to IT systems to enable the right support for patients with learning disabilities to be booked in advance reducing the time it takes for them to receive a diagnosis
- Providing cervical screening opportunities for NHS staff at work and providing bespoke support for patients with severe mental illnesses and learning disabilities to access breast and cervical screening
- Used Patient Led Interviews to support culturally competent engagement events & reduce fear and stigma of a cancer diagnosis
    - Introduced patient-led interviews to hear stories and insights of cancer diagnosis from the different communities
    - Used insights to run engagement events for healthcare providers and community leaders to listen to patients' concerns and experiences
    - Increase in community trust and willingness to discuss cancer
    - Developed culturally sensitive materials and shared widely
    - Increase in breast and cervical screening in these community groups

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2. Transforming what we do

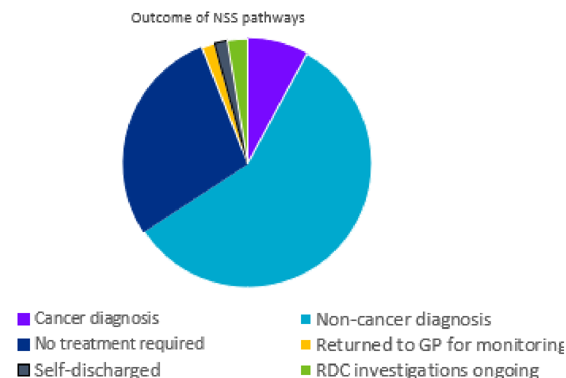
2.3 Reduce the number of patients diagnosed with cancer following an emergency admission

Latest data showed that in 22/23 497 people were diagnosed with cancer following an emergency admission

We are supporting improvement by:

- Commissioning a new data review to explore diagnosis following emergency admission against a range of factors. We aim to work with communities on solutions
- Improving public awareness of signs and symptoms
- Providing education and data to primary care to aid local understanding and identify actions

- We opened a new referral service for people with worrying symptoms not specific to one type of cancer – the non-site-specific symptom (NSS) pathway
    - Dedicated pathway with coordinated diagnostics
    - High diagnosis rate of non-cancer causes
    - High diagnosis rate for cancers that are rare or difficult to detect – 56%
    - Better patient experience



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3. Improving health and care services today

3.1 Maintain high numbers of people being diagnosed/given an all clear within 28 days of referral

76.5% patients were diagnosed/given an all clear within 28 days of referral in July. On target to meet 77% by March 2025 but not uniformly across all specialties

We are supporting improvement by:

- GP education and direct access to diagnostic tests supporting faster triage to the right clinic
- Teledermatology pilot – education and use of dermatoscopes in primary care plus review of all referrals by medical photography ensures all skin referrals can be triaged to the correct clinic using an image
- Implementing nurse led models to support access to faster diagnostic tests in colorectal, gynaecology and urology
- Funding a series of projects in pathology to increase speed of sample processing and reporting
- Lung cancer clinic moved to the community diagnostic centre co-locating CT scanners for a one stop shop
- Conducting a detailed review of prostate pathway to identify opportunities to improve time to diagnosis

- FIT testing – simple home test, positive result supports referral into endoscopy.
    - Referral process supports access straight to diagnostic test – funded extra nurses
    - Avoids unnecessary diagnostics
    - 24/25 performance of 76.3%
    - Provides opportunities to triage to different diagnostic tests

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3. Improving health and care services today

3.2 Increase the number of people receiving treatment within 62 days of referral

67.2% of patients were treated within 62 days of referral so far in 24/25, over half of the total breaches of the 62-day target occurring in the Urology pathway (72/121 breaches)

We are supporting improvement by:

- Providing extra capacity to address the backlog of patients waiting longer than 62 days
- Implementing nurse led models for prostate biopsy and cancer diagnosis clinics releasing consultant capacity as well as reviewing theatre usage models to increase capacity
- Developing self-management pathways for urology patients on long term hormone and radiotherapy
- Funded increased workforce delivering systemic anti-cancer therapy to meet increased demand and deliver new therapies
- Funding extra resource in pre-op assessment to allow review and action to decrease time to surgery
- Implementing genomic testing across cancer pathways so that the right treatment can be selected for the patients type of cancer
- Implementing the new national Accend staff training program providing improved career pathway and education to support staff retention in nursing and Allied Health Professional roles
- Implementing Blueprism, a Robotic Process Automation to 'intelligently' automate manual, time-intensive, and repetitive tasks releasing administrative staff to expedite next steps on patient pathways and support patients along their cancer journey
- Participating in a regional data project to identify areas of variation where quality of care can be improved and best practice shared

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Priorities going forward

Early intervention and improved outcomes

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

Transforming what we do

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

Improving services

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

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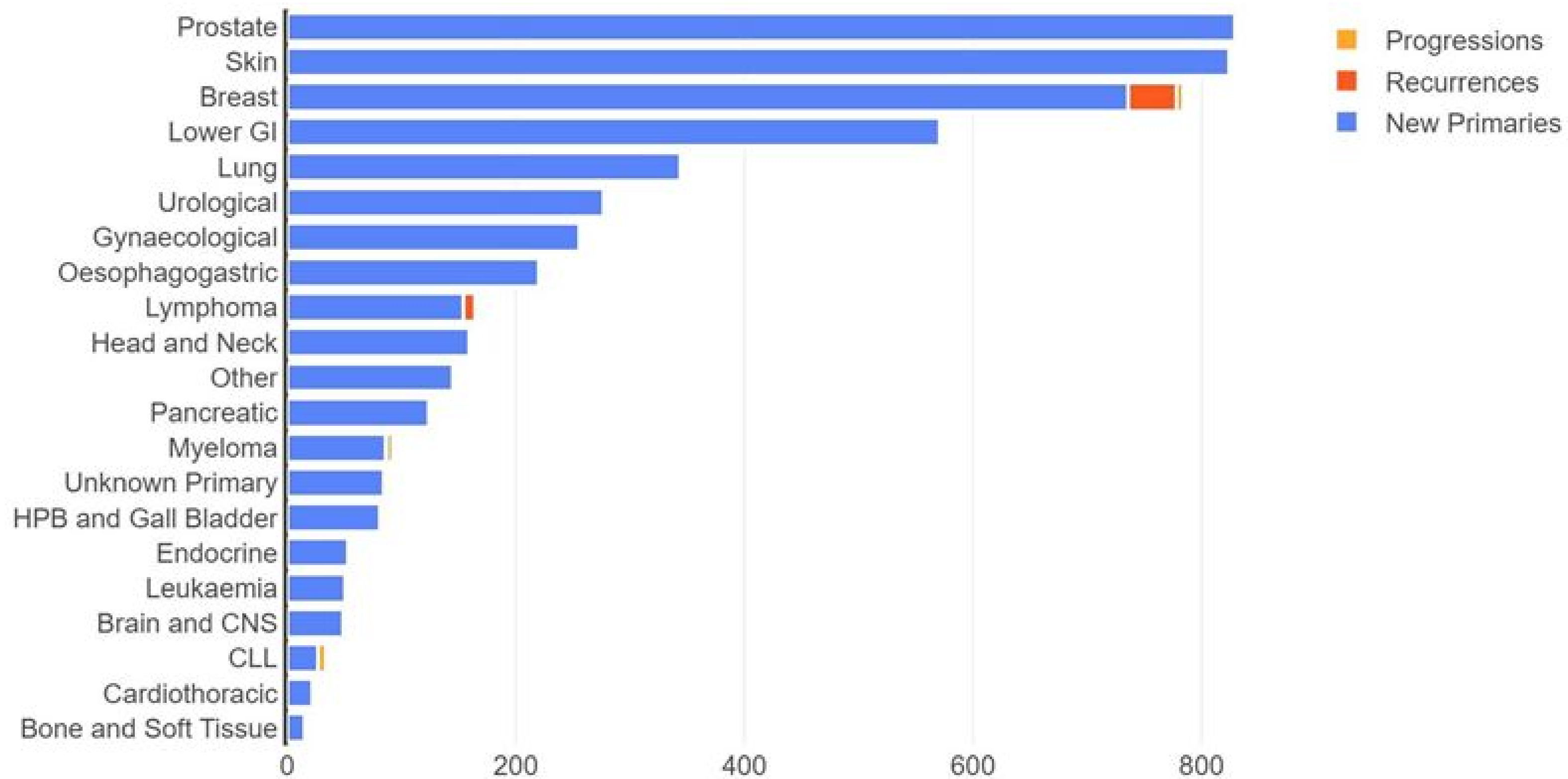
Appendix

Cancer diagnoses by type in Gloucestershire 2023/24



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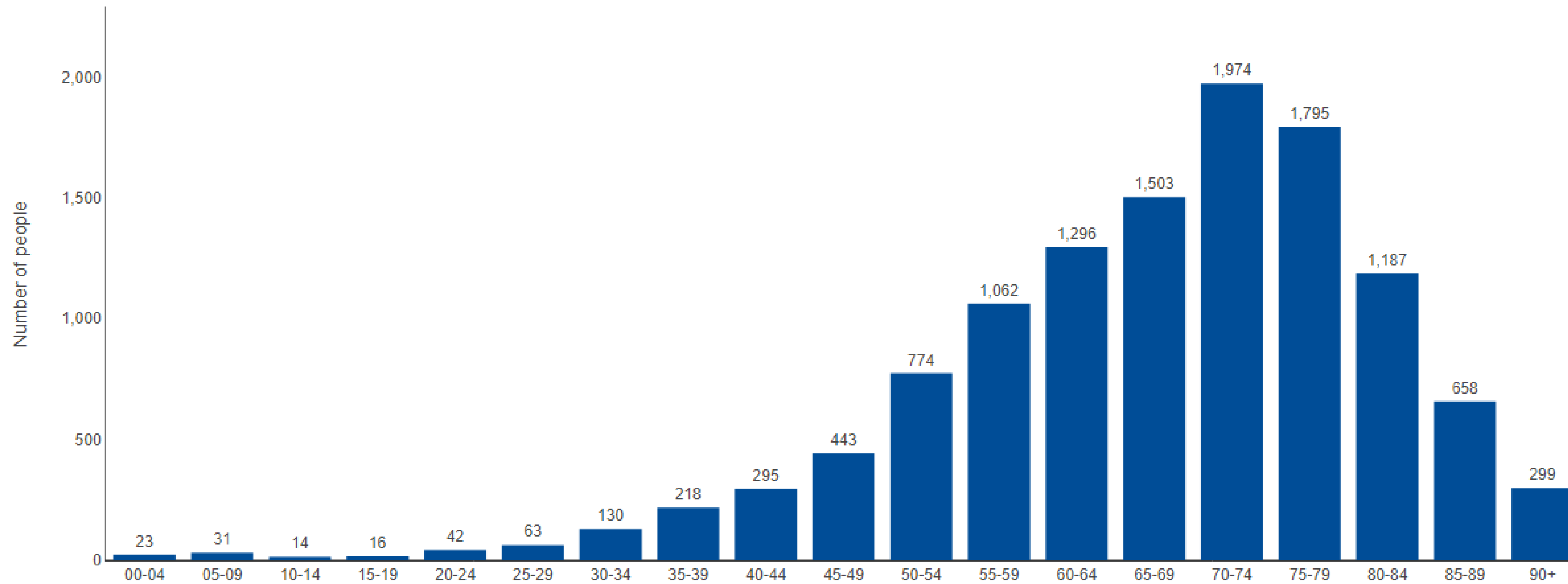
Number of people living with and beyond a cancer diagnosis by age group in Gloucestershire - 2021



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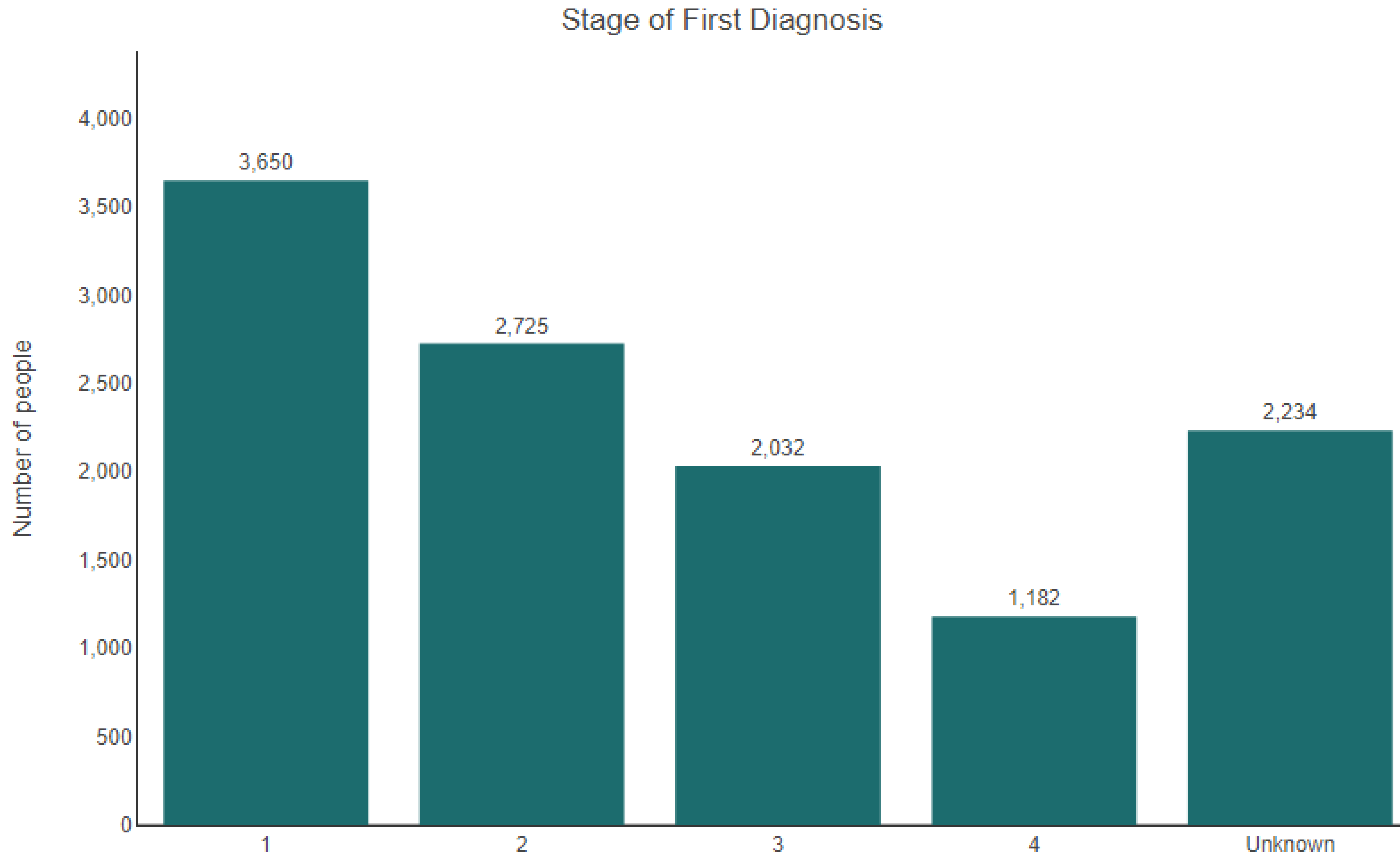
Number of people diagnosed at each stage in Gloucestershire - 2021



Stage 1 and 2 diagnosis 54% against a target of 75% by 2028

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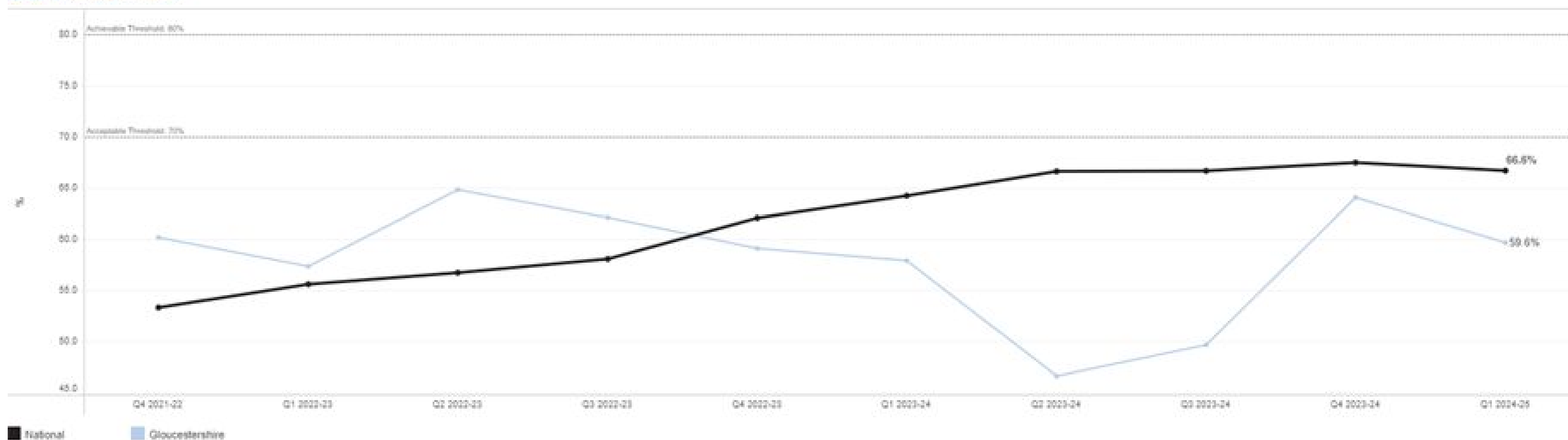
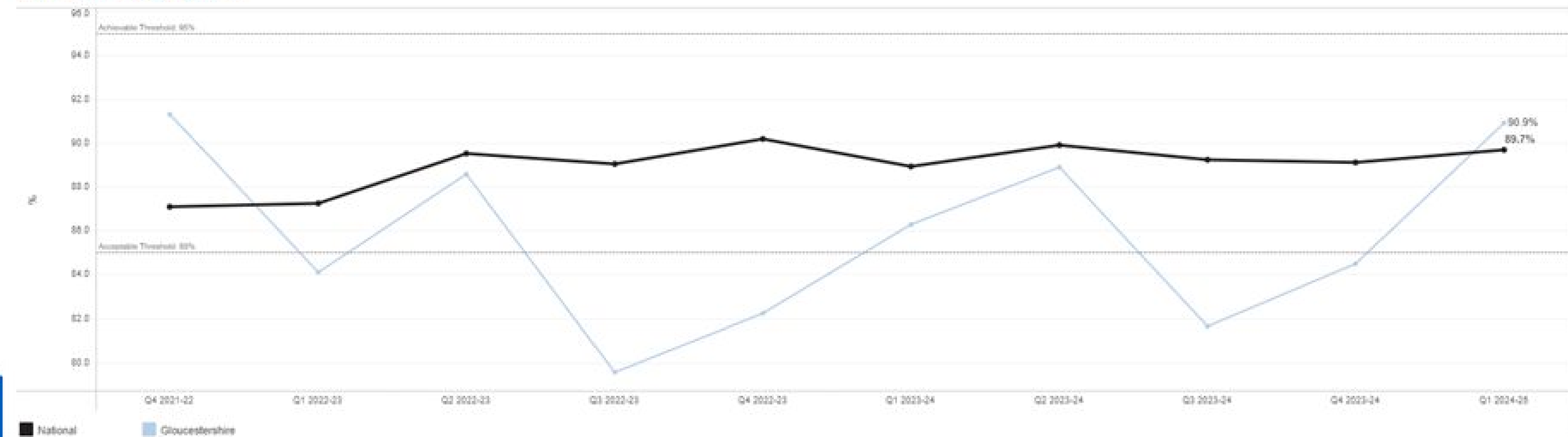
Uptake of routine and very high-risk breast screening

S03a: Uptake (routine)



S03b: Uptake (very high risk)



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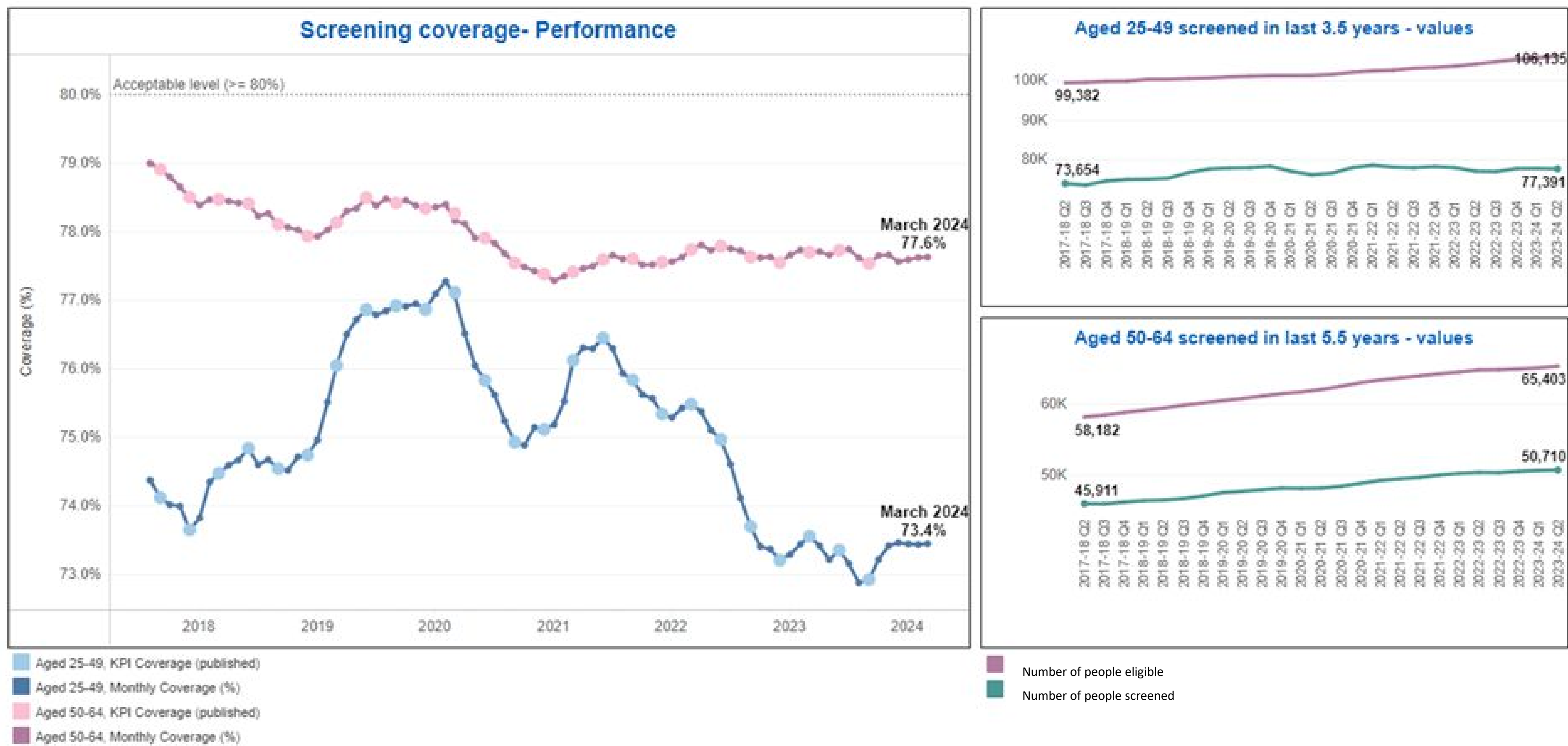
Cervical screening uptake by age group



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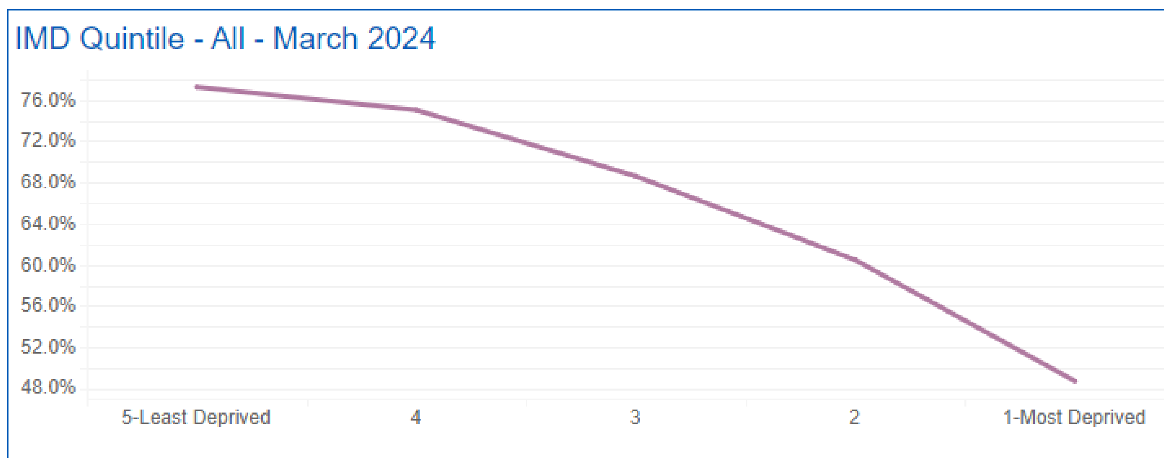
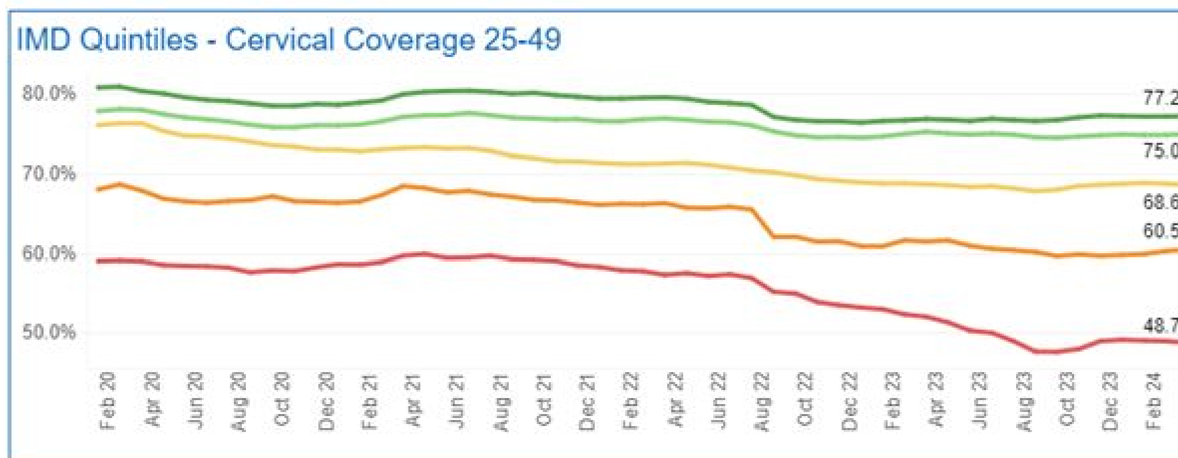
Percentage uptake of cervical screening uptake in Gloucestershire by deprivation



Uptake of cervical screening in Gloucestershire by deprivation in people aged 25-49



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Bowel screening uptake across Gloucestershire

Bowel screening coverage by age group across Gloucestershire

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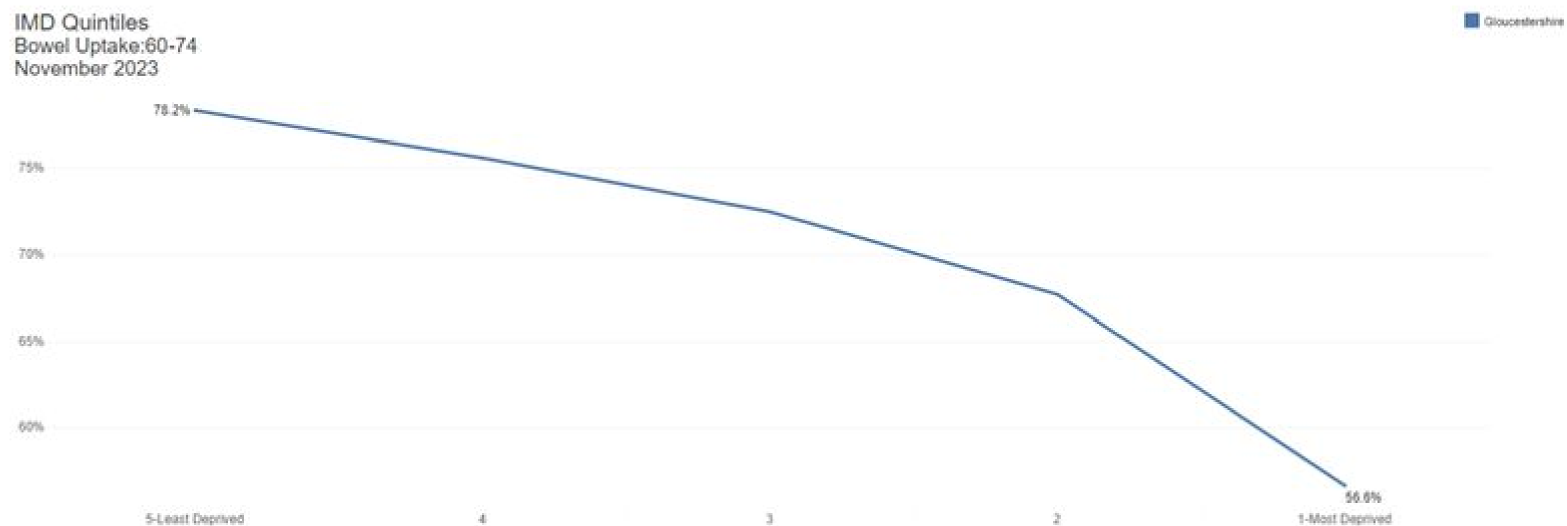
Percentage uptake of bowel screening uptake in Gloucestershire by deprivation



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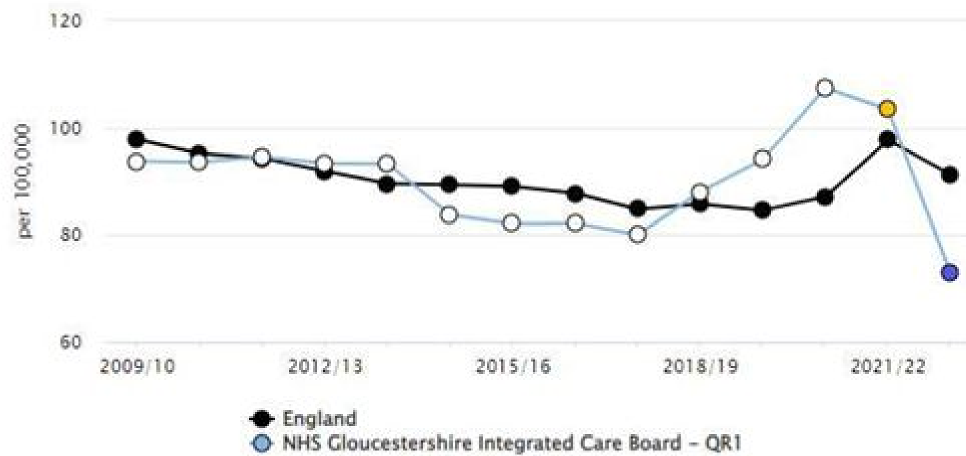
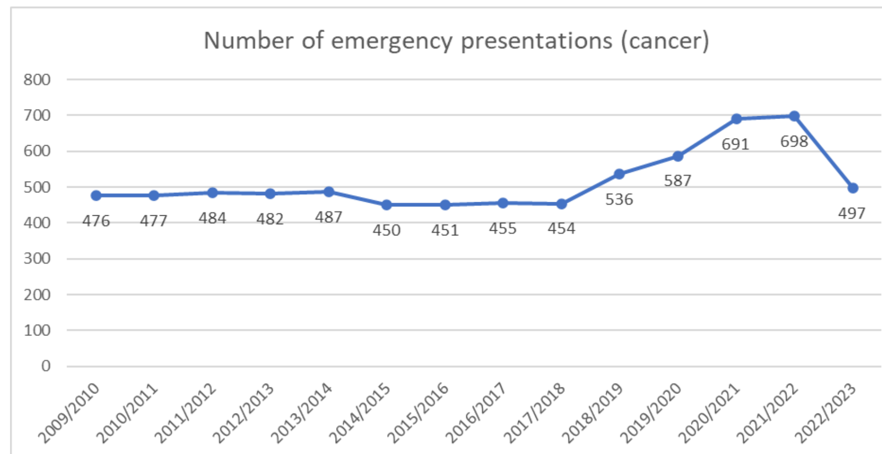
Rate of emergency diagnosis of cancer per 100,000 population in Gloucestershire



Number of emergency diagnosis of cancer per 100,000 population in Gloucestershire



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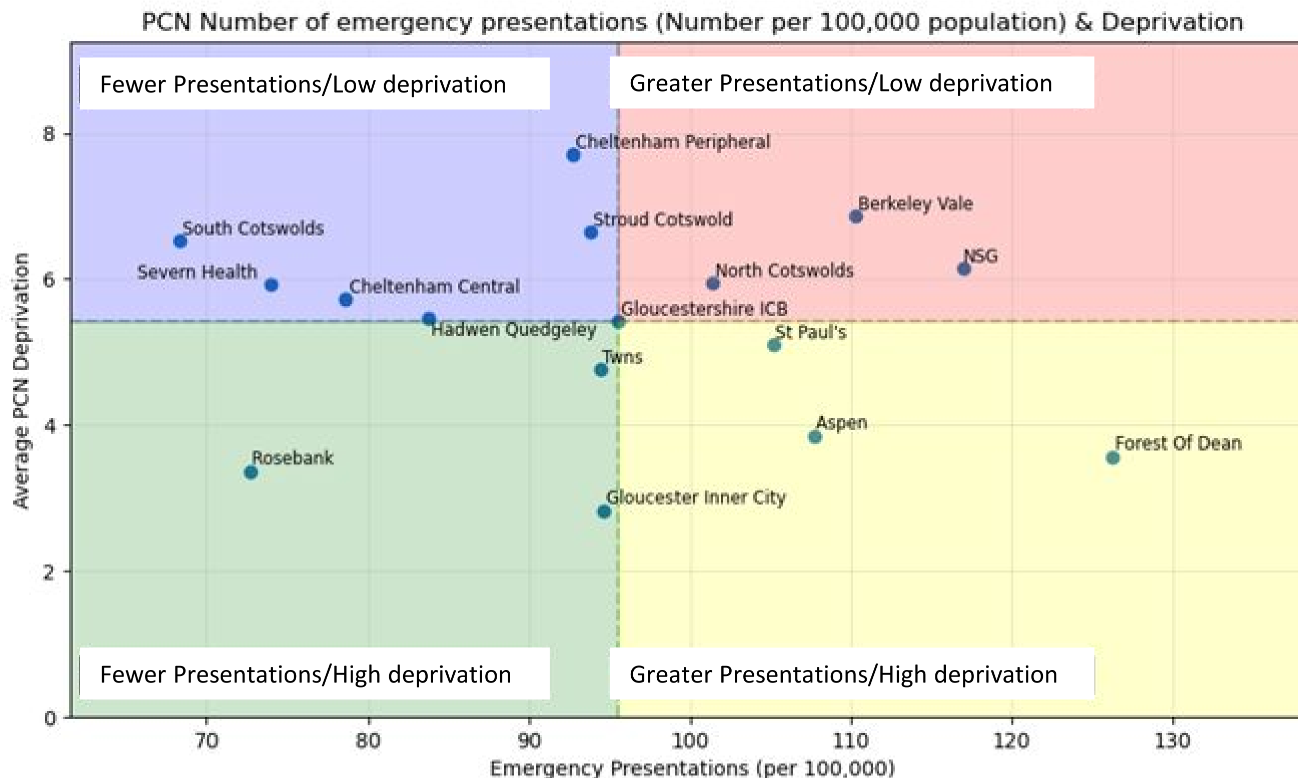
Emergency Presentations of cancer per 100,000 (Performance & Deprivation) by PCN in Gloucestershire - 2021



- Differences in age, types of cancer diagnosis etc will also influence performance against this measure and need to be considered. For example PCNs with low numbers of people aged 65+ would expect a lower number of presentations by any route.
- Age data is on the following slide for comparison

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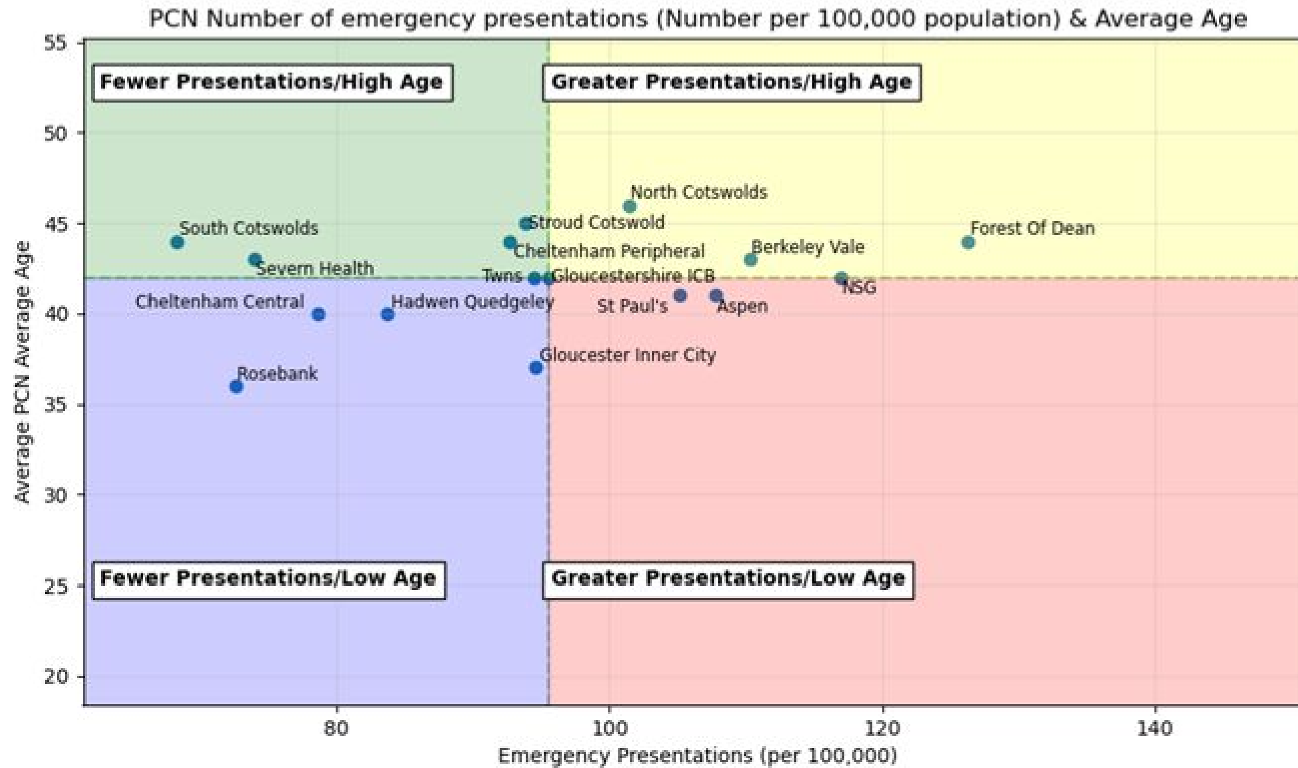
Emergency Presentations of cancer per 100,000 (Performance & Age) by PCN in Gloucestershire - 2021



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Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 25th September 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: • **National General Practice Pilot, Chair and CEO Urgent Action September 2024** • **Collective Action Update** • **Patient Safety and Quality of Care in Pressurised Services** • **Blood Pressure Checks – know your numbers**				
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				

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

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

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Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 25th September 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. National GP Pilot

2.1 Gloucestershire ICB is one of seven ICBs selected as a national test site to pilot and helped to inform the national conversation around developing a sustainable model for general practice into the future, and how to create a clearer path to achieve this by offering a better future for practices, staff and patients. The pilot is looking to understand the current gaps in information around; demand and resource capacity against 2028/29 levels, workload across five core functions of general practice (On-the-day demand, LTC management, population health management, screening and immunisations & care for complex cohorts) and understanding the funding gap associated with this. As well as understanding how additional clinical staffing combined with other positive actions and interventions within a quality improvement (QI) approach could help close any gap. The outputs of the Programme and learning will be used to inform both ICB and national strategies.

2.2 Following the national process; expressions of interest were sought from Gloucestershire Primary Care Networks (PCNs) by 1st July and national application forms to participate were completed and submitted by the 12th July.
Two PCNs submitted applications:

- Rosebank PCN
- Cheltenham Central PCN

2.3 The applications were marked against a nationally pre-defined criteria and scores were taken to a National Review Panel held in London with NHSE and the other six ICBs by the Deputy Director of Primary Care & Place, to agree final test site selection for the pilot, with two PCN Test Sites per ICB to be selected (15-20 nationally, covering over a 1 million population size).

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2.4 Rosebank PCN & Cheltenham Central PCN were approved by the National Review Panel as the two PCN Test Sites for Gloucestershire ICB. Nationally written successful outcome letters and section 96 applications have been sent to the two PCNs for signature. The two PCNs have returned signed copies of their section 96 agreements.

2.5 The Programme takes a 'before and after' approach to identify benchmarks and be indicative around the impact of interventions. A baseline will be established between October 2024 and January 2025 before the PCN Test Sites implement an initial set of interventions including additional clinical staff in line with the NHS Long Term Workforce Plan for 2028/29. The Programme will study the changes resulting from these initial interventions and look to make further improvements through a clinically led QI approach run by the GIRFT Academy. The choice of additional interventions will be determined by the PCN Test Sites and ICBs in response to the QI insight that is generated.

Baselines:

The Programme will begin by establishing a clear data baseline to underpin the 'before and after' approach. ICBs, PCN Test Sites and the NHSE team will all play a role in generating the required baseline data, which includes:

- **Primary Care Commissioning Baseline** – variations in direct and indirect spend on primary care medical services to understand the impact on overall general practice income, capacity and workload.

- **Baselining Audit Weeks** – PCN Test Sites will conduct three separate audit weeks of intensive data collection at the practice and PCN level.

- **System Performance Data** – data on the activity of other system partners, for example 111 calls, A&E attendance and Pharmacy First usage and requests of those partners through referral activity (data is already collected and will be included in PCN Test Site dashboards).

- **PCN and Practice Cost Audit –** PCN Test Sites will share data on the total income and costs for the PCN and each practice, and the proportion focused on GMS/PMS/APMS and PCN DES delivery.

- **Patient Experience Survey** – NHSE have commissioned the ONS to boost the uptake of the 'Health Insights Survey' in PCN Test Site areas to help us understand the impact of interventions on patient experience.

- **Staff Satisfaction Pulse Check** – NHSE will coordinate a short and simple pulse check to understand the impact of interventions on staff satisfaction.

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2.6 **Initial Interventions to Accelerate to '2028/29' & QI Sessions:**

Once a robust baseline is established, PCN Test Sites will be accelerated to '2028/29', using five types of initial interventions, with specific actions to be agreed by the PCN Test Sites and ICB:

1. **Optimising key aspects from Primary Care Access and Recovery Plan (PCARP)**
   - Expanding the uptake of the NHS App and Pharmacy First
   - Improving communication to patients about the primary care workforce and digital channels
   - Ways to reduce the workload, clinical and administrative, across the primary-secondary care interface.

2. **Advancing Modern General Practice beyond PCARP**
   - Implement digital methods for risk stratification and repetitive process automation tools to reduce administrative workload and better utilise resource.

3. **Enhancing proactive population health management (PHM)**
   - Implement agreed key actions for effective PHM, such as identifying patient searches for case or medication reviews (e.g. CQC searches, CVDPREVENT reviews, frequent fliers).

4. **Define and apply best practices for MDTs for complex cohorts**
   - With input from national clinical directors, define and measure the impact of MDTs for complex cohorts by 2025/26.

5. **Increasing clinical capacity**
   - Funding to increase clinical capacity as outlined in the Long-Term Workforce Plan (LTWP) for 2028/29 (approximately a 10% increase).

2.7 These initial interventions will be co-developed with ICBs and PCN Test Sites in parallel to the baselining exercise and discussed at workshops in November and December 2024. QI meetings will occur approximately monthly from October 2024, alternating between all-day face-to-face and half day Teams meetings.

2.8 **2025/26 and 2026/27:**

At the close of 2025/26, ICBs within the pilot will need to choose to either continue the evaluation or withdraw participation payment for 2026/27, based on programme-level review of learnings to date. Capacity funding for 2026/27 will be adjusted to reflect any capacity increases via core contract funding, to ensure selected PCNs continue to test the '28/29 model'. The programme will close at the end of March 2027 and programme

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payments will stop. NHSE has advised they will work with ICBs to manage any remaining capacity gap, when contract uplifts from now to April 2027 will be known. The programme will close at the end of March 2027.

2.9 **Governance and sign off by the ICB Board (Chair and CEO action)**

2.10 NHSE has advised this is the first programme to be run as a genuine partnership between ICBs and NHSE, with governance designed by NHSE to fit into existing ICB and NHSE reporting structures. NHSE has produced a national delivery plan for the pilot, which outlines the following governance for the programme with decision-making taking place at three levels:

1. **Programme Direction and Strategic Choices**
    - Responsibility: NHSE and the ICBs programme sponsors.
    - Decisions: Overall programme direction and managing key risks (e.g. an ICB exiting the programme).
    - Leaders: NHSE National Director for Primary Care and Community Services, and the ICB's programme sponsor (CEO of NHS Suffolk and North East Essex ICB).
    - Accountability: Both leaders share responsibility for keeping the NHS Chief Executive and NHSE Board updated as requested.

2. **Operational Programme Delivery (including Funding)**
    - Responsibility: ICB Group.
    - Decisions: Group PCN Test Site participation issues, data and insight generation, interventions selection, QI topics selection and managing operational risks.
    - Leaders: ICB Chief Executive convenor
    - Accountability: ICB Chief Executives have the responsibility to update their ICB Boards as aligns with local governance protocols.

2.11 The participation in the Pilot has been discussed internally at the Operational Executive meeting on 25th June 2024, and at the Primary Care & Direct Commissioning Committee on 5th August 2024 with their support this has been taken forward for the Chair and CEO to consider and make a decision.

2.12 **Urgent Decision on the part of the Chair and Chief Executive Officer**
ICBs taking part in this pilot are required to obtain the approval of the ICB Board and sign the Delivery Plan for the pilot, however due to the pilot commencing in mid September with the launch event taking place on 18th September prior to the ICB Board meeting, the Chair and CEO took an urgent decision on behalf of the ICB Board to approve the pilot and therefore sign the pilot plan. This urgent decision by the Chair and CEO is in line with the ICB's Standing Orders s.4.9.5 and s.4.9.6. In line with the SOs the exercise of these powers should be reported to the ICB Board at its next meeting (i.e. 25th September 2024) for formal ratification and the subsequent Audit Committee for oversight (i.e. December

2024). Further information on the pilot is available including the Delivery Plan for the Pilot to board members.

3. GP Collective Action

3.1 In July 2024 the British Medical Association (BMA) balloted its GP contractor/partner members to seek support for 'collective action' that may stop or reduce certain work. Collective Action is not the same as industrial action and does not require a formal notification period, nor is it confined to specific dates. During Collective Action, practices are still required to fulfil their contracted opening hours, appointments, care and advice, prescriptions, long term condition management, vaccinations, diagnoses and referrals, and continuity of care.

3.2 The BMA published 10 possible/recommended (but not mandated) actions for practices to consider taking, broadly grouped as:

i. Working within stricter operational parameters
ii. Restrict digital and information sharing
iii. Defer improvement and transformation decisions and activities

3.3 A weekly Task and Finish Group of system partners has been established with PMO programme and Communications team support. This group reviews risks, mitigations and management actions, monitors activity trend information, and ensures ongoing collaborative conversations and open lines of communication between all partners. This approach provides a robust management approach in the context that our collective priority is the safest possible patient care during the period in which the BMA and the government work to a solution.

3.4 There are potential financial risks for the system, notably increasing UEC workforce costs beyond plan; non-achievement of Elective Recovery Fund plans; slippage on planned returns on investment; overall reduced achievement of in-year savings against plan.

3.5 The ICB Primary Care team continue to work closely with the Local Medical Committee (LMC) to ensure clarity and ongoing excellent relationships, and decisions so far have been pragmatic and constructive. The LMC has surveyed practices to gain understanding on which actions will be taken by whom. Through August and early September there were no significant impacts of Collective Action, although this is anticipated to change through Autumn should practices start implementing the BMA actions.

3.6 The Task and Finish Group will report regularly to ICB Operational Executive, and to Strategic Executive and Primary Care and Direct Commissioning Committee

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4.1 **Patient Safety and Quality of Care in Pressurised Services**

4.1 On 26th June 2024 NHSE wrote to all ICB's, NHS Trust's and Local Authority's to ask for a renewed focus on maintaining the safety and quality of people accessing pressurised services across the unscheduled care pathway. The letter asks all organisations to provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence. There are required actions aimed at maximising in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds taking place regularly throughout the day, and timely discharge, regardless of the 'pathway' on which a patient is leaving hospital or a community bedded facility.

4.2 NHSE outlined a number of actions for all Integrated care systems to take through partner collaboration. Through our Working as One Programme we are addressing these actions alongside our commitment to deliver the NHSE Urgent and Emergency care year 2 recovery plan and meet our operational planning requirements. Our 2023/24 ICS Winter Debrief was targeted at reviewing the lessons learnt from winter and our system response through the lens of reducing harm, by reducing any unnecessary care delays. We took a 'patient and people based' approach to reviewing our pathways and considered our ability to manage high levels of demand across acute and community urgent care. The key outputs from this will inform our winter plans this year and the ongoing strategic transformation of our urgent care services, ensuring that we align safety and quality with operational performance and service delivery.

4.3 In addition to our focus on improving safety within the urgent care pathways it has also been noted that the Standardised Hospital-Level Mortality Indicator (SHMI), for Gloucestershire Hospitals, currently at 1.158, has been above the expected limits for six consecutive months. This is a 12-month rolling average with the last full dataset covering the period April 2023 - March 2024. Based on National Quality Board (NQB) guidance, as a system we will now move to 'Enhanced Surveillance'.

4.4 Gloucestershire ICB is working closely with Gloucestershire Hospitals trust colleagues to oversee a number of actions to improve. These include looking at the quality and depth of coding and improving clinical pathways. Our immediate aim is to bring SHMI inside control levels, with a medium-term aim to get it down to 1 and below. Due to the retrospective nature of this indicator being measured, it is important to note that there will be a considerable time lag before improvements begin to show in our data reports. System oversight is through the system quality processes, and this issue remains on the Board assurance framework risk register. External peer review and support will be from NHSE Southwest and regional colleagues.

One Gloucestershire
Transforming Care, Transforming Communities

NHS Gloucestershire

5. Check your blood pressure – know your numbers

5.1 The NHS in Gloucestershire supported Know Your Numbers Week, an annual campaign led by charity Blood Pressure UK, with a series of health check drop-in events where people got their blood pressure checked.

5.2 One Gloucestershire's Information Bus and the Outreach Vaccination and Health Team was out and about every day from Monday 2 September to Sunday 8 September at locations across the county. People dropped-in for a blood pressure check and a chat with members of the team about how to make positive changes to their health or wellbeing such as stopping smoking, improving diet and increasing exercise as well as advice on where to get further support if needed.

5.3 High blood pressure is a major cause of heart attacks and stroke. Around one in three adults have high blood pressure, but many do not realise it because it often doesn't have any symptoms until it's too late. This is why the week organised by the NHS across Gloucestershire was so important as there were opportunities for members of the public and NHS staff to take time out of their busy lives to check their blood pressure and then start to make healthier lifestyle changes and / or take medication to help bring down their blood pressure. In Gloucestershire, the Outreach Vaccination and Health Team have given more than 1,250 BP checks at drop-in health check events over the last year, with around 150 people referred to their GP for further support.

6. Recommendation

6.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 25th September 2024

<table>
<tr><td>Report Title</td><td colspan="4">Board Assurance Framework</td></tr>
<tr><td>Purpose (X)</td><td>For Information</td><td colspan="2">For Discussion
X</td><td>For Decision</td></tr>
<tr><td>Route to this meeting</td><td colspan="4">Risks are reviewed by Directorates and Executives each month.

ICB Internal | Date | System Partner | Date
ICB Operational Executive | 17/09/2024 | Strategic Executive | 19/09/2024</td></tr>
<tr><td>Executive Summary</td><td colspan="4">The BAF was refreshed earlier in the year with the risks aligned to the three pillars, the strategic objectives and priorities for 2024/25. For each of the sub-committees of the ICB
• System Quality Committee
• Resources Committee
• People Committee
• Primary Care & Direct Commissioning Committee
a cut of the BAF risk and corporate risks related to that committee are included in the committee papers at each meeting. The discussion on those risks appears early in the agenda to set the frame and tone and to ensure that the committee cross checks the risks being discussed at the committee meeting with those that appear on the CRR and BAF.

Where modifications need to be made to the risks following the committee meeting these are followed up after the meeting and incorporated within the BAF and CRR. It should be noted that the Audit Committee receives the full BAF and CRR at each of its meeting and provides feedback on the risks, including the controls, assurances and action plans.</td></tr>
<tr><td>Key issues</td><td colspan="4">Since the last board meeting all the risks on the BAF have been reviewed and updated. Each strategic risk has an up to date Director’s report which provides detail on progress that has been made. None of the strategic risks have been risk rated higher or lower than the July report. Risk ratings remain the same. It should be noted that BAF 6 has been substantially updated to reflect the current situation with GP collective action.</td></tr>
<tr><td>Key Risks:
Original Risk (CxL)
Residual Risk (CxL)</td><td colspan="4">The risk associated with not reporting risks is that key issues may not be identified and/or discussed at committee and board level.
(4x3) 12
(4x2) 8</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">There have been no conflicts of interest in producing this report. If there are conflicts of interest identified, they should be managed in line with the Standards of Business Conduct Policy.</td></tr>
<tr><td></td><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
</table>

Resource Impact (X)	**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 • note the report			
Author	**Christina Gradowski**	**Role Title**	**Associate Director of Corporate Affairs**	
Sponsoring Director (if not author)	**Tracey Cox, Director of People, Culture and Engagement**			

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

Strategic Risks – Board Assurance Framework

September 2024 Summary

Pillars	ID	Entry Date	Strategic Risk	Last Updated	Lead	Original Score (IxL)	Current Score (IxL)	Target Risk (IxL)	Committee	Note
1: Making Gloucestershire a better place for the future	**Strategic Objective 1:** *Increase prevention and tackle the wider determinants of health and care.* **Strategic Objective 3:** *Achieve equity in outcomes, experience, and access.*									
	BAF 1	13/11/23	The failure to promote and embed initiatives on health inequalities and prevention.	17/09/2024	Director of Op. Planning & Perf.	**12** (4x3)	**12** (4x3)	**8** (4x2)	Resources ICP System Quality	*Current score unchanged.*
2: Transforming what we do	**Strategic Objective 2:** *Take a community and locality focused approach to the delivery of care.*									
	BAF 2	14/11/23	The risk is that our delivery structures are unable to drive the acceleration required on community and locality transformation. This is also impacted by limited capacity to drive the change.	16/09/2024	Director of Primary Care & Place	**12** (4x3)	**12** (4x3)	**4** (4x1)	System Quality	*Current score unchanged.*
	Strategic Objective 4: *Create a One Workforce for One Gloucestershire.*									
	BAF 3a	01/11/22	Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan.	17/09/2024	Director of People, Culture & Engagement	**16** (4x4)	**20** (5x4)	**5** (5x1)	People	*Next review at People Committee* *17/10/24*
	BAF 3b	15/02/24	Equality, Diversity, and Inclusion: There is a risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse, and engaging culture for staff we employ.	17/09/2024	Director of People, Culture & Engagement	**12** (4x3)	**12** (4x3)	**4** (4x1)	People	*Next review at People Committee 17/10/24*
	Strategic Objective 5: *Improve quality and outcomes across the whole person journey.*									
	BAF 4	07/11/23	The risk is that the ICB fails to assure safe and effective care delivery and identify opportunities to improve quality and outcomes across the system for patients.	16/09/24	CNO & CMO	**15** (5x3)	**16** (4x4)	**4** (4x1)	System Quality	Current score unchanged
3: Improving health and care services today	**Strategic Objective 6:** *Address the current challenges we face today in the delivery of health and care.*									
	BAF 5	13/11/23	Risk that the ICB fails to deliver and/or sustain performance and improvement in Urgent and Emergency Care.	17/09/24	Deputy CEO / Director of Strategy & Transf.	**20** (5x4)	**12** (4x3)	**8** (4x2)	Resources	*Current score unchanged.*

##

	BAF 6	15/11/23	Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures.	17/09/24	Director of Primary Care & Place	**16** (4x4)	**20** (5x4)	**5** (5x1)	PCDC	*Current score unchanged.*
	BAF 7	01/11/22	Failing to deliver increased productivity requirements to meet both backlogs and growing demand.	17/09/2024	Director of Operational Planning & Perf.	**12** (4x4)	**16** (4x4)	**4** (4x1)	Resources System Quality	*Current score unchanged*
	BAF 8	01/11/22	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes.	13/09/24	Director of Integration	**12** (4x3)	**12** (4x3)	**4** (4x1)	People	*Current score unchanged.*
	BAF 9	01/11/22	Insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity.	12/09/2024	Chief Finance Officer (CFO)	**16** (4x4)	**16** (4x4)	**8** (4x2)	Audit Resources	*Current score unchanged.*
	BAF 10	30/01/23	The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling deliver of high-quality care.	12/09/2024	Chief Finance Officer (CFO)	**16** (4x4)	**16** (4x4)	**8** (4x2)	Audit Resources	*Current score unchanged.*
	BAF 11	01/11/22	EPRR - Failure to meet the minimum occupational standards for EPRR and Business Continuity.	17/09/2024	Chief Nursing Officer (CNO)	**12** (4x3)	**16** (4x4)	**4** (4x1)	System Quality Audit	*Current score unchanged.*
	BAF 12	15/02/24	Failure to detect Cyber Security threats and attacks which could result in serious consequences for operating the business of the ICS.	17/09//24	Chief Clinical Information Officer	**20** (5x4)	**20** (5x4)	**10** (5x2)	Audit	*Current score unchanged.*

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

Key Changes since July 2024 report

1	Health Inequalities risk has been reviewed with **significant update to the Director's report.**
2	Community and locality transformation risk has been reviewed. There are updates to the controls and assurances. The actions have been updated and correspond with the Director's update.
3A	People and Culture risk has been reviewed, the actions and Director's report have been updated. The BAF risk will be **reviewed at the People Committee on 17th October 2024.**
3B	Equality, Diversity, and Inclusion has been reviewed actions and Director's Report updated. The BAF risk will be **reviewed at the People Committee on 17th October 2024**
4	Quality Risk has been reappraised by the Chief Nursing Officer. **The Director's Report has been updated.**

##

5	Urgent and Emergency Care risk, **this risk has been reviewed and remains unchanged for this report; there is a Working as One workshop on 25th September 2024.**
6	Primary Care risk had been rearticulated. The risk remains at a score of 20 in light of collective action **so the cause / impact narrative has been enhanced, there is more detail on the controls, assurances and actions as well as an updated Director's report.**
7	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 September report **significant updates to the controls, assurances, gaps in assurance and action plan have been made. The Director's report has been updated.**
8	Mental Health services This risk has been reviewed by the Mental Health Team and **there are no changes to be made for the September Report**.
9	Financial Sustainability risk: this has been reviewed and the actions and Director's report has been updated. **The risk has been reviewed there are updates to the actions and Director's report and the risk scoring remains unchanged since the March report..**
10	Estates Infrastructure risk this has been reviewed and the actions and Director's report has been updated. **The risk has been reviewed there are updates to the actions and Director's report and the risk scoring remains unchanged since the March report.**
11	EPRR is included as the ICB is a Category 1 Responder. This risk has been reviewed and a comprehensive Director's update included. **This risk has been updated see Director's report and the scoring remains unchanged at this point in time.**
12	Cyber Security risk has been reviewed and **there is more detail about the cause and impact, updates made to the controls, assurances and a Director's report.**

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

##

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

Entry date:	13/11/23	**Last updated:**	17/09/2024
Owner:	Mark Walkingshaw, Director of Operational Planning and Performance		
Committee	ICP, Resources, System Quality		
Aligned with System Partner Risk(s):	**GHC Risk ID 2** *There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population, potentially reinforcing health inequalities.* **(Red 12) May 2024**		
Aligned with ICB Risk(s):	PCE 02:		

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

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

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

Key Priorities 23/24: *Continue to increase the focus on prevention for health and care – for people of all ages; Work with wider partners and communities to enable people to take an active role in their own health and care.*

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

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

Due to:	Impact:
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.	Can result in earlier health deterioration, higher incidence of frailty, greater burden of mental and physical health conditions and ultimately higher mortality - all associated with greater cost to the individual, society and the health and social care system.

Current Controls *(to mitigate risk):*

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

Known Gaps in Controls

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

Current Assurances *(of controls effectivity):*

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

Known Gaps in Assurances

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

##

7. Health Inequalities annual statement – reviewing the status of specified metrics as defined by NHSE.
8. Organisational level self-assessment and peer review tool.
9. ED&I Insights Manager ensures feedback and experiences of seldom heard communities informs service development & delivery.
10. Commitment to patient participation in all workstreams.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. 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	1. The Health Inequalities Framework for the ICS is now being developed by all system partners, to identify key priorities for work on health inequalities at organisational level for the next 12 months. This will set the parameters for the aligned reporting template to enable partners to report the work that they are doing in relation to the framework, allowing us to track outcomes and guide priorities. This will be summarised at the November 2024 board meeting. 2. The Gloucestershire Statement on Health Inequalities has been presented at several system and internal meetings to raise awareness, and a development meeting in in pace for the 25th September to agree priorities and next steps with Public Health and system BI colleagues. 3. The ICS Health Inequalities Intelligence Group is being reconvened to work collaboratively to build the intelligence around health inequalities across the system and ensure a coordinated approach to health inequalities analysis – dates are being circulated with system partners. 4. intern supporting the Health Inequalities team has reviewed the national Major Conditions Strategy and identified areas of focus for Gloucestershire, including specific review of Spirometry access and inequalities associated with this in line with recommendations for respiratory associated conditions. 5. Specific focus on Gloucester Inner City in underway as Targeted Lung Health checks are rolled out – this will include support for patients with incidental findings in addition to those identified as having suspected cancer funding has now been agreed through the s256 joint funded monies to support targeting health inequalities 6. Focus on the Darzi review and findings associated with Health Inequalities will be a focus as we commence the 2025/26 operational planning round. We are currently liaising with programmes to ensure the health inequalities focus in the operational plan is up to date and covers all planned work for the next financial year.

Relevant Key Performance Indicators
Health inequalities narrative and system outcome measures to be included in bi-monthly integrated performance report
Performance against NHS constitutional targets (e.g., RTT, Cancer Wait times, Diagnostic access, UEC waiting and response times.)
Joint Forward Plan metrics.

##

NHSE Statement on Inequalities – system annual reporting

##

BAF 2	**Risk that delivery structures are unable to drive the acceleration required on community and locality transformation, this is also impacted by limited capacity to drive the change.**

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

Pillar 2: *Transforming what we do.*

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

Key Priorities 23/24: *Continue to support improvements in outcomes for people at every stage of life – delivering care that is closer to home and person-centred*

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

Due to:

Multiple and competing demands to transform services, couple with increased demand for services and challenges in recruitment and retention. Delivery requires prioritisation across GHC and primary care as well as GCC teams to ensure progress is delivered in 24/25.

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.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Neighbourhood Transformation Steering Group in place to oversee the transformation of care at neighbourhood level, integration of health & care workforce and the introduction of new models of care. **2.** UEC prevention workstream adopting a population health approach to support those at greatest need and risk of deterioration. **3.** Working with BI colleagues to understand our cohorts. **4.** Supported by 24/25 PCN Network Contract Specification - *A PCN must contribute to the delivery of multi-disciplinary proactive care for complex patients at greatest risk of deterioration and hospital admission, by risk stratifying patients and offering care in accordance with the guidance. This must be done as part of INTs, with the aim of reducing avoidable exacerbations of ill health, improving quality of care and patient experience, and reducing unnecessary hospital admission.* Pg43.	**1.** Data quality and data sharing between ICS organisations may limit the ability to identify health inequalities with confidence. **2.** Sufficient change management resource to deliver sustainable change across the ICS in the timeframe required. **3.** Permission & time for operational staff to actively engage.	**1.** Reporting through the Gloucestershire Neighbourhood Transformation Steering Group (GNTG). **2.** Ongoing monitoring.	**1.** Further development of the performance and benefits realisation trajectories required. **2.** Outcome measures to be reviewed at The Gloucestershire Neighbourhood Transformation Steering Group on 18th September.

##

5. All PCNs/Neighbourhoods included within the programme.			

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

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

##

BAF 3a	Risk of failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan.

Entry date:	01/11/22	Last updated:	17/09/24
Owner:	Tracey Cox, Director of People, Culture and Engagement		
Committee	People		
Aligned with System Partner Risk(s):	**GHFT SR16:** *Inability to attract and recruit a compassionate, skilful, and sustainable workforce* ***(risk rating 20, Sept 24)*** **GHC ID3:** *There is a risk that we fail to recruit, retain, and plan for a sustainable workforce to deliver services in line with our strategic objectives* **(Red 16) May 2024** **GHC ID12:** *There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target* ***(risk rating 9, May 24).***		

Pillar 2: *Transforming what we do.*	
Strategic Objective 4: *Create a One Workforce for One Gloucestershire.*	
Key Priorities 23/24: *Increase staff retention, provide good training and development opportunities of our One Gloucestershire workforce and build an inclusive and compassionate culture.*	
Aligned with ICB Risk(s):	**PCE 02:** *Social work placement assessment* **PCE 05:** *CPD/WFD funding* **PCE 15:** *System wide AP strategy without enabling infrastructure as ICS AP Lead Role secondment ends Dec 24* **PCE 22:** *Leadership Development Support* **PCE28:** *Industrial Action*

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

Due to:	Impact:
High levels of vacancies across key staffing groups.	Increased pressure on existing staff, impacting staff morale and wellbeing, and impacting on bank and agency targets for 2024-25.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Utilisation of all available resources from NHSE monies for Continuing Professional Development and leadership development to support staff training & development. 2. Some leadership learning and development programmes in place. 3. People Promise Leads in both Trusts focusing on all aspects of People Promise elements and best practice. 4. System level delivery plans focusing on agreed priority areas for action in 24/25 for each Steering Group	1. Lack of an adequately defined and resourced system-wide and medium-term plan for staff relating to leadership development (Mapping of current leadership development approaches and offers completed the ICS, options for future being developed).	1. Reporting to the People Board, People Committee, and the Board of the ICB. 2. On-going monitoring of progress on key workforce metrics through Integrated Performance Report.	1. Implementation details relating to supporting delivery of NHS Workforce Plan. 2. Reduced funding for workforce transformation and remaining uncertainty relating to 2024/25 funding (e.g., CPD funding) and mechanisms to sustain targeted work.

##

5. Robust organisational plans in place for EDI, retention and temporary staffing spend reduction. **6.** Colleague Communications & Engagement. **7.** System-wide careers and engagement team (2-year FTC) focused on promoting careers in health and care.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. People Promise Leads and work programmes in both GHFT and GHC. **2.** System wide EDI actions focusing on 3 areas, data, anti-discrimination & recruitment/career progression. **3.** Collective focus on agency and temporary staffing spends in response to revised 3.2% target for 2024/25, zero off-framework usage from July 2024 and no revenue non-clinical agency usage from April 2024. **4.** On-going recruitment activities at organisational level e.g. GHFT's Workforce Sustainability programme aimed at transforming it's recruitment process. Roll out of system wide recruitment promotion campaign 'Be in Gloucestershire'. **5.** Draft health and L&D 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). **2.** ICS Temporary staffing group in place to bring shared system oversight and sharing of initiatives and best practice. Agency spend remains within agreed cap of 3.2%. **3.** Recruitment: We Want You project team has transitioned into a new service arrangement with the commencement of two system careers engagement officers. **4.** HWB strategy approved by People Committee. Regional conversations to establish housing hub ongoing and local recruitment of Housing Officer role underway, Homeshare element continues to be provided (by Age UK). **5.** Discussion on future priorities for System wide leadership development at Strategic Executive on 18th September 2024. Next leadership event planned for 23rd October

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

##

BAF 3b

ED&I: Risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse, and engaging culture for staff we employ.

Entry date:	**01/11/22**	**Last updated:**	**17/09/24**
Owner:	**Tracey Cox, Director of People, Culture and Engagement**		
Committee	**People**		
Aligned with System Partner Risk(s):	**GHFT SR17** *Inability to attract a skilful, compassionate workforce that is representative of the communities we serve, (Culture & Retention.)* **(Risk rating 20, Sept 24)** **GHC ID4** *There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment.* **(Risk rating 9, May 24)**		

Pillar 2: *Transforming what we do.*

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

Key Priorities 23/24: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

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

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

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.

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

Actions to Mitigate Risk & Implementation Dates	**Directors Updates on Actions to Date (Updated Quarterly)**
1. One Glos People Strategy priority and commitment to ED&I. **2.** All NHS partners engaged in Equality Delivery System framework.	**1.** Regional focus on 90 challenge for greater diversity in senior nursing roles, with three projects: a. Talent management (Gloucestershire lead) b. Appraisal / career conversation (BSW lead) c. Application and recruitment process (Cornwall lead)

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3. Action planning in response to 6 high impact actions in national EDI Improvement Plan.
4. System wide commitment to support agenda prioritising:
    a. Data collation and presentation,
    b. anti-discrimination policy and practice &
    c. recruitment/career progression.

Relaunch of SW Regional EDI work programme and action plan being developed with nominated CEO/HRD leads.

2. Inclusive recruitment workshop held with all partners on 1 August, areas of good practice shared and gaps in inclusive processes explored along with collaboration opportunities.
3. Clear and tangible actions being developed as part of 2024 work programme based on national EDI improvement plan and WRES/WDES analysis.
4. 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.
5. EDS2 discussions relating to preparatory work for 2024-25 requirements initiated. ICB will refresh its EDI web based information in line with Public Sector Equality Duty requirements by end of September.
6. Individual organisational level action plans progressing focusing on anti-discrimination approaches and reporting of incidents.

Relevant Key Performance Indicators
Workforce Race Equality Standard report (metrics on % of BME staff employed, according to pay band, chance of shortlisting for jobs, entering the disciplinary process and staff survey WRES metrics
Workforce Disability Equality Standard report (metrics on % of Disabled staff employed, according to pay band, chance of shortlisting for jobs, entering the disciplinary process and staff survey WDES metrics).
Gender Pay Audit – gender pay gap includes data on pay gap (mean and median hourly rates).
Racial Disparity Ratios and Staff Survey results for each organization.

##

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

Entry date:	07/11/23	**Last updated:**	17/07/24
Owner:	Marie Crofts, Chief Nursing Officer & Ananthakrishnan Raghuram, Chief Medical Officer		
Committee	System Quality		
Aligned with System Partner Risk(s):	**GHFT SR2** *Failure to implement the quality governance framework.* **(Risk rating 16)** **GHFT SR 5** *Failure to implement effective improvement approaches as a core part of change management (risk rating 16)* *GHFT SR1 Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System.* **(Risk rating 25)** **GHC ID 1** *There is a risk that failure to: (i) monitor & meet consistent quality standards for care and support; (ii) address variability across quality standards; (iii) embed learning when things go wrong; (iv) ensure continuous learning and improvement, (v) ensure the appropriate timings of interventions*. **(Risk rating 12) May 2024**		

Pillar 2: *Transforming what we do.*	
Strategic Objective 5: *Improve quality and outcomes across the whole person journey.*	
Key Priorities 23/24: *Increase support for people living with major health conditions – shifting to a more preventative approach and earlier diagnosis.*	
Aligned with ICB Risk(s):	**Integration 13:** *Midwifery Staffing Levels.* **Integration 15:** *Antenatal Screening* **Integration 28:** CQC *community & mental health inspection reports* **Integration 30:** *Paediatric Palliative Care Support at Home* **Integration 31:** *Children's Continuing Care staffing availability impacting on timely assessment and meeting statutory duty.* **Integration 32:** *Post Partum & Massive Obstetric Haemorrhage* **Integration 34:** *Antenatal Scanning capacity*

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

Due to:	Impact:
Lack of robust oversight and intelligence to ensure high quality care is delivered by organisations.	Patients and citizens will be potentially put at risk of harm or suboptimal outcomes and have a poor experience if providers are unable to deliver high quality care.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput **2.** Reporting from and attendance at Provider Quality Committee. **3.** Learning from Case Reviews. **4.** System Quality Group.	**1.** New PSIRF will turn on the previously mentioned Patient Safety System Group. **2.** Colleagues leading the work on the System Safety, Effectiveness and Experience groups will be meeting to ensure new groups are aligned. **3.** Until groups are in place and functional existing control methods will continue as a risk mitigation.	**1.** Reporting to the System Quality Committee. **2.** Quality Assurance discussions. **3.** Intelligence gathering through data relating to all aspects of quality. **4.** Contract Management Boards. **5.** Regulatory reviews.	**1.** There are gaps in some of the controls as stated and while there is a sound governance system in place for oversight, we will not have full assurances until we assess if the controls around PSIRF and alignment of groups (System Safety, Effectiveness and Experience groups) are working.

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

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. NHSE supporting with development of the System Effectiveness Group by highlighting good practice from other systems. **2.** System Safety and Learning Group to be instigate by 31st December. **3.** PSIRF to be ratified by Quality Committee in February 2024. Continued focus on personalised care training across the system. **4.** Established Quality and clinical gov internal ICB group – first meeting 30th May 2024. TOR to triangulate data drafted.	**1.** PSIRF now in place although early days of new approach. Some enhanced measures and reporting in place, beyond PSIRF oversight, with maternity services owing to the level of surveillance and concerns **2.** Internal ICB Quality and Clinical Gov group to bring together triangulated data more formally across the system to promote learning and ensure focus support on challenged areas. First meeting has taken place and TOR drafted. **3.** **System Mortality**: The national ONS/NHSE data tool, shows that the Standardised Hospital-Level Mortality Indicator (SHMI), for Gloucestershire Hospitals, currently at 1.158, has been above the expected limits for six consecutive months. This is a 12-month rolling average with the last full national mortality tool data covering the period April 2023 - March 2024. Based on National Quality Board (NQB) guidance, we will now move to 'Enhanced Surveillance' led by Gloucestershire ICB with support from NHSE Southwest and regional colleagues. The ICB is overseeing a number of actions looking at improving quality of depth of coding and improving clinical pathways. Our immediate aim is to bring SHMI inside of control levels, with a medium-term aim to get it down to 1 and below. Due to its retrospective nature, there will be a time lag before improvements begin to show. ICB oversight is through the System Quality processes and mortality remains on the Board assurance framework risk register. **4.** Quality Improvement Group (QIG) remain in place for maternity services and currently subject to enhanced surveillance owing to Section 31 notice. **5.** Significant challenges within UEC and GHFT risk rated at 25.

Relevant Key Performance Indicators
Summary Hospital-Level Mortality Indicator (SHMI)
NHS staff survey safety culture theme score.
Percentage of patients describing their overall experience of making a GP appointment as Good.
National Patient Safety Alerts not declared complete by deadline.
Consistency of reporting patient safety incidents.

##

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

Entry date:	13/11/23	**Last updated:**	17/09/24
Owner:	Ellen Rule, Deputy CEO and Director of Strategy and Transformation		
Committee	Resources		
Aligned with System Partner Risk(s):	**GHFT SR1** *Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System.* **GHFT SR5** *Failure to implement effective improvement approaches as a core part of change management.*		

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

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

Key Priorities 23/24: *Support improvements in the delivery of urgent and emergency care.*

Aligned with ICB Risk(s):	**U&EC 1:** *Risk of insufficient access to alternative pathways to ED* **U&EC 3:** *Workforce & Delivery Priorities* **U&EC 6:** *Risk of failure to meet core UEC performance metrics. Risk of failure to meet National Ambulance Response times, Risk of non-delivery of reduction in hospital length of stay & Risk of failure to meet National targets for UEC waits: Emergency Department (ED) and Ambulance Handovers [UEC ED Flow])* **U&EC 4:** *Risk of insufficient system Resilience*

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

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

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

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5. Use of demand and capacity funding, additional capacity funding, discharge and BCF funds to deliver improvements within UEC system flow.
6. Newton diagnostic completed to inform design and opportunities of long-term strategic transformation programme.
7. System wide operating plan to align with Transformation priorities for 2023/24.
8. Agreed UEC Transformation Programme in place including Working as One across all system partners.
9. Annual Winter Plan to be developed and in place to communicate to patients about where to access services during winter.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Transformation Workstreams continue to deliver priority trials at pace to agreed schedule, all workstreams to have completed a trial by December 2023, with further iterations of trials through first half of 2024 dependant on learning (Action adapted to account for PDSA / Trial methodology). **2.** Benefits realisation being developed, Programme metrics to be finalised by December 2023. **3.** Communication and Engagement plan developed, core narrative and supporting materials to be shared in November 2023 (action to remain open). **4.** Improvement trials targeted to areas where performance improvements are needed (ongoing action with regular review at UEC CPG).	**1.** All workstreams have a trial mobilised or are in further iterations of trials (as at July 2024) Hospital Flow workstream is progressing into sustain phase with LOS reductions seen, whilst continuing to consider where further improvement cycles could support. **2.** Programme metrics for Working as One are in place. Workstream measures have been developed. Action remains open whilst quality and outcome measures are refined, alongside automated reporting. Automated reporting has been developed, under review prior to roll out across the system **3.** In line with the target date of November 2023 Working as One communications and engagement plan in place and core narrative shared and regular bulletins are distributed across the system. Action remains open whilst we continue to explore the impact of comms material and how we can increase reach. A Working as One Workshop will be held on 25th September inviting system partners. **4.** Integrated Hub went live on 19th February (4-week trial) to improve hospital flow and reduce no criteria to reside. Options Appraisal for continuation to be considered at August Exec Programme Board. **5.** Audit of Ward 6A completed in GHFT to understand ambulance handover delays to create an improvement plan. Plan on Page agreed by system and shared with regional NHSE, SWASFT and ICB colleagues as part of SWASFT contract arrangements. **6.** Implemented schemes through winter support resilience and reduce reliance on beds.

Relevant Key Performance Indicators

IPR Reporting for Acute, Winter monitoring and Ambulance Metrics.

##

BAF 6	**Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures.**

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

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

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

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

Key Priorities 23/24: *Support a resilient and accessible primary care for the public and increasing workforce recruitment and retention.*

Due to:

Practices are facing new financial challenges due to the increase in costs associated with staffing, energy, goods and supplies as well as a significant increase in patient demand due to the changing nature of general practice, therefore impacting increasing workloads.

Practices are increasingly unable to afford to replace staff and are having to consider ways to reduce costs at a time when they are holding more risk due to extended wait times for secondary care.

There is also a general concern regarding workforce resilience and retention across all roles within primary care and estates constraints to delivery. 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.

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

Note that there is a new risk for Community Pharmacies, who are also experiencing cost of living pressures similar to general practice but also due to drug shortages and pricing. Community Pharmacy Action planned for a day w/c 16th September 2024, although community pharmacies will remain open.

Impact:

These challenges could result in practices facing serious financial hardship with potential contract hand backs and foreclosure of loans on premises. If GPs are made bankrupt, they are unable to hold a medical services contract, therefore the local population could have no contract holder for medical services or premises to operate from, leading to significant instability.

This is also impacting on delivery of services with waiting times increasing for patients to see primary care professionals, poor morale, and hence higher turnover of staff. There is also a wider risk to the system of increased demand on other services if primary care is unable to deliver core services due to complete saturation or through taking steps to manage down capacity or through collective action, this will also have an impact on patient care and experience.

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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Primary Care Team continues to provide on-going support to practices, to identify mitigations and provide resilience funding where appropriate.	**1.** Details on the level of industrial action to determine which areas of work/system this will impact.	**2.** The Primary Care Operational Group receives regular reports on practice resilience and the schemes and initiatives to	**1.** Volume of shared care and additional ‘discretionary’ activity, are both

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

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

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

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

Relevant Key Performance Indicators

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

##

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

Entry date:	**01/11/22**	**Last updated:**	**17/09/2024**
Owner:	**Mark Walkingshaw, Director of Operational Planning and Performance**		
Committee	**System Quality, Resources**		
Aligned with System Partner Risk(s):	**GHC 3** *There is a risk of demand for services beyond planned and commissioned capacity.*		
Aligned with ICB Risk(s):			

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

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

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

Key Priorities 23/24: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

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.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Clinical validation and prioritisation of system waiting lists plus regular contact with patients to notify them of delays and what to do if clinical condition changes. Elective waiting list prioritised with P codes. **2.** Weekly check and challenge meetings in place at GHFT to focus on longest waits by specialty and instigate immediate remedial actions. **3.** Elective care hub undertaking patient level contact, validation, and link to social prescribers as well as escalation of any patients with a worsening condition to the relevant specialty.	**1.** Stratification of waiting list based on other health and socioeconomic factors under development. **2.** Specific plans for improving C&YP access to elective services in development. **3.** Elective recovery plans for Gloucestershire patients treated at out of county NHS providers subject to further development.	**1.** Performance Reporting to the Planned Care Delivery Board, System Resources Committee and the ICB. **2.** Elective recovery planning and oversight provided by the Planned Care Delivery Board (PCDB) with escalation via Programme Delivery Group and ICS Execs as required. **3.** Weekly 65wk wait delivery meetings with NHSE in place.	**1.** Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans. **2.** Lack of visibility of delayed follow ups at ICB contract, performance and quality meetings.

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4. Additional elective activity commissioned with Independent Sector providers both for new referrals and transfer of long waiters from GHFT where required. New providers entering the market via the Provider Selection Regime (PSR) process. **5.** Additional capacity commissioned with GHFT in key long waiting specialties as part of annual planning process using ERF funding stream. **6.** Work continues with primary care through the Referral Optimisation Steering Group (ROSG) to manage referral demand into secondary care. Increase in A&G services and access to Cinapsis as well as progress with "Advice First" approach and RAS role out. Expanded GP education programme and G-Care pathway content. **7.** Operational and transformational delivery monitored by system Planned Care Delivery Board. Reallocation of ERF slippage undertaken here. **8.** Regular analysis of waiting lists in place to ensure equity of access, waiting times and outcomes for our most deprived populations and ethnic minority groups. Weekly check and challenge meetings at GHFT to micromanage long waiters in place. **9.** Clinical harm reviews undertaken for all long waits. **10.** Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility and theatres in CGH.	**4.** Lack of specific plans to address the delayed follow up backlogs and associated clinical risk	**4.** Reporting to NHSE/I on waiting times. Any elective cancellations reported to NHSE/I. System waiting times monitored through the WLMDS tableau report. Regular Elective Recovery COO and Performance Directors meetings with NHSE for the region. **5.** Regular contract and performance management governance structures in place to review performance and associated recovery plans with all independent sector providers.	

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Commitments made in the 24/25 Operational plan monitored through Planned Care Delivery Board (ICS level meeting with GHFT represented). **2.** Additional capacity investments via ERF agreed and underway. Delay in delivery may provide opportunity to reallocate any ERF slippage (PCDB to agree). **3.** Additional elective activity planned for 2024/25 (e.g., endoscopy, WLI GLANSO lists as well as insourcing and outsourcing). **4.** Additional pathways continuing to be rolled out at the CDC to fully utilise available estate. **5.** Additional activity commissioned from ISPs as part of 24/25 operational planning. **6.** 3rd Cath Lab being commissioned for 24/25 – go live date delayed, currently planned for January 2025. **7.** New FoD community hospital being commissioned with endoscopy facility now due to open in the new year. **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. **10.** ROSG and Interface meetings established to improve communication and flow between GPs and specialists recognising the potential workload shift.	**1.** Operational plan being delivered and monitored by PCDB. ERF to continue through 2024/25 with system aiming to achieve significantly higher recovery than the 2023/24 position in addition to 5% productivity increase. M3 freeze position is above plan which will generate additional income for the system if sustained. **2.** ERF schemes have been approved and funding provided to GHFT for delivery. Delays in the sign off process have meant that some schemes will be compromised and may not deliver within the necessary timescales. Slippage can be reallocated to other schemes that can deliver within year. **3.** Additional 2x daycase theatre capacity at CGH now operational. Refurbishment of theatres at GRH complete and now operational. **4.** GHFT theatre utilisation improvement project has seen good progress with decreases in time lost to early finishes and late starts, and overall improvement in % utilisation continues towards 85%. **5.** New project established to look at utilisation and productivity of community hospital outpatient and theatre capacity. **6.** 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). **7.** ISP contract and activity confirmed for 2024/25 with potential new providers being available through the PSR process. ISP ERF achievement is 37% above plan. ICB has received 4 applications from new ISPs under the PSR process to provide additional elective activity to Gloucestershire ICB. **8.** Working assumption to start using new endoscopy facility at FoD for 2 days a week has been delayed. Funding implications still to be finalised and prioritised alongside other elective investments. Revised business case to come back to ICB in September.

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	9. Patient Engagement Portal (PEP) gone live with phase one. **10.** Going Further Faster GIRFT initiative to be undertaken in 19 outpatient specialties. Handbooks and self-assessment checklist have been shared and programme underway. Gloucestershire also part of NHS Confederation Interface Improvement Collaborative (Advice and Guidance Optimisation).

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

##

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

Entry date:	01/11/22	Last updated:	13/09/24 (reviewed)
Owner:	Benedict Leigh, Director of Integration		
Committee	People		
Aligned with System Partner Risk(s):	**GHC ID3** *There is a risk of demand for services beyond planned and commissioned capacity, which cannot be managed through usual mechanisms, resulting in services not meeting the expectations of our community.* **(Risk rating 16)** **GHC ID4** *There is a risk that we fail to recruit, retain, and plan for a sustainable workforce to deliver services in line with our strategic objectives.* **(Risk rating 16)** **GHC ID9** *There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs.* **(Risk rating 6)**		

Pillar 3: *Improving health and care services today.*	
Strategic Objective 6: *Address the current challenges we face today in the delivery of health and care.*	
Key Priorities 23/24: *Improve mental health support across health and care services.*	
Aligned with ICB Risk(s):	**Integration 06:** *Tier 4 Eating Disorder Beds* **Integration 27:** Childrens Mental Health Capacity

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

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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Eating Disorder Programme including system wide prevention through to crisis workstreams established. **2.** CAMHS recovery plan including within service provision and system wide to support improvements. **3.** Neurodevelopmental business case and plan in place. Project team established to oversee recommissioning of ADHD/ASC pathway. **4.** Adult Community Mental Health Transformational programme: Transformation programme has officially finished as of end of Q4 23/24. The process of transferring to BAU is in progress. Service specification has been drafted for key transformational changes. 6-month extension to programme management agreed. ICB PM resources	**1.** No significant gaps identified as a monthly system-wide multi-agency meeting is well established and any and all matters of programme management around and performance against the trajectories within the action plan for eating disorders are progressed. If the programme is of trajectory, then the matter is escalated. **2.** No significant gaps identified as a monthly meeting is in place with CAMHs and a system wide multiagency meeting monitors progress bi-monthly. **3.** No significant gaps in the Adult Mental Health Transformational programme. **4.** ICB PM resource that supported CMHT will now be used to support UEC mental health programme which was previously reported as a gap.	**1.** Clinical Leads and Team Manager of the Eating Disorder Service are completing regular caseload reviews to ensure throughput. **2.** Waiting times for urgent and non-urgent referrals are reducing for eating disorders. **3.** There is in place a significant recruitment and retention plan to tackle issues around capacity. **4.** Robust governance arrangements in place for community mental health with experts by experience included. **5.** Neurodevelopment Project Team established between GHC/ICB to oversee development of new pathways including working on shared care issues between primary/secondary care.	**1.** No gaps in assurance.

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released to support UEC MH programme/Right Care Right Person.	**5.** Shared care arrangements for ADHD prescribing between primary/secondary care.		

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Ongoing monitoring of the mitigations and engagement with service review around increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals. **2.** Proposal to commence 3-year contract for both TIC+ and Young Gloucestershire to enable security and retention of staff and ensure business continuity. **3.** Regular reporting to the Children's Mental Health Board and Adult Mental Health Board. **4.** SEND inspection complete and ICB SEND programme board established. **5.** Work is progressing in this area.	**1.** The significant work on SEND and across services for children has started to show results, with improving services and greater impact. We are continuing to focus on waiting lists and on appropriate provision. Partnerships with the VCS and with education are delivering excellent results. **2.** Both TIC and Young Gloucestershire contract proposals approved by Operational Executive during February in line with SFIs/ procurement policy. **3.** Embedding the community transformation for adult mental health remains a challenge, particularly in the context of significant national policy changes in relation to system partners. Work with police colleagues on a local RCRP implementation model is developing well but remains a work in progress. **4.** Data and intelligence challenges remain, particularly in the area of understanding demand changes and modelling future impact.

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

##

BAF 9	**Risk of having insufficient resources to meet the delivery our strategic priorities which ensure financial sustainability and deliver improvements in value for money and productivity.**

Entry date:	01/11/22	Last updated:	10/09/2024
Owner:	Cath Leech, Chief Finance Officer		
Committee	Audit, Resources		
Aligned with System Partner Risk(s):	**GHC: 8** *There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care.* **GHC 9 Funding -** *National Economic Issues: There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs.* **(Risk rating 6)** **GHFT: SR9 -** *Failure to deliver recurrent financial sustainability* **(Risk rating 25)**		
Aligned with ICB Risk(s):	**F&BI 9 -** *The ICB does not meet its breakeven control total in 2024/25 (noted that these risks are to be updated on ICB risk management system).* **F&BI 10 -** *The ICS does not meet its breakeven financial duty in 2024/25 (noted that these risks are to be updated on ICB risk management system).*		

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

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

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

Key Priorities 23/24: *Creating a financially sustainable health and care system.*

Due to:	Impact:
- Increasing demand for services, increased inflation, ongoing impact of the covid pandemic on a wide range of services and staff and new service requirements. - Lack of delivery of recurrent savings and productivity schemes. - Recruitment & retention challenges leading to high-cost temporary staffing. - Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost. - Decrease in productivity within the system. - Impact of industrial action leading to additional costs and a loss of elective activity leading to reduced elective recovery funding	- Underlying deficit position within the system as a whole revenue and the system is unable to achieve breakeven recurrent position - Increased requirement to make savings leading to inability to make progress against ICS strategic objectives. - Capital costs growth meaning that the system is unable to remain within its capital resource limit.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Governance in place in each organisation and System-wide Financial Framework in place **2.** Monthly review of whole-system financial position by Directors of Finance, Strategic Executives with reporting into relevant Committee for ICB, GHFT, GHC. **3.** Financial plan aligned to commissioning strategy. **4.** ICS single savings plan in place managed by PMOs & BI teams across the system forming part of the monthly finance review process. **5.** Contract monitoring in place.	**1.** Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. **2.** Methodology on realisation of productivity benefits not in place. **3.** Capacity of teams through the system to deliver programmes of work required to transform system is limited particularly in times of ongoing urgent care escalation.	**1.** Reporting into Board of the ICB and relevant Committee for each organisation. **2.** Monthly monitoring of organisational financial positions in place within organisations and monthly monitoring by Resources Steering Group of overall position. **3.** Capital monitoring is produced monthly and reported to organisational Committees and Boards including the ICB. Reporting is reviewed jointly by Directors of Finance with a view to managing and maximising the value of the capital resource limit across the system.	**1.** Gaps in knowledge of continuation of some funding sources in future years leading to uncertainty in planning plus changing requirements in year leading to financial risk.

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6. Robust cash systems monitoring early warnings. **7.** System Plan in place and further development in progress. **8.** Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to inflation and wider risks within the system resulting from a slower capital programme.	**4.** Monitoring of workforce numbers is incomplete currently across the system.	**4.** Annual internal audit reviews on key financial controls.	

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. GHFT internal financial improvement plan progressing and plans for new financial year being included, control review is ongoing. Reporting through to the GHFT Finance Committee. **2.** System savings plan for new year and longer term in development, monitoring of progress and delivery by individual organisation and at system level each month to Executives. **3.** Working as One Programme Board focus on the delivery of benefits with significant focus on trajectories and the actions required to enable recurrent savings in addition to the quality and operational benefits	**1.** Work underway within GHFT on changes in productivity since 2019/2020 key areas of focus identified and programmes in outpatients and theatres progressing, impact being brought into elective recovery programme **2.** Actions to identify non recurrent and other measures to help close the financial gap in the plan for 24/25 progressing, PMO support in place. **3.** Workforce monitoring for budgeted and worked WTE progressing with monthly reporting and monitoring within organisations and to the system in development, initial reporting at M3 planned. **4.** Weekly meetings with CEOs and DoFs to monitor progress of plans for working as one programme

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

##

BAF 10	Risk that the estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling deliver of high-quality care.

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

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

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

Key Priorities 23/24: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

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

Due to:	Impact:
- Increasing inflation on capital costs. - Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost. - Decrease in productivity within the system. - Impact of industrial action leading to additional costs and a loss of elective activity leading to reduced elective recovery funding. - High level of backlog maintenance within GHFT (c£72m).	- Capital allocation "buys less" as a result of increasing inflation and System may be unable to live within its capital resource limit. - Inability to reduce the level of high-risk backlog maintenance, to replace equipment when due or to refurbish facilities across the system in a timely manner leading to down time for unplanned maintenance and reduced productivity across the system

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Governance in place in each organisation. **2.** Monthly review of whole-system financial position by Directors of Finance with reporting into relevant Committee for ICB, GHFT, GHC. **3.** Regular attendance at Monthly Capital Meeting with NHS England and raising issues relating to inflation and wider risks within the system resulting from a slower capital programme. **4.** Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed. **5.** EPRR in place, to support any critical infrastructure failures within provider organisations. **6.** Mature Provider estates planning forums to manage risk and capital planning oversight.	**1.** Longer term strategic plan which delivers sustainably for the system	**1.** Reporting into Board of the ICB and relevant Committee for each organisation. **2.** Monthly capital monitoring is produced and reported to organisational Committees and Boards including the ICB. Reporting is reviewed jointly by Directors of Finance with a view to managing and maximising the value of the capital resource limit across the system.	**1.** Gaps in knowledge of continuation of some funding sources in future years leading to uncertainty in planning plus changing requirements in year leading to financial risk

##

7. This risk will form part of the ICB infrastructure plan.			

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. ICS Health Infrastructure Plan (HIP) in progress with support from NHSPS. **2.** 5-year capital plan developed and longer term look as part of the infrastructure strategy **3.** Disposals across the system identified and included in the capital plan. **4.** Developing a ‘library’ of GHFT & ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes. **5.** 24/25 capital programme agreed including additional capital available for 24/25 with focus on mitigating highest risks.	**1.** Capital and Estates Infrastructure meeting in place – Terms of Reference being refreshed. GHFT CEO chairing the meeting **2.** ICB Health Infrastructure Plan (HIP) in progress with support from NHSPS, initial draft completed and submitted, next steps to finalise the strategy and develop an implementation plan in progress.

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

##

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

Entry date:	**01/11/24**	**Last updated:**	**19/09/24**
Owner:	**Marie Crofts, Chief Nursing Officer**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	**GHFT** *SR12 Failure to detect and control risks to cyber security* **(score Red 20)** **GHC 8** *Cyber There is a risk of inadequately maintained and protected the breadth of IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care etc* **(score Red 20)**		

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

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

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

Aligned with ICB Risk(s):

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

Due to:	Impact:
Lack of oversight and resource in the ICB's emergency planning and business continuity team to fulfil the functions and responsibilities of a Category 1 responder.	Unable to fulfil our responsibilities as a Category One responder, and effectively lead a robust, effective and coordinated system response to a major incident.

Current Controls *(to mitigate risk):*	Known Gaps in Controls	Current Assurances *(of controls effectivity):*	Known Gaps in Assurances
1. EPRR on-call manager training. **2.** EPRR exercises. **3.** Oversight of EPRR through the Local Health Resilience Partnership.	**1.** Insufficient internal debriefs have been performed for exercises that the ICB has participated in or that lessons learned have not been embedded. **2.** Lack of progress on the implementation of the cyber security exercise action plan points relating to the joint working and processes required with the cyber and EPRR teams. **3.** Insufficient resources within the EPRR team (the team are currently reviewing capacity and benchmarking against other ICBs.)	**1.** Reporting to Quality Committee. **2.** NHS England system assurance review and provider assurance process against national standards. **3.** BDO Internal Audit Report (November 2023) moderate assurance for design and effectiveness.	**1.** BDO Internal Audit Report which rated the ICB as moderate for design opinion and moderate for design effectiveness, with four medium recommendations (November 2023). **2.** NHS System Assurance all but one of the Partners has achieved a standard of at least "Substantially Assured" with one (PPG) achieving Fully Assured. One organisation (E-MED PTS) has been assessed regionally as "non-Compliant". ICB itself has seen its overall rating fall from that obtained in 2022 (substantially assured) to a rating in 2023 of "partially assured".

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. We have now updated our On-Call rota system matching skills where possible to compliment those on-call. We have also brought titles in line with EPPR frameworks, with Manager and Senior on call being replaced with Tactical and Strategic leads. **2.** A full programme of training has been set up, with a dedicated EPPR training manager in place. **3.** There is a plan to review the resources of the team initially with some dedicated administrative support and secure some permanent funding for the training post if appropriate.	**1.** All on call managers and senior managers have access to a clearly defined work programme which enables all of these staff to achieve and maintain minimum National Occupational Standards. More work needs to be undertaken to ensure all staff take up training opportunities. **2.** The ICB, as part of the EPRR work plan for business continuity, is currently undertaking a three-month programme ensuring departments review and update their departmental Business Continuity Management (BCM) plans /Business impact analysis with local departmental walkthrough /discussion of what they would do for a loss or partial loss of service.

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4. There are some further long-term discussions to be had with system partners about revisiting the work undertaken that proposed a system wide EPRR Function.	**3.** Review if all areas of previous partial compliance against core standards taking place to ensure compliance this year or identify any gaps. **4.** Band 4 admin/EPRR assistant now being recruited to support team. **5.** Exec briefing session planned to reiterate Cat 1 responder duties and responsibilities and update. **6.** Currently recruiting to the EPRR Manager role and the assurances meetings on EPRR will follow shortly, after that point the risk scoring will be reappraised.

Relevant Key Performance Indicators
N/A

##

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

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

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

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

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

Key Priorities 23/24: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):

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

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

##

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

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

Relevant Key Performance Indicators

N/A

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

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

##

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

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

Agenda Item 10.1

NHS Gloucestershire ICB Board meeting held in public

Wednesday 25th September 2024

Report Title	**Integrated Performance Report**			
Purpose (X)	**For Information**	**For Discussion** X	**For Decision**	
Route to this meeting	N/A			
	ICB Internal	**Date**	**System Partner**	**Date**
			Strategic Executive meeting	19th September
Executive Summary	This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for September 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			

<table>
<tr><td rowspan="2">Resource Impact (X)</td><td>Financial</td><td>X</td><td colspan="2">Information Management & Technology</td><td>X</td></tr>
<tr><td>Human Resource</td><td>X</td><td colspan="2">Buildings</td><td>X</td></tr>
<tr><td>Financial Impact</td><td colspan="5">See financial section of the report.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td colspan="5">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.</td></tr>
<tr><td>Impact on Health Inequalities</td><td colspan="5">See Performance section of the report.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td colspan="5">See Performance section of the report.</td></tr>
<tr><td>Impact on Sustainable Development</td><td colspan="5">None</td></tr>
<tr><td>Patient and Public Involvement</td><td colspan="5">The Integrated Performance Report (Quality section) currently provides information on patient and public feedback.</td></tr>
<tr><td>Recommendation</td><td colspan="5">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.</td></tr>
<tr><td>Author</td><td colspan="2"><u>Performance:</u>
Kat Doherty

<u>Workforce:</u>
Tracey Cox

<u>Finance:</u>
Chris Buttery
Shofiqur Rahman

<u>Quality:</u>
Rob Mauler

<u>PMO:</u>
Jess Yeates

Mark Golledge</td><td>Role Title</td><td colspan="2">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</td></tr>
</table>

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

Integrated Performance Report

September 2024

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NHS

Improving Services & Delivering Outcomes (Our Performance) (System Resources Committee)	Our People (People Committee)
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Feedback from Committees

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System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	5 September 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Please note that the formal Committee Meeting in September was shortened as the Committee held a workshop focusing on where we currently spend our money within Gloucestershire. The outputs and actions from the session will be followed up on by System Resources Committee and be used to inform our approach to medium term planning across the ICS.				
Performance	LIMITED	Committee heard of good improvements in cancer treatment in 62 days and strong continued Elective Recovery Performance (provisionally performance increasing to 117.2% against a target for the year of 118%) so confidence this will be achieved. There remains a national focus on urgent care – with particular focus on ED performance and ambulance handover delays. Recovery of other cancer targets (patients waiting over 62 days and 104 days) remains an area of concern across the system with additional capacity being rolled out to challenged specialities.	Continued focus and working within Urgent and Emergency Care. Continued focus on reducing the treatment backlog for cancer treatment across the system. The reduction of long elective waits remains a focus on the system (with focused work in Oral Surgery, ENT and T&O where the longest waiters are).	End of October 2024 for a review of progress
Finance	LIMITED	Committee heard an update that the system and all organisations are forecasting a breakeven outturn position. Year to date income and expenditure compared to plan is a £0.6m deficit. Key risks to the year-end position include GP collective action and delivery of the savings plan including Working as One savings. Savings are forecast to be delivered in full against plan currently – there are ongoing actions to mitigate high risk pressures.	Actions are continuing to deliver against the single savings plan for 2024/25. This includes reducing the system financial pressure by mitigating schemes that are high risk to delivery.	End of September 2024 for a review of progress

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

Issues referred to another committee

Topic	Committee
None	None

4

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
Failure to secure, retain and develop workforce necessary to deliver the ICS's strategic objectives	LIMITED	All organisations continue to focus on a range of recruitment and retention initiatives inc People Promise Managers appointed in both Trusts.	Organisational level workforce plans in place focusing on EDI, staff engagement, recruitment, staff wellbeing and back and agency costs. Continued focus on International recruitment for social care. Continuation of We Want You careers engagement and outreach initiatives.	Throughout 2024/25
Long-term Workforce plans impacted by short-term financial pressures	NOT ASSURED	All organisations experiencing reduction in available development opportunities (apprenticeships, lack of placements for those in university courses etc)	Other opportunities (e.g. T-Levels) to be considered Discuss as Board Development Session	Throughout 2024/25
Advanced Practice Strategy implementation	LIMITED	Advanced Strategy was approved, and that the Advanced Practice model is key to a number of clinical transformation initiatives, however implementation resource priority not yet secured beyond this year (2024)	Business case to be developed for AP strategy implementation resource	End 2024
Apprenticeship strategy implementation	LIMITED	The Apprenticeship Strategy was approved. The risk of meeting the LTWP and implementing the strategy was raised and discussed as opportunities for apprenticeships have been reducing across the system. This links to the above issue around short term financial constraints versus longer term workforce impact.	Approved Apprenticeship strategy to be implemented Monitor systemwide apprenticeship opportunities Continue system wide discussion around mitigations to increase apprenticeship opportunities	Throughout 2024/25

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

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

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Quality Committee

Accountable Non-Executive Director	Jane Cummings
Meeting Date	7 August 2024

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Mortality	LIMITED	The Standardised Hospital-Level Mortality indicator remains outside of control levels. Issues relating coding and care quality were explored, as well as variation based on day of admission.	• Paper being taken to Strategic Executives with a subsequent discussion at a future Board meeting.	September
ICB Safeguarding/ Children in Care report	SIGNIFICANT	The Annual Children in Care report was brought to the Committee along with the new quarterly Safeguarding report. The committee was positive about the addition of the quarterly reporting process.	• The Safeguarding report will be delivered quarterly.	Quarterly
GP Collective Action	SIGNIFICANT	The committee took updates on the potential impact of GP collective action and how the impact will be managed. Work is already underway to mitigate risks, especially in the interface of secondary/primary care.	• The ICB has good relationships with Primary Care. Practices are communicating with the LMC on the actions they may take. • Further plans will be worked up following receipt of intended action.	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

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

- Patients remaining in hospital once they are ready to go home (patients with No Criteria to Reside NCTR) has been a focus for the system to support flow and improved response times across all services. GHFT reported their lowest recorded number of patients (107) with NCTR in the first week of September. This is a huge achievement as the average throughout 2023/24 was 186.
- We have seen continued good performance in ensuring patients requiring a mental health admission are treated locally – with no inappropriate Out of Area placements reported in August 2024. Inappropriate Out of Area placements reduced significantly throughout 2023/24 and have continued to remain an exception in 2024/25 to date.
- Elective Recovery Performance has continued to be strong in the first quarter of 2024/25, with the system position increasing VWA to 117.2% (provisional performance as at July 2024 – with performance expected to increase as uncoded episodes are added). The system target for ERF is to reach 118% so there is confidence that this will be achieved. Latest fully validated position is June 2024, where 119.8% was achieved.

Areas of Focus

- There is a national focus on UEC performance – with increased scrutiny from NHSE around ED performance and ambulance handover delays. GHFT have been offered intensive support in response to recent fluctuation in performance.
- Elective long waits over 65 weeks are expected to be eliminated by September 2024, with weekly review at a currently undertaken by the system and NHSE to assure Gloucestershire's position against this target. Current forecasts indicate that in a worst-case scenario there will be a small number of outstanding 65 week waits predominantly in ENT and Spinal Surgery. GHFT continue to work to mitigate these wherever possible with additional capacity and use of other providers, particularly across specialties with the longest waits – ENT, Oral Surgery and Cardiology.
- Patients waiting over 62 and 104 days for treatment once diagnosed with cancer remain an area of concern for the system. Additional capacity has been rolled out in particularly challenged specialties which has reduced the number treated over 104 days in 2024/25 to date. Focus on treating patients waiting over 62 days has led to drops in performance against the 62-day treatment target in July 2024, and we are expecting this to continue in August 2024. Continued focus on reducing the patient treatment backlog will support sustainable performance in this metric.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Funding Opportunities
- Funding request submitted for NHSE WT&E Specification for System Delivery of AHP Priorities

Strategy & Planning
- The following strategies were approved by the people committee:
  - ICS Apprenticeship strategy
  - ICS Advanced Practice High Level Strategic Ambitions
  - ICS Staff Health and Wellbeing strategy

System-wide Development Programmes
- System first-time manager programme outline agreed and two pilots scheduled for 2025

People Team
- ICS Principal Data Analyst (Strategic Workforce) appointed and commences 7th October

Education & Training
- ICB T-Level and apprenticeship awareness day held on 10th Sept
- Attendance at Primary Care away days to promote T-Level and apprenticeship opportunities

Areas of Focus

Strategy & Planning
- Review Joint Forward Plan/medium term plan
- Discuss and start to draft potential workforce workstream business cases for 25/26 planning round

System-wide Development Programmes
- Comms for ICS Leadership event in October launched and registrations opened, 150 delegates registered to date
- Agree delivery plan for system first-time manager programme commencing early 2025

International Recruitment
- Further focused promotion of international recruitment of care workers for eligible providers following slow update of initial offer. Proposal to widen recruitment to displaced international workers
- Continue the pastoral care support arrangements.

People team
- Recruitment process for housing hub officer underway

Programme Delivery
- Submission of NHSE Q2 update reports
- We Want You Careers Engagement away day
- Discussion around collaborative attendance at events

Quality – Safety, Experience and Effectiveness

Please note: The Quality report is updated bimonthly.

Quality

Key Achievements

- A team within the ICB have attended Black Maternity Matters anti-racist training for seniors' leaders . A further system wide cohort will commence in the Autumn. There has been positive engagement with local black & Asian communities and who are supporting the coproduction of service and quality improvements.
- Our Safeguarding team successfully visited Kingfisher Treasure seekers and were assured by their safeguarding processes. The team are supporting the provider with an offer of ongoing help.
- Research Engagement Network (REN) members have prepared an application to NHSE to fund their ongoing participation up to March 2025. The application includes the aspiration to extend the REN to include more VCSE organisations to increase diversity still wider.
- The Regulators' Pioneer Fund awarded the CQC a grant to develop a framework for use by Integrated Care Systems (ICS) to help them measure how well they listen to the experiences and needs of people and communities to reduce health inequalities. The CQC are working in collaboration with the Point of Care Foundation and National Voices to create this framework and the associated learning tools. NHS Gloucestershire ICB has been selected as one of four ICSs to pilot the framework this autumn.

Areas of Focus

- Under National Quality Board guidance, the ICB are facilitating three Quality Improvement Groups (Maternity, Berkeley House and SHMI). These groups bring system partners together to agree areas of improvement and provide rigor and monitor progress. These are discussed in the body of the report. All three groups report into the System Quality Committee.
- Special Allocation Service (SAS) – service review underway which will include consideration for the prison capacity pressures and changes to determinate sentences.
- GP collective action – ICB are leading the Task & Finish Group to monitor and mitigate against the GPC England 10 suggested actions.
- Many communities have mentioned that they struggle to access dentistry services; not knowing where to go when they have problems or are in pain. The ICB Engagement and Communications Teams have worked together to provide clear, simple information, stripping back all contextual information. WhatsApp has been used to share the information, which is a novel approach.
- The new ICS-wide contract for translation and interpretation provider commenced on 1 September 2024. Bespoke training for staff working in GP practices, Trusts and GCC was provided to support a smooth transition to the new provider Word 360.

Finance and Use of Resources

Finance

Key Messages: Month 5

Statement of Net Income & Expenditure Position (£'000)			
Month 5 2024/25 – August	**Month 5 Plan Surplus / (Deficit)**	**Month 5 Actual Position Surplus / (Deficit)**	**Month 5 Variance to Plan Favourable / (Adverse)**
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	(9,489)	(9,192)	297
Gloucestershire Health and Care NHS Foundation Trust (GHC)	287	289	1
Gloucestershire Integrated Care Board (ICB)	0	0	0
System Surplus / (Deficit)	**(9,202)**	**(8,904)**	**298**

- The system financial plan included a significant amount of financial risk, in particular, the level of savings including the Working As One savings, to achieve breakeven. Mitigations are in varying stages of development and the associated risk to delivering the breakeven plan remains high.
- The year-to-date (YTD) income and expenditure position is £0.3m favourable to plan, in line with the forecast outturn position. This is attributable to non-recurrent benefits achieved by GHFT. The YTD position does not include funding to be received in respect of Industrial Action costs incurred by GHFT during June/July, this pressure continuing to contribute towards the unmitigated outturn pressure at GHFT. The YTD GHFT non-recurrent benefits total circa £4m and are offsetting cost pressures relating to pay, non pay drugs and clinical supplies. GHC and the ICB are on plan YTD.
- The system and all organisations are forecasting a breakeven outturn position. Key risks to this position include GP collective action, delivery of savings plans including Working as One savings, the high level of organisational savings and assumes no additional funding to support winter pressures. The forecast assumes full funding for the 24/25 pay award, ERF over delivery and industrial action. Slippage in delivery of the working of one savings is forecast; there is work underway to mitigate identified slippage.
- Year to date capital expenditure is £9.6m below the 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 for both GHFT and GHC remains below 3.2% national cap.

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NHS

Improving Services & Delivering Outcomes (Our Performance) (System Resources Committee)	Our People (People Committee)
Quality (Safety, Experience and Effectiveness) (Quality Committee)	Finance and Use of Resources (System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

ICP Dashboard

Colour	Meaning	Colour	Meaning
Green	Significantly better than the national average	Purple	Significantly better than the county average
Amber	No significant difference to the national average	Blue	No significant difference to the county average
Red	Significantly worse than the national average	Pink	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
Overarching	0.2	Life Expectancy	Life expectancy at birth (female)	83.6	84.7	83.5	81.7	83.8	84.5	83.6
Overarching	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
Overarching	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
Pillar 1: Health and Wellbeing Board	1.2*	ACEs	% of Children reporting 'When you are worried about something, is there a trusted adult you can go to for help?'	86.8	86.1	85.0	81.7	81.5	86.8	84.3
Pillar 1: Health and Wellbeing Board	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
Pillar 1: Health and Wellbeing Board	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
Pillar 1: Health and Wellbeing Board	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
Pillar 1: Health and Wellbeing Board	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
Pillar 1: Health and Wellbeing Board	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

Colour	Meaning	Colour	Meaning
Green	Significantly better than the national average	Purple	Significantly better than the county average
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Pillar	Ref	Theme	Indicator	Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 2: Transforming what we do	2.1	Health equity	Inequality in life expectancy at birth (male), 2018-2020	9	1.1	5.8	13.5	4.7	6.5	7.6
	2.2	Health equity	Inequality in life expectancy at birth (female), 2018-2020	8.4	-1.0	3.8	10.2	2.9	7.4	5.8
	2.3*	Health equity	Excess under 75 mortality rate in adults with severe mental illness (2020-2022)	N/A	N/A	N/A	N/A	N/A	N/A	562.9
	2.4	Health equity	% School Readiness	69.5	70.7	63.5	65.2	68.1	71.3	67.8
	2.5	Employment exemplar theme	Gap in the employment rate between learning disability and overall employment rate	N/A	N/A	N/A	N/A	N/A	N/A	76.4
	2.6	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage,2023	14.4	14.1	N/A	12.3	12.7	N/A	13.0
	2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+) - %	12.6	6.3	11.3	18.1	8.7	9.3	11.5
	2.8	Smoking exemplar theme	Smoking Prevalence in Routine and Manual Occupations - %	23.7	6.9	21.1	31.5	25.8	15.6	23.3
	2.9*	Blood pressure exemplar theme	% of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	68.1	72.3	68.6	63.9	72.3	67.9	68.5
	2.10*	Blood pressure exemplar theme	% 58.4	55.5	58.4	58.1	61.3	59.2	54.9	58.4

Updated metrics indicated with *

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

Improving Services & Delivering Outcomes

ICP Dashboard

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Pillar	Ref	Aim	Indicator	Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 3: Improving Health and Care Services Today	3.1*	Improve access/ reduce backlogs	Numbers/breakdown of waiting lists by locality – rate per 1000	103.7	104.9	123.2	111.3	99.7	96.9	106.6
	3.2*	Improve access to primary care	Primary care: GP headcount per 100k population	82.4	88.9	70.6	81.2	88.5	78.5	82.7
	3.3	Improve support for people with mental health conditions	% SMI register health check uptake	82.6	74.3	81.1	76.5	84.2	80.1	79.8
	3.4*	Support Improvements in delivery of UEC	A&E attendances – rate per 1000	21.5	12.7	15.5	25.0	13.8	16.3	18.9
	3.5*	Support Improvements in delivery of UEC	Emergency admissions – rate per 1000	7.8	8.3	9.9	10.8	8.3	8.0	9.0
	3.6*	Support Improvements in delivery of UEC	Long lengths hospital stay (proxy of availability of out of hospital support).	77	60	59	107	56	35	394
	3.7	*Improve access to care: Cancer*	*% of cancers diagnosed at Stage 1 and 2, 2020*	54.0	53.7	54.1	52.6	46.8	54.2	52.4

Updated metrics indicated with *

Please note:
Indicators 3.1-3.6 show Locality (population based on registered GP practice) rather than District level data
Indicator 3.7 is under review to develop an outcome indicator that has more timely updates

Improving Services & Delivering Outcomes

ICP Dashboard – narrative (updated metrics)

1.2 Percentage of Children reporting that 'When you are worried about something, is there a trusted adult you can go to for help?'

This data is collected through a pupil wellbeing survey delivered to pupils across Gloucestershire every two years. Due to changes in how the question is asked it is not possible to compare this data with previous periods. As this information is collected locally the data can't be compared to other areas or England but does allow for comparisons between districts.

The proportion of children reporting that 'When you are worried about something, is there a trusted adult you can go to for help?' is significantly lower than the county average in Gloucester and Stroud. The proportion in the Forest of Dean is similar to the county average, while in Cheltenham, Cotswold and Tewkesbury it is significantly higher than the county average.

2.3 Excess under 75 mortality rate in adults with severe mental illness.

This metric measures inequalities in premature mortality between those with a serious mental illness and the general population. The excess under 75 mortality rate in adults with Severe Mental Illness (SMI) has been significantly worse than the England average since at least 2015-17 (when comparable data became available). The latest data for 2020-2022 shows there has been no significant change at a Gloucestershire level since the previous period (2019-2021) and the risk of someone with a serious mental illness dying before they are 75 years old is over 5 and a half times greater than in the general population. Data is not available at district level for this indicator, meaning it is not possible to understand variation across the county.

2.9 Percentage of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age-appropriate treatment threshold.

We have seen increases in the % of patients with blood pressure reading below the treatment threshold in the latest quarter (Q4 2023/24), with all areas showing improvement. The county average (68.5%) remains below the national position (70.9%) which has also risen in Q4 of 23/24) and both the national and county position fail to meet the target of 77%. There is a larger gap between the most deprived quintile of our population and the other quintiles of the population (based on deprivation), with the most deprived having significantly lower likelihood of having a reading below the age-appropriate treatment threshold.

2.10 Percentage of patients aged 18 & over with no GP recorded CVD & a GP recorded QRISK score of ≥20% on lipid lowering therapy.

We have seen increases in the % of appropriate patients on lipid lowering therapy in the latest quarter (Q4 2023/24), with Gloucester locality in particular showing significant improvement and meeting the target of 60%. The county average (58.4%) remains below the treatment target and the national position (62.1%), which has now met the target for the last two quarters.

Improving Services & Delivering Outcomes

ICP Dashboard – narrative (previous updates)

1.1 Percentage of physically inactive adults

At a county level the percentage of physically inactive adults saw no significant change between 2021/22 and 2022/23.

At a district level, no districts saw a significant change in the percentage of physically inactive adults between 2021/22 and 2022/23.

However, there were some changes relative to the county average. In 2021/22 Cotswold had a significantly lower rate of physically inactive adults, in the latest period 2022/2023 the rate of physically inactive adults in Cotswold was similar to the county average. In 2021/22 the Forest of Dean had a similar rate of physically inactive adults as the county, however in 2022/23 the rate of physically inactive adults was significantly worse than the county average.

1.3 Emergency hospital admissions for intentional self-harm

At a county level the rate of emergency hospital admissions for intentional self-harm saw a significant improvement between 2021/22 and 2022/23. This saw the rate go from being similar to the national average in 2021/22 to significantly better than England in 2022/23.

At a district level the trend is mixed. The rate of emergency hospital admissions for self-harm improved significantly in Cheltenham and Gloucester in 2022/23 when compared to the previous period. In Cotswold, Forest of Dean, Stroud and Tewkesbury emergency hospital admissions for self-harm remained similar between 2021/22 and 2022/23.

This has resulted in some changes in district rates relative to the county average. In 2021/22 Cotswold had a significantly lower rate of emergency hospital admissions for self-harm, in the latest period 2022/23 the rate was similar to the county average. In 2021/22 Gloucester had a significantly higher rate of emergency hospital admissions for self-harm than the county, however in 2022/23 the rate was similar to the county average.

2.5 Gap in the employment rate between learning disability and overall employment rate

At a county level the 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 saw no significant change between 2021/22 and 2022/23.

Data is not available at a district level for this indicator, meaning it is not possible to understand variation across the county. .

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' When you are worried about something, is there a trusted adult you can go to for help?'	2024
1.3	Mental Wellbeing	Emergency hospital admissions for intentional self-harm (Directly Standardised Rate)	2022/2023
1.4	Social Isolation & loneliness	Percentage of adults who feel lonely often/always or some of the time	2019/2020
1.5	Healthy Weight	Year 6: Prevalence of obesity	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	2020-2022
2.4	Health equity	School Readiness: percentage of children achieving a good level of development at the end of Reception,	2022/2023
2.5	Employment exemplar theme	Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	2022/2023
2.6	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage	2023
2.7	Smoking exemplar theme	Smoking Prevalence in adults (18+)	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 March 2024
2.10*	Blood pressure exemplar theme	Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	To March 2024

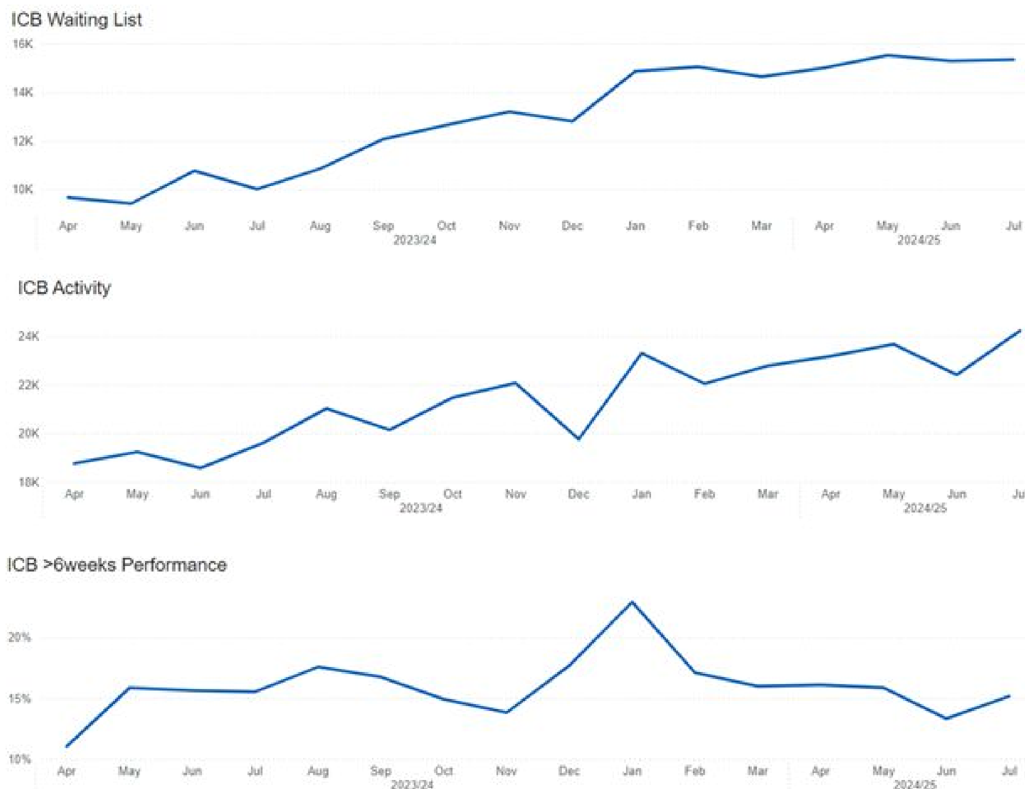
Improving Services & Delivering Outcomes

ICP Dashboard: Indicator full description & source

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

Improving Services & Delivering Outcomes

Area of focus: Diagnostics – DM01

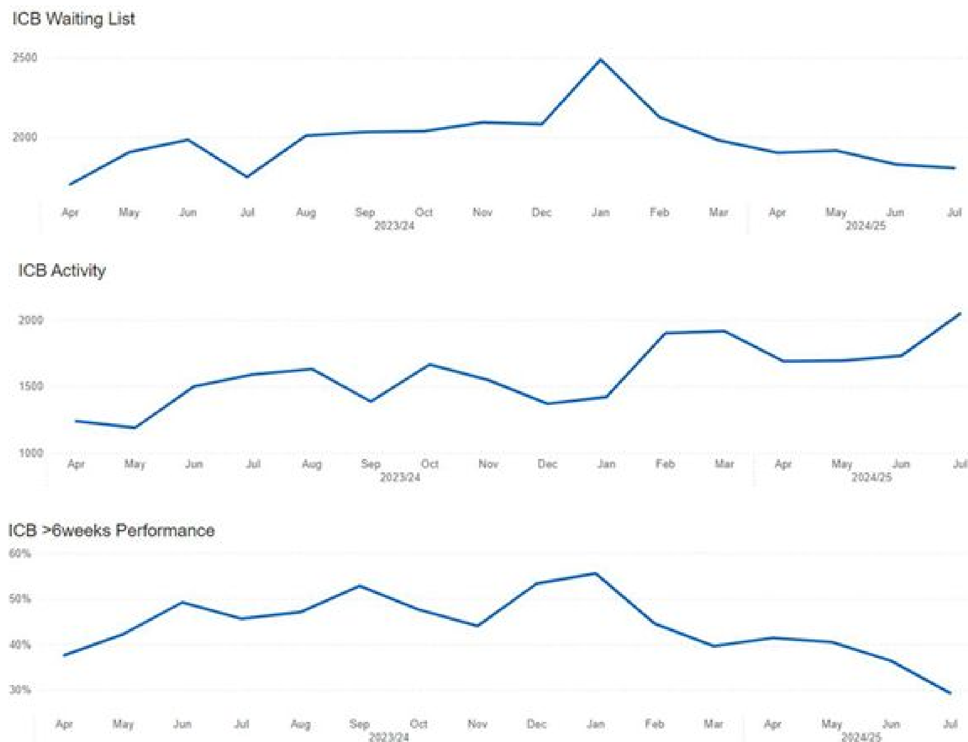


- Diagnostic performance remains stable with 15.2% of the waiting list for 15 key modalities over 6 weeks at the end of the month in July 2024, GHFT performance was 16.3%. The waiting has remained at c.15,500 people across the system throughout 2024/25 to date (covering all providers submitting to the DM01 national monitoring, including out of county providers); July saw the highest activity level for the ICS on record, with 24,214 tests carried out (significantly higher than the monthly average throughout 2023/34 of 20,700).
- There were 599 patients waiting over 13 weeks at the end of July 2024 – 505 at GHFT. The majority of these waits were in Colonoscopy, Cystoscopy and Echocardiography. Over 6-week breaches were at 2,326 at the end of July – with Echocardiography the main modality of concern – with 835 breaches and performance at 45.1%.

The 2024/25 Operational Plan committed to improving diagnostic performance to 10% (of patients waiting over 6 weeks at the end of March 2025). This does not meet the national ambition of 5% (which is itself an interim recovery target – the national standard for diagnostic waiting times is 1%). The ask for 2025/26 is likely to be to reach at least 5% if not full recovery to 1% - despite the increases in activity, demand for diagnostic tests is rising and reaching these levels of performance will be challenging within current capacity.

Improving Services & Delivering Outcomes

Area of focus: Diagnostics - Endoscopy

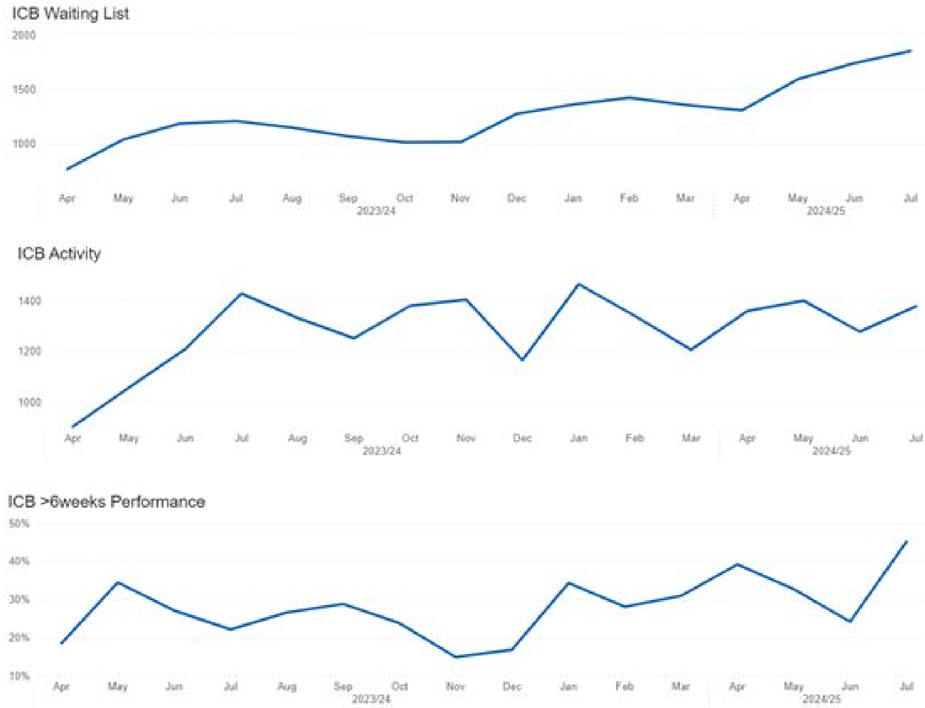


- Additional capacity across the system, including community sites is being confirmed, with independent sector options also being used (for example additional capacity at the Winfield Hospital).
- A navigator post is now in place to support patients with patients with inflammatory bowel disease, particularly around support for recalls for screening.
- A GP with special interest (in Gastroenterology) is currently in training to help support Advice and Guidance performance and avoid unnecessary referrals for endoscopy.
- A Capsule Sponge service is being scoped for development at the CDC and a Colon Capsule Endoscopy service is in development in collaboration with North Bristol Trust to provide alternative pathways for patients where this may be appropriate.

- Endoscopy performance has improved substantially, with the impact of additional resource clear in activity and performance trends. July's waiting list across Colonoscopy, Gastroscopy and Flexi Sigmoidoscopy is at the lowest level in the last year.
- The surveillance backlog has now been cleared using temporary resource, with patients planned to be booked proactively from October onwards to avoid them hitting the DM01 waiting list.
- Additional demand has been seen from the urgent suspected cancer pathway, and further demand is expected as the Bowel Cancer Screening programme extends the eligibility age for testing downwards.
- Staffing changes mean that there is now a period where capacity in the service is reduced – this will put performance at risk in the coming months.

Improving Services & Delivering Outcomes

Area of focus: Diagnostics - Echocardiography



GHFT Echocardiography Waiting list 2024/25

Diagnostic Group	Diagnostic Modality		2024/25			
			Apr 2024	May 2024	Jun 2024	Jul 2024
Physiological Measurement	Cardiology - echocardiography	Breaches	498	507	407	832
		Total Waiting	1,222	1,493	1,669	1,807
		Total Breaches	498	507	407	832

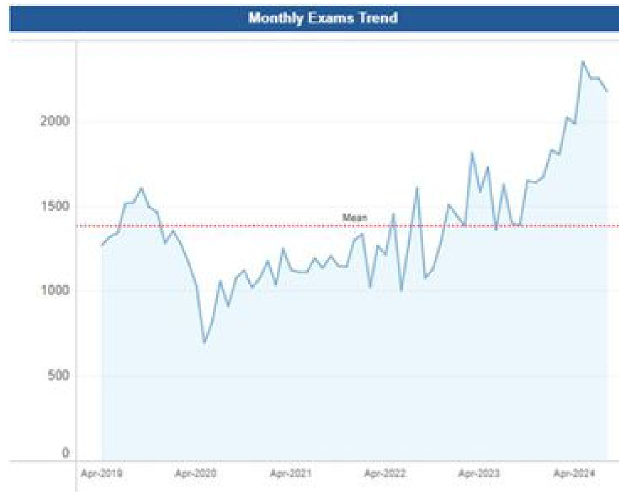
- Echocardiography performance has declined throughout 2024/25 to date.
- Inpatient demand and overall activity has been stable; therefore, pressure is driven by activity reduction compared to 2022/23. Activity is below the operational plan for 2024/25.
- Planned work with Four Eyes will also support demand and capacity analysis as part of a review of cardiology more widely.
- A plan is place to purchase handheld scanners that can be used in ED/AMU to help reduce the urgent inpatient demand.
- GP open access for Echo referral is under consideration with learning from other areas across the South West to be reviewed.
- A full workforce plan is being developed by the service:
  - Recruitment to substantive posts for the CDC Echo Clinic is underway now that recurrent funding beyond 2025 has been confirmed.
  - A 7-day Echo service is being scoped – this would require additional staffing (2 WTE B7 Physiologists and 2 WTE administrators) and would support timely response to demand for inpatient Echo diagnostics. A business case is in development.
  - An Echo support worker is within the 2025/26 business plan to improve service productivity and efficiency.

Improving Services & Delivering Outcomes

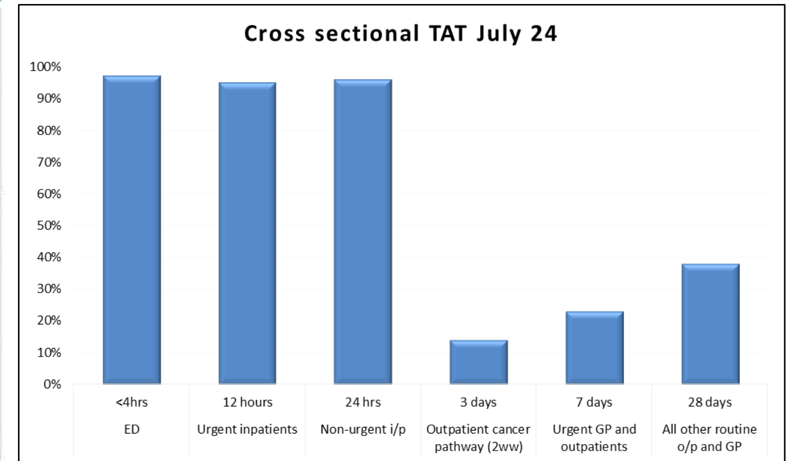
Area of focus: Diagnostics – Turnaround Times CT and MRI

ED referrals demand

2ww referrals demand



Reporting times



Inpatient and Emergency department referrals are reported within target timescales for CT and MRI, however urgent cancer and GP referrals as well as routine scans are missing reporting target timescales by some distance. ED demand has been rising, putting pressure on the imagine service to be able to deliver routine work in a timely manner.

80% of cancer referral scans are reported within 10 days, but this misses the 3-day target by a week and puts pressure on the 28-day Faster Diagnosis Standard. Cancer scan demand has also been increasing.

Recovery actions include a new outsourcing strategy due to go live imminently, review of job plans to increase capacity, and audit of referrals to ensure they are being made appropriately. Specific work on the cancer pathways includes reducing referral to appointment time for scans. Additional workforce is being scoped to support performance, with a business case being worked up.

Imaging service	Referral category	Maximum TAT
Cross-sectional imaging: – CT, including cone beam CT – MRI	Urgent inpatients	12 hours, with <4 hours post acquisition of images for ED or acutely unwell inpatients (includes radiologist trainee provisional reports)
	Non-urgent inpatients	24 hours
	Outpatient faster diagnosis standard cancer pathway	3 days
	Urgent GP and outpatients	7 days
	All other routine outpatient and GP studies	28 days

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- There has been improvement across several UEC performance metrics throughout July and August. In August, 62.7% of patients were seen and treated and admitted/ discharged within 4 hours or less in a Type 1 setting. Gloucestershire system saw 77.6% of patients in all settings within 4 hours. Performance across UEC services remains fragile, with the last two weeks of August seeing a dip in performance in Type 1 settings, following a four-week period where Type 1 performance was above 64% (from 22nd July to 12th August). GHFT has been selected as one of 19 trusts nationally for additional focus to improve ED performance and all system partners are working with NHSE in delivery of the UEC Year 2 recovery plan to take up this opportunity for extra support.
- There has been significant improvement in the number of patients in hospital with No Criteria to Reside (NCTR) at GHFT. The lowest number of patients with NCTR (106) on record was reported in the first week of September, with numbers now routinely averaging ~130, down from an average of 184 throughout 2023/24.
- Ambulance average response time for Category 2 incidents was 32.0 minutes in August 2024, just above the 30 minute ambition (interim performance target for 2024/25). Continued focus on ambulance handover delay in both SWAST and GHFT has led to a reduction in total hours lost to handover delay, which has dropped to 1900 hours in August (from over 3000 per month in Q1 of 2024/25). Average handover time in August has improved to 49.5 minutes.
- The August bank holiday impacted performance against the abandonment rate target (3%) in the NHS111 call service – with performance in the final week of August deteriorating to 7%, driven by increased demand and abandonment performance at 15% on the bank holiday Monday following several weeks of performance which met the target. Overall, August abandonment performance was 3.2% of calls made to the service.
- The new Integrated Urgent Care Services (IUCS) covering NHS111, a clinical assessment service and Out of Hours service will mobilise at the end of November 2024 with joint work ongoing between the ICB and the provider Gloucestershire Health and Care NHS Foundation Trust who will deliver the IUCS in a partnership with social enterprise organisation Integrated Care 24 (IC24), who currently deliver services such as 111 in other areas of England.
- The Working As One programme has been identifying key operational actions to help support delivery of performance, specifically focussing on a quality and improvement approach. As the infrastructure around this programme begins to be stepped down in the coming months the system will ensure focus on these requirements is maintained to ensure long term benefits can be delivered and sustained across the whole system.

Improving Services & Delivering Outcomes

Elective Care

- There is increased national scrutiny on all patients waiting over 65 weeks for elective treatment, with the national target to eliminate these by the end of September now reviewed weekly in tiering meetings with systems. GHFT continues to work to provide additional capacity and use alternative providers to meet the target in September, current forecasts show expected breaches reducing week on week as patients are booked in – current forecast is 50 65 week breaches at the end of the month. Specialties providing additional capacity include ENT, Cardiology and Urology, with specific waiting list initiatives also planned for cardiology and spinal surgery to reduce risk of breaches further.
- RTT performance was 65.7% in July (% of the waiting list under 18 weeks). The overall waiting list remained stable at 78,365 patients. 52-week waits decreased from 2,920 in June to 2724 in July and 65-week waits reported in July were at 549. There were 9 over 78-week waits for Gloucestershire patients in July (1 at GHFT in Oral Surgery).
- Elective recovery fund update: M4 2024/25 Flex is currently calculated based on the baseline used for the 23/24 calculation with an uplift for 24/25. The 24/25 baseline will be finalised by NHSE therefore may be subject to change. Current performance is showing Value Weighted Activity at 117.2% of 2019/20 including pathways avoided to the end of M4 (this includes activity recovery overall of 112.6% at GHFT, and all avoided pathways using Advice and Guidance). This is likely to increase when finalised data is available (M3 Freeze position is 119.8%. The operational plan commitment for ERF in 2024/25 is to reach 118% of 19/20 levels, so the system remains on target).
- Use of Advice and Guidance (A&G) continues to be strong in the county with total use of A&G running at 65% above planned levels in 2024/25 to date, including the use of Referral Assessment services (RAS). GP collective action may impact this performance in coming months and will be kept under review.
- Patients discharged to a Patient Initiated Follow Up pathway (PIFU) continue to be above planned levels, ensuring that patients are avoiding unnecessary return trips to hospital, and can refer themselves for continued support if required.
- A finalised M12 position from NHSE has not yet been received for 2023/24, so the full year performance against the Elective Recovery Fund target for 2023/24 remains in draft at 105.6% M12 freeze based on our local data. The target for the year had been reduced to 103% to account for the impact of industrial action.

Improving Services & Delivering Outcomes

General Practice

- 400,397 appointments were delivered in general practice in Gloucestershire in July 2024. Same day appointments made up 41.3% of these - 165,167 appointments across the month.
- Performance against the appointments offered within 2-weeks metric 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 (July) showed that 81.8% of these appointments were booked within 2 weeks of the request, against the operational planning target of 75%.
- The percentage of appointments that were conducted in a face-to-face setting has decreased in July 2024 by 8.1% to 64.7% of appointment activity, compared to a national drop of 4.4% for the same month. However, the number of actual face to face appointments in Gloucestershire has increased from 217,904 in July 19 to 259,202 in July 24. This is an increase of over 40,000 Face to Face appointments. Gloucester has increased overall appointments by c.48,000 since July 23.
- Compliance with FIT testing for Lower GI suspected cancer referrals continues to be strong, with 81.1% of referrals being sent with recent FIT test results, above the planned target of 80%.

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 72% of contracted dental units are delivered. Annual access figures show that from our population, 29.5% adults have seen an NHS dentist in the last 24 months, and 50.9% of children have seen an NHS dentist within 12 months.
- 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

- A key target for 2024/25 is the increase in the Faster Diagnosis Standard (FDs) threshold (people receiving a diagnosis or all clear following a cancer referral within 28 days of the referral being made), from 75% of patients to 77% by March 2025. The system continues to be on target to meet this expectation, with latest performance (June 2024) at 76.7%. This was similar to the national position which was 76.2% in July. GHFT continues to focus on improving FDS performance which will in turn impact on 62-day performance (the majority of patients breaching the 62-day treatment target, first missed the FDS target).
- Specialties failing to reach 75% in the FDS standard have consistently been Gynaecology, Head and Neck, Urology, Haematology and Non-specific symptoms throughout 2024/25 – Urology and Head and Neck in particular are specialties with long elective backlogs which is also contributing to performance pressure. Additional capacity in these specialties has now commenced though focus will still be required to reach Best Practice Timed Pathway (BPTP) milestones. Lower GI has met the 75% threshold for FDS to date in 2024/25 due to the increased endoscopy capacity, however is struggling to meet the BPTP milestones and a review of the diagnostic pathway is taking place to stratify referrals based on FIT testing, as well as scoping the possibility of an offer of capsule colonoscopy via a joint clinic with NBT. A deep dive into the gynaecology and Lower GI pathways has now taken place and action plans are being drawn up to improve performance.
- 62-day performance declined in July to 65.3% (patients treated within 62 days of referral), with over half of the total breaches of the 62-day target occurring in the Urology pathway (72/121 breaches). National performance against the 62-day target was 67.7% in July. The interim 62-day treatment target for 2024/25 is to reach 75% by March 2025. Focus on the Urology and Lower GI pathways will be needed to ensure this can be sustained. Lower GI has recently seen improved performance against the treatment target improving to reach 68.1% (the highest in the last three years) in June and 65.0% in July following the reduction of backlogs in the early diagnostic part of the pathway.
- 31-day treatment performance improved to 95.3% in July, narrowly missing the 96% target. National performance against the 31-day treatment target was substantially lower, at 91.9% in July.

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 July performance for core CAMHS at GHC at 55.2% - 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. Patient choice is also having an impact – with exams and holidays contributing to requests for later appointments.
- Talking Therapies recovery rate remains excellent, at 56.5% in July 2024. Reliable recovery rates were 52.9% (meeting the operational planning commitment of 48%), while recovery 68.1% (meeting the operational planning target of 67%). Completed treatments in July 2024 were significantly higher than plan (656 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, alongside a recent increase in staff sickness which has contributed to a decline in performance against appointments within 2 weeks of referral (17.9% in July). All referrals were seen within 6 weeks.
- Out of Area placement days continue to be low, in 2024/25 in the end of July there was 1 patient at the end of each month inappropriately out of area at each month end. No patients were out of area inappropriately at the end of August (there were two appropriate placements) and the total number of bed days inappropriately out of area in 2024/25 is currently 24/25 out of area placements to date are on track to meet operational plan commitments.
- 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.
- Gloucestershire had two regional winners in the South West Parliamentary Awards. These were our VCSE partner the Music Works and Gloucestershire Health and Care NHS Foundation Trust's Mental Health Liaison and Emergency Department team. They both now go through to the national awards.

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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Our People (Workforce)

Please note: The Workforce report is updated bimonthly.

Our People Strategy: Focussed Pillars

Recruitment and Retention

- Independent Social Care sector international recruitment applications have slowed down, scope of this project to be expanded to include displaced workers who already in the UK.
- Independent social care and primary care collaborating pastoral care for internationally recruited staff.
- Both Trusts are currently under the 3.2% agency spend as % of total pay spend cap. As at M4 GHC is at 2.1% and GHFT 3%.

Innovation

- Enabling staff movements project formally commenced with a focus on Digital Staff Passports (for NHS trusts). Working in collaboration with regional ICS partners in BNSSG and BSW
- The Housing Hub officer post is being recruited to

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 finalised. County-wide Circle 2 Success careers fair in November. Aiming to attend as a system with representation from each organisation.
- Several non-clinical T-Level placement students are being planned for the ICB and social care.
- Supported internship student from Glos Coll starting in September for 6 months at the ICB across business admin/comms/WWY team
- T-Level in health with a focus on social care is going to be delivered from September by Cirencester College. Several providers have expressed an interest in hosting a T-Level student placement.
- Successful Primary care information days resulting in an increase in enquiries for apprenticeship information. Widening participation in primary care information week planned for September
- ICS Apprenticeship Strategy approved and to be published in October
- Apprenticeship & Careers website – information collation started. One Glos website being populated.
- Care Leavers Covenant –Final report and exec summary completed. Moving to implementation and monitoring phase
- ICS work experience 'one stop shop' being developed.

Our People (Workforce)

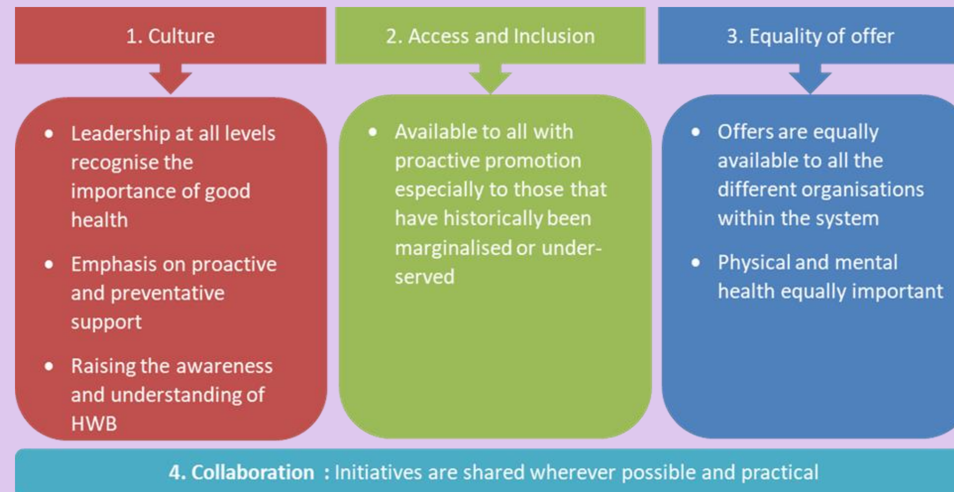
Please note: The Workforce report is updated bimonthly.

Our People Strategy: Focussed Pillars

Valuing and looking after our people

Staff health and wellbeing strategy ratified by People Committee with the following vision and key themes:

Vision: Supporting you to thrive in work and life.



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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Foundation Themes

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

- Inclusive recruitment practices workshop held where the significant work taking place across each of the organisations was shared and opportunities for collaboration explored.
- Communications launched and registrations opened for the ICS Leadership conference to be held in October. The theme for this second conference is “Turning Uncertainty into Opportunity”. To date over 150 delegates have registered for the conference.
- Collaborative Leadership programme for first time leaders, two pilot cohorts agreed planned for delivery 2025. This will complement organisational programmes.
- Regional workforce planning support being explored for nursing, pharmacy and ARSS roles in primary care
- Digital workforce strategy in final stage of development, projects focused on Essential Digital Skills, Learning Management Systems, Technology Enhance Learning

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes
(Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality
(Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The POD Quality Report for Q1 has been received from the SW Collaborative Commissioning Hub (CCH). The CCH report that no new issues, risks, concerns, or patient safety incidents relating to ICB community pharmacy, optometry and dental services were notified to the SW Quality and Patient Experience Team in Quarter 1. There is one ongoing safeguarding concern under investigation.4 dental complaints, 1 pharmacy complaint and no optometry complaints were received in Q1.

Maternity

- The Quality Improvement Group (QIG) chaired by the CNO continues following a CQC section 31 warning notice. The service remains rated inadequate and is on increased surveillance, under the National Quality Board Guidance. The QIG remains bi-weekly to ensure rapid improvement is achieved and progress is being seen in the 5 workstreams, Included in the QI programme are also 2 other areas identified as a concern, antenatal screening and scanning capacity. Updates and progress on all 7 are reported to the QIG. The Maternity service remains on the NHSE Safety Support Programme. The trust also reports all progress monthly to the CQC. There has been an increased focus on Governance in Maternity Services, ensuring that it aligns with the Trust Governance processes.
- The Trust has commissioned 2 external reviews –one related to Maternal deaths over the last 7 years and one related to neo natal deaths over the last 3 years. This will provide assurance and identify any further thematic learning. The ICB facilitated a review of 3 cardiac cases, with external support from the maternity medicines network, outstanding practice was identified in all 3 cases. Maternity PSIRF workshops have taken place, a maternity process is being developed aligning with the Trust plans.

Urgent and Emergency Care - Working as One

- Progress across the main delivery workstreams:
- Rapid Response Capacity and Demand modelling work, and the Front Door changes in AMU and Frailty becoming BAU
- Hospital Flow has been prioritising improvement in the medical division Length of Stay improvements project.
- Intermediate Care trials starting to see positive results.
- At the Benefits workshop GHFT presented their improved position particularly re. the improved quality resulting from the UEC system improvements.
- Digital workstream has been progressing

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 GHFT and the LMC to resolve the interface issues from Badgernet. Good progress in the majority of areas 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, one patient has had to return to BH after a period of challenging behaviour, GHC are working closely with the provider to support a transition back into the community.
- Work has commenced to amend the current format of the Trust's Quality Dashboard to an Integrated Quality and Performance Report.
- There has been a small increase in pressure ulcer harm incidents. Levels remain within upper control limits, but additional training, monitoring and oversight is in place. A deep dive into Community Nursing Services and pressure ulcers is due to report at Novembers Quality Committee.
- Due to steady improvements in wait times, recruitment and retention, the Trust is pleased to report a reduction in the CAMHS risk rating with data also showing improvements in MH inpatient demand and capacity. A pleasing IPC Annual Report was received by the Trust's Quality Committee this month. The Allied Health Professional Annual Report and Learning from Deaths Report for Q1 was also presented.

Migrant Health

- The remaining hotel has seen a significant downturn in new arrivals (currently at 65% capacity).
- Beachley Barracks continues to see new arrivals with currently over 600 Entitled Personnels (EPs) on site. Longest stay – 25 Entitled Personnels (EPs) who arrived in November 2023.Following a policy update from NHSE, all Entitled Personnels (EPs) across both sites are now requiring a permanent GP registration. There are currently one hundred 5 years and under, which is putting a strain on the Health Visiting team. Plus 10 pregnant women on site. Onsite medical provision through GDOC continues and is working well. The team are working with Public Health and the Birmingham Infection Diseases Team regarding child presentations.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Patient Safety Incident Investigations

- Under PSIRF organisations are prompted to respond proportionally. This might be through new SWARM huddles or After-Action Reviews. For the most complex events, organisations can open a Patient Safety Incident Investigation (PSII).
- In July and August 2024 three PSIIs have been opened; two at GHC and one at GHFT. Two of the three involved an unexpected death and will go forward for a full investigation with the respective Trusts' boards holding oversight, as is policy under PSIRF.

PSIRF development

- Providers have started to work on updates to their Patient Safety Incident Response Plans to incorporate changes based on learning from 'work as done' over 'work as imagined'. This includes specific plans for maternity related events.

Quality Alert

- We are currently working with ICB Communications colleagues to develop a new webform to enable GPs to report Quality Alerts. This will support system facilitation of problem resolution.

Patient Safety Huddles

- ICB safety huddles continue every Tuesday morning at 9am. One key discussion has been around how we can develop PSIRF and LFPSE with primary care.

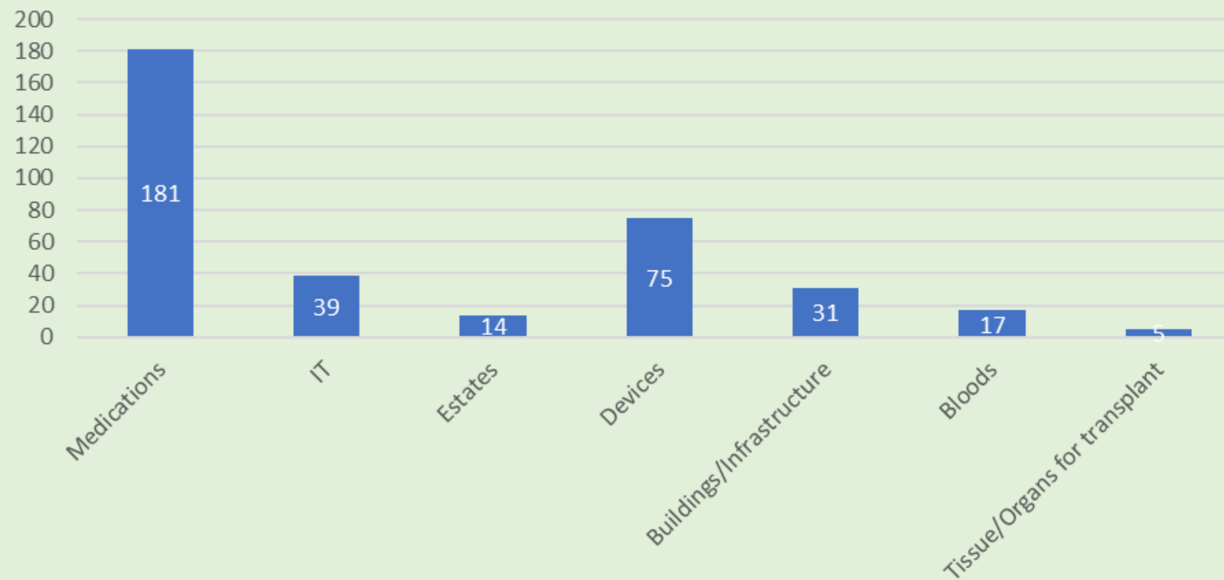
Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Safety

Learn from Patient Safety Events (LFPSE)

- NHS England have launched the first version a new tool that will eventually enable the ICB to look at whole system data. While LFPSE is aimed to deliver Machine Learning of all incidents across the whole of England, we have now started to receive Gloucestershire data. Events are increasing each month with 2714 events being reported in August 2024.
- These break down to GHFT = 1292, GHC =1367 and others = 55
- Reporters are asked to classify events and while the majority go unclassified, there is an emerging theme that medication events are consistently the highest classified. Of those reported only seven were considered to have potentially caused moderate physical harm linked to dispensing errors, dosing errors and missed medications.
- All seven were from different specialities process GHFT and GHC.



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Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test (FFT) April 2023 – April 2024 [May data not yet available at time of preparing this report]

		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%	92%
	% Negative	4%	3%	3%	3%	5%	6%	5%	5%	6%	4%	3%	3%	4%
GHT A&E	% Positive	83%	81%	78%	79%	78%	75%	73%	78%	77%	78%	76%	77%	79%
	% Negative	12%	11%	14%	12%	13%	17%	16%	13%	15%	14%	17%	16%	14%
GHC Mental Health	% Positive	87%	83%	87%	82%	89%	83%	82%	80%	85%	78%	87%	86%	86%
	% Negative	7%	6%	6%	7%	5%	10%	10%	10%	5%	10%	6%	6%	6%
GHC Community	% Positive	94%	94%	95%	94%	95%	94%	94%	94%	95%	96%	95%	94%	95%
	% Negative	3%	3%	3%	3%	2%	3%	2%	3%	2%	2%	2%	3%	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.

Quality – Safety, Experience and Effectiveness

Please note: The Quality report is updated bimonthly.

Effectiveness

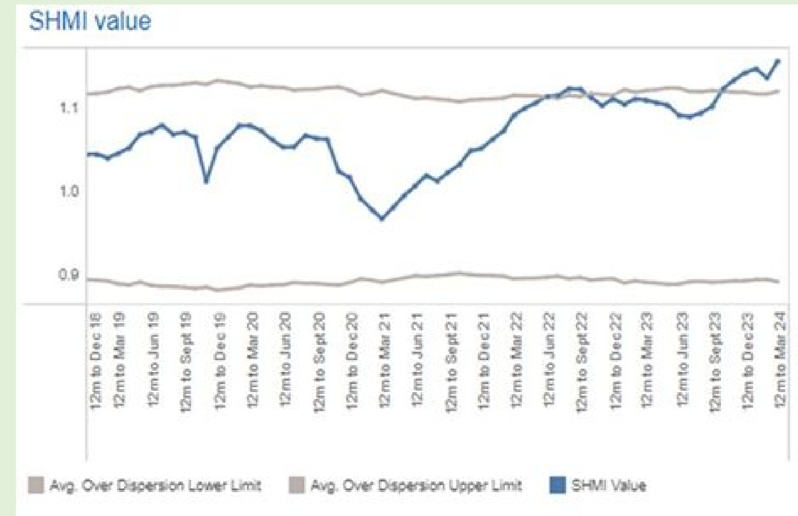
System Clinical Effectiveness Group

- 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 1.158.
- Existing actions to address this will now be brought together under a 'Quality Improvement Group' (as set out by the National Quality Board). This will be led by the ICB and supported by NHS England.

- Key workstreams include:
    - Primary diagnosis audit
    - Dementia coding review
    - Excess mortality clinical audits/improvement plans
    - Weekend admission variation
    - ED Delay related Harm data review



Medical Examiner Roll-out

- The Medical Examiner Service rolls out to all non-coronial deaths from 9th September. This will have a significant impact on Primary Care with the ICB working to address concerns.

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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NHS

ICS Finance Report

Month 5 2024/25 – August 2024

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Finance and Use of Resources

Key Financial Performance Indicators : Dashboard (1)

	Month 5 Plan	Month 5 Actual	Month 5 Variance	Previous Month Variance	Month 5 Actual GHC	Month 5 Actual GHFT	Month 5 Actual GICB
Overall System Financial Performance			**Surplus / (Deficit)**				
Year to Date (£m)	(9.2)	(8.9)	0.3	(0.6)	0.3	(9.2)	0.0
Year End Forecast (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Efficiency Plan Status							
Year to Date Delivery (£m)	33.1	32.6	(0.4)	2.9	6.4	11.2	15.1
Year to Date Delivery (%)	100%	99%	(1%)	11%	100%	127%	84%
Forecast Outturn Delivery (£m)	93.2	93.2	0.0	0.0	0.0	0.0	0.0
Forecast Outturn Delivery (%)	100%	100%	0%	0%	100%	100%	100%
System Capital			**Over / (Under)**				
YTD spend against total CDEL (£m)	18.1	8.5	(9.6)	(6.1)	1.3	7.3	0.0
FOT spend against total CDEL (£m)	59.8	57.8	(2.0)	(2.0)	8.7	46.0	3.1

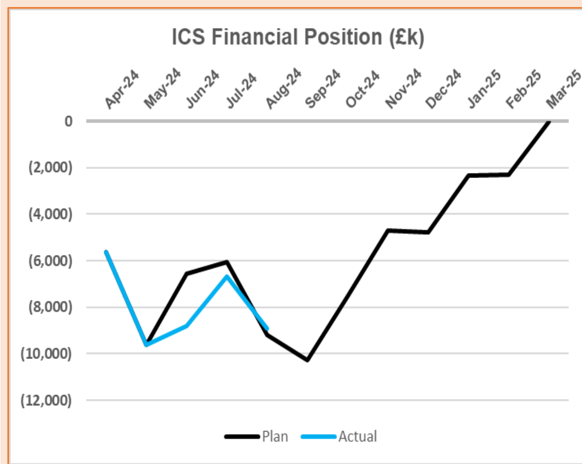
Finance and Use of Resources

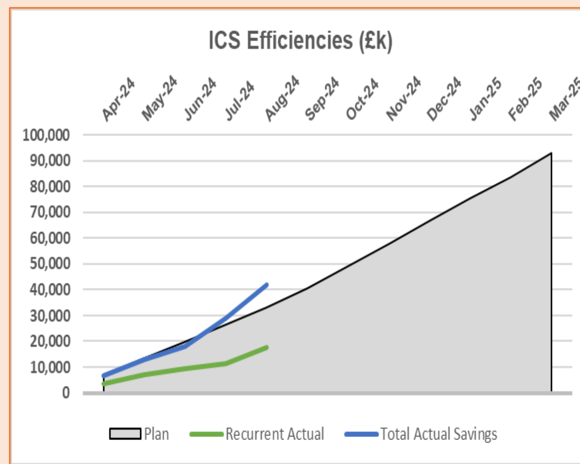
Key Financial Performance Indicators : Dashboard (2)

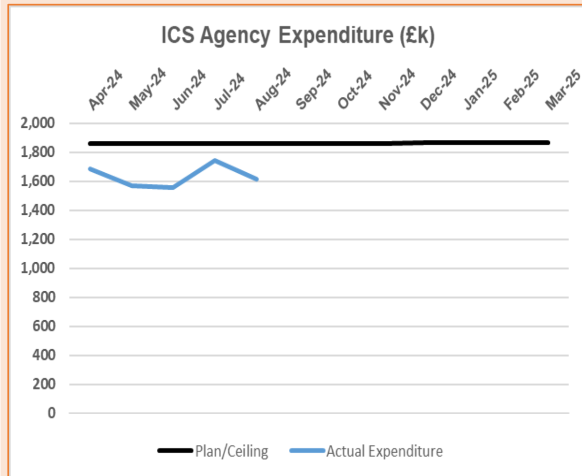
	Month 5			Previous Month	Month 5 Actual	
	Plan	Actual	Over / (Under)		GHC	GHFT
Workforce						
Year to Date Agency expenditure v Cap (£m)	9.3	8.2	**(1.1)**	**(0.9)**	2.0	6.1
Forecast Outturn Agency expenditure v Cap (£m)	22.3	20.5	**(1.8)**	**(1.7)**	5.1	15.4
YTD Agency spend as % of total Staff costs	3.2%	2.7%	**(0.5%)**	**(0.5%)**	2.1%	3.0%
Liquidity (Cash)						
Year to Date Cash Balance v Plan (£m)	90.0	101.2	**11.2**	**17.8**	44.9	56.3
Forecast Outturn Cash Balance v Plan (£m)	81.2	89.6	**8.4**	**9.3**	52.6	37.0
Other Key Financial Indicators						
Better Payment Practice Code (no. organisations not complying with 95% payment volume and value targets)			**1**			
Elective Recovery Fund fully coded flex performance v 19/20 baseline			**119.8%**	**118.9%**		

Finance and Use of Resources

ICS Financial Performance Overview: Analysis (1)







Key risks to delivery of the financial plan

- Delivery of the system savings plan.
- Delivery of the Working as One programme.
- Collective GP industrial action
- 24/25 pay award being fully funded by NHSE.
- ERF activity over performance being fully funded by NHSE.

System Financial Position

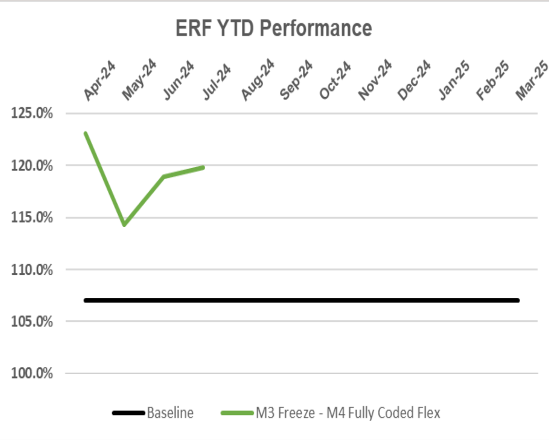
- The System set a challenging plan including a high level of savings to deliver a breakeven financial plan. Savings schemes are progressing, however, there slippage against plans. The value of recurrent savings is lower than needed by the system to maintain or improve the underlying financial position. Delivery plans for the £15m stretch are in various stages with the majority in delivery and a smaller number being scoped. The financial risk remains significant.
- The year-to-date variance is a surplus of £0.3m. This is due to non-recurrent benefits released by GHFT. These benefits are offsetting other GHFT pay overspends in nursing, non-pay overspends in the medicine division drugs and clinical supplies. The ICB and GHC are breakeven versus plan. All organisations are forecasting breakeven by year end. Recovery actions are in place within organisations to manage expenditure in line with plan and identify schemes for unidentified savings.
- **Efficiencies**: slippage against the working as one savings delivery has been flagged, this is currently being assessed and non-recurrent mitigations are being progressed. The recurrent level of savings for the year is 40% of total savings which is below the value required to maintain the underlying financial position. Full delivery of efficiency plans by year end is forecast.
- **Agency**: M5 agency expenditure was £1,611k. The year-to-date expenditure versus total pay bill is 3.0% for GHFT and 2.1% for GHC.

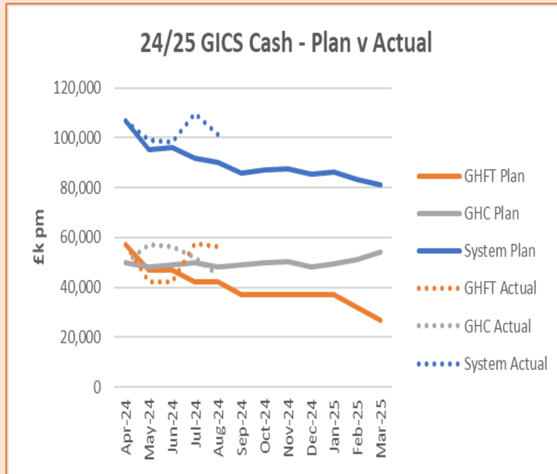
Finance and Use of Resources

ICS Financial Performance Overview: Analysis (2)

Full Year Charge Against Capital Allocation (£m)

System Capital Allocation	44.7
Disposal	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	82.0%	N	89.1%	N
GHFT	98.5%	Y	97.7%	Y
GICB	96.7%	Y	99.7%	Y
System Average	92.4%	N	95.5%	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. Subsequent performance has reduced. Within the M4 flex position there are a number of uncoded episodes of care which once coded may generate an additional c£585k to ERF achievement and improve the July position at 117.2% VWA.

Cash

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

Better Payment Practice Code

- System achieving target in respect of YTD volume of invoices paid. GHC below target due to focus on clearing old invoices and tightening up on procedures for receipting that is impacting short term performance. Action plan in place to address.

Finance and Use of Resources

System Financial Risks: Overview

Key Financial Risks	Mitigating Actions
Slippage or non-identification of savings, leading to a worsening of the financial position. Unidentified savings c£2.8m (previous month £4.6m): red rated savings £19.6m (previous month £21.7m). The Working as One programme savings are now forecast to slip by c£6m.	Savings monitored monthly through the Programme Delivery Group and Strategic Executive meetings as well as via internal governance routes, monitoring being strengthened. Working as One Programme Board focus on the delivery of cashable savings and implementation plan to deliver savings. The identification of further non recurrent savings in progress to mitigate risk of part year impact of recurrent savings delivery
The ICB & Systems plan are dependent on delivery of the elective activity as per the plan; the Elective Recovery plan is 118%, the overall value of the additional elective recovery funding (ERF) above the baseline value is c£18.5m. The plan is currently on trajectory; however escalation pressures could impact on delivery. The range of risk is c£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. The risk of impact in this financial year is reducing with more significant impact potentially in 2025/26.	The potential impact on services and costs is being reviewed based on available information, the system is responding to consultations as they are issued.
Primary Care: high risk of contract hand back due to growing operational & financial pressures. Indicative direct costs £0.6m -c£1m per practice.	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices is underway to identify issues early and work with practices on mitigating actions which can include investment in training and additional support.
GP collective action has started planned, the impact of which is could be significant. Direct financial risks include prescribing savings, c£1.1m, advice and guidance ERF, £3.5m.	Planning for industrial action across the system is managed within organisations and across the system drawing on experience from 23/24 to minimise impact. GP collective action impacts are being assessed.
ICB delegated POD (Pharmacy, general Ophthalmic, and Dental) budget activity flagging a potential overspend risk, c£400k	Activity being validated with delegated host organisation.
Publication of new MH White paper; this is assessed to be more likely to impact now in 2025/26	Circa £1m of additional costs in respect of more staff to deal with new processes outlined in paper.
Winter pressures in respect of higher activity and staffing costs.	Advance capacity and resource planning.

Finance and Use of Resources

System Efficiencies

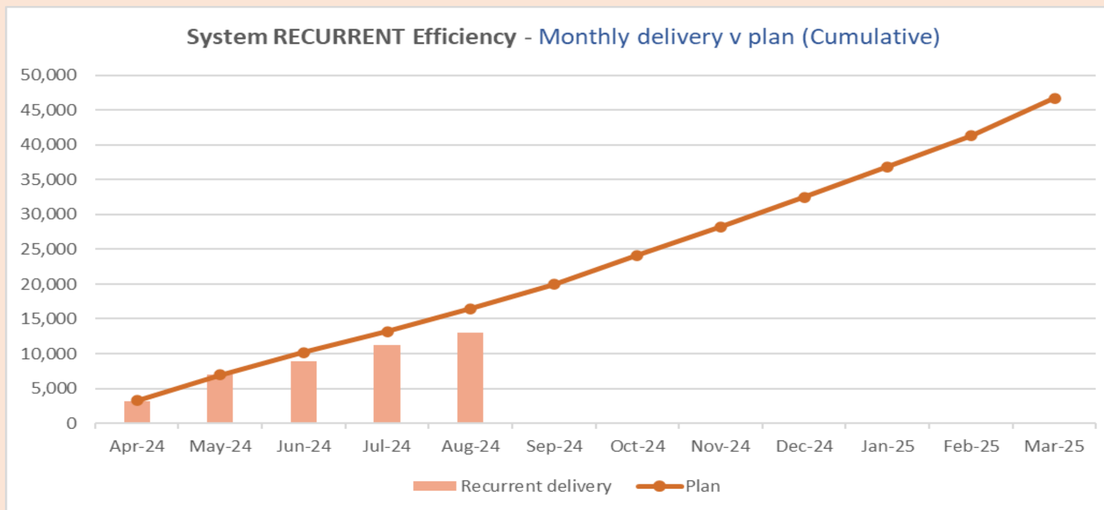
	PLAN	FORECAST							
Organisation	Savings requirement	Forecast Savings	Unidentifed	Identified Schemes Total	High	Medium	Low	Recurrent	Non-Recurrent
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gloucestershire Hospital's NHS Foundation Trust	37,389	37,389	-	37,389	9,400	10,710	17,279	19,650	17,738
Gloucestershire Health & Care NHS Foundation Trust	12,980	12,980	2,673	10,307	2,673	2,145	8,162	7,319	5,661
ICB	29,578	29,578	-	29,578	1,500	10,686	17,392	13,694	15,884
System-Held - (Incl. part of £15m Recovery)	13,293	13,293	80	13,213	6,062	2,028	5,203	9,175	4,118
Gloucestershire System Financial Savings Plan - 2024/25	**93,240**	**93,240**	**2,753**	**90,487**	**19,635**	**25,569**	**48,036**	**49,838**	**43,401**
Percentages compared to Savings Plan Requirement	**100%**	**100%**	**3%**	**97%**	**21%**	**27%**	**52%**	**53%**	**47%**
Other Recovery Actions	5,200	7,012	0	7,012	1,000	1,500	4,512	2,812	4,200

- ICB System-Held unidentified savings have now reduced from the month 4 position of £1.924m. These changes result in this reducing to £0.08m at Month 5.

Finance and Use of Resources

System Efficiencies

	System Plan	System Actual	Over / (Under) Delivery	GHC	GHFT	GICB
Efficiency Plan Delivery (YTD £k)	33,083	32,650	**(433)**	0	2,373	(2,805)
Efficiency Plan Delivery (YTD %)			**99%**	100%	127%	84%
Efficiency Plan Delivery (FOT £k)	93,240	93,240	**0**	0	0	0
Efficiency Plan Delivery (FOT %)			**100%**	100%	100%	100%



System Savings

- System savings for the Working as One Programme are now forecast to slip against the in-year plan, the level of slippage is currently being assessed. Non recurrent mitigating actions are being identified by all partners. The focus for the programme remains delivery of the full recurrent savings.

ICB

- The medicines management programme is underway with good progress being made, the key risk to delivery is the potential impact of GP Collective action.

GHC

- GHC is slightly ahead of plan on delivery of both recurring and non-recurring efficiencies at M5. Recurrent savings delivered at M5 were £3,137k, ahead of plan by £391k. Non recurrent savings delivered at M5 were £3,765k, ahead of plan by £150k. Overall FOT efficiencies remains breakeven v plan. There remains a risk to delivery of full recurring savings target.

GHFT

- Although ahead of plan, two thirds of achieved savings are non-recurrent, impacting on the underlying financial position. The programme is weighted into H2, in addition to being red rated. The £2.4m favourable variance relates to interest receipt benefits, and timings of one-off items compared to plan. Areas of additional savings are being developed within medicines management, digital, commercial income and reviewing different models within surgical wards.
- The volume of high-risk schemes is reducing.

Finance and Use of Resources

System Capital: Performance

YTD (£k)				
	GHC	GHFT	ICB	System
DIGITAL	515	1,689	0	2,204
MEDICAL EQUIPMENT	4	183	0	187
ESTATES	699	4,273	0	4,972
OTHER	0	(77)	0	(77)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**1,218**	**6,068**	**0**	**7,286**
IMPACT OF IFRS 16	34	526	0	560
Total Charge against Capital Allocation (including impact of IFRS 16)	**1,252**	**6,594**	**0**	**7,846**
NAT PROG. GRANTS, DONATIONS & OTHERS	0	1,806	0	1,806
Gross Capital Spend Total	**1,252**	**8,400**	**0**	**9,652**
Less Donations and Grants Received and PFI	0	(1,145)	0	(1,145)
Total Capital Departmental Expenditure Limit (CDEL)	**1,252**	**7,255**	**0**	**8,507**
Plan	2,636	15,428	0	18,064
Over / (Under) Plan	**(1,384)**	**(8,173)**	**0**	**(9,557)**

FOT (£k)				
	GHC	GHFT	ICB	System
DIGITAL	3,515	7,020	964	11,499
MEDICAL EQUIPMENT	903	8,953	0	9,856
ESTATES	5,071	20,157	150	25,378
OTHER	(2,000)	(77)	28	(2,049)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**7,489**	**36,052**	**1,142**	**44,683**
IMPACT OF IFRS 16	1,215	7,412	0	8,627
Total Charge against Capital Allocation (including impact of IFRS 16)	**8,704**	**43,464**	**1,142**	**53,310**
NAT PROG. GRANTS, DONATIONS & OTHERS	0	4,265	2,000	6,265
Gross Capital Spend Total	**8,704**	**47,730**	**3,142**	**59,576**
Less Donations and Grants Received and PFI	0	(1,758)	0	(1,758)
Total Capital Departmental Expenditure Limit (CDEL)	**8,704**	**45,972**	**3,142**	**57,818**
Plan	8,704	45,972	5,142	59,818
Over / (Under) Plan	**0**	**0**	**(2,000)**	**(2,000)**

GHC

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

GHFT

- Headline drivers of YTD position being £8.2m behind plan are:
    - Right of Use Assets (£4.6m) driven by two contracts.
    - CT/MRI Services (£2.7m) Delay in entering into new contract due to understanding operational need and procurement requirements. Expected to be concluded soon.
    - Cirencester Lease (£1.1m) Delay in entering a new agreement with GHC to continue to use Cirencester Theatres. Initiating talks with GHC to prepare terms.
- Operational Capital - IGIS (Estates) (£1m) – Delays in project and revised timetable agreed, expected to close gap by M7.
- Medical Equipment replacements (>£1m) – Holding contingency to cover any unplanned equipment failure.

ICB

- The ICB capital plan relates to GP IT and minor improvement grants is planned to take place from quarter 2 onwards.
- The system plan is an underspend of £2m against the system capital resources with the intention to use this for the 25/26 capital programme. Forecast outturn is to deliver the plan.

Finance and Use of Resources

Elective Recovery Fund (ERF): Overview

- ERF data reported in month 5 is based on the month 3 freeze (fixed), and month 4 flex (interim) position.
- NHSE have still not yet released the granular baseline data for 24/25 reporting, so all performance is based on those baselines issued for 23/24 with an uplift for 24/25.
- The national baseline for Gloucestershire is 107% value weighted activity (VWA) against the 2019/20 baseline and Gloucestershire's plan is 118% VWA of the 2019/20 baseline.
- The Out of County position now only refers to contracted providers (low value activity is now excluded).

		Apr	May	Jun	Jul	YTD (Flex)	YTD (Freeze)
Total ICB (incl. A&G)	Plan	13,407,518	14,449,579	13,536,801	15,313,917		
	% Target	107.0%	107.0%	107.0%	107.0%		
	Actual 2019/20	12,530,391	13,504,279	12,651,216	14,312,072	52,997,957	38,685,886
	FLEX - 2024/25	*14,420,977*	*14,342,109*	*14,148,014*	*15,797,533*	62,131,795	
	FREEZE - 2024/25	*15,548,499*	15,498,342	15,287,421			46,334,262
	Graph	*15,548,499*	15,498,342	15,287,421	15,797,533		
	% of 19/20	124.1%	114.8%	120.8%	*110.4%*	117.2%	119.8%
	Variance (Plan)	£ 2,140,981	£ 1,048,763	£ 1,750,620	£ 483,617		

- Within the July position there are 361 episodes of care currently generating a UZ code, these could generate an additional c£585k to the overall ERF achievement.

Finance and Use of Resources

System Workforce: Worked WTE

Worked WTEs per Organisation (PWRs)						
	GHC	GHFT				System Total
		GHFT (excluding GMS)	GMS	Total		
March (M12) 22/23	**4,443.5**	**7,983.6**	**686.0**	**8,669.6**		**13,113.1**
Movement M1-7 of 2023/24	70.9	20.4	28.2	48.6		**119.5**
October (M7) 23/24	**4,514.4**	**8,004.0**	**714.2**	**8,718.2**		**13,232.6**
Movement M8-12 of 2023/24	74.0	299.9	46.7	346.6		**420.6**
March (M12) 23/24	**4,588.5**	**8,303.9**	**760.9**	**9,064.8**		**13,653.2**
August (M5) 24/25	**4,577.3**	**8,349.9**	**774.1**	**9,124.1**		**13,701.3**

- 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.

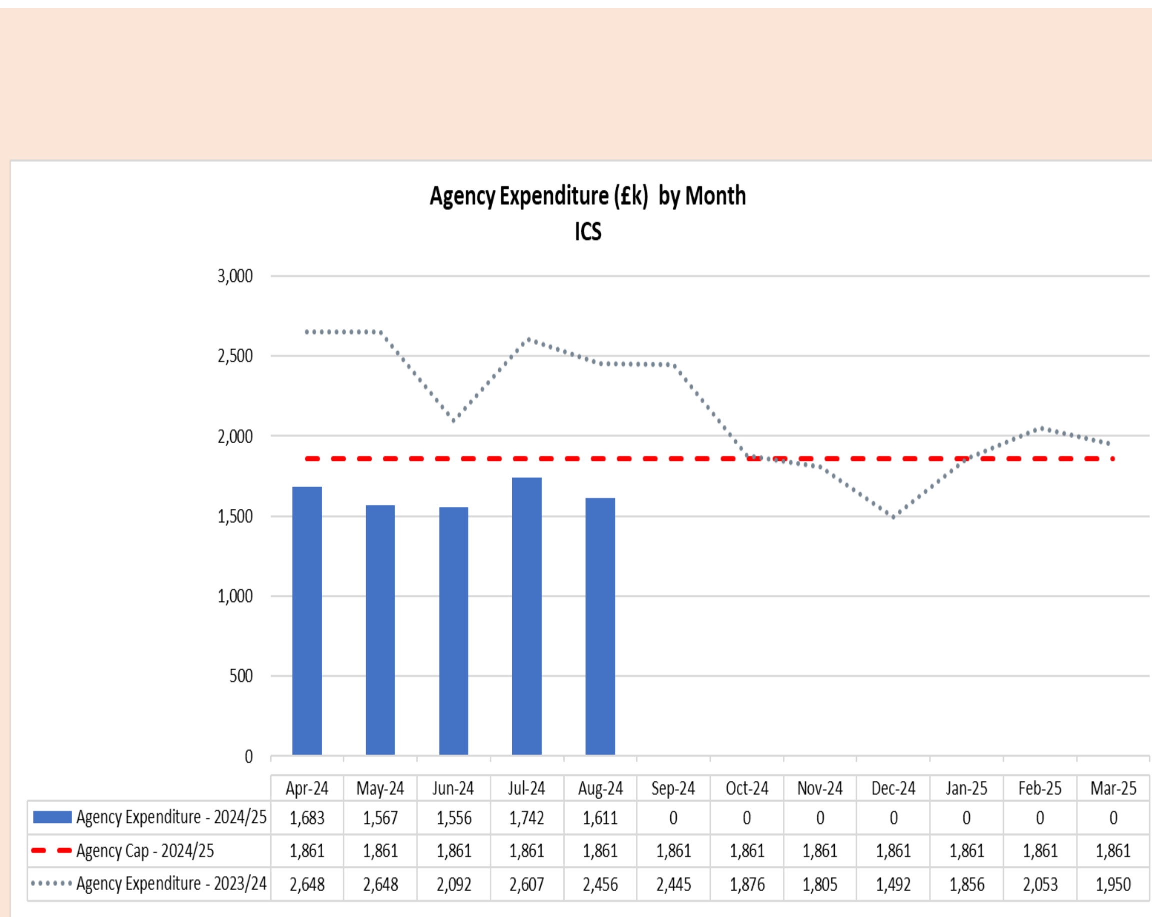
- The position at month 5 reflects an overall increase in worked WTE. This is inclusive of an element of double counting of Junior Doctor WTE reporting attributable to the August rota crossover.

- Trend analysis remains 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. 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	1,742	1,611	0	0	0	0	0	0	0
Agency Cap - 2024/25	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861	1,861
Agency Expenditure - 2023/24	2,648	2,648	2,092	2,607	2,456	2,445	1,876	1,805	1,492	1,856	2,053	1,950

GHC

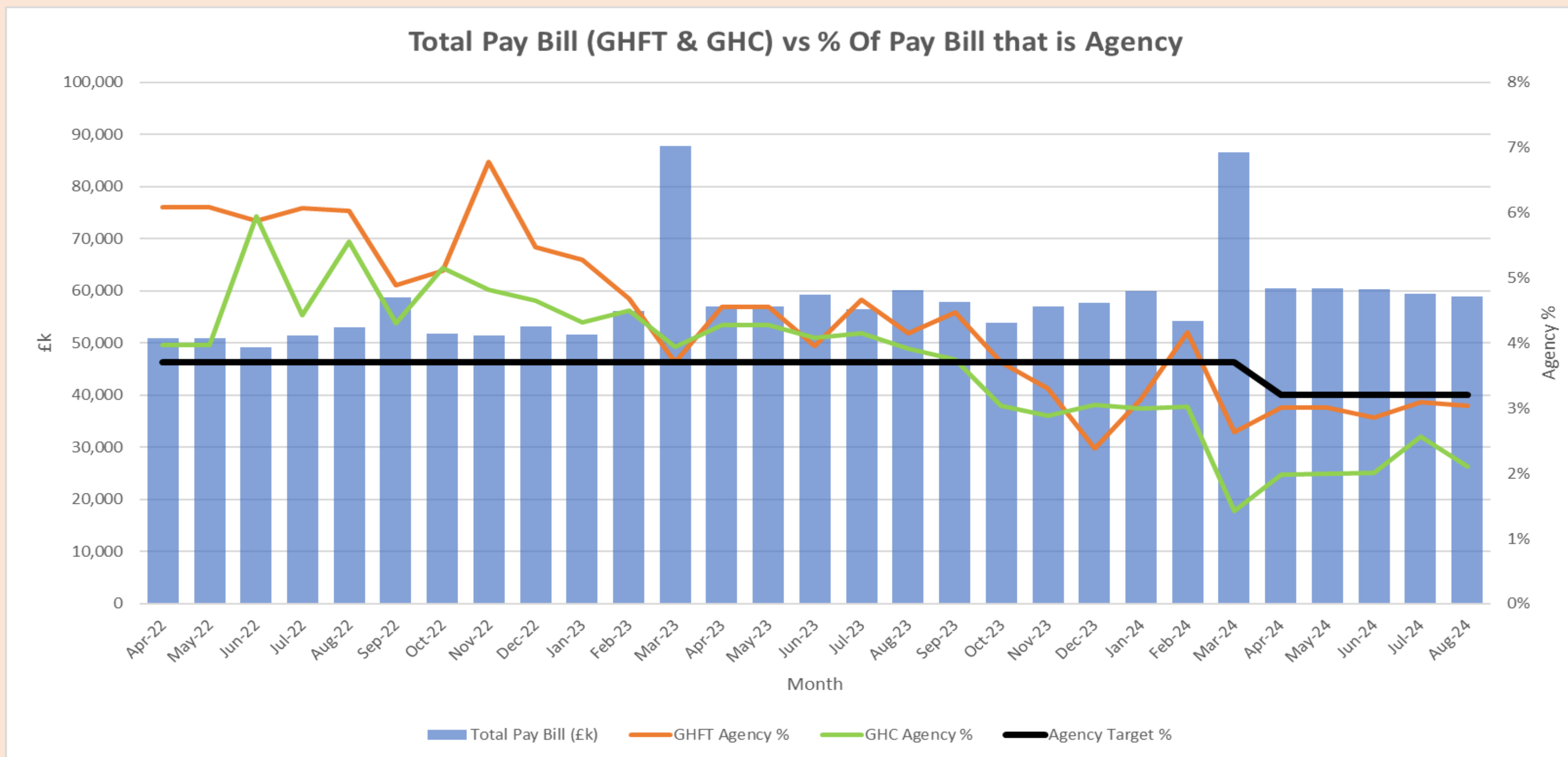
- In month shifts filled by agency primarily attributable to Nursing, Midwifery & Health visiting and Healthcare Assistants & other support.
- The Trust has a strong process in place to ensure that all requests for agency go through appropriate governance, in particular the use of off framework agencies.

GHFT

- In month shifts filled by agency totalled 2,371, these split across admin and clerical (including capital) 818, medical 410, nursing 697 and other scientific 446.
- Off framework shifts totalled 5 within nursing and midwifery, having been authorised according to the Trust escalation process.
- The Trust has processes in place to ensure agency requests are approved alongside wider workforce controls overseen by the Workforce Impact Group.

Finance and Use of Resources

System Workforce: 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
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
GHC Agency Spend (k)	£ 618	£ 618	£ 953	£ 693	£ 903	£ 782	£ 852	£ 799	£ 785	£ 777	£ 808	£ 1,020	£ 777	£ 777
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

	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
GHFT Agency Spend (k)	£ 1,616	£ 1,818	£ 1,747	£ 1,744	£ 1,350	£ 1,304	£ 969	£ 1,323	£ 1,515	£ 1,561	£ 1,306	£ 1,179	£ 1,171	£ 1,252	1208
GHC Agency Spend (k)	£ 748	£ 726	£ 709	£ 702	£ 526	£ 501	£ 523	£ 533	£ 538	£ 389	£ 377	£ 388	£ 385	£ 490	403
Total Agency Spend (k)	£ 2,364	£ 2,544	£ 2,456	£ 2,446	£ 1,876	£ 1,805	£ 1,492	£ 1,856	£ 2,053	£ 1,950	£ 1,683	£ 1,567	£ 1,556	£ 1,742	£ 1,611

ICB Finance Report

Month 5 2024/25 – August 2024

@One_Glos
www.onegloucestershire.net

Finance and Use of Resources

Financial Overview and Key Risks

Overview

- The ICB month 5 position is a forecast outturn position of breakeven as per plan. However, the position contains a significant amount of risk as it is predicated on delivery of a high level of savings.
- The prescribing forecast is breakeven. Prescribing data for Month 3 has been received and growth year to date has decreased, this is not in line with the trend seen to date so it is uncertain whether this will continue. The anticipated price reduction for rivaroxaban has been notified and the risk relating to savings for prescribing has therefore reduced.
- Elective Recovery Funding - the Gloucestershire target is 107% with the system operational plan value set at 118% value weighted activity of 19/20. Based on Month 3 flex (interim) data the system is on track to deliver the planned overperformance.
- Continuing Health Care & Placements - adult continuing care is currently on plan and forecast is breakeven against the plan. However, there is a risk due to a very high cost placement which is currently being managed within the position. Children's placements are currently fewer in number than last year but there remains risk within the position as this can change very rapidly.
- The Mental Health Investment Standard (MHIS) for 24/25 is £111.503m and is forecast to be delivered.

Finance and Use of Resources

Financial Overview and Key Risks

Key Financial Risks	Mitigating Actions
Slippage or non-identification of savings, leading to a worsening of the financial position.	Savings monitored monthly through the ICB Operational Executive meeting, progress and remedial actions also followed up at System meetings as relevant Programme Board for Working as One developing a delivery plan.
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. The risk of impact in this financial year is reducing with more significant impact potentially in 2025/26.	The potential impact on services and costs is being reviewed based on available information, the 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 hand back due to growing operational & financial pressures. Indicative direct costs £0.6m - c£1m per practice	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices
ICB delegated POD (Pharmacy, general Ophthalmic, and Dental) budget activity flagging a potential overspend risk, c£400k	Activity being validated with delegated host organisation.

Finance and Use of Resources

ICB Allocation – M05

- The ICB's confirmed allocation as at 31st August 2024 is £1,375m.

Description	Recurrent £'000	Non-Recurrent £'000	Total Allocation £'000
BALANCE BROUGHT FORWARD M04	**1,317,593**	**56,592**	**1,374,185**
Infection Prevention and Control		40	40
Regional Funding for Cancer Phase Two		74	74
Perioperative Programme Funding		13	13
Culture of Care Programme Implementation		55	55
Pharmacy Integration Fund – PCT Independent Prescribing Pathfinder		1	1
Revenue for Digital Histopathology Acceleration to West of England Pathology Network for GHT		238	238
RSOM and TSFA sites		442	442
Contribution towards Contingency Accommodation for Asylum seekers		12	12
TOTAL IN-YEAR ALLOCATION 24/25 @ M05	**1,317,593**	**57,467**	**1,375,060**

Finance and Use of Resources

ICB Statement of Comprehensive Income

Statement of Comprehensive Income (£'000)						
Month 5 2024/25 - August	M4 Plan	M4 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	277,591	277,586	5	657,639	658,127	(488)
Mental Health Services	56,272	55,278	994	135,052	134,630	422
Community Health Services	52,513	51,475	1,038	126,278	125,787	491
Continuing Care Services	36,174	35,946	228	88,180	88,180	0
Primary Care Services	79,513	79,138	375	192,665	192,465	200
Delegated Primary Care Commissioning	53,482	53,411	72	124,224	124,224	0
Other Commissioned Services	16,371	16,551	(180)	37,449	37,717	(267)
Programme Reserve & Contingency	(3,464)	(981)	(2,484)	2,794	3,121	(327)
Other Programme Services	263	311	(48)	631	661	(31)
Total Commissioning Services	**568,713**	**568,713**	**(0)**	**1,364,912**	**1,364,912**	**(0)**
Running Costs	4,228	4,228	0	10,148	10,148	0
TOTAL NET EXPENDITURE	**572,942**	**572,942**	**0**	**1,375,060**	**1,375,060**	**(0)**
ALLOCATION	**572,942**	**572,942**	**0**	**1,375,060**	**1,375,060**	**0**
Outside of Envelope	**0**	**0**	**0**	**0**	**0**	**0**
Underspend / (Deficit)	**0**	**0**	**0**	**0**	**0**	**(0)**

Finance and Use of Resources

ICB Savings and Efficiencies Overview

- Gloucestershire Integrated Care Board (GICB) has a savings programme amounting to £29.577m for the 2024/25 financial year.
- **Working as One -** £8.175m savings requirement. The programme is flagging that there will be in year slippage against the savings plan, the value is currently being assessed. Non recurrent mitigations to this slippage are actively being identified within the ICB and system organisations
- **Medicines savings** – forecast savings at month 5 include £1.5m in respect of national price changes for Rivaroxaban. These price changes commence from September and monitoring and update will follow as required. Focus on new 2024/25 scheme implementation is taking place to support project development and delivery.
- **CHC / Placements** – savings delivery to date are from Electronic Call monitoring and CHC reviews. There are still shortfalls in capacity, both within the ICB and GCC to carry out additional adult CHC reviews and re-assessments, this is likely to limit the in-year savings delivery and presents an ongoing financial risk.
- **ERF** - Elective Recovery (ERF release) - £20.8m overall additional allocation contributing to resources (£8.8m allocation within the ICB savings plan) and this is dependent on successful elective recovery.
- **Non recurrent Slippage -** there is a savings requirement of £3.194m. At month 5 all savings have now been identified.

Finance and Use of Resources

ICB Savings and Efficiencies

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB)
2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 5

PROGRAMME	PROJECTS	YEAR TO DATE EFFICIENCY PLAN £'000	YEAR TO DATE EFFICIENCY ACHIEVED £'000	YEAR TO DATE VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FULL YEAR OUTTURN EFFICIENCY PLAN £'000	FORECAST OUTTURN EFFICIENCY (YTD ACTUALS + FORECAST REMAINING MONTHS) £'000	FORECAST OUTTURN VARIANCE TO PLAN FAVOURABLE / (ADVERSE) £'000	FORECAST OUTTURN AS % OF TARGET	HIGH LEVEL IN-YEAR RISK RATING
PRIMARY CARE MEDICATION	Primary Care Medicines Optimisation	2,080	1,177	(903)	5,000	5,000	0	100.00%	Amber - Medium risk
	Home Oxygen	65	65	0	150	150	0	100.00%	GREEN - Low Risk
	PRIMARY CARE MEDICATION OPTIMISATION - TOTALS	**2,145**	**1,242**	**(903)**	**5,150**	**5,150**	**0**	**100.00%**	
CONTINUING HEALTHCARE (CHC) & PLACEMENTS	Individual Personal Commissioning - Continuing Healthcare (CHC) / Joint Placements	665	665	0	1,600	1,600	0	100.00%	Amber - Medium risk
	CONTINUING HEALTHCARE (CHC) & PLACEMENTS- TOTALS	**665**	**665**	**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.)	2,892	2,892	0	6,944	6,944	0	100.00%	GREEN - Low Risk
	OTHER RECURRENT EFFICIENCIES - TOTALS	**2,892**	**2,892**	**0**	**6,944**	**6,944**	**0**	**100.00%**	
OTHER - NON-RECURRENT	ICB Non-Recurrent Efficiencies	6,617	6,617	0	15,884	15,884	0	100.00%	Amber - Medium risk
	OTHER NON-RECURRENT EFFICIENCIES - TOTALS	**6,617**	**6,617**	**0**	**15,884**	**15,884**	**0**	**100.00%**	
	2024/25 ICB SAVINGS PROGRAMME - TOTALS	**12,319**	**11,416**	**(903)**	**29,578**	**29,578**	**0**	**100.00%**	Amber - Medium risk

Finance and Use of Resources

ICB Savings and Efficiencies (System Efficiencies)

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD - SYSTEM HELD EFFICIENCIES
2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 5

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	2,156	-	(2,156)	5,175	5,175	0	100.00%	RED - High Risk
	URGENT EMERGENCY CARE SAVINGS - TOTALS	2,156	-	(2,156)	5,175	5,175	0	100.00%	
DISCHARGE	P2 Bed savings (System)	418	418	0	1,000	1,000	0	100.00%	RED - High Risk
	DISCHARGE SAVINGS - TOTALS	418	418	0	1,000	1,000	0	100.00%	
ELECTIVE	ERF Productivity	1,250	1,250	0	3,000	3,000	0	100.00%	Amber - Medium risk
	ELECTIVE SAVINGS - TOTALS	1,250	1,250	0	3,000	3,000	0	100.00%	
OTHER	Non-Recurrent slippage	914	1,969	1,055	2,194	2,194	0	100.00%	Amber - Medium risk
	Unidentiied Savings - Non-recurrent	801	0	(801)	1,924	1,924	0	100.00%	GREEN - Low Risk
	OTHER & UNIDENTIFIED SAVINGS - TOTALS	1,715	1,969	254	4,118	4,118	0	100.00%	
	2024/25 ICB SAVINGS PROGRAMME - TOTALS	5,539	3,637	(1,902)	13,293	13,293	0	100.00%	RED - High Risk

Agenda Item 11.1

NHS Gloucestershire Board Meeting held in public

25th September 2025

<table>
<tr><td>Report Title</td><td colspan="5">One Plan for all Children & Young People in Gloucestershire 2024-30</td></tr>
<tr><td rowspan="2">Purpose (X)</td><td>For Information</td><td></td><td>For Discussion</td><td></td><td>For Decision</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">Route to this meeting</td><td colspan="5">Describe the prior engagement pathways this paper has been through, including outcomes/decisions:
September 2023 – initial conversations within ICS Board Development Day focussing on Children and Young People
May 2024 – draft approved by Gloucestershire Children’s Wellbeing Coalition
May – August 2024 – series of face to face and virtual engagement events open to stakeholders across the county
June 2024 – draft reviewed at ICB Board Development Session
July 2024 – draft approved by Health and Wellbeing Board / Partnership
September 2024 – Plan approved by Gloucestershire County Council Cabinet
September 2024 – final version approved by Children’s Wellbeing Coalition
November 2024 – approval sought from Gloucestershire Full Council
November 2024 – ceremonial One Plan signing event</td></tr>
<tr><td>ICB Internal</td><td>Date</td><td colspan="2">System Partner</td><td>Date</td></tr>
<tr><td></td><td>dd/mm/yyyy</td><td colspan="2">Strategic Executive Meeting</td><td>19/09/2024</td></tr>
<tr><td>Executive Summary</td><td colspan="5">The One Plan for all Children & Young People in Gloucestershire 2024-30 (One Plan) is Gloucestershire’s Children and Young People’s Plan.

It has been developed with children, young people, families and partners and is designed to set out how, together, we will achieve our vision for Gloucestershire to be a great place for all our children to grow up in and go on to live lives of choice and opportunity.

The One Plan has been developed with four sections:
an overarching section that sets out our intent and summarises our approach and findings
a section on starting well (the first five years)
a section on growing well (primary through to early secondary), and,
a section on being well (adolescence and early adulthood to 25 years).</td></tr>
</table>

Key Issues to note	Gloucestershire should be a great place to grow up where all children and young people can thrive and go on to live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identity, special educational needs or disability. We have recognised the need for a plan that brings partners together in pursuit of a common set of aspirational goals for our children, young people and families and particularly those facing the greatest disadvantage.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	**Risk**: The One Plan is not effective in delivering improved outcomes for children and young people in Gloucestershire. (3x3) **Mitigation**: The One Plan will be subject to oversight and input from all Children and Young People's Wellbeing Coalition members. Clear outcomes are set and will be monitored, with opportunities to work with an academic partner in the evaluation of impact of the delivery of the Plan. (2x2) **Risk**: Some partners are insufficiently engaged in the delivery of the action plan for each pillar of the One Plan (i.e. Starting Well, Growing Well and Being Well). (3x3) **Mitigation**: the Plan has been co-constructed and reviewed at a series of world café events over the summer of 2024. Opportunities for engagement and delivery will continue and the three sub-groups are formed with a wide range of members ready to drive forward its priorities. (2x2)
Management of Conflicts of Interest	None
Resource Impact (X)	**Financial** [ ] **Information Management & Technology** [ ] **Human Resource** [ ] **Buildings** [ ]
Financial Impact	There are no direct financial implications arising from this Plan as it does not commit resources that are not already committed through other routes. Approval to implement the delivery projects described in the strategy shall be sought at the relevant time through the appropriate governance decision-making route.
Regulatory and Legal Issues (including NHS Constitution)	Gloucestershire County Council constitution lists the Children and Young People Plan as being part of the Council's policy framework, the One Plan 2024-2030 is presented as that Plan.
Impact on Health Inequalities	Equity, closing the gap and eliminating inequalities, is one of the four objectives of the Plan.

Impact on Equality and Diversity	An EQIA has been undertaken and is included within these papers. A summary is provided below. Our data tells us people who have the least in Gloucestershire struggle more than they would in other parts of the country. The reasons for this require further investigation but are likely to include higher costs of living, challenges due to Gloucestershire's rural geography, and a focus on average population outcomes rather than incentives to target children falling behind. We must work together to create the conditions for children to thrive and target our resources where they are most needed. We know we have more to do to create an inclusive society, that values and respects people regardless of their age, cultures, religion, ethnicity, gender, sexuality or disabilities. For example, our data shows us some ethnic groups are more likely to experience poor outcomes and this may in part be due to unconscious bias and prejudice. We must build a workforce that has inclusion at its core.
Impact on Sustainable Development	There are no direct climate change implications arising from the approval of the One Plan. A Climate Impact Assessment Tool has been completed. Due to the wide spectrum of areas the One Plan covers, it is difficult to assess specific climate impacts, however in general, the following should be prioritised to help reduce climate impacts; • Opting for suppliers who exhibit sustainable practises when procuring related services. • Requesting staff and users (where applicable) to walk, cycle, car share or utilise public transport instead of private vehicle use. • Sites should be encouraged to be appropriately insulated and utilise renewable energy systems to reduce fossil fuel reliance, where possible. Staff and service users should also be encouraged to adopt energy saving practises such as turning off equipment when not in use, turning off taps etc. • Items should only be purchased if necessary, e.g. if existing items cannot be repaired and are no longer fit for purpose. Hiring of items is preferred to purchase and single use goods should not be purchased unless necessary to prevent waste.
Patient and Public Involvement	In developing the One Plan, the County Council and the Children and Young People's Wellbeing Coalition have undertaken extensive consultation with children and families, parents, carers and a range of local partners and stakeholders. This has included bespoke insight gathering with young people and families commissioned for the Plan, a review of existing insight evidence from partners such as Healthwatch and Gloucestershire Parent Carer Forum and a series of engagement events with stakeholders. Feedback has been positive, a number of iterations of the plan have been subject to approval by Children and Young People's Wellbeing Coalition and Gloucestershire's Health and Wellbeing Board.

<table>
<tr><td>Recommendation</td><td colspan="3">The Board is requested to:
provide its support to the One Plan for all Children & Young People in Gloucestershire 2024 to 2030 as a unifying plan, developed with children, families and partners setting out our ambitions for all children and young people in Gloucestershire.
note that there will be a signing and launch event with statutory and voluntary sector partners planned for November 2024.</td></tr>
<tr><td>Author</td><td>Beth Bennett-Britton</td><td>Role Title</td><td>Public health Consultant</td></tr>
<tr><td>Sponsoring Director (if not author)</td><td colspan="3">Ann James, Executive Director Children's Services, GCC</td></tr>
</table>

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 PLAN

for all Children and Young People in Gloucestershire

2024-2030

Foreword

"Hey, as young people we have faced many new challenges, from growing up in a digital world where we have been exposed to harm and bullying, to being in lockdown and a cost of living crisis. We also know we are failing our planet. And were worried about our future.

It's important for us to be a part of the bigger conversations in regards to our futures and our mental and physical health. And with less resources within our communities, and less communication with decision makers, it feels like our voice is getting lost.

We need services to be accessible for all. We need our voices to be heard. We need our choices to be respected.

We want an inclusive, safe, sustainable society for all, where our input is celebrated and nurtured, and we want everyone to join together to support this.

This Plan is a call to action. It's bigger than our now, it's our future."

Composed by representatives of young people from Gloucestershire who contributed to shaping this Plan.

"We ask you to plant the trees knowing you may never lie in their shade."

Arch, Ambassador for vulnerable children & young people, aged 18

Introduction

Gloucestershire is a diverse county, rich in natural resources and steeped in history. We aspire to make the most of our many assets and be a county of opportunity, where people are healthy, resilient, prosperous and connected within communities and environments that nurture.

This plan sets out our ambitions for all children and young people in Gloucestershire based on what they, their families and professionals told us were their experiences and priorities.

The One Plan for Children and Young People in Gloucestershire has been developed with input from many and presents a vision and set of common activities to achieve that vision. Essentially, we asked the question, how do we become a county in which all children and young people thrive and can go onto live lives of choice and opportunity?

This is particularly relevant as the data and feedback from our children, young people, families, and communities shows us that, whilst our headline data is often good when compared with national data and sometimes our peer local authorities, it does not tell the same story for those who face the greatest disadvantage and barriers, protected characteristics, isolation and the intersection of these.

Our vision became:

A great place to grow up where children and young people thrive and live lives of choice and opportunity

To achieve our vision we commit to four objectives:

- **Equity** – close the gap and eliminate inequalities
- **Access** – right help at the right time for all children
- **Inclusion** – a county where everyone belongs and we celebrate diversity
- **Quality** – effective, outstanding services.

To achieve these objectives, we have developed the three Pillars outlined below, all connected by a foundation of Living Well. Each has their own set of priorities that will enable us to deliver our objectives, and ultimately, our vision. These recognise the rights of every child as they grow and develop. They recognise the primacy of the family, the importance of our communities, and the critical role played by universal services in ensuring children and young people are afforded the health, education, safety, nurture, and freedoms we would want for our own children:

- **Starting well** – pre-birth through early years to reception age
- **Growing well** – primary through to early secondary
- **Being well** – middle teenage through post 16 to 25 years
- **Living well** – creating the conditions to thrive.

Through our established partnership, the Children's Coalition for Gloucestershire, we will deliver this shared strategy and take responsibility for holding the system to account to achieve its objectives. It is what we do, how we act and how we influence that will be key to the experience of our families and to children achieving their potential.

What you've told us you'd like for all children in Gloucestershire

We recognise that our county does not look the same and is not experienced in the same way by all. Reference has already been made to those facing disadvantage but equally, the contrast between urban and rural parts of the county, as well as differences between communities who share interests, those with protected characteristics (such as sexual orientation or religion), and how these factors connect and cross over, all impacts how our county is experienced and delivered for children and young people. How is it, for example, to be a newly arrived family in Cirencester, as compared to the same family arriving in Gloucester City? Are they able to access high quality health, education, social care and community support, and how do they find out about it in the first place?

We have brought together the views of parents, children and young people through listening events hosted by partners, including Healthwatch, Future Me and the Parent Carer Forum, and by research agencies such as ICE Creates and Shared Intelligence. We've summarised these key messages here.

- More opportunities to engage with nature and enjoy our surroundings green spaces.
- Affordable childcare.
- Recording systems that enable timely and swift data sharing and referrals between services.

Easier ways to contact services and be referred, shorter waiting times and tailored support while waiting and on next steps.

"Waiting lists are long... I have been seeking support for at least 4 years... I am struggling to find the energy to fight all the time."

parent

Never experiencing prejudice, racism or discrimination from services which are there to help.

"There is a bias where a black woman is seen as strong and if you speak up or get upset you are perceived as this angry black woman, but you're just supporting your child."

parent

Opportunities to socialise and make friends in a safe and welcoming environment outside school and be active in their community.

"More hubs for youngster and then outreach to get the information out there digitally (Instagram and TikTok)."

parent

- Feeling listened to, taken seriously and respected by professionals, such as teachers and health professionals.
- Professionals use language that can easily be understood by young people.

Reliable, regular, affordable and safe public transport, which gets people to where they need to go such as college.

"Services are too far away from where we live. I can't drive because of my epilepsy so my child cannot attend certain events."

parent

"Cirencester College is a three-hour round trip for Gloucester but many (asylum seeking young people) have to attend this college instead of their local college. This means they wake up very early and don't get home until late – it is not fair."

professional working with asylum seekers

- Easier processes and clearer communication to help with Education Health and Care Needs Assessments and their outcome.

Sufficient and inclusive education and childcare places that support children with additional needs effectively, including children with Special Educational Needs and Disabilities.

"We are struggling with home educating our child, but are not yet able to find a school that is suitable."

parent

Help with transitions from early years to primary, primary to secondary and then into further education, training and employment, especially those with Special Educational Needs and Disabilities (SEND) and asylum seeking children.

"Feel as though we've hit a brick wall as no other services offered/continued/ involved. Very concerned about transition to adulthood which isn't far away."

parent

Feeling safe when out and about from anti-social behaviour, serious violence and around busy roads.

"Don't feel safe - kids hanging outside shops and there have been weapons in area. Don't feel safe to go to park."

child, aged 9

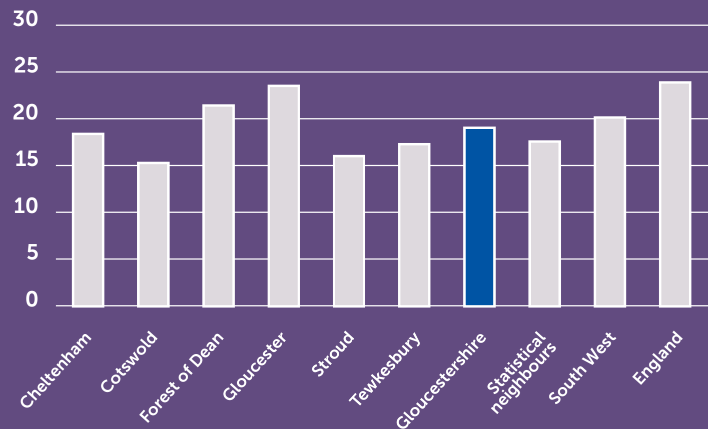
- Help to find work-experience and local employment opportunities, including more 'modern' career options (such as social media).
- Flexibility and understanding across services so young people can manage competing needs of health, education and care appointments.
- More early intervention to stop needs increasing.
- Better promotion of services that are available in their own local area and involve young people in the design and creation so it appeals to them.

What it's like to be a child in Gloucestershire

Gloucestershire has a population of 646,627, living within the two urban centres of Gloucester and Cheltenham and the many market towns and rural villages, covered by six district authorities. Children aged 0-17 make up 20% of the population and a further 7% are aged 18-24 years.

The proportion of children living in child poverty generally fall below England averages, however rates have been increasing over time in line with the national trend, with a sharp increase observed in 2022.

Proportion of primary pupils eligible for free school meals 2023



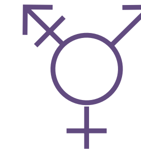
Children that go to school in Gloucestershire generally perform similar or better than England overall in their assessments at the end of their Reception year, Key Stage 2 and Key Stage 4. However inequalities exist, with the gap in performance between those eligible for Free School Meals and those not, consistently being greater for Gloucestershire than England as a whole.

Gloucestershire's population is becoming more ethnically diverse, although it is less diverse than England as a whole:

Percentage includes all ethnic groups excluding 'White British'	Gloucestershire	National
Total population ONS Census 2021	13.0%	28.6%
CYP ONS Census 2021	0-17yrs 16.6% 0-24yrs 15.7%	0-17yrs 32.1% 0-24yrs 31.9%

Our Pupil Wellbeing Survey found that 70.1% of young people identified themselves as heterosexual, which has reduced over time. In 2022 we asked pupils about their gender identity for the first time:

1.1%
identified as transgender (1.5% of biological females and 0.7% of biological males)



1.5%
identified as gender-fluid

1.6%
identified as non-binary

6,138
new births in 2021

although the number of births fluctuates over time, the general trend is starting to decline.

Education

- 606 Early Years settings (91.4% good or outstanding) (June 2024)
- 244 primary schools
- 41 secondary schools
- 20 special schools (including 8 independent special schools)
- 3 alternative provision schools
- 4 further education colleges (including South Gloucestershire and Stroud College)
- Up take of free 2-year-old early education and childcare for eligible families in 2023 70.1%..

Reception - Early Years Foundation Stage	Gloucestershire	England
Overall % meeting expected level	67.8% (all pupils)	67.2% (all pupils)
% of children with SEN achieving 'good level of development'	EHCP 5.2% SEN 21.7%	EHCP 3.8% SEN 24.3%
Gap between FSM and no FSM	47.8% vs. 71.2% - 23.4 percentage points	51.6% vs. 71.5% - 19.9 percentage points

KS2 – expected standard in Reading, Writing and Maths	Gloucestershire	England
Overall % meeting expected level	58.0%	60.0%
Gap between SEN and no SEN	EHCP 10% vs. 71.0% - 61 percentage points SEN 19.0% vs. 71.0% - 52 percentage points	EHCP 8% vs. 70.0% - 62 percentage points SEN 24.0% vs. 70% - 46 percentage points
Gap between FSM and no FSM	36.0% vs. 64.0% - 28 percentage points	44.0% vs. 66.0% - 22 percentage points

KS4 – Average Attainment 8	Gloucestershire	England
Overall Average Attainment 8	49.9	44.6
Gap between SEN and no SEN	EHCP 13.4 vs. 53.6 – 42 percentage points SEN 33.5 vs. 53.6 – 20.1 percentage points	EHCP 14.0 vs. 50.1 – 36.1 percentage points SEN 33.2 vs. 50.1 – 16.9 percentage points
Gap between FSM and no FSM	34.2 vs. 52.7 - 18.5 points	34.8 vs. 49.7 - 14.9 points

(SEN – Special Educational Needs)

Looking at educational outcomes by ethnic groups does not show a consistent pattern, and changes through the stages due to a complex mix of cultural differences, international migration patterns, and children travelling into the county from neighbouring areas for secondary school, amongst others. Asian pupils perform best at Key Stage 2 and Key Stage 4 in Gloucestershire and in England as a whole. In Key Stage 2 the proportion of Black and Other Ethnicity in Gloucestershire achieving the expected level is below the average for the county and below our statistical neighbours and England. In Key Stage 4 all ethnic group categories perform better than their statistical neighbour and England counterparts.

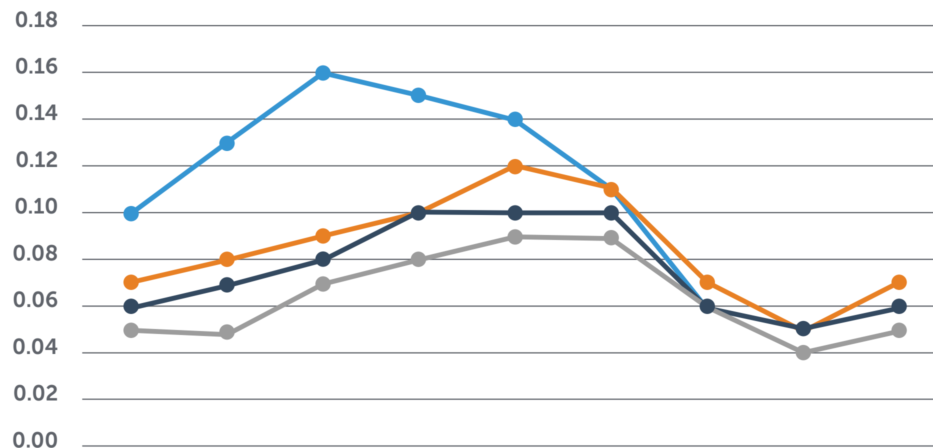
Before the pandemic, around 10% of pupils across all schools were persistently absent (missing 10% or more sessions), in 2022/23 Gloucestershire reported 20% persistent absence, this pattern is similar to that seen nationally. Rates of Electively Home Educated (EHE) children have been rising in Gloucestershire as seen nationally. In Gloucestershire they have risen from 13 per 1,000 CYP aged 5-15 in 2017/18 to 25.6 per 1,000 in 2022/23. The rate of EHE in Gloucestershire in 2021/22 was significantly higher than the statistical neighbour, regional and England average.

Families do not always provide a reason for choosing Elective Home Education; however, where they have provided a reason the most common were Philosophical / Lifestyle / Preferential (19%), Mental Health (19%) and Dissatisfaction with School (combined bullying, SEND, and general dissatisfaction with school - 10%). These proportions are similar to those in our statistical neighbours and the South West region.

Key:
SEN - Special Educational Needs
FSM - Free School Meals
EHCP - Education, Health and Care Plan

Permanent exclusions across all school phases were historically high in Gloucestershire but started to decline in 2015/16 and fell into line with national proportions. A sharp increase was then observed nationally following the pandemic. Exclusion rates in primary age pupils, though low (0.05 in 2021/22) are currently above England (0.02) and Statistical Neighbour averages (0.01) and require monitoring.

Total permanent exclusions - % of school population



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Gloucestershire	0.10	0.13	0.16	0.15	0.14	0.11	0.06	0.05	0.09
South West	0.07	0.08	0.09	0.10	0.12	0.11	0.07	0.05	0.09
Statistical neighbours	0.05	0.05	0.07	0.08	0.09	0.09	0.06	0.04	0.07
England	0.06	0.07	0.08	0.10	0.10	0.10	0.06	0.05	0.08

School suspensions in Gloucestershire have followed a similar trend to England and our Statistical Neighbours, with the most recent data putting us below the national and neighbour rate (6% compared to 7% in 2021/22). Proportion of young people aged 16 to 24 not in education, employment of training (NEET) is lower for Gloucestershire than the England average (2.4% vs. 2.8% in 2023).

Special Educational Needs and Disabilities

The number of children and young people in Gloucestershire identified with a Special Educational Need or Disability (SEND) has been increasing since 2015 in line with national trends. This has been driven by a combination of increased need, awareness, diagnosis, training, and changes to policy. In January 2023 there were:

- 12,569 children with SEN supported in schools
- 5,295 of these are children with an Education Health & Care Plan (EHCP)
- And 525 of these are children with a complex disability.

This rise has coincided with a rise in Education Health and Care Needs Assessment applications, appeals to the needs assessment outcome and a rise in demand for special school places.

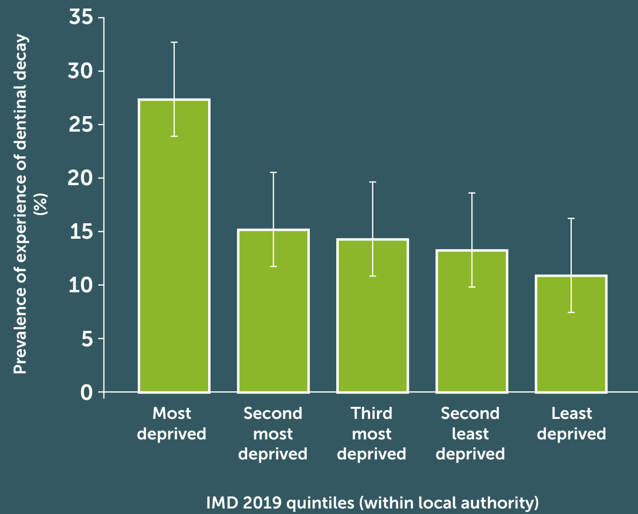
Overall Special Educational Needs are more common in children living in more deprived areas, a pattern seen locally and nationally, though there is variation depending on primary need. Children and young people with a primary need of Moderate Learning Disability; Social, Emotional and Mental Health; and Speech, Language & Communication Needs are significantly more likely to live in areas of deprivation (quintiles 1 and 2) than children without Special Educational Needs.

Deprivation quintile	SEN	No SEN
Q1 most deprived	13.2	8.5
Q2	15.4	10.2
Q3	23.7	21.4
Q4	22.5	23.9
Q5 least deprived	21.4	30.5
Unmatched	3.7	5.5

Health

Overall Gloucestershire tends to perform well against England averages for indicators such as levels of immunisation, breastfeeding rates and oral health, however these mask disparities that exist based on deprivation and ethnicity. For example, the proportion of 5 year olds experiencing dental decay in Gloucestershire is significantly lower than the England average (16.8%) however the prevalence in the most deprived areas of Gloucestershire is almost three times higher than in the least deprived.

Figure 3: Prevalence of experience of dentinal decay in 5 year olds in Gloucestershire, by local authority Index of Multiple Deprivation (IMD) 2019 quintiles.



Note: error bars represent 95% confidence limits.

Benchmarking data shows that we have a higher proportion of admissions to hospital for some childhood illnesses and injuries, this needs further investigation but is in part due to hospital policies on when to admit children and the way data is coded.

Obesity affects 1 in 5 children in year 6 and is a major public health concern. Nationally, the prevalence of obesity among children living in the most deprived neighbourhoods continues to be more than double that of those in the least deprived areas. There are also ethnic differences with rates highest amongst Black children and lowest for Chinese children.

Positively, the Pupil Wellbeing Survey 2022[1] has found that the amount of exercise young people are doing has been increasing steadily since 2018, improvements were also seen in healthy eating habits with an increase in the proportion eating 5 a day and a reduction in sugary and energy drink consumption.

The proportion of pupils reporting drinking alcohol has also been steadily declining, and the proportion reporting trying illegal drugs fell between 2020 and 2022. The proportion of pupils reporting that the relationships and sex education they have received has been helpful had increased and the majority of young people who reported having intercourse reported they used a condom.

Teenage conception

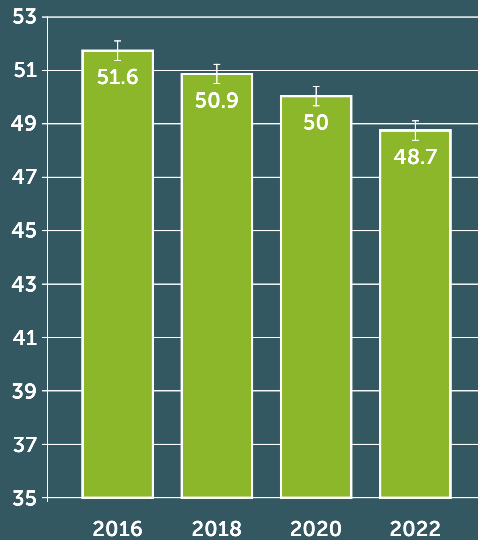
9.2 per **1,000** vs. **13.1** Eng 2021

[1] gcc_3722-pupil-wellbeing-survey-county-report-2022_dev15.pdf (gloucestershire.gov.uk)

Mental Health

Mental wellbeing in school age children is declining.

Mean WEMWBS score - all pupils



The Pupil Wellbeing Survey responses demonstrate that those in minority ethnic groups and those in areas of deprivation report finding it harder to access mental health support. In addition referrals to Child and Adolescent Mental Health Services (CAMHS) are disproportionately higher for the White British ethnic group.

Care and safety

First time entrants to Youth Justice System
80.4 per **100,000**
vs.
148.8 Eng.

The number of cases open to children's social care in Gloucestershire has been higher than peers but in recent years has started to reduce and we are becoming more in line with our peers, from 2022 to 2023 there were 331.9 per 10,000 children open to social care compared to 303.79 for our statistical neighbours and 311.9 across the South West region.

We have observed a steady increase in referrals for early help and targeted support in recent years, which in part reflects earlier intervention to prevent children escalating to social care. In July 2024 there were 10,101 children open on a My Plan or My Plan Plus, of these 80% were notified by education or early years settings, 13% to Gloucestershire County Council services such as Families First and the Education Inclusion Team, 5% to children and family centres and 1% to a combination of health agencies and the voluntary and community sector.

First time entrants to Youth Justice System are below the England average at 80.4 per 100,000 vs. 148.8. While White children are underrepresented in the offending population, mixed heritage children are the most over-represented at 15% despite only making up 5% of the total 10-17 year old population in Gloucestershire. Using the term 'child' in this context is particularly important to emphasise their relative vulnerability, rights and needs and avoid 'adultification'.

In the Pupil Wellbeing Survey 7.1% reported carrying a weapon. The highest reported level of carrying a weapon (10.4%) was in independent schools, this was significantly higher than the county average. Pupils at Selective schools were significantly less likely to report carrying a weapon. The percentage reporting carrying a weapon has been fairly consistent over time. Of these 63.3% report carrying a bladed weapon.

Emerging concerns

Despite the numbers reporting smoking cigarettes declining over recent years, 2022 saw a huge rise in young people vaping, meaning overall exposure to nicotine rose by 42% between 2020 and 2022.

The Pupil Wellbeing Survey has also highlighted a reduction in the proportion of pupils reporting they get the recommended number of hours sleep per night,

from **60.7%** in 2018 to **51.5%** in 2022

This is coupled with an increase in the proportion of pupils reporting they used the Internet, gaming, social network and texting between going to bed and going to sleep.

What do we want for all children and young people in Gloucestershire?

We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, no matter of where they live, their ethnic background, sexuality, gender identity, special educational needs or disability. Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision:

A great place to grow up where children and young people thrive and live lives of choice and opportunity

Objective 1

Equity

close the gap and eliminate inequalities

Our data tells us people who have the least in Gloucestershire struggle more than they would in other parts of the country. The reasons for this require further investigation but are likely to include higher costs of living, challenges due to Gloucestershire's rural geography, and a focus on average population outcomes rather than incentives to target children falling behind. We must work together to create the conditions for children to thrive and target our resources where they are most needed.

Objective 2

Access

right help at the right time for all children

Young people and their families tell us the right support isn't always there when they need it. We acknowledge that services are under strain and need to invest in innovative approaches to improve efficiency, early identification of needs and build independence.

Objective 3

Inclusion

a county where everyone belongs and we celebrate diversity

We know we have more to do to create an inclusive society, that values and respects people regardless of their age, cultures, religion, ethnicity, gender, sexuality or disabilities. For example, our data shows us some ethnic groups are more likely to experience poor outcomes and this may in part be due to unconscious bias and prejudice. We must build a workforce that has inclusion at its core.

Objective 4

Quality

effective, outstanding services

Whilst in the main our services perform well, it is essential that we maintain standards and raise performance where this isn't the case. We must move with the times and capitalise on technology developments and innovations, as well as growing a sustainable workforce.

Responsibility for driving progress against these objectives will be owned by Gloucestershire's Children and Young People's Coalition board and three subgroups themed around the life stages of Starting Well, Growing Well and Being Well.

To deliver this vision we will be guided by the following principles:

1. We will listen
work in partnership 'with' children, families and communities, not 'for' or 'to', build on existing children, family and community assets and aspirations, ensuring everyone can make a contribution, is respected, and that we take a whole family approach.

2. We will care
build a culture within our workforce of empathy, using language that cares, acknowledging children and their parents and carers are the experts in their lives and being welcoming and inclusive for families and children of all ages, cultures, religions, ethnicities, genders, sexuality and disabilities.

3. We will be fair
prioritise resources to those that need it most, ambitiously aim to reduce inequalities in outcomes and close the gap.

4. We will act early
aim to reduce escalation and specialist support through early identification of needs, building resilience, using restorative approaches, and reduce trauma for children and young people.

5. It will feel easy
strive to create integrated services, smooth transitions and pathways to give consistency to children and families' experience of support.

6. It will work well
seek to ensure value for money with our resources, avoid duplication and inefficiency, embrace innovations and build on existing evidence-based approaches.

We are not starting from scratch, we have fantastic foundations to build from and powerful drivers for change. We have many examples of best practice, innovation and learning that we need to continue to develop and share as a system to effect change against our objectives and improve outcomes.

Examples of innovation and best practice in Gloucestershire

Equity

No Child Left Behind is an initiative in Cheltenham, that aims to help all young people to thrive and improve the outcomes of the 4400 children and young people living in poverty. The borough council, supported by partners, led a three-year action for change project based on a different theme for every month of each year.

Due to its success the initiative has continued with a focus on local industries supporting and sponsoring community projects that help vulnerable children and their families within their own communities. At the end of each year there is an award ceremony that celebrates the achievements of children and recognises the local business who contribute.

Video Interactive Guidance (VIG) is a preventative, therapeutic, early intervention with a strong research evidence base in the UK and worldwide and aims to strengthen the attachment relationship between parent/carer and child through improved communication.

This offer is being piloted by Gloucestershire's Health Visiting Service and has been funded by the Integrated Care System as part of the perinatal mental health pathway.

Our work to help children and families thrive is making us think about **'The Gloucestershire Way'** - an approach used by teachers, social workers and other professionals which works with the whole family and helps to show how family members' actions impact on each other.

It is based on building a safe space to listen, share, show kindness, understand each other's feelings and perspectives and ultimately help to resolve difficulties by working together and building trust. It is based on growing research into Trauma Informed Relational Practice, Systemic Practice and Family Led Decision Making.

To help support communities to be empowered to build on the strengths and assets they have, **we have created six Integrated Locality Partnerships** across covering each of the six districts that make up Gloucestershire.

They each have wide membership from partners and communities with the aims of proactively reducing the root causes of health inequalities, improving health and wellbeing, working collectively to redesign care for people in localities and supporting them to live well at home.

Children and young people's mental health and wellbeing is a common priority and the groups continue to grow their membership, reach and impact.

We launched 'Levelling Up Together' in Autumn 2022 as a flexible targeted grant scheme aiming to invest into the communities in Gloucestershire falling into the top 10% 'most deprived' (according to the Index of Multiple Deprivation, 2019). Fifty-two grants have been awarded, totalling just under £1.5million, and many of our 49 Levelling Up partners support children and families facing difficult circumstances through a diverse array of initiatives.

This includes through the provision of affordable or free food (such as Hesters Way Partnership's Pantry), the recruitment of volunteers to support families and listen to children read in schools (such as Home Start North West Gloucestershire and Read with Me CIC), the creation and renovation of youth groups and leisure facilities (such as the Islamic Society of Gloucester and Gas Green Youth Club), mental health support for young people from diverse communities (such as Brendan's Bridge and TIC+), and free play and physical activity sessions (such as Sportilly and Play Gloucestershire).

More information about the Levelling Up Together partners and projects can be found here: www.gloucestershire.gov.uk/your-community/levelling-up-together

Inclusion

We recently launched the **Dynamic Support Register** as a way to keep a digital record of key information about children under 18 with a diagnosed learning disability or autism who are at risk of going to hospital and may behave in a way that professionals may find challenging and/or complex to manage.

The key information helps professionals understand how best to help, ensure young people are treated with dignity and respect, and help to get them back home as smoothly and safely as possible.

Access

In September 2024 we'll be launching a new **ADHD and Autism assessment pathway**. Schools and early years settings will be able to refer to a single team that are able to assess for Autism, ADHD or a combination. Additional investment from the NHS Integrated Care Board will enable more assessments to be made and reduce waiting times.

There's more information on this new webpage Support a child's neurodiversity - Gloucestershire (support-child-neurodiversity-southwest.nhs.uk)

The Mental Health Support Teams in Gloucestershire, locally known as Young Minds Matter (YMM) first launched in 2019.

There are now 7 teams across the county, supporting young people from 5-18 in over 140 schools, with low level anxiety and low mood through cognitive behavioural therapy (CBT) interventions.

The teams work closely with the wider MH system, including TIC+, School Nursing, Early Help and Education Inclusion to ensure young people get the right support for their needs. The teams have now supported over 4500 young people and are the best performing team within the South West. This year the team are expanding their offer to work with adolescents who are struggling to engage with education with an enhanced offer of high-intensity CBT from a senior clinician within the team.

Quality

Gloucestershire Education Forum was formed in April 2022 to bring key systems leaders in the local education system together to consider issues important to and impacting the local education system and how we can work together and share best practice to respond and improve outcomes for children. It has secured funding to improve educational outcomes for disadvantaged children and shown the difference that can be made:

- 16 schools in South Cotswolds (primary and secondary) in a Year of Reading project;
- 15 Gloucester City secondary schools Attendance project;
- 42 Gloucester Schools Partnership focused on word power project;
- 22 Diocese of Gloucester Academy Trust schools focused on social prescribing approaches to improving attendance;
- Stroud schools project to identify the features of their schools that is supporting improved attainment trends for disadvantaged children and young people;
- Study visits and seminars on supporting SEND in the mainstream classroom.

Building on the national **Healthy Schools initiative** launched over two decades ago, we developed Gloucestershire Healthy Living and Learning, which continues to thrive and provide support to all schools in the county.

The team of Lead Teachers (qualified teachers working in Gloucestershire who are employed as Lead Teachers one day per week) support a group of schools to achieve their Healthy Schools Award, as well as developing teaching resources, delivering training and advising on evidence based interventions schools can use to support pupil's health and wellbeing and improve the school environment.

Many of the photos used in this Plan were taken at the **Holiday Activities and Food** programme celebration festival in the summer of 2024. This programme, funded by the Department for Education, with £1.9 million additional funding from Gloucestershire County Council, has awarded grants to almost 100 local voluntary, community, faith and social enterprise agencies and District Councils to provide free activities and nutritious food for children and young people during the holidays, with a focus on those facing greater disadvantage. The programme has been a huge success delivering over 150,000 activity sessions, with over 27,000 unique children and young people attending from across Gloucestershire since it was first piloted in 2021.

National Policy Direction

It is also key that our focus locally responds to the national policy direction, including:

- Greater access to early education and childcare, particularly for working families
- Providing a universal offer to all families that supports parents and carers to nurture the health and development of their babies and children from conception, throughout the early years, and into the start of adulthood through a Family Hubs approach
- Earlier intervention and support for children with Special Educational Needs and Disabilities to enable them to access and thrive in mainstream provision where possible and improving transitions to adulthood by strengthening Post 16 advice, guidance and provision
- Putting lifelong loving relationships at the heart of the care system by recognising that families are the experts in their own lives and the system needs to collaborate and co-produce plans in true partnership with parents and carers, whilst providing intensive help to families in crisis
- Safer, more equitable and more personalised maternity and neonatal care for women and babies
- Prevent crime before it occurs and build safety and security by working closely with communities, schools and other partners, build trust in neighbourhoods and understand local needs, with a diverse and skilled police workforce.

Our priorities for all children and young people in Gloucestershire

Starting well

(pre-birth through early years to reception age)

- Best Start Offer
- Positive parenting, attachment and parental mental health
- Early education and childcare
- Transition to school
- Healthy behaviours

Growing well

(primary through to early secondary)

- Wellbeing and resilience
- Holiday and out of school activities
- School attendance
- Transition to secondary
- Online safety
- Healthy behaviours

Being well

(middle teenage through post 16 to 25 years)

- Transition to independence
- Transition to adult's services
- Youth offer
- Healthy relationships
- Travel
- Young people's voice

Joint priorities

- Use the Graduated Approach to effectively respond and prevent needs escalating
- Create a Family Hubs eco-system
- Develop a sustainable and empathetic workforce
- Recognise and respond to experiences of adversity and trauma

Living well (creating the conditions to thrive)

- Quality housing and employment opportunities
- Affordable transport that gets us where we need to go
- Safe communities and online spaces

How we will measure our success

Equity

Equity

- The attainment gap for children eligible for Free School Meals and those with Special Educational Needs and Disabilities will narrow
- Uptake of free 2-year-old childcare for low income families will increase
- The number of children open to social care will reduce.

Inclusion

Inclusion

- School attendance will increase
- Exclusions, deferred entry to school and placement moves will reduce
- Families becoming Electively Home Educated for reasons other than philosophical / lifestyle / preferential will reduce.
- Reported bullying will reduce.

Access

Access

- Children will tell us they feel safe
- Waiting lists for specialist services will reduce
- The use of Family Hubs by underserved communities will increase
- More effective transport for children to access school will be established.

Quality

Quality

- There will be sufficient early years provision at good or outstanding Ofsted standard
- The quality of Education, Health and Care Plans for those children who need them will increase and the number of tribunals will reduce.

How we will deliver our One Plan for all Children and Young People in Gloucestershire

Gloucestershire's Children and Young People's Coalition board will oversee the delivery of this strategy and will hold partners to account in delivering our priorities.

The coalition is rooted in Section 10 of the 2004 Children's Act which gives responsibility to Gloucestershire County Council to co-ordinate partner activity for securing the health and wellbeing of all children and young people in Gloucestershire.

The Coalition reports to the One Gloucestershire Health and Wellbeing Board and Partnership, and the One Plan aligns to the Integrated Care Strategy and Joint Health and Wellbeing Strategy.

The coalition sits alongside the Gloucestershire Safeguarding Children Partnership, with its focus on the effectiveness of multi-agency safeguarding arrangements across the county, the Safer Gloucestershire Partnership Board, and the Children's Ambitions Board, which drives the continuous improvement in children's social care. The coalition will take ownership and responsibility for delivering the 'Living Well' foundation to this Plan.

Three sub-groups report into the coalition board to drive forward the Starting Well, Growing Well and Being Well priorities of the One Plan.

Coalition members commit to ensuring alignment and advocating for the interests of children and young people throughout the system, including, but not limited to, district plans; voluntary, community, faith and social enterprise sectors; equality, diversity and inclusion strategy; strategic housing partnership; anchors and economic strategy; domestic abuse, early help, SEND and inclusion strategies.

Progress against our priorities and outcomes for children and young people will be evaluated on an annual basis and will inform an annual review of the strategy for its lifetime. This will also enable partners to continue to hold each other to account for delivering improved outcomes for our children and young people.

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ONE PLAN

for all Children and Young People in Gloucestershire

2024-2030

ONE PLAN
for all Children and Young People in Gloucestershire
Being Well Pillar

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Introduction

This strategy was written by bringing a multi-agency group of around 60 people together to identify themes under the four headings of equity, inclusion, quality and access. Following this a subgroup of providers across the county came together to test the thinking with young people, following this a range of one plan events were convened testing all of the strands.

The adolescent and young adult years are a period of rapid change in both brain and body. These transformations occur at varying rates and encompass both exciting exploration of identity and the pursuit of independence. However, adolescence can also be a stressful and challenging time due to the swift adjustments taking place. Professionals, caregivers, and communities must provide meaningful support to all young individuals no matter their circumstances as they navigate this transformative period.

This strategy sets out how we aim to achieve this for all young people in Gloucestershire today. It represents one of three pillars across the child's life stages ('Starting Well', 'Growing Well' and 'Being Well'), underpinned by a foundation of 'Living Well' that will inform the way we work with, and for, children and young people in the county. 'Being Well' describes our collective vision for adolescents and young adults, the outcomes we want to achieve and our priorities for action.

The strategy has been developed, and will be delivered, in partnership with a wide range of stakeholders, including young people themselves. We begin with our vision and principles, feedback from young people and an overview of challenges and opportunities facing young people and their families locally. We then set out the outcomes we want to achieve for this age group and conclude with our priorities for action.

A more detailed action plan will be developed for each pillar, to set out a range of actions that will be taken to ensure the priorities are delivered and outcomes achieved.

What we want for all young people in Gloucestershire

We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identify, special educational needs or disability.

Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision:

Equity - close the gap and eliminate inequalities.

Access – right help at the right time for all children

Inclusion – a county where everyone belongs, and we celebrate diversity.

Quality – effective, outstanding services

Responsibility for driving progress against these objectives will be owned by Gloucestershire's Children and Young People's Coalition board and three subgroups themed around the life stages of Starting Well, Growing Well and Being Well.

To deliver this vision we will be guided by the following principles:

1. **We will listen –** work in partnership 'with' children, families and communities, not 'for' or 'to', build on existing children, family and community assets and aspirations, ensuring everyone can make a contribution, is respected, and that we take a whole family approach.
2. **We will care –** build a culture within our workforce of empathy, using language that cares, acknowledging children and their parents and carers are the experts in their lives, and being welcoming and inclusive for families and children of all ages, cultures, religions, ethnicities, genders, sexuality and disabilities.
3. **We will be fair** - prioritise resources to those that need it most, ambitiously aim to reduce inequalities in outcomes and close the gap.
4. **We will act early** - aim to reduce escalation and specialist support through early identification of needs, building resilience, using restorative approaches, and reduce trauma for children and young people.
5. **It will feel easy** - strive to create integrated services, smooth transitions and pathways to give coherence to children and families' experience of support.
6. **It will work well** - seek to ensure value for money with our resources, avoid duplication and inefficiency, embrace innovations and seek to build on existing evidence based approaches.

What it's like to be a young person in Gloucestershire

For the majority of Gloucestershire's young people, they do well in our communities we have:

- Strong schools with 80% of Secondary schools rating Outstanding. 7 Outstanding secondary schools in Gloucestershire. 3 of which are Grammar Selected schools.
- Better than national average GCSE exam results
- Lower than national average unemployment rates for young people

However, there is a disparity for our most disadvantaged young people and for some of our young people the story isn't so positive. This strategy seeks to change the narrative for the most disadvantaged and to improve opportunities for all in our county. It is important to note to achieve the best outcomes we can for young people in our county relationships are key, this means we need to utilise a partnership approach working across statutory sector, voluntary sector, community groups and families to ensure our young people can be well and reach their potential ensuring Right child, right support, right time, every time.

> 83% of young people surveyed told us having their voice heard matters: 'It matters to me that people ask me about what I want and listen to what I have to say. Everyone has a voice, and everyone's voice should be heard'.

Education, employment, and training

Significant progress has been made in reducing the number of children not in education, employment, and training, Gloucestershire's performance improvement has been quicker than England and is significantly better than the England average. However, the GCSE outcomes gap for disadvantage pupils in Gloucestershire has been consistently higher than the national average over the last decade. Although disadvantaged pupils' grades in Gloucestershire initially made up some ground during the pandemic (with the measured gap falling in 2020 and 2021 towards the national gap), the Gloucestershire gap then widened again in 2022 and reversed most of the apparent progress that disadvantaged pupils had made during the two previous years. Gloucestershire has a larger disadvantage gap at KS4 than 42 per cent of local authorities in England.

Despite having higher-than-average GCSE attainment, Gloucestershire pupils are less likely to participate in education and training at ages 16 and 17 than nationally (85 per cent compared to 87 per cent). there has also been a small but steady increase in the proportion not in Education, Employment, or Training (NEET) in Gloucestershire.
Disadvantaged young people in Gloucestershire are notably less likely to progress to higher education (or further education) than disadvantaged young people nationally and are instead much more likely to enter employment immediately after 16 to 18 study. (Educational outcomes in Gloucestershire 2023)

Gloucestershire's exclusion rates have reduced, but for those who are excluded isolation and disadvantage becomes a barrier. Gloucestershire's online pupil survey reports 47.8% of children who reported at least one exclusion from school, said they were not listened to in the process and did not have a say in what happened afterwards. 1 in 5 children who reported at least one exclusion said if there is an incident or issue at school pupils weren't listened to or involved in making it right compared to 1 in 4 children who had not been excluded. When children had been excluded, they were less likely to have someone to go to for help if they were worried than those who had no exclusion (64.5% vs. 81.0%). Pupils who had been excluded from school were significantly more likely to report Low Mental Wellbeing (LMW) than those who had no exclusion (38.8% vs. 35.3%). Pupils who said they were often in trouble were also significantly more likely to report LMW (44.6%) than those who did not (35.8%).

82.7% vs. 74.7% pupils from ethnic minority groups reported less confidence about their future than their white British peers. Pupils with all vulnerable characteristics were significantly more likely to say they felt worried about going to school than their non-vulnerable peers.
Pupils identifying as LGBTQ+ (51.0%), those with LMW (50.8%), and pupils who were seriously bullied (52.4%) were the most likely to say the felt worried about going to school.

71% of young people told us consistency of adult and support is important: 'I care about having the same adults around and knowing that the things I access will be there every week, Consistency is very important which links with trust'.

Focusing on improving outcomes for young people in education employment or training is therefore crucial we need to address the following:

- Ensure young people have appropriately identified school places and are supported to move into them (including specialist education placements).
- Young people who are not in school due to illness, poor mental health, anxiety, and other barriers require support to overcome barriers.
- Young people transitioning post 16 who are likely to become NEET require support and guidance.
- Young people excluded from schools require support to reengage with mainstream education quickly and appropriately.
- Support for young people transitioning from primary to secondary school.
- Young people in care need support to improve education outcomes.
- Support young people to remain within School and feel safe when they are there. We need to work with young people and Schools to understand where they feel safe and where they don't, so we can build safety in School and create a space for learning and development.
- Recognizing that certain groups of young people, for example gender exploring, BAME, UASC will have more barriers to access, we need to ensure that these young people have appropriate support, advocacy, and inclusion so that their needs are met, and they can take next steps.

Gloucestershire is already responding to this need (examples below) which require building upon

- S19- Providing a multi-agency approach to hear the young person's voice and create an appropriate pathway of support to reengage young people in education. Creating opportunities for a multi-disciplinary team to explore alternative ways of educating and supporting young people.
- Transition Chat – Providing support for those most at risk of becoming NEET to progress into post 16 options, with a 90% success rate (2023) of moving young people into positive destinations.
- Virtual schools is ensuring all children in care have access to education.
- Contextual safeguarding approaches help understand the context in which young people are being harmed outside of the home to help build safety. We are seeing locality responses being developed to work with Schools to create safety for young people and to help keep them in School.
- Improving process and connectivity around reintegration of young people into mainstream school from alternative provision.

Case study

Three years before Tom came to work with Transition Chat, he had a tough time at school. Tom has ADHD, and the school could not meet his needs because of this, Tom struggled to socialise and make friends and became isolated. Since working with Transition Chat, Tom returned to education and began interacting with people again. He also expressed his passion for fishing and was very keen to get outside. Transition Chat arranged fishing trips where Tom made new friends and connected with people he hadn't met before. Tom built the confidence to volunteer at Kingsway Manor Farm, where he helped repair their fishing lake so that he could fish there. Additionally, he encouraged less confident individuals to join him for fishing. After struggling in education, Tom got back on his feet and is thriving. While doing this, we helped Tom secure a spot at Prospects Training for Maths and English. He also gained valuable work experience in an area he was interested in. He plans to help other

young people take up fishing and intends to continue supporting Kingsway Manor Farm's future projects.

Healthy lifestyles and health harming behaviours

Positively, the Pupil Wellbeing Survey 2022 has found that the amount of exercise young people are doing has been increasing steadily since 2018, improvements were also seen in healthy eating habits with an increase in the proportion eating 5 a day and a reduction in sugary and energy drink consumption. However, obesity rates have increased with (2021/22) of obesity in Year 6 age children is 20.7% in Gloucestershire, compared to 19.8% in the Southwest Region. (https://www.gloucestershire.gov.uk/media/uw2mp1yp/inequalities-in-ncmp-obesity-report_v1_2023.pdf)

The proportion of pupils reporting consuming alcohol has also been steadily declining, and the proportion reporting trying illegal drugs fell between 2020 and 2022. However over 26.1% of pupils (in Y8 and above) had been offered drugs with cannabis the drug most offered to pupils (23.9%). 14.2% of YP reported ever trying drugs; again, Cannabis was the drug they had most likely to have tried (12.5%). There is a disparity with a young person's personal situation and likelihood of engaging with drugs. The proportion of pupils reporting having tried drugs was highest in schools where the majority of pupils lived in quintile 5 (least deprived), 10.3% and lowest in schools where the majority of pupils lived in quintile 1 (most deprived), 8.5%. With different districts showing different prevalence, pupils at schools in Forest of Dean district, reported the highest level of drug use (18.3%).

Despite the numbers reporting smoking cigarettes declining over recent years, 2022 saw a huge rise in young people vaping, meaning overall exposure to nicotine rose by 42% between 2020 and 2022. (online pupil survey 2022) and whilst evidence suggests that vaping is less harmful than smoking, it is not without risk.

Gloucestershire's mental health waiting lists have continued to rise post Covid, with an increasing need in our mental health and eating disorder services. Whilst this is the case a growth in multiagency working to respond to these needs have developed. Between 2016 and 2022 pupils in Y10 saw the biggest increase in self-harming behaviour; a rise of 8.9 percentage points, Y10 pupils also saw the biggest increase specifically during the pandemic period. The proportion of young people reporting self-harming in 2022 was highest in pupils at maintained school IMD quintile 2 and 4 (27.6% and 27.8% respectively). We still see the rate of hospital admissions for mental health conditions in children aged under 18 at 120.4 per 100,000 and admissions as a result of self-harm (for ages 10 to 24 years) at 447.1 per 100,000, both are significantly worse than the England average. There continues to be a national challenge in response to Gender questioning and gender fluid young people, with limited specialised support in our county.

The number of children and young people seeking support for emotional wellbeing and mental health has grown since the pandemic resulting in a significant amount of investment and development of mental health services to meet these needs, informed, and coproduced with children and young people. There has been the development of a **young adults' service**, led jointly by the Voluntary Sector (Young Gloucestershire) and Gloucestershire Health and Care Trust, comprising mental health and youth work to ensure young people can get the right practical as well as emotional support. TIC plus counselling service have developed the range and breadth of services and support thousands of children and young people every year including, a peripatetic face to face service for 9-25 year olds as well as online counselling, on line emotional wellbeing sessions, anonymous chat and support for parents. The CAMHS service have expanded to meet growing demands and are working hard to reduce waiting times, alongside developing urgent and emergency care and home treatment services which has successfully reduced admissions to tier 4 units.

There has been Investment in a range of voluntary sector counselling and alternative approaches e.g., creative health/social prescribing, therapeutic play to widen our offer to meet broad ranging needs. We have also introduced digital technologies from mental health promotion, navigation and prevention through to early intervention as a way to respond to increasing needs. Mental Health Support teams cover over 50% of our student population in 138 schools and we are working collaboratively to

develop whole school approaches including curriculum-based initiatives, e.g., Facts4Life and My Happy Mind. The **'Waiting Well' Initiative** provides emotional skills for young people on the CAMHS waiting list. Two Primary Care networks (PCN) are investing in mentoring and a further PCN is trialling having an experienced mental health practitioner based in the surgery. We will be working with colleagues to evaluate these approaches.

The Mental Health Support Teams in Gloucestershire, locally known as Young Minds Matter or YMM have been established since 2019. There are now 7 teams across the county, supporting young people from 5-18 in over 140 schools, with low level anxiety and low mood through cognitive behavioural therapy (CBT) interventions. The teams work closely with the wider MH system, including TIC+, School Nursing, Early Help and Education Inclusion to ensure young people get the right support for their needs. Since starting nearly 5 years ago, the teams have supported over 4500 young people and the best performing teams within the Southwest. This year the team are expanding their offer to work with young people who are struggling to engage with education within secondary education with an enhanced offer of high-intensity CBT from a senior clinician within the team.

In relation to sexual health, Males are less likely to report understanding consent than females at all ages. Understanding consent appears to be higher in pupils from the least deprived backgrounds, at 90.9% in pupils from selective schools and 90.1% in pupils living in Q5 neighbourhoods. Pupils from black backgrounds (Black Caribbean, Black African, Black other, Mixed-White and Black Caribbean, Mixed-White and Black African) were significantly less likely to say they understood consent than their white British peers.

1 in 10 pupils who had engaged in sexual activity felt they couldn't say no to partaking in sexual activity. Males were twice as likely to say they couldn't say no to partaking in sexual activity than females, this was similar in 2020 and 2022. Pupils from the most deprived areas were the most likely to say they didn't feel they could say no to sexual activity (1 in 5). The vast majority (77.8%) of those who had engaged in sexual activity had had intercourse (12.4% of all pupils Y8 and above)

Pupils from a Gypsy/Roma background were the only ethnic group significantly more likely to report being sexually active than their white British peers (38.9% vs. 13.5%).

2019/20, the percentage of births to mothers under 18 years was 0.5%, similar to 0.7% in England overall.

We also see a gap between young people with a disability or SEND against other peer groups with1 in 3 pupils with disability or SEN/EHCP reporting excessive screentime, significantly higher than their less vulnerable peers, and SEND young people noting, being able to eat healthily relies on healthy choices being available to pupils. Pupils at special schools, those with a disability and those with SEN/EHCP were all significantly less likely to report the food available at home allowed them to eat healthily compared to their less vulnerable peers.

Focusing on improving outcomes for young people in healthy outcomes is therefore crucial we need to:

- Raise awareness of the harmful impact of substances including vaping.
- Continue to offer appropriate sexual health education and the C Card for our county's young people.
- Increase services for those young people impacted by substance misuse early to ensure improved outcomes.
- Provide healthy awareness education for young people.
- Reduce obesity and harmful eating behaviors in young people.
- Support young people to improve health outcomes through diet and exercise.
- Expand mental health support, exploring alternative youth focused approaches rather than clinical.
- Create opportunities for young people to engage in fun activities improving their wellbeing.
- Affordable and accessible activity offer to negate barriers.

- Targeting Schools in our least deprived areas around substance misuse and associated harm given the outcome of the Pupil Wellbeing Survey 2022

Gloucestershire is already responding to this need (examples below) which require building upon:

- The commissioning of Beezee bodies across Gloucestershire providing more family focussed physical activity opportunities, Ideas, and skills for the family to be active outside, focus around healthy cooking on a budget, including the use of frozen and tinned foods.
- Active Gloucestershire's partnerships to embed active lifestyle in all areas of work.
- Health and well-being board working together to focus on key themes and outcomes for Gloucestershire.
- Improving mental health support of Gloucestershire hospital wards with youth workers present.
- The partnership work of VCS and GHC to deliver a range of interventions
- Commissioning of a new Youth Support offer offering open access youth provision.
- A Childhood Obesity and Safeguarding Working Group has been established by Public Health to bring together a group of professionals that work across a range of CYP services to strengthen the local position around this area.

Case study

Eleven-year-old Nathan and his family had got into unhealthy snacking habits, and treats had become an everyday thing, when they heard about BeeZee Families through school. Like many kids, Nathan enjoys playing computer games, making videos and playing with friends. He also loves going to karate class once a week. His parents explained how signing up for BeeZee Families together had helped them all get into healthier habits. A lot has changed, we are content with having treats on occasion and not regularly, like we did previously. It has now become a habit to have more vegetables with our meals daily. We are mindful of portion sizes for Nathan. He has started skipping as a fun thing and is enjoying it. We have a better understanding of what the various food groups do for our bodies and we are mindful of what we should be eating more of or avoiding. The realisation that we are not alone have support available whenever we need it. We don't get to create healthy habits overnight, so we need to be kind to ourselves and keep going.

Adverse Childhood Experiences and Trauma

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years).
For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide.

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- substance use problems.
- mental health problems
- instability due to parental separation or household members being in jail or prison (https://www.cdc.gov/violenceprevention/aces/fastfact.html)

In 2018 Pupil Wellbeing Survey introduced ACES to their questions asking how many Adverse Childhood Experiences young people had experienced. Of those who answered 25.3% pupils reported having experienced four or more ACEs, this was significantly higher than in 2018, when a fifth (20.1%) reported 4 or more ACEs. It is noted that pupils experiencing 4+ ACEs are much more likely to engage in health harming behaviours such as smoking, trying illegal drugs and getting less than the recommended hours of sleep.

Young people in care are at a higher risk of ACES and trauma, however Care leavers in Gloucestershire in the bright spots survey 2022, were statistically more likely than care leavers in other LAs to feel that they had been given a good enough explanation as to why they had been in care (86% vs. 77%). However just 17% of young people had kept the same social worker in the previous 12 months, creating a challenge around consistency and trusting adults.

91% of young people told us trust was important to them: 'I want to be able to trust those who are involved in the things I'm doing Trust and loyalty is the only thing in life that matters to me as well as love'.

Focusing on improving outcomes for young people in relation to ACES and trauma is therefore crucial we need to:

- Reduce the exposure to ACES for young people. whilst also recognizing that experiencing adverse child experiences does not define young people and their capacity to thrive and achieve.
- Create opportunities for trusted adults to improve outcomes.
- Work to improve consistency for young people in care.
- Develop a culture of early intervention and identification when children and young people are at risk of exploitation.
- Understand and respond to the challenges around adultification and the intersectionality of discrimination and oppression.
- Early identification to enable interventions and support systems to be put in place early.
- Adopting trauma informed practice in various setting e.g. schools, healthcare etc.
- Providing opportunities to build resilience through mentorship programs (trusted adult), activities, therapeutic interventions.
- Adopting flexible education support. e.g flexible learning environments, tutoring, trauma informed classroom practices
- Engaging families and communities
- Resilience trumps ACE's therefore we need to continue to seek ways to increase resilience through a wide and varied offer of both clinical and non- clinical practice.

Gloucestershire is already responding to this need (examples below) which require building upon:

- The Gloucestershire Mentoring Partnership securing grant funding to develop a partnership of mentoring providers across the county providing support to young women at risk of involvement in the criminal justice system.
- Action on ACES response to Gloucestershire working mutli agency to respond to young people's needs (https://www.actionaces.org/)
- A multi-agency pilot which brings agencies together to identify and agree the most appropriate response to children where there are worries about their mental health and well-being. The aim is to reduce multiple referrals and delays through navigating various systems to access a service.
- Gloucestershire have a co-located multi agency safeguarding hub (MASH) which allows professionals to quickly share proportionate and relevant information to understand a young person's situation to inform what action, if any, is needed to safeguard a young person and promote their wellbeing following potential safeguarding concerns being shared with children's social care.

Case study

GMP is a partnership of providers across Gloucestershire coming together to explore improving outcomes for young people by working together, learning together, and sharing knowledge and resources. Each organization runs their own mentoring programme with volunteers who are recruited, trained, and matched to young people. However, the organisations come together to develop recruitment campaigns, policies, volunteer training, suitably match young people to mentors and to reflect and learn on practice. Creating an opportunity for a county wide offer from multiple partners who are building capacity and learning together.

Transition to adulthood.

For some young people duties placed on services, create the opportunity for outcomes to be improved. The offer of personal adviser's support to all care leavers towards whom the local authority had duties under section 23C of the Children Act 1989, up to age 25 - irrespective of whether they are engaged in education or training, including care leavers who return to the local authority at any point after the age of 21 up to age 25 and request such support.
https://gloucestershirechildcare.proceduresonline.com/p_leaving_care.html ensures there is a key offer for targeted groups of young people with support to transition.

For others the different approach of adults to child services creates anxiety, challenge and can reduce access for young people. The difference in adult to child thresholds for help in services, the approach of adult services to children services can all create reduction in young people accessing

services and understanding how to engage with them, Safeguarding is a key example of this. For young people under 18, safeguarding duties are intended to protect all those at risk of harm. Adult safeguarding focuses on people with care and support needs who might find it more difficult to protect themselves from abuse or neglect because of those care and support needs. This can sometimes be misinterpreted as limiting or restricting which local services are permitted to support. This can result in some young adults experiencing significant safeguarding risks in their lives and not receiving support when they need it. Young autistic people or those with learning needs are a particularly important group to consider, alongside those at risk of exploitation. (Bridging the gap: Transitional Safeguarding and the role of social work with adults (publishing.service.gov.uk)

> 76% of young people told us it was important to them to have services that understand their need: ‘feel like I’m different to everyone else. I struggle with even explaining how I feel most days I need services that understand my individual needs—whether it's how I feel, my health, or my financial situation’

Focusing on improving outcomes for young people in relation to Transition to adulthood is therefore crucial we need to:

- Increase the voice of young people in the development of their services.
- Reduce the transition gap created by child services ending at 18 and young people not being able to access suitable adult services.
- Create a multi-agency approach to transitioning young people.
- Ensure Leaving Care young people receive the required support.
- Explore transitional services for young people 16-25.
- Developing a transitional safeguarding needs led approach removing child/adult silos.

Gloucestershire is already responding to this need (examples below) which require building upon:

- Young adult service (YAS) – a multi-agency approach hosted within the voluntary sector responding to young people’s mental health 18-25 ensuring they don’t drop between the gap of child and adult mental health services.
- Mental health services – A number of voluntary sector organization TIC+ and Young Gloucestershire are now commissioned to provide support to young people 11-25, removing the end of services at 18.
- Specific services for Leaving care young people such as the Linked up+ mental health offer.
- The ambassadors programme, employing 15 young people with lived experience are paid by GCC to represent the voice of young people. They are experts by experience bringing knowledge of support for children in care and care leavers, children with disabilities, young people in the youth justice system, and children’s mental health. They share their own experience and engage with other vulnerable children and young people to complete the feedback loop to improve services. Ambassadors help us to remain child-focussed; they challenge us, work with us, and often identify work that requires improvement.
- A Peer Mentoring Service, managed by care experienced young people and supported by the Participation Team. Supporting children / young people with things like transitions. Recruiting and training care experienced young people to become Peer Mentors

Language that Cares -

Harm outside of the home, including risk from Exploitation, Serious violence, and anti-social behaviour.

Many young people report being concerned around their safety in their community,

10

83% of young people told us it is important they feel safe and welcome in the places the go: 'I don't like going out at night as I don't feel safe.'

In the pupil survey 12.8% of pupils said they had been in serious trouble with the Police, males were more than twice as likely to report being in serious trouble with the Police than females (4.0% vs. 1.5%). Pupils from the following groups were more likely to say they had been in serious trouble with the Police:

- Young carers (8.9%)
- Those known to social care (8.2%)
- Those who are bullied (7.4%)
- Those with a disability (7.2%)
- Those reporting 4+ ACEs (6.9%)
- Those eligible for FSM (6.6%)
- Those with SEN/EHCP (6.1%

1.4% of CYP reported joining a gang, males were not significantly more likely to report being in a gang than females. CYP known to social care (4.6%) were over 4 times as likely to report being in a gang than those not known to social care (1.1%).

Whilst violence and anti-social behaviour is the presenting issue it is essential to not address a young person's issue (for example, persistent low attendance) in isolation. A whole-family approach is needed to ensure the family is worked with and supported as a unit, given issues impact a family as a collective. The whole-family approach ensures that practitioners can understand the root cause of behaviour and find out what family factors could be driving it. This promotes a culture of not treating the symptoms of an issue but addressing the underlying cause to stop the issue re-emerging.

Focusing on improving outcomes for young people in relation to harm outside of the home, including exploitation, violence and antisocial behavior is therefore crucial we need to:

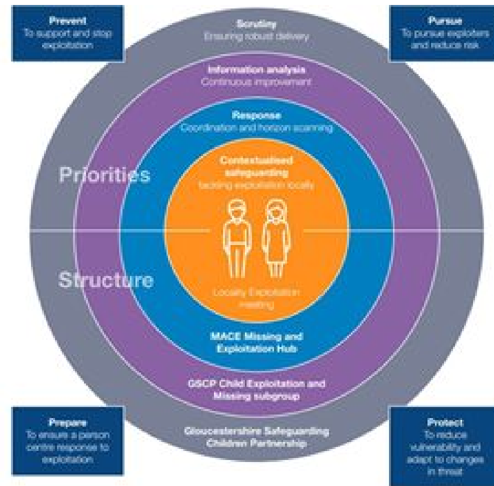
- Look at the whole person and family rather than addressing present problems in isolation.
- Improve education, post 16 engagement and positive role models for young people.
- Work as a partnership to understand the context in which harm is occurring and pursue the adult exploiters causing harm.
- Gloucestershire Children's service Ambitions plan – Ambition 9 commits to "Adopt a contextualised approach to managing complex safeguarding, ensuring that it is intelligence led and promotes disruption actively". Services will be shaped through co-design with young people, their parents and carers.
- When we are most worried, we have occasionally sought to remove a young person from the area. However, removing young people from their family and friendship networks can disrupt all their relationships, cause further trauma and often those worries remain, or increase. Therefore, young people need their communities to work together to increase safety and help them remain within their family and community networks.
- Provide earlier intervention for young people from groups most at risk
- Provide safe environments – accessible youth spaces.
- Youth empowerment in being part of or having a say in e.g. youth spaces, their perspectives on youth violence.
- Social media - violence on social media is hard to avoid – so online harms knowledge and support.

Gloucestershire is already responding to this need (examples below) which require building upon:

- Urban Street Gangs multi agency approach
- Serious Violence Duty response
- Strategic crime prevention strategies and agendas
- Violence working groups in the city.
- The legacy of the knife angel visit
- Mentoring programmes for young people
- Strategic Safeguarding board
- Youth justice, children first approach
- An established Child Exploitation team co-located with the Police. Specialist social workers in the team working alongside locality

social workers to undertake direct work with young people, offering time and space to build a trusting relationship.

- Implementing a pilot to share information at the earliest opportunity of young people who go missing or have been in custody to improve information share and agree the right response at the earliest opportunity.
- Adopting a contextualised approach to managing complex safeguarding, ensuring that it is intelligence led and promotes disruption actively, for example, locality MACE meetings.
- Undertaking a review of how the partnership protected children and young people from the risk of harm outside of the home.
- Series Violence duty



Case study
Feedback from a young person regarding her relationship with her CE social worker:

“Hey, if you’re not gunna see this right now but I just wanna say thank you for everything you’ve done for me this year, I appreciate it so so much, and I don’t know what I would’ve done without you, you’ve helped me realise my worth and become more confident, I couldn’t ask for a better support worker, you really inspire me and anyone’s lucky to have you in their life. Thank you”

What we'll do for all young people in Gloucestershire

We have identified the following priorities to deliver our four objectives of equity (closing the gap and eliminating inequalities), access (ensuring the right help at the right time for all children), inclusion (creating a county where everyone belongs, and we celebrate diversity) and quality (delivering effective, outstanding services). We believe that collective action against these priorities will achieve our vision for Gloucestershire as a great place to grow up where all children and young people thrive and live lives of choice and opportunity.

Objective 1: Equity – close the gap and eliminate inequalities.

Developing early intervention responses, that reduces inequalities and ensures all young people have a fair chance no matter their background or situation. Ensuring that access to services are equitable and suitable for the needs of young people.

Priorities	Indicators to measure our success against
Reduce the gap and improve outcomes for those at greatest disadvantage (e.g. due to ethnicity, young people with disabilities or neuro diversity, young parents, those impacted by Domestic Violence, those in poverty, those at risk of online harms, those at risk of hidden harm and young offenders) Continually review and act upon the needs of young people ensuring diverse young people's voices are at the centre. Utilise community assets, building capacity to provide opportunities for young people to connect, build resilience, be active, gain work experience and develop their independence in ways that appeal to young people. Ensure consistent and effective use of the graduated approach to ensure needs are met, prevent escalation, and support a culture that children should live within their family, wherever it is safe for them to do. Co-create a Family Hub Approach with communities across Gloucestershire offering a universal, welcoming hub for families to connect and support to be provided at the earliest opportunity when needed. Supporting parents in their roles. Develop partnerships and closer working together to understand services being delivered, gaps/needs and reduce duplication. Work with system partners to prevent harm and trauma and where it exists, provide services to limit the harm and build children's resilience. Create safe and nurturing environments, in the areas young people live and online	Improving engagement of young people in services Young people report services are fit for purpose and meet their need. Young people and families feel heard. Increased partnership working, improved services for young people, sharing of resources and assets to benefit young people.

Objective 2: Access - right help at the right time for all children

Working together across all sectors to improve partnership and strategic relationships to improve access for young people to services. Ensuring that young person's voice is at the centre and appropriate services are provided when and where young people require them.

Priorities	Indicators to measure our success against
Improve collaboration of data and data sharing and data quality, across all agencies, statutory and VCS to improve outcomes for young people and transitions between children's and adults' services into greater independence. Improve all transitions for young people from primary to secondary school and then young people to adult services. Understanding thresholds and barriers to services. Explore opportunities of delivering new and dynamic approaches to early intervention appropriate youth provision including AI, online offers, and other blended approaches to meet new and diverse community needs.	Increased data sharing across agencies, improving support to young people. Improved transitions for young people across services, less young people fall through the gaps of services not receiving required support.

Priorities	Indicators to measure our success against
Form a multidisciplinary approach to addressing the travel challenges our young people face in the county. Improve data quality including ethnicity recording so we know when services are not accessible. Improve safety in public spaces and reduce the threat from anti-social behaviour and violent crime, so children, young people and families can get out and about and feel welcome. Ensure services are available and promoted by the community and in local community hubs such as libraries. Ensuring services expand with population demand of birth rates or housing developments. Improve transitions for young people as they move into adults' services. Develop earlier intervention services to promote healthy lifestyles and reduce health harming behaviours. Ensuring nutrition information, immunisations and mental health are considered to build resilience, understanding the impact of ACES	Increased provision for young people in Gloucestershire. New partnerships developed. Increased partnership working to improve outcomes for young people. A developing alternative youth work offer. Improved access to services and opportunities for young people.

Objective 3: Inclusion - a county where everyone belongs and we celebrate diversity.

Seeking to develop an inclusive approach for young people's services, improving equity of access, young person's voice and right service, right place, right time for young people in our county.

Priorities	Indicators to measure our success against
Work with the network of youth providers to understand the challenges to services being more inclusive and seek proactive ways to respond to the challenges. Develop a formal approach to hearing diverse young people's voices, from all types of young people, all backgrounds across all districts and areas. Ensure everyone is trauma informed, empathetic, use language that cares and help build resilience in individuals and communities. Create communities that celebrate and nurture children's diversity and operate in a climate of inclusivity, including coproduction, awareness raising, adaption of services including length of access for SEND and training to improve skills and knowledge. Ensure professionals understand neurodiversity and hidden disabilities and provide the right support to increase access to schools and community assets. Ensure all young people and their parents are heard. Develop consistency and continuity of services. Reduce absenteeism/exclusion of young people within our county. Reduce exposure to ACEs and build resilience in young people.	Services that are more inclusive to all young people. Increased young people's influence on services and opportunities in the Gloucestershire

Objective 4: Quality - effective, outstanding services

Developing a multidisciplinary workforce across statutory and VCS to ensure services on offer are of the highest quality with young person's voice at the centre. Learning from best practice, collaboration and sharing at the centre.

Priorities	Indicators to measure our success against
Create a network for those delivering to young people bringing multiple voices together to respond to their needs.	Better connected, working together organisations achieving outcomes for young people.
Share resources and training to create an outstanding youth offer in our communities.	
Develop a common approach to safeguarding our young people.	Improved outcomes for young people.
Create truly meaningful multi-agency partnerships and approaches centred around the child that are needs led, not service led, learn and build on strengths and take action to change where required.	Young people access the right support at the right time.
Increase collaboration of statutory and VCS sector to understand gaps, reduce duplication, improve services and build capacity.	
Develop systems for sharing data to prevent people having to repeat their story and improve the speed and coordination of response.	The right decisions are made for all young people as all agencies are aware and engaged.
Utilise our Joint Strategic Needs Assessment and robust evaluation to inform system development and to raise the standard of services.	The workforce is appropriately trained.
Use integrated approaches, co-produced with children and families, to ensure children are offered the right service at the right time and in the right place, reduce firefighting and improve response.	
Support recruitment into services for children, including strategies to recruit men and other underrepresented groups into the sectors and develop an integrated induction offer for people working with families.	
Improve workforce development, develop good quality and empathetic workforces.	
Improve the commissioning/funding framework to reduce competition, reduce short term pilots and fund strategic as well as operational provision.	

ONE PLAN
for all Children and Young People in Gloucestershire
Growing Well Pillar

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Introduction

> *This generation of children has lived through difficult and destabilising times. We must make sure they grow up with the curiosity, confidence and passion to pursue their goals – and the education, skills and security to achieve them.*
>
> The Annual Report of His Majesty's Chief Inspector of Education, Children's Services and Skills 2022/23

During this period children are maturing, learning the skills they need to become resilient, confident adults and reach their potential. To achieve this they need access to high quality, inclusive education, backed up by activities in their community to help them develop their interests and friendships, alongside a secure and stable home environment.

This strategy sets out how we aim to achieve this for all children between primary and secondary school age living in Gloucestershire today. It represents one of three pillars across the child's life stages ('Starting Well', 'Growing Well' and 'Being Well') that will inform the way we work with, and for, children and young people in the county. 'Growing well' describes our collective vision for children in primary school through to secondary school.

The strategy has been developed, and will be delivered, in partnership with a wide range of stakeholders, including young people themselves.

The elements in this pillar aim to work with schools and parents in partnership to promote healthy behaviours for all children, including diet and nutrition, physical activity, importance of sleep, online safety and resilience and reduce nicotine exposure. We will need to utilise community assets and build capacity to provide opportunities for children to play, connect, build resilience and independence, and explore their interests outside school. We need to understand and respond to the barriers preventing children attending school.

begin with our vision and principles, feedback from parents and carers and an overview of challenges and opportunities facing children and their families locally. We then set out the outcomes we want to achieve for this age group and conclude with our priorities for action.

A more detailed action plan will be developed for each pillar, to set out a range of actions that will be taken to ensure the priorities are delivered and outcomes achieved.

What we want for the children and their families in Gloucestershire

We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identify, special educational needs or disability.

Bringing together the feedback received from children and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision:

Equity - close the gap and eliminate inequalities

Access – right help at the right time for all children

Inclusion – a county where everyone belongs and we celebrate diversity

Quality – effective, outstanding services

Responsibility for driving progress against these objectives will be owned by Gloucestershire's Children and Young People's Coalition board and three subgroups themed around the life stages of Starting Well, Growing Well and Being Well.

To deliver this vision we will be guided by the following principles:

1. **We will listen** – work in partnership 'with' children, families and communities, not 'for' or 'to', build on existing children, family and community assets and aspirations, ensuring everyone can make a contribution, is respected, and that we take a whole family approach.
2. **We will care** – build a culture within our workforce of empathy, using language that cares, acknowledging children and their parents and carers are the experts in their lives, and being welcoming and inclusive for families and children of all ages, cultures, religions, ethnicities, genders, sexuality and disabilities.
3. **We will be fair** - prioritise resources to those that need it most, ambitiously aim to reduce inequalities in outcomes and close the gap.
4. **We will act early** - aim to reduce escalation and specialist support through early identification of needs, building resilience, using restorative approaches, and reduce trauma for children and young people.
5. **It will feel easy** - strive to create integrated services, smooth transitions and pathways to give coherence to children and families' experience of support.
6. **It will work well** - seek to ensure value for money with our resources, avoid duplication and inefficiency, embrace innovations and seek to build on existing evidence based approaches.

We are not starting from scratch; we have fantastic foundations to build from and powerful drivers for change. We have many examples of best practice, innovation and learning that we need to continue to develop and share as a system to effect change against our objectives and improve outcomes.

What you've told us it's like to be child in Gloucestershire

For most Gloucestershire's children, they do well in our communities, however there is a disparity for our most disadvantaged young people and for some of our young people the story isn't so positive. This strategy seeks to change the narrative for the most disadvantaged and to improve opportunities for all in our county. It is important to note to achieve the best outcomes we can for young people in our county relationships are key, this means we need to utilise a partnership approach working across statutory sector, voluntary sector, community groups and families to ensure our young people can be well and reach their potential ensuring Right child, right support, right time, every time.

You have told us you want:

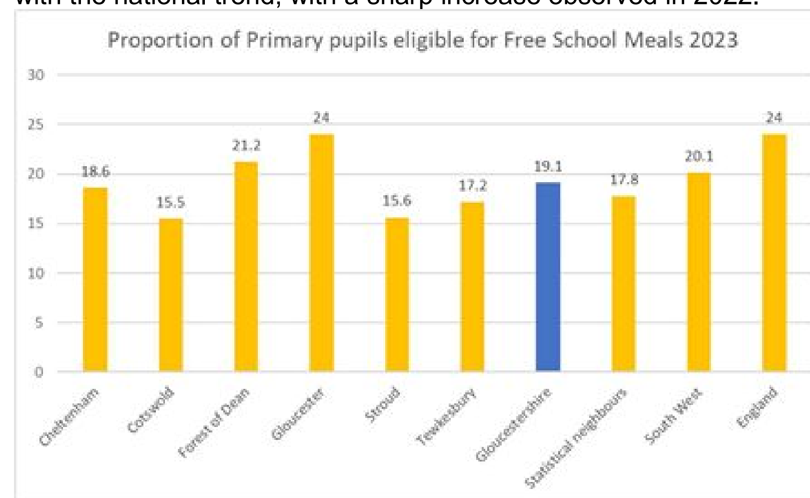
- *More opportunities to engage with nature and enjoy our surroundings green spaces.*
- *Affordable childcare.*
- *Easier ways to contact services and be referred, shorter waiting times and tailored support while waiting and on next steps.*
- *"Waiting lists are long... I have been seeking support for at least 4 years... I am struggling to find the energy to fight all the time." (parent)*
- *Help with transitions from early years to primary, primary to secondary and then into further education, training, and employment, especially those with SEND and asylum-seeking children.*
- *"Feel as though we've hit a brick wall as no other services offered/continued/involved. Very concerned about transition to adulthood which isn't far away." (parent)*
- *Easier processes and clearer communication to help with Education Health and Care Needs Assessments and their outcome.*
- *Sufficient nursery and school places to support children with Special Educational Needs and Disabilities.*
- *"We are struggling with home educating our child but are not yet able to find a school that is suitable." (parent)*
- *Never experiencing prejudice, racism or discrimination from services which are there to help.*
- *"There is a bias where a black woman is seen as strong and if you speak up or get upset you are perceived as this angry black woman, but you're just supporting your child." (parent)*
- *Feeling listened to, taken seriously, and respected by professionals, such as teachers and health professionals.*
- *Professionals use language that can easily be understood by young people.*
- *Reliable, regular, affordable, and safe public transport, which gets people to where they need to go such as college.*
- *"Services are too far away from where we live. I can't drive because of my epilepsy so my child cannot attend certain events." (parent)*
- *"Cirencester College is a three-hour round trip for Gloucester but many [asylum seeking young people] must attend this college instead of their local college. This means they wake up very early and don't get home until late – it is not fair" (professional working with asylum seekers)*
- *Opportunities to socialise and make friends in a safe and welcoming environment outside school and be active in their community.*

- *"More hubs for youngster and then outreach to get the information out there digitally (Instagram and TikTok.)," (parent)*
- *Feeling safe when out and about from anti-social behaviour, serious violence, and around busy roads.*
- *"Don't feel safe - kids hanging outside shops and there have been weapons in area. Don't feel safe to go to park." (Child, aged 9)*
- *Help to find work-experience and local employment opportunities, including more 'modern' career options (such as social media).*
- *Flexibility and understanding across services so young people can manage competing needs of health, education, and care appointments.*
- *More early intervention to stop needs increasing.*
- *Better promotion of services that are available in their own local area and involve young people in the design and creation, so it appeals to them.*

What it's like to be a child in Gloucestershire

Gloucestershire has a population of 646,627, living within the two urban centres of Gloucester and Cheltenham and the many market towns and rural villages, covered by 6 District Authorities. Children aged 0-17 make up 20% of the population and a further 7% are aged 18-24 years.

The proportion of children living in child poverty generally fall below England averages, however rates have been increasing over time in line with the national trend, with a sharp increase observed in 2022.



Gloucestershire's population is becoming more ethnically diverse, although it is less diverse than England as a whole:

Percentage includes all ethnic groups excluding 'White British'	Gloucestershire	National
Total population ONS Census 2021	13.0%	28.6%

CYP ONS Census 2021	0-17yrs 16.6% 0-24yrs 15.7%	0-17yrs 32.1% 0-24yrs 31.9%

Our Pupil Wellbeing Survey found that 70.1% of young people identified themselves as heterosexual, which has reduced over time. In 2022 we asked pupils about their gender identity for the first time:

- 1.1% identified as transgender (1.5% of biological females and 0.7% of biological males)
- 1.5% identified as gender-fluid.
- 1.6% identified as non-binary.

Education:

- 244 primary schools
- 41 secondary schools
- 20 special schools (including 8 independent special schools)
- 3 alternative provision schools

Children that go to school in Gloucestershire generally perform similar or better than England overall in their assessments at the end of their Reception year, Key Stage 2 and Key Stage 4. However, inequalities exist, with the gap in performance between those eligible for Free School Meals and those not, consistently being greater for Gloucestershire than England as a whole.

Looking at educational outcomes by ethnic groups does not show a consistent pattern, and changes through the stages due to a complex mix of cultural differences, international migration patterns, and children travelling into the county from neighbouring areas for secondary school, amongst others. Asian pupils perform best at Key Stage 2 and Key Stage 4 in Gloucestershire and in England as a whole. In Key Stage 2 the proportion of Black and Other Ethnicity in Gloucestershire achieving the expected level is below the average for the county and below our statistical neighbours and England. In Key Stage 4 all ethnic group categories perform better than their statistical neighbour and England counterparts.

Before the pandemic, around 10% of pupils across all schools were persistently absent (missing 10% or more sessions), in 2022/23 Gloucestershire reported 20% persistent absence, this pattern is similar to that seen nationally.

Rates of Electively Home Educated (EHE) children have been rising in Gloucestershire as seen nationally. In Gloucestershire they have risen from 13 per 1,000 CYP aged 5-15 in 2017/18 to 25.6 per 1,000 in 2022/23. The rate of EHE in Gloucestershire in 2021/22 was significantly higher than the statistical neighbour, regional and England average. Families do not always provide a reason for choosing Elective Home Education; however, where they have provided a reason the most common were Philosophical / Lifestyle / Preferential (19%), Mental Health (19%) and Dissatisfaction with School (combined bullying, SEND, and general dissatisfaction with school - 10%). These proportions are similar to those in our statistical neighbours and the South West region.

Permanent exclusions across all school phases were historically high in Gloucestershire but started to decline in 2015/16 and fell into line with national proportions. A sharp increase was then observed nationally following the pandemic. Exclusion rates in primary age pupils, though low (0.05 in 2021/22) are currently above England (0.02) and Statistical Neighbour averages (0.01) and require monitoring.

School suspensions in Gloucestershire have followed a similar trend to England and our Statistical Neighbours, with the most recent data putting us below the national and neighbour rate (6% compared to 7% in 2021/22).

Special Educational Needs and Disabilities: The number of children and young people in Gloucestershire identified with a Special Educational Need or Disability (SEND) has been increasing since 2015 in line with national trends. This has been driven by a combination of increased need, awareness, diagnosis, training, and changes to policy. In January 2023 there were:

- 12,569 children with SEN supported in schools

- 5,295 of these are children with an Education Health & Care Plan (EHCP)
- And 525 of these are children with a complex disability

This rise has coincided with a rise in Education Health and Care Needs Assessment applications, appeals to the needs assessment outcome and a rise in demand for special school places.

Overall Special Educational Needs are more common in children living in more deprived areas, a pattern seen locally and nationally, though there is variation depending on primary need. Children and young people with a primary need of Moderate Learning Disability; Social, Emotional and Mental Health; and Speech, Language & Communication Needs are significantly more likely to live in areas of deprivation (quintiles 1 and 2) than children without Special Educational Needs.

Feedback through engagement events has highlighted a need for professionals and parents to recognise that school is a community – children spend a lot of time in school, but these can also be places of pressure. Schools need to be safe community space.

Health: Overall Gloucestershire tends to perform well against England averages for indicators such as levels of immunisation, breastfeeding rates and oral health, however these mask disparities that exist based on deprivation and ethnicity. For example, the proportion of 5-year-olds experiencing dental decay in Gloucestershire is significantly lower than the England average (16.8%) however the prevalence in the most deprived areas of Gloucestershire is almost three times higher than in the least deprived. Benchmarking data shows that we have a higher proportion of admissions to hospital for some childhood illnesses and injuries, this needs further investigation but is in part due to hospital policies on when to admit children and the way data is coded.

Mental Health: Mental wellbeing in school age children declining Pupil Wellbeing Survey responses demonstrate that those in minority ethnic groups and those in areas of deprivation report finding it harder to access mental health support. In addition, referrals to Child and Adolescent Mental Health Services (CAMHS) are disproportionately higher for the White British ethnic group.

Care and safety: The number of cases open to children's social care in Gloucestershire has been higher than peers but in recent years has started to reduce and we are becoming more in line with our peers 2022 to 2023 331.9 per 10,000 compared to 303.79 for our statistical neighbours and 311.9 across the Southwest region.

First time entrants to Youth Justice System 80.4 per 100,000 vs. 148.8 England. While white children are underrepresented in the offending population, mixed heritage children are the most over-represented at 15% despite only making up 5% of the total 10–17-year-old population in Gloucestershire. Using the term 'child' in this context is particularly important to emphasise their relative vulnerability, rights and needs and avoid 'adultification'.

Emerging concerns: The Pupil Wellbeing Survey has also highlighted a reduction in the proportion of pupils reporting they get the recommended number of hours sleep per night, from 60.7% in 2018 to 51.5% in 2022. This is coupled with an increase in the proportion of pupils reporting they used the Internet, gaming, social network and texting between going to bed and going to sleep.

Analysis of factors that contribute to school exclusions has highlighted the increased use of smart phones and social media which may be impacting on attention, speech & language skills, social skills and ability to articulate and express emotions.

What we will do for all children in Gloucestershire:

We have identified the following priorities to deliver our four objectives of equity, access, inclusion and quality. We believe that collective action against these priorities will achieve our vision for Gloucestershire as a great place to grow up where all children and young people thrive and live lives of choice and opportunity.

This pillar will focus on:

- Developing services that are available through school/education.
- All children to have access to education.
- Family hub model to ensure service delivery to children and their families.
- Needs identified and support provided at primary age to reduce trauma and further needs developing through their childhood/adolescence.
- Focus on community need and voluntary sector support.
- Recognising the importance of place and the need for children "to be children"
- Embrace the benefits of digitalisation but also recognise that children and young people will be more advanced in their knowledge of this and this needs to be used to support engagement.
- This pillar plan will also link to other plans, including the Children's Social Care Ambitions Plan, the Early Help Strategy and the SEND and Inclusion Strategy.

Objective 1: Equity – close the gap and eliminate inequalities.

Our data tells us people who have the least in Gloucestershire struggle more than they would in other parts of the country. The reasons for this require further investigation but are likely to include higher costs of living, challenges due to Gloucestershire's rural geography, and a focus on average population outcomes rather than incentives to target children falling behind. We must work together to create the conditions for children to thrive and target our resources where they are most needed. There are children living in poverty who have fewer opportunities to achieve in comparison to their peers. The county is large and is diverse in the more urban areas, but data tells us that children from different cultures or ethnicities are more likely to be over-represented in criminal/statutory services. We need to create services that meet the needs of all our residents and ensure that everyone has the same opportunities. For this pillar we see higher numbers of children being excluded from school and not having the same developmental or educational opportunities possibly due to unconscious bias and discrimination. Parents and inspection feedback informs us that there is a culture of parental blame that exists amongst some professionals in Gloucestershire – there is a need for this plan to address this and change this culture.

Priorities	Indicators to measure our success against
Build on our Healthy Schools programme (delivered by Gloucestershire Healthy Living and Learning) to further support healthy behaviours. This will be achieved by working in partnership with school nursing, and include access to and understanding of the importance of healthy	Children's attendance, GHLL Healthy Schools Awards, equitable uptake of school nursing services. Reduction in neglect

meals and promoting physical activities in and outside of school. This programme will also need to consider those children who do not attend an education setting. We want to utilise community assets and build capacity to provide opportunities for children to play, connect, build resilience and independence, and explore their interests and this will be achieved through investing in youth charity groups, community partnerships, in and out of school activities. Develop a countywide programme to consider how family's access local resources, community centres, children's centres churches/ religious settings. This programme will also need to consider how children access early support for emotional and mental well-being. Develop a sense of belonging in their communities for our young people through a co-created Family Hubs Approach. Work with partners to improve the system for informing parents and carers of the opportunities for disabled children to ensure they have access to the same mainstream provision as their peers. Improve engagement with practices that promote positive wellbeing such as	of children in the community, closing the gap in equality. Improvement in community relationships, more opportunities for children and fewer children experiencing harm though exploitation and anti-social behaviours. Children and their families will have earlier access to the services they need, and waiting lists will have reduced. Increased service provision and opportunities for all children including disabled children and children with SEND.

exercise, good quality sleep, personal resilience and community connection. Analyse the drivers for the disparity in educational attainment between some ethnic groups and low-income families to inform action. Ensure consistent and effective use of the graduated pathway to ensure needs are met, prevent escalation and support a culture that children should live within their family, wherever it is safe for them to do. Work with relevant agencies to prevent domestic abuse, substance misuse and hidden harms, and where it exists, provide services to limit the harm and build children's resilience.	

Objective 2: Access: right help, right time, right place.

In Gloucestershire there is a need for communities and professionals to work together to identify those children who have some identified needs and then ensure these needs are responded to at the earliest point to avoid them to need a statutory response later in their loves. Young people and their families tell us the right support isn't always there when they need it. We acknowledge that services are under strain and need to invest in innovative approaches to improve efficiency, early identification of needs and build independence.

Priorities	Indicators to measure our success against
Improving attendance and reducing PA (persistent absence) and SA (severe absence) using the existing Attendance Multi-Agency Working Party. Improving inclusion and reducing preventable exclusion with the support of the existing SEND Exclusions Working Party. There is a good understanding amongst educational staff in relation to the barriers preventing children attending school. Focussed work is required to respond to and remove some of these barriers. There may be some identified groups where there should be some targeted interventions to support a culture change and travelling families will need to be considered within this programme development.	We will see a reduction in numbers of children out of school We will see a reduction in families choosing (**for reasons other than** Philosophical / Lifestyle / Preferential) to EHE Parents will report feeling supported by schools, less escalations around education provision.
Professionals and carers need to understand trauma and how to respond to this at the earliest point in a child's life. Increased access to holiday clubs and after school activities for all children – develop sense of belonging and a connection to the community. We need to improve safety in the community so children and families can get out and about. Promote a Whole School Approach to internet safety and building digital resilience, working closely with partners such as police. Earlier identification and support for children with neurodiversity or experiences of adversity or trauma to reduce over reliance on diagnostic pathways and ensure children and families can access services at the right time. Continue to improve access to mental health support, and factors that in all schools and in the community – at the point of need. Improve data quality including ethnicity recording so we know when services are not accessible.	Reduction in repeat work/interventions for children. This will be evidence in individual agencies data/statistics. Pupil Wellbeing Survey will show a reduction in children telling us that they are experiencing online grooming/abuse. Decrease in bullying.

Objective 3: Inclusion: A county where everyone belongs.

We know we have more to do to create an inclusive society, that values and respects people regardless of their age, cultures, religion, ethnicity, gender, sexuality, or disabilities. For example, our data shows us some ethnic groups are more likely to experience poor outcomes and this may in part be due to unconscious bias and prejudice. We must build a workforce that has inclusion at its core.

Priorities	Indicators to measure our success against
All children need to be able to read at an appropriate level. If children fall behind in reading, it affects everything and is the gateway skill. Develop specific support and training for school staff which will improve resources for children experiencing/witnessing domestic abuse/drug and alcohol misuse of parents with poor mental health. Education/community and faith settings need to embrace and celebrate difference in everything that they do. In Gloucestershire all professionals should take responsibility for this and ensuring that children whose first language is not English have access to all learning appropriate to their age.	Education attainment. Resources related to domestic abuse will be embedded in schools. Teachers will know how to safety plan and seek help for children. Use of family hubs. Increased use of the local offer. Parents will tell us that they feel more informed.
Develop and improve support, services, and guidance for parents with children with Special Educational Needs (SEN Support and EHCP). There needs to be attention to building positive working relationships with schools, professionals, and parents to ensure a streamlined Graduated Pathway process, including the EHCP process. The Education Inclusion Service to continue to develop and support strong connections within and between mainstream settings around children with vulnerabilities, additional needs, no SEN, and at SEN Support, and continue to support the development of inclusive practice to help prevent escalation. The SEND Services to continue to develop and support strong connections within and between mainstream and special schools (school leaders) to ensure every child with an EHCP makes progress. Continued development of Gloucestershire's Inclusion Framework for Schools, with associated Inclusion Toolkit. Ensure practitioners understand neurodiversity and hidden disabilities.	Measure this through technological developments and Family Information Service (GCC) Seeking feedback from parents, children and The Parent/Carer Forum will inform us of improvements. We will see a reduction in complaints and an increase in compliments. Clear pathways for children with a disability. Professionals can navigate family hubs, local offer, family information service.

Improved access to external professionals by mainstream providers for children with high/complex needs and other SEND Ensure a smooth transition into school with child centred communication between all relevant agencies and routine check-ins Encourage everyone to be trauma informed, empathetic, use language that cares and help build resilience in individuals and communities. Create communities that celebrate and nurture children's diversity and operate in a climate of inclusivity, including coproduction, awareness raising and training to improve skills and knowledge. Co-production – parents and children will be listened to, and plans will be produced with them. Respectful practice needs to be a part of the professional culture within Gloucestershire.	

Objective 4: Quality: an offer that is an outstanding standard

Whilst in the main our services perform well; it is essential that we maintain standards and raise performance where this isn't the case. We must move with the times and capitalise on technology developments and innovations, as well as growing a sustainable workforce.

Priorities	Indicators to measure our success against
Agencies need to come together and consider a programme of work that considers how agencies share data with each other to enable a response at the earliest point. Responses for families in crisis and in need of early help need to be planned and considered but also need to be quick and effective. This will require a strong methodology based on multi-agency planning. Development of a multi-agency curriculum to improve channels for sharing of information and to create opportunities for professionals to come together and learn and reflect. Increase collaboration of statutory and VCS sector to understand gaps, reduce duplication, improve services and build capacity.	Children are supported at the earliest opportunity. Professionals work cohesively in the best interests of children. Multi agency decisions are made and co production exists across the board.

Develop systems for sharing data to prevent people having to repeat their story and improve the speed and coordination of response. Utilise our Joint Strategic Needs Assessment and robust evaluation to inform system development and to raise the standard of services. Support recruitment into services for children, including strategies to recruit men and other underrepresented groups into the sectors and develop an integrated induction offer for people working with families.	

Images from the Holiday Activity and Food Programme celebration event, August 2024

ONE PLAN

for all Children and Young People in Gloucestershire

Starting Well Pillar

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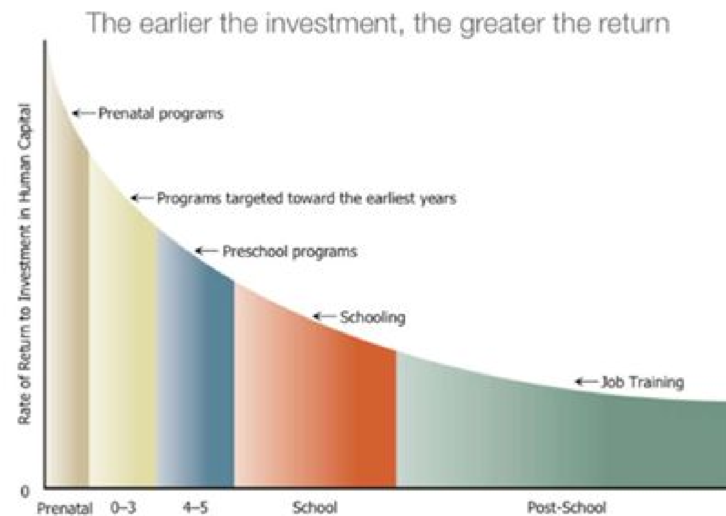
Introduction

> *Science tells us that a child's experiences from conception through their first five years will go on to shape their next 50. It tells us that the kind of children we raise today will reflect the kind of world we will live in tomorrow. It tells us that investing in the start of life is not an indulgence, but economically, socially and psychologically vital to a prosperous society.*
>
> Jason Knauf, CEO of the Royal Foundation, December 2020
> Ipsos MORI | State of the Nation: Understanding Public Attitudes to the Early Years, November 2020

The coordination of services, to enable a universal and targeted framework of support from prebirth to age five, is critical for improving the outcomes of children, families, communities and society. In short, there is no better stage in a child's life in which to invest, if we are committed to long-term change. All families need support from time to time to help their babies and children thrive, whether that's from friends, family, volunteers, or practitioners. Our ambition is for every family to receive the support they need, when they need it. All families should have access to the information and tools they need to care for and interact positively with their babies and children, and to look after their own wellbeing.

Evidence is clear that identifying risks early and preventing problems from escalating leads to better long-term outcomes. Universal services which are available to all local families who need them, can help to spot and respond to issues before they develop into more complex problems.

This strategy sets out how we aim to achieve this for the youngest children in our communities and their families in Gloucestershire today. It represents one of three pillars across the child's life stages ('Starting Well', 'Growing Well' and 'Being Well'), underpinned by a foundation of 'Living Well' that will inform the way we work with, and for, children and young people in the county. 'Starting Well' describes our collective vision for giving children the best start, the outcomes we want to achieve and our priorities for action.



The strategy has been developed, and will be delivered, in partnership with a wide range of stakeholders, including children and families themselves. We begin with our vision and principles, feedback from parents and carers and an overview of challenges and opportunities facing children and their families locally. We then set out the outcomes we want to achieve for this age group and conclude with our priorities for action.

A more detailed action plan will be developed for each pillar, to set out a range of actions that will be taken to ensure the priorities are delivered and outcomes achieved.

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Bringing together the feedback received from children and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision:

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Responsibility for driving progress against these objectives will be owned by Gloucestershire's Children and Young People's Coalition board and three subgroups themed around the life stages of Starting Well, Growing Well and Being Well.

To deliver this vision we will be guided by the following principles:

1. **We will listen** – work in partnership 'with' children, families and communities, not 'for' or 'to', build on existing children, family and community assets and aspirations, ensuring everyone can make a contribution, is respected, and that we take a whole family approach.
2. **We will care** – build a culture within our workforce of empathy, using language that cares, acknowledging children and their parents and carers are the experts in their lives, and being welcoming and inclusive for families and children of all ages, cultures, religions, ethnicities, genders, sexuality and disabilities.
3. **We will be fair** - prioritise resources to those that need it most, ambitiously aim to reduce inequalities in outcomes and close the gap.
4. **We will act early** - aim to reduce escalation and specialist support through early identification of needs, building resilience, using restorative approaches, and reduce trauma for children and young people.
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What the data tells us it's like to start a family in Gloucestershire

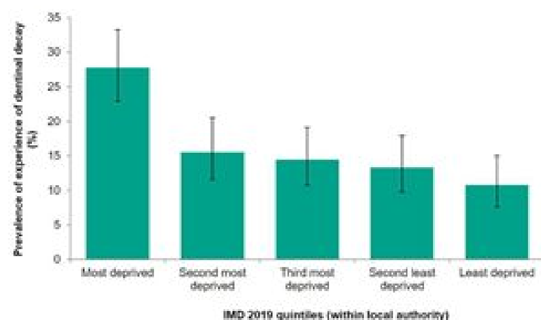
Population change

Gloucestershire sees just over 6,000 new births each year, although the number of births fluctuates over time, the general trend has been declining over recent years[1].

Despite the overall increase in population size between the 2011 and 2021 census', this growth was not driven by children age 0-4, which saw an overall decline of almost 4% over the period[2].

Health indicators

Overall Gloucestershire tends to perform well against England averages for indicators such as levels of immunisation, breastfeeding rates and oral health, however these mask disparities that exist based on deprivation and ethnicity. For example, the proportion of 5 year olds experiencing dental decay in Gloucestershire is significantly lower than the England average (16.8%) however the prevalence in the most deprived areas of Gloucestershire is almost three times higher than in the least deprived.



Benchmarking data shows that we have a higher proportion of admissions to hospital for some childhood illnesses and injuries, this needs further investigation but is in part due to hospital policies on when to admit children and the way data is coded.

The Healthy Start Scheme is a government funded scheme that launched in 2006 with an aim to provide a nutritional safety net and improve access to a healthy diet for low-income families. In March 2024, uptake for the digital scheme was 62% across England, Wales and Northern Ireland. Uptake for Gloucestershire is currently 61%.

Early Help

Early help and targeted support is an essential part of the offer for children across Gloucestershire. We have observed a steady increase in referrals for targeted support in recent years, which in part reflects earlier intervention to prevent children escalating to social care. In July 2024 there were 10,101 children open on a My Plan or My Plan Plus, of these 80% of the notifications came from education or early years settings, 13% from Gloucestershire County Council services such as Families First and the Education Inclusion Team, 5% from children and family centres and 1% from a combination of health agencies and the voluntary and community sector.

Early education and childcare

Every Local Authority has a duty to ensure, so far as is reasonable, that there are sufficient childcare places to enable children to access their entitlement of funded early education and childcare to support parental employment.

As of June 2024, there are 606 EY settings across the county offering 15,073 places.

[1] birth-trends-in-gloucestershire.pdf

74.3 % of childminders and 85.8% of day care providers are registered to offer funded places for eligible 2-year-olds.

78.2% of childminders and 94.3% of day care settings are registered to offer funded places for 3- and 4-year-olds.

Take up of free early years provision for 3- and 4-year-olds is 92% in Gloucestershire and is 76% for eligible 2-year-olds (Autumn term 2023) however local data indicates that children from the most deprived areas and those from minority ethnic groups are less likely to access the offer.

Childcare Reforms announced in the Spring 2023 budget, has extended the entitlement of funded early education/childcare.

From **April 2024**, working parents of two-year-olds will be able to access 15 hours of government funded childcare.

From **September 2024**, 15 hours of government funded childcare will be extended to all children from the age of nine months.

From **September 2025,** working parents of children under the age of five will be entitled to 30 hours government funded childcare per week.

91.4% of EY settings are registered good or outstanding, 5% compliant/Met.

Early Years Foundation Stage (EYFS) Profile

The EYFS profile is a statutory assessment of children's development at the end of the early years' foundation stage (known as a summative assessment) and is made up of an assessment of the child's outcomes in relation to the 17 early learning goals (ELGs). It is intended to provide a reliable, valid, and accurate assessment of each child's development at the end of the EYFS.

The Early Years Foundation Stage (EYFS) was reformed in September 2021 to improve outcomes for children by ensuring depth of learning; strengthen their language development and vocabulary, particularly for children from disadvantaged backgrounds; to introduce a focus on self-regulation and oral health and to reduce workloads so that practitioners spend more time with the children, supporting their learning.

Children are defined as having reached a Good Level of Development (GLD) at the end of the EYFS if they have achieved the expected level for the ELGs in the prime areas of learning (which are: communication and language; personal, social and emotional development; and physical development) and the specific areas of mathematics and literacy. This helps to understand broadly what a child can do in relation to national expectations.

In Gloucestershire over two thirds (67.8%%, 2022/23) of children meet the 'Good Level of Development' standard at the end of EYFS. Gloucestershire performs well in comparison to other areas nationally (average 67.2%) and is in line with the peer group average (68%). However, a lower percentage of pupils with vulnerable characteristics (Special Educational Needs and Disabilities and Free School Meals) as well as those from minority ethnicities in Gloucestershire attained the expected level in comparison to the Southwest and England.

Special educational needs and disabilities

National research undertaken by Dingley's Promise in October 2023 found that 79% of settings have seen a significant rise in the number of children with SEND (Special Educational Needs and Disabilities). Overall, 95% have seen a rise in the number of children with SEND. 27% of providers said they had no more spaces for children with SEND and that once the new entitlements come into place, this will rise to 57%.
National research evidences that parents report significant difficulty in finding early years provision for children with SEN and disabilities and that settings are finding it increasingly difficult to support children with SEN.

In Gloucestershire Early Years Providers are encouraged and supported to actively consider the additional support needs of children with SEND as part of their annual business planning.

Gloucestershire County Council Early Years service provide a range of training, advice, support and resources to early years practitioners and families to support children with SEND.

In Gloucestershire, in the current academic year 2023/24, 132 EHCPs (Education, Health and Care Plan) have been issued for children aged 5 years and under.

Although all EY provision delivered by the private, independent and voluntary sector in the county is mainstream, we have a small number of providers who actively promote themselves as supporting children with SEND. These providers operate in the Cotswolds, Stroud, and the Forest of Dean. Gloucestershire County Council has commissioned an Early Years Provision in Gloucester city, this is currently delivered by Dingley's Promise.

Impact of Covid

The pandemic has had a significant impact on access to services for children and families. While many services responded quickly and adapted services in real time to support families, access to face-to-face services, referrals and diagnostics were greatly reduced. The evidence of impacts on babies, children and young people is continuing to emerge, but there are early indications of increased demand for mental health services and a particular impact on those with additional vulnerability, special educational needs and/or disabilities

Babies born around the Covid-19 pandemic have had significantly less opportunity for socialisation, usual activities of baby clinics, stay and play sessions and other activities for new parents did not take place for this group. This has impacted typical patterns of child development, in particular speech and language development and healthy attachments with parents, who may also have suffered stress. Parents' confidence has also been affected by having missed out on opportunities to connect with other parents, gain advice and support and build friendships. All of which serve to secure a vital social network at what can be a challenging and isolating time of transitioning to parenthood.[3] The effects of limited universal support have also led to an escalation of needs for some families which has then put pressure on more specialist services.

Mental health and isolation

Isolation due to the rural nature of the county is a risk and this can be particularly challenging for new families, where contact with other new parents and services can be critical to supporting them on the right path from the start. Mental health is particularly impacted by isolation, and there is a knock-on effect from new parents to our youngest children as they develop at their most critical stage.

[3] Research exploring impact of the COVID-19 pandemic on children, young people and families (ncb.org.uk)

What you've told us it's like to start a family in Gloucestershire

Start Well consultation with parents/carers

Insight commissioned to support the Co-production of the Children and Young People's Strategy in September 2023 found that:

- Parents reflected on the importance of children, aged 0-5, having access to outdoor activities and being able to engage with nature. Parents reported there are not enough safe outdoor spaces or outdoor activities on offer, meaning children are not able to meet their desire to explore their surroundings.
- Parents noted that 'good homes' are dependent on parent's understanding of how to support their children to be confident and well-adjusted. Participants recognised the valuable role of health visitors and felt they would benefit from more support from the team if it were available. Parents also reported childcare options are limited, and affordable childcare is often not available.

LGA Early Years Strategy report for Gloucestershire March 2023:

- Parents described services as working very separately, with different recording systems used by different health professionals. Parents were concerned that this leads to delays in referrals being received.
- Parents were concerned about waiting times (up to two years) and telephone appointments for health services. They described rising anxiety during this time. Parents identified feeling that it would be really helpful to be able to access advice whilst waiting for health services. They suggested that early intervention groups would be useful, to access more timely early support and meet other parents in a similar position.
- Transition was felt to need greater support. Providers identified that movement from early years to primary was a concern for children with SEND, due to the significant change of adult-to-children ratios.
- Parents would like clarity around requesting EHC needs assessment for young children. Some parents reported frustration with the current EHC needs assessment timeframe and would welcome more consistent communication with the local authority whilst waiting.
- Parents reported that some nurseries are reluctant to accept children with SEND; the reason given being that they may be unable to meet children's needs. Some parents were concerned that the number of special school placements was insufficient and that this may mean their child staying on in nursery for another year, or being placed in a school that they feel didn't meet their needs.
- Stakeholders reported that recruitment and retention in the early years sector is currently difficult. Providers highlighted that local college placements have stopped (affecting ongoing recruitment of these people). There is work underway by the local authority, with job centres and colleges, to address this issue. The early years workforce (in Gloucestershire and nationally) appears to feel overwhelmed with the increased numbers of children with additional needs. Parents reported that information about early years in general was insufficient; describing the advice as generic rather than tailored. There was confusion over what the different services offered and a desire for more clear information on next steps once a need was identified.

What we'll do for all babies, young children and their families in Gloucestershire

We have identified the following priorities to deliver our four objectives of equity, access, inclusion and quality. We believe that collective action against these priorities will achieve our vision for Gloucestershire as a great place to grow up where all children and young people thrive and live lives of choice and opportunity.

Objective 1: Equity – close the gap and eliminate inequalities

Our data tells us people who have the least in Gloucestershire struggle more than they would in other parts of the country. The reasons for this require further investigation but are likely to include higher costs of living, challenges due to Gloucestershire's rural geography, and a focus on average population outcomes rather than incentives to target children falling behind. We must work together to create the conditions for children to thrive and target our resources where they are most needed.

Priorities	Indicators to measure our success against
Support children and families to be ready for learning and experience positive transition to school.	• Increasing the number of children achieving expected level of development aged 2-2.5 years (Ages and Stages Questionnaire)
Work with families, communities and partners to understand and address the factors that influence lower Early Years Foundation Stage attainment for some cohorts of children	• Increase in the percentage of eligible children accessing early education entitlement. • Increase in the percentage of children achieving a good level of development at the end of reception year (EYFS) • Narrowing the gap between the lowest achieving 20% in the Early Years Foundation Stage Profile and the rest of the cohort (DfE) • Narrowing the EYFS attainment gap for children eligible for FSM, those with SEND and those from minority ethnic groups • Reduction in the inequality in life expectancy at birth • Fewer children living in absolute low-income families
Promote healthy routines and lifestyles (toothbrushing, immunisation, good diet and nutrition, smoke free homes) through advice, information and support.	• Increase immunisation uptake broken down by target groups • Reduced rates of tooth decay in lowest deprivation quintile • Increased breastfeeding rates by target groups • Reduced rates of smoking at time of delivery • Reduced overweight prevalence in reception • Increased numbers registering for Healthy Start Vouchers • Fewer late bookings for first midwifery appointment • Reduced rates of emergency admissions 0-4 years
Ensure the consistent and effective application of the Graduated Approach, supporting needs to be met early, reducing the risks of escalation and ensuring children and families are receiving the right support, at the right time, from the right service	• Reduced number of re-referrals • Reduced rate of escalation to statutory support • Increased number of My Plans and My Plan Plus registered demonstrating effective early intervention with families from across the partnership of agencies.

Deliver a core offer of support, services and activities that are accessible to all families, so they are connected to the right advice and support at the earliest opportunity through a network of Family Hubs. **Work with relevant agencies to prevent domestic abuse, substance misuse and hidden harms, and where it exists, provide services to limit the harm and build children's resilience.**	

Objective 2: Access – right help at the right time for all children

Families tell us the right support isn't always there when they need it. We acknowledge that services are under strain and need to invest in innovative approaches to improve efficiency, early identification of needs and build independence.

Priorities	Indicators to measure our success against
Develop and publish (in formats accessible to all) a clear Best Start Offer, that sets out universal support available, affordable and accessible to all families.	
Work with providers of children and family services and activities to ensure that all families can access childcare, learning, play and support, relevant to their needs, ability, cultural and religious beliefs etc	• Increased range and number of services and activities available in all communities • Parental satisfaction/feedback • Increased take up of universal support – by all members of the community
Use all available technology and communication channels to provide information about the support and services available within communities.	
Ensure early education and childcare places are available for and meet the needs of, all children, including those with SEN and disabilities.	• Monitor and reduce the number of children with SEND unable to access EY/childcare • Increase the percentage of children with SEND attaining a good level of development at end of EYFS
Improve data quality including ethnicity and SEND recording so we know when services are not accessible to or not meeting the needs of specific groups of children and families.	
Improve safety in public spaces and reduce the threat from anti-social behaviour and violent crime, so children, young people and families can get out and about.	

Objective 3: Inclusion – a county where everybody belongs and we celebrate diversity

We know we have more to do to create an inclusive society, that values and respects people regardless of their age, cultures, religion, ethnicity, gender, sexuality or disabilities. For example, our data shows us some ethnic groups are more likely to experience poor outcomes and this may in part be due to unconscious bias and prejudice. We must build a workforce that has inclusion at its core.

Priorities	Indicators to measure our success against
Ensure all practitioners supporting young children and families are confident to welcome and meet the needs of all children, using trauma informed approaches, through a core offer of support and training.	• Increased confidence of practitioners
Ensure a smooth transition into school with child centred communication between all relevant agencies.	• Reducing numbers of children with deferred school entry or on reduced timetables • Reduced exclusion in reception and primary years • Parent satisfaction, particularly feedback following transitions
Provide services and support through Children's Centre partnerships that help communities to build resilience and confidence so that families can support themselves.	
Create communities that celebrate and nurture children's diversity and operate in a climate of inclusivity, including coproduction, awareness raising and training to improve skills and knowledge. **Provide training for professionals to ensure they understand neurodiversity and hidden disabilities and provide the right support to increase access to schools and community assets.**	

Objective 4: Quality – effective, outstanding services

Whilst in the main our services perform well, it is essential that we maintain standards and raise performance where this isn't the case. We must move with the times and capitalise on technology developments and innovations, as well as growing a sustainable workforce.

Priorities	Indicators to measure our success against
Raise and maintain the profile and standard of early years education, childcare and best start services. **Develop a joint workforce strategy across partners to attract new talent and offer joint training and induction opportunities to improve integrated and collaborative working.** **Increase collaboration between statutory and VCS sector to share data, understand gaps, reduce duplication, improve services and build capacity to ensure families are offered the right service at the right time and in the right place.** **Develop systems for sharing data across agencies to prevent people having to repeat their story and improve the speed and coordination of response to support families.** **Develop and provide services that respond to the needs of individual communities, using all available population and community data.**	• Increasing the number of childcare settings with a good or outstanding Ofsted rating • Vacancy and staff turnover rates

Equality Impact Assessment (EqIA)

The Equality Act 2010 introduced the Public Sector Equality Duty which states that a public authority must, in the exercise of its functions, have due regard to the need to:

1. Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

This document demonstrates how the Council is meeting the Public Sector Equality Duty by setting out the findings of an equality analysis that has been undertaken in relation to a proposed change to assess whether it has a disproportionate impact on people who share a protected characteristic. The Council's Equality Impact Assessment (EqIA) process covers additional groups not 'protected' by section149 of the Equality Act 2010, including care leavers and care experienced adults.

1. Background

Directorate	Children's Services
Service area	
Title of the proposed change being assessed i.e. the policy, service or other development	One Plan for all Children & Young People in Gloucestershire 2024-30

Describe the purpose of the proposed change and the intended outcomes
This One Plan for all Children & Young People in Gloucestershire 2024-30 (One Plan), has been co-constructed with children and families, parents, carers and other partners, it is a high level, ambitious and unifying plan that sets out what we want to do as a county to deliver improved outcomes for children. We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identity, special educational needs or disability. Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision: **A great place to grow up where children and young people thrive and live lives of choice and opportunity.** • **Equity** – closing the gap and eliminate inequalities • **Access** – right help at the right time for all children

- **Inclusion** – a county where everyone belongs and we celebrate diversity.
- **Quality -** effective, outstanding services

Who is affected by the proposals?

Service users:	Yes
Wider community:	Yes
Workforce:	Yes
Other (please specify):	Partners such as Health, Education, Police, Voluntary sector, etc..

Decision to be taken and decision maker	That Cabinet 1. Recommends to the full Council that it should approve the One Plan for all Children & Young People in Gloucestershire 2024 to 2030 attached at Appendix 1 (the "One Plan"), this is a unifying plan, developed with children, families and partners setting out our ambitions for all children and young people in Gloucestershire and 2. Delegates authority to the Executive Director of Children's Services, in consultation with the Cabinet Member for Children's Safeguarding and Early Years, to make any final amendments to the One Plan following it being considered by the Gloucestershire Children and Young People's Wellbeing Coalition Board at the end of September in readiness for it to be presented for approval at Full Council on 6 November and a signing and launch event with statutory and voluntary sector partners at the end of November 2024. .

Person(s) responsible for completing this assessment	Clarisse Forgues Beth Bennett Britton
Date of this assessment	10 July 2024

2. Information and Data Collection

Summarise how you have collected the information and data required to assess the current situation (section 3.1 below) and the potential or actual impact of the proposed change (section 3.2 below) on those who share the protected characteristics and the additional groups (e.g. survey of services users, running community focus groups, analysing service usage data, engaging with staff networks). The actual information and data should be set out in Appendix 1 (Service Users) and Appendix 2 (GCC staff).

If there are any gaps, include an action in section 4 to fill these. This does not mean that you cannot complete the equality impact assessment, but you need to follow-up the action and revisit as part of the monitoring and review arrangements set out in section 5.

Stakeholders	Engagement and Consultation	Other Sources
Service Users / Wider Community	The One Plan has been co-constructed and based on what we know about life for children, young people and families in our county The development of the One Plan started last summer asking families what's it like to live in Gloucestershire, in your community and what should change? Three world café events have been organised in May and June 2024, these were attended by over 120 representatives from a range of organisations	The One Plan drew on other information from children and families: - Bright Spots – care experienced - LEP research and consultation - Parent Carers views - Voluntary sector - Schools - Police and other health colleagues - Session with children's services and social care leaders - District councils
Workforce	Three world café events have been organised in May and June 2024, these were attended by over 120 representatives from a range of organisations including GCC staff.	

Partners	Three world café events have been organised in May and June 2024, these were attended by over 120 representatives from a range of organisations A number of iterations of the One Plan have been subject to approval by Children's Wellbeing Coalition and Gloucestershire's Health and Wellbeing Board .	
Other		

3. Equality Assessment

Indicate the impact on each group and explain how you have reached your conclusions (i.e. through analysis of the information and data that was collected through the engagement, consultation and other sources / methods that were set out in section 2).

Consider sub-categories (e.g. different kinds of disabilities) and how the groups are interconnected (e.g. young women) resulting in particular needs or types of disadvantage and discrimination (sometimes known as intersectional or combined discrimination).

3.1 – Status Quo

If the proposal involves changing an existing activity (e.g. policy, service), summarise the key findings from your assessment of the current situation for each of the groups below. If the proposal is completely new, then move straight to section 3.2.

	Service Users	Gloucestershire County Council (GCC) Staff

Protected Characteristics (Equality Act 2010)	Our county does not look the same and is not experienced in the same way by all. Data and feedback from our children, young people, families and communities shows us that, whilst our headline data is often good when compared with national data and sometimes our peer local authorities, it does not tell the same story for those who face the greatest disadvantage and barriers, protected characteristics, isolation and the intersection of these. We know we have more to do to create an inclusive society, that values and respects people regardless of their age, cultures, religion, ethnicity, gender, sexuality or disabilities. For example, our data shows us some ethnic groups are more likely to experience poor outcomes and this may in part be due to unconscious bias and prejudice. We must build a workforce that has inclusion at its core.	
Additional Groups (including care leavers / care experienced adults)		

3.2 – The Proposed Change

Summarise your assessment of the likely or actual impact of the proposed change on each of the groups. If an action is required, this should be recorded in Section 4.

Service Users

Protected Characteristics / Additional Groups	Positive Impact	Neutral Impact	Negative Impact	Not Sure	Summary of Impact	Action Required (Y/N)?
Age	√				We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identity, special educational needs or disability. Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision: **Equity** - close the gap and eliminate inequalities. **Access** – right help at the right time for all children **Inclusion** – a county where everyone belongs, and we celebrate diversity. **Quality** – effective, outstanding services	
Disability	√					
Sex	√					
Race	√					
Gender reassignment		-				
Pregnancy & maternity		-				
Religion and/or belief	√				We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic	
Sexual orientation	√					

					background, sexuality, gender identity, special educational needs or disability. Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision: **Equity** - close the gap and eliminate inequalities. **Access** – right help at the right time for all children **Inclusion** – a county where everyone belongs, and we celebrate diversity. **Quality** – effective, outstanding services	
Marriage & civil partnership		-				
Armed Forces community		-				
Carers		-				
Care leavers / care experienced adults	√				We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identity, special educational needs or disability. Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision: **Equity** - close the gap and eliminate inequalities. **Access** – right help at the right time for all children **Inclusion** – a county where everyone belongs, and we celebrate diversity. **Quality** – effective, outstanding services	
Digital exclusion		-				

Geography, for example, urban and rural areas	√				We believe Gloucestershire should be a great place to grow up where all children and young people can thrive and live lives of choice and opportunity, irrespective of where they live, their ethnic background, sexuality, gender identity, special educational needs or disability. Bringing together the insight from young people and families, as well as what the data tells us, has led us to identify four objectives to deliver our vision: **Equity** - close the gap and eliminate inequalities. **Access** – right help at the right time for all children **Inclusion** – a county where everyone belongs, and we celebrate diversity. **Quality** – effective, outstanding services	
Socio-economic disadvantage	√					
Vulnerable groups of society	√					
Interconnected Characteristics / Groups	Positive Impact	Neutral Impact	Negative Impact	Not Sure	Summary of Impact	Action Required (Y/N)?

Gloucestershire County Council Staff

Protected Characteristics / Additional Groups	Positive Impact	Neutral Impact	Negative Impact	Not Sure	Summary of Impact	Action Required (Y/N)?
Age		-				
Disability		-				
Sex		-				
Race		-				
Gender reassignment		-				
Pregnancy & maternity		-				
Religion and/or belief		-				
Sexual orientation		-				
Marriage & civil partnership		-				
Armed Forces community		-				
Carers		-				
Care leavers / care experienced adults		-				
Digital exclusion		-				

Geography, for example, urban and rural areas		-				
Socio-economic disadvantage		-				
Vulnerable groups of society		-				
Interconnected Characteristics / Groups	Positive Impact	Neutral Impact	Negative Impact	Not Sure	Summary of Impact	Action Required (Y/N)?

4. Action Plan

Set out the key actions that will be undertaken, following the equality assessment in section 3, to further maximise the positive impact or mitigate the negative impact of the proposal on the protected characteristics and additional groups prior to implementation (any negative consequences should be eliminated, minimised or counter-balanced by other measures):

Identified Potential or Actual Impact	Recommended Action(s)	Owner	Target Completion Date
Starting well – pre-birth through early years to reception age.	See Starting well Plan which details the actions which will be implemented to deliver the four objectives of equity (closing the gap and eliminating inequalities), access (ensuring the right help at the right time for all children), inclusion (creating a county where everyone belongs and we celebrate diversity) and quality (delivering effective, outstanding services).	Children's Coalition for Gloucestershire	Progress against our priorities and outcomes for children and young people will be evaluated on an annual basis .
Growing well – primary through to early secondary.	See Growing well Plan which details the actions which will be implemented to deliver the four objectives of equity (closing the gap and eliminating inequalities), access (ensuring the right help at the right time for all children), inclusion (creating a county where everyone belongs and we celebrate diversity) and quality (delivering effective, outstanding services).	Children's Coalition for Gloucestershire	Progress against our priorities and outcomes for children and young people will be

			evaluated on an annual basis .
Being well – middle teenage through post 16 to 25 years.	See Being well Plan which details the actions which will be implemented to deliver the four objectives of equity (closing the gap and eliminating inequalities), access (ensuring the right help at the right time for all children), inclusion (creating a county where everyone belongs and we celebrate diversity) and quality (delivering effective, outstanding services).	Children's Coalition for Gloucestershire	Progress against our priorities and outcomes for children and young people will be evaluated on an annual basis .

5. Monitoring and Review

Public bodies must have regard to the aims of the duty not only when a policy, service or development is being created and decided upon, but also when it is implemented and at regular intervals thereafter. The Equality Duty is a continuing duty.

Lead officer(s):	Children's Coalition for Gloucestershire

Part 1 – Initial arrangements (up to around six months following implementation)

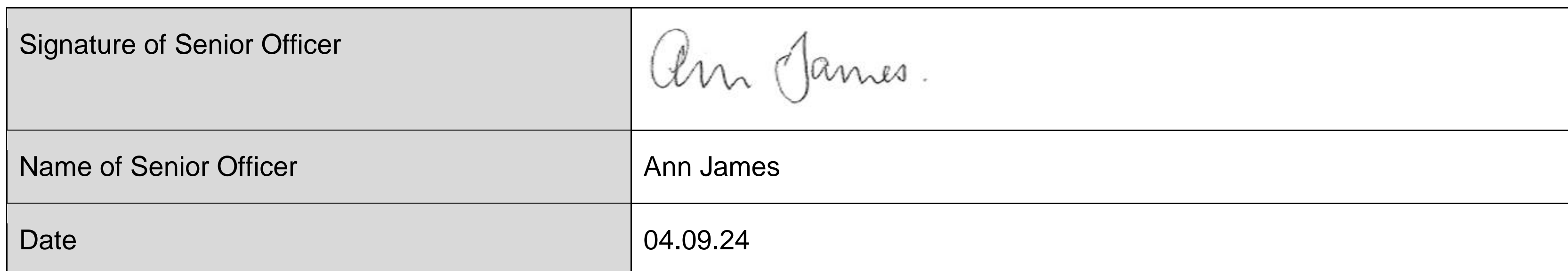
Date of the post implementation review:	
Approach to measuring the impact of the change to enable a comparison between the anticipated impact (as set out in section 3) with the actual impact: ▪ What mechanisms will be used? ▪ How will service users / the wider community / GCC staff and other stakeholders be involved?	Three sub-groups (one for each pillar) report into the Coalition board to drive forward the Starting Well, Growing Well and Being Well priorities of the One Plan. There will be also strong and robust local arrangements in place, namely: • Children's integrated locality board – chaired by the GCC Assistant Director for the Area: these will bring partners together on a "place basis" to coordinate and lead work at a strategic level (e.g. of volunteers, or responding to a 'hot spot', horizon scanning • Operational groups – able to discuss and allocate work: these will ensure network is working on the ground and lead professional is identified and well supported

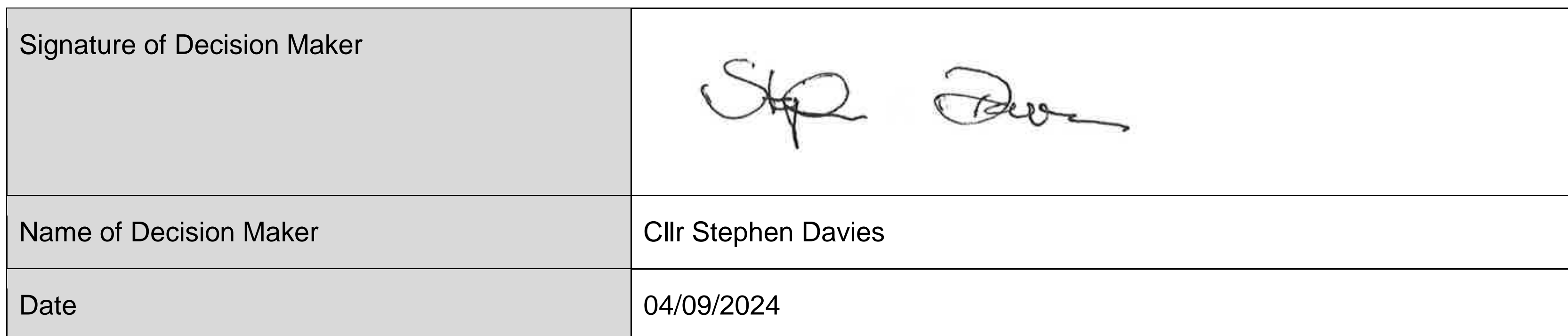
Part 2 – Ongoing arrangements (from around six months onwards)

Frequency of monitoring and review:	Annual review
What mechanisms will be used? How will service users / the wider community / GCC staff and other stakeholders be involved?	Gloucestershire's Children and Young People's Coalition board will oversee the delivery of this strategy and will hold partners to account in delivering our priorities. The Coalition is rooted in Section 10 of the 2004 Children Act which gives responsibility to Gloucestershire County Council to co-ordinate partner activity for securing the health and wellbeing of all children and young people in Gloucestershire.

	The Coalition reports to the One Gloucestershire Health and Wellbeing Board and Partnership, and the One Plan aligns to the Integrated Care Strategy and Joint Health and Wellbeing Strategy.

6. Approval

Signature of Senior Officer	
Name of Senior Officer	Ann James
Date	04.09.24

Signature of Decision Maker	
Name of Decision Maker	Cllr Stephen Davies
Date	04/09/2024

Appendix 1 – Service User Data and Information

Details of service users affected by the proposed activity: [NB Ensure you follow the data suppression guidance in the annotated version of the EqIA to reduce the risk of inadvertently disclosing personal data and therefore breaching GDPR]

Groups	Service User Data and Information
Age	Note: Key demographic data is set out in the One Plan and each of the three Pillars plans
Disability	
Sex	
Race	
Gender reassignment	
Pregnancy & maternity	
Religion and/or belief	
Sexual orientation	
Marriage & civil partnership	
Armed Forces community	
Carers	
Care leavers / care experienced adults	
Digital exclusion	

Geography, for example, urban and rural areas	
Socio-economic disadvantage	
Vulnerable groups of society	

Appendix 2 – Gloucestershire County Council Staff Data and Information

Details of GCC staff affected by the proposed activity: [NB Ensure you follow the data suppression guidance in the annotated version of the EqIA to reduce the risk of inadvertently disclosing personal data and therefore breaching GDPR]

Groups	GCC Workforce Data and Information
Age	
Disability	
Sex	
Race	
Gender reassignment	
Marriage & civil partnership	
Pregnancy & maternity	
Religion and/or belief	
Sexual orientation	
Armed Forces community	

Carers	
Care leavers / care experienced adults	
Digital exclusion	
Geography, for example, urban and rural areas	
Socio-economic disadvantage	
Vulnerable groups of society	

AUDIT COMMITTEE 5th September 2024 **Agenda item 12.1**

ASSURANCE REPORT

Part I

Area	Assurance	Notes
Internal Audit	**AMBER**	Committee noted the: • Progress report and Sector Update report. • Data Security and Protection Toolkit (DSP Toolkit) report. • Benchmarking report. • Global Risk Landscape report. • Patient Safety Incident Reporting Framework (PSIRF). • Internal Audit Follow-Up report. Assurance reduced by actions on Business Continuity, and Emergency Preparedness, Resilience and Response (EPRR) as being overdue.
External Audit	**GREEN**	2023-24 reports and supporting papers were submitted to the Committee in June 2024. Development of 2024-25 Audit Plan underway and confirmed as adequately resourced
Risk Management	**AMBER**	Committee noted that the increase in the recorded risks in the CCR was not indicative of increased risks in the organisation but an improvement in risk detection. Joint work on standardising system risks is progressing and a workshop on the system wide risk platform is in development. Deep Dive on Integration Directorate Risks highlighted the inherent inefficiency of operating across multiple risk systems. Further work to articulate both controls and risk mitigations was requested.
Conflicts of interest	**GREEN**	The ICB is compliant with its targets for decision makers and the board to fully declare their interests.
Committee Effectiveness Survey	**n/a**	The ICB survey results and recommendations for improvements were discussed at the meeting and further followup actions will be reported to the board
Audit Committee ToR Review	**n/a**	The Terms of Reference were discussed further revisions to be made and reported back to the December Audit Committee for their support before being submitted to the January ICB Board for approval
APB ToR & Delegation Agreement	**n/a**	A decision was made to approve the APB & Delegation Agreement before the end of September and that the decision would be reported to the December Audit Committee.
Counter Fraud	**GREEN**	The Committee approved the amended Counter Fraud, Bribery and Corruption policy and noted the following reports, no issues raised. • Counter Fraud Progress report. • Final year 2023-24 Counter Fraud, Bribery and Corruption annual report.

		• Summary of Counter Fraud investigations.
IUC Procurement & Lessons Learnt	**GREEN**	The Committee noted the thorough review of ICU Procurement and the standard set for all future procurement exercises and thorough approach undertaken which should be the process and procedure for any full scale procurement
Financial Management	**GREEN**	Losses and Special Payments and Debt Write Offs – noting to report. Aged Debt report - all controls were in place and functioning well. Members expressed satisfaction with management action and the low level of risk.

KEY

Key GREEN (full assurance)	**AMBER (partial assurance)**	**RED (limited assurance)**

NHS Gloucestershire ICB Audit Committee Part 1 Meeting

Held at 09.30am on Thursday 24th June 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)
Bilal Lala	BL	Non-Executive Director, GHC
Dr Jo Bayley	JB	Chief Executive Officer, GDOC
Karen Clements	KC	Non-Executive Director, ICB
Participants:		
Andrew Davies	AD	Engagement Manager, Grant Thornton LLP
Adam Spires	AS	Partner, BDO LLP
Christina Gradowski	CGi	Associate Director of Corporate Affairs, ICB
Cath Leech	CL	Chief Finance Officer, ICB
Grace Hawkins	GH	Public Sector Audit Director, Grant Thornton LLP
Justine Turner	JT	Audit Manager, BDO LLP
Mary Hutton	MH	Chief Executive Officer, ICB
Paul Kerrod	PK	Deputy Head of Local Counter Fraud Service
Shofiqur Rahman	SR	Deputy Chief Finance Officer, ICB
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Ryan Brunsdon	RB	Board Secretary, ICB
Josie Kendall *(Agenda Item 10)*	JK	Value for Money Manager, Grant Thornton LLP
Tracey Cox *(Agenda Item 12)*	TC	Director of People, Culture & Engagement, ICB

1. Introduction and Welcome

1.1 The Chair welcomed new member, Bilal Lala, to the Committee and thanked in absentia the outgoing member, Marcia Gallagher, for her contribution and unwavering commitment to the work of the Committee.

2. Apologies for Absence

2.1 An apology was received from Mike Napier.

2.2 The Chair confirmed that the Audit Committee meeting was quorate.

3. Declarations of Interests

3.1 JB declared that she is the Chief Executive Officer of GDOC Ltd and that, on that basis she could potentially be conflicted when discussing items on the agenda which covered procurement and administration of medical services. The other members considered the

declaration and concluded that the inclusion of JB in the proceedings was consistent with the terms of reference and her participation with full rights of members was not prejudicial to the proceedings, or to the Gloucestershire Integrated Care Board (thereafter "the ICB").

4. Minutes of the Last Audit Committee Meeting Held on 7th March 2024

4.1 Minutes of the meeting held on 7th March 2024 were approved as an accurate record of the meeting.

5. Matters Arising & Action Log

5.1 **Action No.22, 07.12.2023, Items 7.3.1 & 7.3.2,** POD Governance. Reports had not been submitted and CL agreed to contact the Primary Care Team. **Item to Remain open.**

5.2 **Action No.26, 07.03.2024, Item 7.4.2,** EDI. The ED&I Report including management actions was included in the June Audit Committee papers. **Closed.**

5.3 **Action No.27, 07.03.2024, Item 7.7.1,** POD Audit Report. The report has been circulated to members. **Closed.**

5.4 **Action No.28, 07.03.2024, Item 14.1.** JS suggested that trends and administration of waivers be included in the Annual Report. Members agreed that this matter required further consideration. Item could further be discussed at the 5th September 2024 meeting. **Item remains open.**

5.5 **Action No.29, 07.03.2024, Item 19.1,** Any Other Business. The Plan was distributed. **Closed.**

The Chair directed that for practical purpose, meeting items would not necessarily follow the order set in the agenda.

7. Going Concern

7.1 CL presented and outlined the requirement for management to assess the ICB's ability to continue operating as a going concern. CL further stated that the accounting concept of going concern referred to the basis on which the organisation's assets and liabilities were recorded and included in the accounts. CL highlighted that the ICB review had determined that the ICB was a going concern. Members agreed with the outcome of the review.

RESOLUTION: The Audit Committee noted the report and agreed that the ICB Accounts be continued to be prepared on the basis of going concern.

9. Service Auditor Report

9.1 CL presented and explained that the ICB employed third party services to perform specific operations. CL listed the relevant third parties as:

1. Capita Business Services Ltd which provided Primary Care Support services such as processing GP, ophthalmic and pharmacy payments, and pensions administration.
2. South, Central and West Commissioning Support Unit (SCW) CSU which provided a reporting and payments calculation platform for General Practitioner (GP) practices.
3. IBM driven ESR payroll and human resources management system implemented within the ICB, and across the NHS.
4. NHS Business Services Authority which provided prescription payment platform and dental payments process system.
5. NHS Shared Business Services Ltd provided finance and accounting services to the ICB.

9.2 CL stated that Grant Thornton PWC, Mazars and Deloitte were commissioned to carry out audits and prepare Service Auditors reports on the design and operating effectiveness of controls put in place by third parties providing services. CL highlighted that all the controls in place were found to be effective, and she stated that the ICB added its own controls. Members discussed the report and gave an Assurance rating of Green.

RESOLUTION: The Audit Committee noted the Service Auditor report.

6. Gloucestershire ICB Annual Report 2023/24

6.1 CGi presented and explained that the report had been compiled by teams from across the ICB. The report highlighted outcomes delivered by the ICB and its system partners during the year. CGi clarified that a summarised version of the report had been produced as a public facing document. The report provided details on finances, operational activities, and developments underway. CGi explained that the Annual Report and its summarised version would subsequently be published on the ICB website.

RESOLUTION: The Audit Committee recommended the 2023-24 Annual Report for approval by the Board.

8. 2023-24 Annual Accounts

8.1 SR presented the draft annual accounts and explained that there were no material changes to the accounts from the original draft account and that they had been prepared following the relevant guidance. SR stated that the ICB's revenue resource limit was £1,348,775,000 and the total operating cost for the financial year was £1,348,682,000. The ICB therefore made an in-year surplus of £93,000. SR added that the surplus brought forward from 2022-23 was £20,890,000 and the cash position as of 31st March 2024 was £59,000.

8.2 CL presented the letter of representation to members for scrutiny and initial assurance. SR outlined timelines for submission of the Accounts. He stated that fully audited and approved accounts would be submitted by 28th June 2024, and they would be published on the ICB website by 30th September 2024, together with the governance statement and the head of internal audit opinion.

RESOLUTION: The Audit Committee:

1. **Recommended that the Letter of Representation be taken to the ICB Board.**
2. **Recommended approval by the ICB Board of the ICB 1st April 2023 – 31st March 2024 Statutory Accounts and Annual Report.**

10. External Auditor's Report

10.1 Auditors Annual Report for the Year Ending 31st March 2024

10.1.1 AD presented and emphasised that the audit was conducted in accordance with accepted auditing standards. AD stated that the external auditors had completed all the fieldwork relating to the ICB audit and their work had not identified any evidence of significant weaknesses in the transactions and arrangements audited. AD stated that there were no material mis-statements or omissions in the financial statements thus leading to an unqualified opinion. AD added that the ICB had in place good arrangements to monitor and assess risk. Effective processes and systems were in place to ensure budgetary control.

10.1.2 AD highlighted that the ICB favoured a system level approach to financial planning and collaborated with system partners to develop year 2024-25 ICS financial plan. AD stated that monthly finance reports to the System Resources Committee were of good quality and provided a clear understanding of the ICB and the system financial position. AD added that the ICB's governance arrangements were satisfactory. AD agreed that the ICB Board made well informed decisions with clear agenda items, and it received regular committee reports.

10.2 Value for Money (VFM) Audit

10.2.1 JK presented and stated that the auditors had assessed the efficiency and effectiveness in the use of public funds and resources through conducting systematic examination of governance, systems and procedures employed to manage resources. JK highlighted that the audit had established that there were appropriate arrangements in place to manage risk, produce financial plans, and monitor financial position. JK explained that whilst the audit did not identify any areas of significant weakness auditors observed some opportunities for improvement and issued recommendations.

10.2.2 AD highlighted that the areas requiring few improvements included POD services. JS emphasised members' commitment to continuing to improve risk management. JS and CGi stated that they were working with partner organisations to look at system risk scoring. **Action: CGi to provide an update on progress on 5th September 2024.** JS will raise the POD recommendation with the Chair of Primary Care & Direct Commissioning (PC&DC) Committee. **Action: JS to liaise with the PC&DC Chair and review processes leading to improvement of POD services assurance.** Members discussed the report and gave an overall Assurance rating of Green.

CGi

JS

RESOLUTION: The Audit Committee noted the External Audit report.

11. Internal Audit

11.1 Progress Report and Sector Update

11.1.1 AS presented the report and gave a brief overview of the internal audit work carried out in year 2023-24. AS highlighted that the areas audited mostly achieved moderate rating in terms of design and effectiveness. AS gave timelines for year 2024-25 internal audit work. AS provided a sector update and stated that the Covid pandemic informed new work models such as virtual health delivery service.

11.1.2 AS explained that NHS England had issued a letter to NHS provider chief finance officers regarding payments to NHS charities. The letter stated that HM Treasury had declined approval of payments made by two NHS foundation trusts in November 2023 to their associated hospital charities and it clarified that any similar payments were unlikely to receive HM Treasury approval.

11.2 POD Dental Arrangements Update

11.2.1 JT presented the report and stated that following the delegation of Primary Care Commissioning functions in April 2023, the ICB took on full commissioning responsibilities for pharmaceutical, ophthalmic and dental (‘POD’) services. JT explained that the audit identified dental service pressures, and it established that the ICB was exploring opportunities to prevent poor oral health and protect, expand access, and deliver high quality care. JT commended that although commissioning POD services was still in the early stages the ICB was able to achieve substantial rating in terms of both design and effectiveness. The Committee commended the good work of the ICB team.

11.3 Equality, Diversity and Inclusion (EDI) Advisory Report

11.3.1 JT presented the report and emphasised that implementing the Workforce Race Equality Standard (WRES) was a requirement for ICBs. JT clarified that the guidance required the ICB to show progress against several indicators of workforce equality. CGi highlighted that the ICB was working with partners to standardise EDI templates across the system. TC reassured that the ICB sought to find interventions to address inequality and was keen to improve ways of supporting EDI.

11.3.2 JT stated that the auditors were cognisant of the fact that some of the ICB target outcomes were not immediate but long term, and she commented that the ICB had an effective approach to EDI and was amongst the leading organisations in that area. JB requested information on guidance and policy position regarding constructively criticising and contributing to social media debate on ICB commissioning activities. JB stated that she was of the view that policy clarity would mitigate risk of offending the law and good governance practice. **Action: TC and CGi to draft a paper on privacy policy and social media policy.** **CGi**

11.4 Data Security and Protection Toolkit (DSP Toolkit)

11.4.1 JT presented and explained that DSP Toolkit formed part of the framework for ensuring that organisations were implementing recommended data security standards. JT stated that an audit conducted to test compliance established the following:

- the ICB had a framework in place to support conformity with prescribed laws and standards;
- staff contracts were clear on staff responsibilities regarding data security and protection;
- the ICB assessed the data security and protection training needs of its members and staff;
- the ICB proactively promoted information governance and cybers security, and any concerns were handled diligently in a transparent manner.

11.4.2 JT stated that overall, they had issued a moderate assurance over the design and operational effectiveness of the ICB’s data security and protection controls.

11.5 <u>HealthCare Outlook Report</u>

11.5.1 AS presented the report and cited some of the challenges impacting the HealthCare sector AS explained that standardising internal processes through integrating existing technologies and retiring redundant tools allowed HealthCare organisations to create true inter-operability and increase cost savings. AS further highlighted that digital solutions such as automation cut costs and allowed reinvesting of the money saved into upskilling programs which could lead to increased job satisfaction and better retention rates.

11.5.2 JT concurred and emphasised that automating communications and offering patients self-service capabilities made care more accessible at reduced cost. AS explained that challenges such as the Covid pandemic inherently brought about fundamental changes to the health delivery landscape. AS added that virtual HealthCare service delivery methods and new partnership models emerging out of the Covid crisis proved to be increasingly vital to addressing workforce and financial pressures faced in the health sector.

11.6 <u>Internal Audit Follow-Up Report</u>

11.6.1 AS stated that all recommendations from auditors had been taken on board by the ICB and most of these had been implemented. AS explained that the outstanding recommendations were for six areas of which four scored Amber and two scored Red in terms of risk rating AS mentioned that the recommendations to improve Business Continuity & EPRR training were still to be fully implemented.

11.6.2 AS added that local system service desks were collectively working on establishing efficacy in the administration of cyber security as part effort to mitigate risk. AS further stated that the recommendation to tighten administrative privilege was receiving sufficient attention. AS highlighted that recommendations to improve Personal Health Budget (PHB) were being implemented but faced challenges.

11.7 <u>Internal Audit Annual Report and Annual Statement of Assurance</u>

11.7.1 JT explained that the role of internal audit was to provide an opinion on the adequacy and effectiveness of the internal control system in the areas reviewed. JT presented the areas audited during year 2023-24 as follows:

- Data Security & Protection Toolkit;
- Primary Care Commissioning - Dental Arrangements;
- Key Financial Systems;
- Cyber Security - joint ICS audit;
- Equality, Diversity & Inclusion;
- Transformation Programmes;
- Personal Health Budgets;
- Business Continuity & Emergency Planning.

11.7.2	JT stated that the Annual Statement of Assurance provided assurance on the main financial and management systems reviewed. JT explained that overall assurance on internal controls scored moderate. JS stated that the relevance of the Annual Statement of Assurance report was relevant to the System Resources Committee. Arrangements should therefore be made to take the report to the System Resources Committee. **Action: CGi and MG to facilitate submission of the report to the System Resources Committee.**	**CGi & MG**

<u>RESOLUTION</u>: The Audit Committee:

- **Noted the Progress Report and Sector update.**
- **Noted the POD Dental Arrangements Update report.**
- **Noted the Equality, Diversity and Inclusion (EDI) Advisory report.**
- **Noted the Data Security and Protection Toolkit (DSP Toolkit) report.**
- **Noted the HealthCare Outlook report.**
- **Noted the Internal Audit Follow-Up report.**
- **Noted the Internal Audit Annual Report and Annual Statement of Assurance**

12. Risk Management Report

12.1 CGi emphasised that the effectiveness of risk management depended on the individuals responsible for operating the systems put in place. CGi presented the Board Assurance Framework (BAF) and focused on the 36 risks rated red.

12.2 CGi explained that the Governance team worked with the directorate risk leads and others to re-model risk management process and attain efficacy. CGi also explained that at the beginning of each month the Governance team appraised Executive Directors of the risks impacting their respective directorates. RB presented the Corporate Risk Register (CCR) and explained that there was a total of 101 risks on the CRR. This was an overall increase of 14 risks since March 2024.

12.3 RB requested closure of the following risks:

1. PO&P8: Risk that there were some clinical areas where aspects of NICE guidance had not been fully implemented.

2. PC&P01: Risk that when the specialised commissioning plans were developed by NHS England, they included plans to transfer services which could be a financial risk to the organisation.
3. PC&P06: That there was risk exposure to the Drybrook Practice.
4. PC&P12: Risk to the future of National Network DES Contract for PCNs & associated PCN Core Funding - as there was no national clarification for onward contract for 2024-25 and beyond.

12.4 A Report from the PCE Directorate Team on Risk and Assurance.

12.4.1 TC presented the risks impacting the People, Culture and Engagement (PCE) directorate. TC explained that some of the PCE risks had system level dimensions, and she highlighted the risks. TC described the internal risk architecture informing processes and mitigation tools within the directorate. TC also described the sub-groups and forums which were part of the internal risk architecture. TC explained that risk mitigation required increased high-level collaboration across the system. JS emphasised a need to continue to learn from a wider environment as this would help inform the re-modelling of risk tools and platforms. **Action: CGi to liaise with GHFT and GHC senior colleagues to help map out system level risks and standardisation of risk tools.** Members discussed the report and gave an overall Assurance rating of Amber. **CGi**

RESOLUTION: The Audit Committee

1. **Noted the Board Assurance Framework (BAF).**
2. **Noted the Corporate Risk Register (CCR).**
3. **Approved the closure of risks as requested.**
4. **Noted the Deep Diving report.**

13. Verbal Update on Management of Conflicts of Interest

13.1 GN delivered a verbal update and explained that compliance level stood at 87% at the time of presenting the report; and it was hoped that compliance would go above 95% within the coming four weeks. GN explained that the Registers of senior staff and members would be published on the web for benefit of the public. GN clarified that the ICB was required by NHS England to publish such Registers on the web at least once a year, but the ICB considered it good practice to publish more frequently. JS -being the Conflict-of-Interest Guardian- requested that arrangements be made on her and CGi's behalf to talk with staff on matters relating to conflict of interest. **Action: GN to facilitate.** **GN**

RESOLUTION: The Audit Committee noted the update relating to managing conflict of interest.

14. Committee Effectiveness Report

14.1 CGi presented a self-assessment template and stated that all committees of the Board were required to appraise their own performance every year. This was done to help improve effectiveness in discharging duty. CGi asked the Audit Committee to review the template and

suggest any improvements. CGi stated that the same process would be repeated by other committees of the Board. CGi explained that the self-assessment process utilised an online platform. Members discussed various ways of improving assessment tools and committee performance.

RESOLUTION: The Audit Committee noted the committee effectiveness report.

15. Counter Fraud Report

15.1 PK presented the report and stated that the Local Counter Fraud Service (thereafter "Counter Fraud") team effectively engaged the Audit Committee Chair, the Chief Finance Officer, and other relevant key people in the ICB, and the engagements included one-to-one meetings. PK added that Counter Fraud also engaged Counter Fraud Champions across the local system. PK explained that fraud, bribery and corruption risks remained the only area which lacked substantial rating and he reassured members that Counter Fraud was working closely with the ICB Governance team to strengthen this area. PK presented cases being investigated by Counter Fraud and described the actions being taken. PK presented the year 2023-24 draft Counter Fraud, Bribery and Corruption Annual Report.

15.2 PK stated that Counter Fraud encouraged compliance with legislation during commissioning activities. PK also stated that there was evidence that the ICB staff understood Counter Fraud's role within the ICB. JS highlighted a need to review the Counter Fraud risk scoring. **Action: PK and RB to work on re-aligning risk scoring matrix.** **PK & RB**

RESOLUTION: The Audit Committee:

1. **Noted the Counter Fraud report.**
2. **Approved the Counter Fraud, Bribery and Corruption Annual report for year 2023-24.**

16. Summaries of Procurement Decisions

16.1 There were no procurement decisions to report for this period.

17. Register of Waiver of Standing Orders

17.1 CL presented 19 waivers of Standing Orders approved by the ICB Executive. Members examined the waivers and discussed their impact. Members expressed concern over waivers of large amounts for organisations the ICB engage in business with all the time. Members also expressed concern over the potential for waivers of large volumes of small amounts linked with the same provider. Members emphasised on need to review process and gain assurance on controls.

17.2 JS proposed changes to waiver reporting and stated that waiver reports should be able to highlight waiver characteristics and trends in a way that supported oversight and control. JS stated that analysing data covering a period of 12-18 months could reasonably provide reliable data or information to study trends and characteristics. **Action: DP to provide the first revised report in September 2024**.

<u>RESOLUTION</u>: The Audit Committee noted the Register of Waiver of Standing Orders report.

18. Losses and Special Payments Register

18.1 Nothing was reported under this item.

19. Debts Write-offs

Nothing was reported under this item.

20 Aged Debtor Report

20.1 CL presented the outstanding debt report as at 12th June 2024; this showed total debt of £477,974 of which £47,819 was NHS and £430,115 was non-NHS. CL clarified that the debt had gone down from the March 2024 year end figure of £932,097. 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 gave an Assurance rating of Green.

<u>RESOLUTION</u>:

21 Any Other Business

21.1 JS reminded that the forward plan, going forward, be made a standing item on the agenda.

The meeting ended at 11:50am

Date and Time of Next Meeting: 5th September 2024

Minutes Approved by the Audit Committee:

Signed (Chair):____________________ Date:_____________

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NHS Gloucestershire System Quality Committee Meeting

Wednesday 5th June 2024, 2.00–5.00pm
Boardroom & Virtually from Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Julie Soutter (Chair)	JSo	Non-Executive Director, Audit Committee Chair, GICB
Dr Ananthakrishnan Raghurum	AR	Chief Medical Officer, GICB
Hannah Williams	HW	Acting Director of Nursing, Therapy and Quality, GHNHSFT
Marie Crofts	MCr	Executive Nurse & Director for Quality, GICB
Matt Holdaway	MHo	Director of Quality & Chief Nurse, GHNHSFT
Prof. Sarah Scott	SS	Executive Director of Adult Social Care, Wellbeing and Communities, GCC
Participants Present:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning, GICB
Becky Parish	BP	Associate Director Engagement and Experience, GICB
Suzie Cro	SC	Programme Director for Nursing and Midwifery Excellence, GHFT
Christina Gradowski	CGi	Associate Director of Corporate Affairs, GICB
Julie Symonds	JS	Deputy Chief Nurse, GICB
Annalie Hamlen	AH	Senior Nurse Quality and Integrated Commissioning, GICB
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Sarah Morton	SM	Chief Professional Lead for Allied Health Professionals, GHC
Katie Hopgood *(Part Meeting)*	KH	Consultant in Public Health, GCC
In Attendance:		
Joanna Garrett	JG	Maternity and Neonatal Independent Senior Advocate, GHFT
Ryan Brunsdon	RB	Board Secretary, GICB
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Matthew Dominey *(Item 5)*	MD	Consultant in Public Health, Screening & Immunisation Lead, NHSE
Helen Ford *(Item 7)*	HF	Deputy Director, Integrated Commissioning, GCC and GICB
Jane Haros *(Item 9)*	JH	Deputy Director of Nursing-Integrated Commissioning (Health Care & Communities), GICB
Lindsey Bodman *(Item 9)*	LB	Senior Commissioning Manager, Integrated Commissioning, GICB
Emma Savage *(Item 10)*	ES	Associate Director of Research and Evaluation, GICB
Marion Andrews-Evans *(Item 10)*	MAE	Director – Research & Vaccinations, GICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the meeting.

2. Apologies for Absence

2.1 Apologies were received from Jane Cummings, Jan Marriott, Melanie Munday, Emily White, Siobhan Farmer, Vanessa Catterall and Trudi Pigott.

2.2 The meeting was confirmed to be quorate.

3. Declarations of Interest

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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).

JSo declared that her husband was still on the Board of Governors for the University of Gloucestershire and as there was an item on the agenda today around the University, JS declared this as a potential Conflict of Interest.

4. Minutes of the last meeting held 3rd April 2024

The minutes from the last meeting held on 3rd April 2024 were approved as an accurate record.

5. Matters Arising & Action Log

Action 51, 2WW Breast Cancer: Added to forward Plan but date TBC. **Action to remain Open.**
Action 53, ICB Quality Report: The new style quality report had been introduced and would be discussed at PCDC on the 6th June, with future iterations as required and work to include quality metrics. **Action Closed.**
Action 54, Childrens Social Care: Ambitions Plan had been included as part of the papers. **Action Closed.**
Action 55, Childrens Social Care: Data to be included within the next Childrens Social Care Report. Separate report also attached as part of the papers. **Action Closed.**
Action 56, Health Inequalities: This has not yet gone live, and development is still underway. **Action to remain Open.**
Action 61, Risk Report & BAF: CGi/MCr to meet to discuss potential integration of BAF 4 and BAF 7, involving partners at a later stage. **Action to remain Open.**
Action 62, Future Reporting: Large document still to be examined. **Action to remain Open.**
Action 63, Paediatric Audiology: This has been added to the forward plan for August. **Action to be closed.**
Action 64, ED&I Future Plans: Added to forward plan, but date TBC. **Action to remain Open.**
Action 65, GHC Quality Report reporting: Work remains ongoing. To be brought back to a future meeting. **Action to remain Open.**
Action 66, MARAC Plans: There were now no backlogs for these. **Action to be Closed.**
Action 67, CQC Framework Presentation: Documentation had been circulated. **Action to be Closed.**
Action 68, IPC: This is due for the August meeting. **Action to remain Open.**
Action 69, IPC: This has been added to the forward plan for August. **Action to be Closed.**
Action 70, Mortality: This has been added to the forward plan for August. **Action to be closed.**
Action 71, Safeguarding Children Policy: Completed and sent to the Chair for virtual Chairs action. **Action to be closed.**
Action 72, ADHD: To be brought back to October meeting. **Action to remain Open.**
Action 73, Committee Effectiveness Survey: To be re-circulated by CGi. **Action to remain Open.**

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The Actions from the Action Log were discussed and updated. AH noted that Action 4 on Page 4 should be added to the Action Log relating to a report being brought back on Self harm in young people by RM and TP. DC later added this onto to the Action Log following this meeting.

5.1 National incident identified in high-risk breast screening

5.1.1 MD had to leave the meeting but left his information via MS Teams chat as per the following. MD informed that there had been a breast screening programme which had been run whereby women had not been referral by genetics for screening and annual surveillance.

In the South West, 190 women had been affected (of which 12 had been in Gloucestershire). All required an urgent assessment of an MRI +/- a mammogram. The NHS Commissioning team assured that the Gloucestershire Breast Screening Programme had a clear plan in place to deliver the incident requirements well within national timelines (early July 2024). A formal Trust Action Plan had been received with weekly reporting and regular meetings with the Vaccinations and Screening Team (VaST) scheduled.

Letters had been sent to all individuals affected with the majority now booked in for MRI and mammograms. A small number had been identified as not suitable for screening for a variety of reasons including:

- Bilateral mastectomy
- Pacemaker fittings, making MRI unsuitable

As of 10/5/2024, 81 of 182 cases had now been closed for annual recall. Medical Directors had received correspondence about the requirement to complete a clinical review of those women with breast cancer. Patient lists for those requiring clinical review had now been received. Communications had been shared with GP's, cancer alliances, ICBs and Local Authorities. Programmes had also shared communications throughout Trusts as appropriate.

***Resolution*: The Committee members noted the written update from Matthew Dominey on high-risk breast screening.**

6. Corporate Risk Report and Board Assurance Framework Update

6.1 JS acknowledged the large amount of work having been undertaken by CGi and RB on the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Framework. This was still ongoing with further iterations expected moving forward.

The format would be as streamlined as possible, enabling focus to be on the actual items rather than the way they were reported on in tables. Useful examples from other organisations had been sent in for comparison to JS, ensuring the ICB could focus on familiarity and content. This remains an ongoing piece of work by CGi and RB with oversight from JS.

JS said she would like in this item to focus on significant items of content in the BAF and CRR as some of the themes coming through would later appear on some of the agenda items today with specific papers.

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6.2 CGi detailed the rationale regarding changes on the BAF which had been sent to partners prior to the ICB Board meeting last week. A future Board Development session would be conducting a deeper discussion around risk and the BAF.

- The BAF 4 risk had increased since the last report and had entailed a discussion with MHo, AR and MCr. MHo had shared a lot of risks from GHFT's clinical governance infrastructure, to assist with co-alignment and proper referencing.
- BAF 7 – Quality vs Performance on the operational side. Mark Walkingshaw wanted to keep this under his review as it related to productivity gains and harm around waiting lists.
- Emergency Preparedness, Resilience and Response (EPRR) information about how that risk should be scored had come from a recent BDO Report. **Action: MCr to examine and update the EPRR risk.** **MCr**

6.3 MCr said that KM, CEO at GHFT, had recommended that the BAF 4 risk be increased and following a discussion with Mho it has been increased to 16 due to Urgent and Emergency Care (UEC) and Maternity issues. Some of the BAF other risks from GHFT did not quite align (quality governance processes and UEC) so MCr had raised with Matt Holdaway (MHo) and Kevin McNamara (KM) that there was nothing she could see on their BAF around Maternity. This would be examined together with all the work that AR was leading around the Summary Hospital-level Mortality Indicator (SHMI). AR said that the review had been undertaken in conjunction with providers.

6.4 KH informed that the implementation group had started for the targeted lung health checks which was positive news. The risk still needed to be updated and reduced as the lead had been away. AR said he would need further definitive assurance on this before reducing the score for lung health checks.
Action: Clinical Programme Lead on lung health to provide an update around the lung health checks for a future Committee meeting. **CPG Lead**

6.5 JS said that it would be important for the Board and Audit Committee to pick up some of the emerging risks from individual organisations in terms of how they might be increasing those risks. JS felt that the BAF needed further updating around some of the actions being out of date now and descriptions still needing to be shortened. The assurance sections and input from Directors would be the things examined first, to see how these triangulated through into everything else.

6.6 *Corporate Risk Register Update*

6.6.1 RB ran through the recently updated Corporate Risk Register:

- There had been some changes to the format.
- The Committee had a total of 27 risks assigned from the ICB CRR rated 12 or above – two were rated at 20. The risk S&T 5 around delay in targeted lung health checks pilot screening service was at 16 but had now increased to 20.

It was noted that there were a fair number of risks from the Integration team. MCr reported that the risk rated at 15 was around antenatal screening and was part of the maternity response from the Quality and Improvement Group.

JS expressed concern around the International Recruitment risk which was rated at 16 and seemed higher than would be expected. Many of the risks were still highly rated even following mitigation which was an area to be explored with the Audit Committee. KH informed the meeting that the Implementation Group had started for the targeted lung health checks which was positive news. The risk could probably be reduced. AR

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said he would need to have further assurance before the risk could be reduced. but would.

JS said further discussions would be helpful in the refining of the CRR for the System Quality Committee, with further scrutiny in the Audit Committee to follow, which had responsibility for overseeing the risk management in the other Committees. Any comments or suggestions on how the BAF and CRRs could be made more useful and easier for people to navigate, would be welcomed.

6.6.2 MCr said she would ask TP to examine the Berkeley House risk as this was still high but likely needed updating. The chair observed that unfortunately the more people involved, the greater the disparity between the approaches and risk ratings.

***Resolution*: The Committee noted the verbal updates on the Board Assurance Framework and the Corporate Risk Register.**

7. System Partner Highlight Assurance Reports

7.1 JS said that JCu had emailed her to ask the Committee to cover various items at the meeting today, particularly (and firstly) around Maternity:

1. To try to understand why receipt of a Section 31 had not been anticipated;
2. What had happened around the learning and development since then, from a system perspective and from the Committee’s perspective.

JCu also wanted to examine how the Patient Safety Incident Response Framework (PSIRF) was being implemented, how incidents were being picked up, how that would influence how people worked and how the Committee could fulfil its responsibilities to give assurance to the Board that quality and safety aspects were being surfaced, managed, learnt from and moved forward.

JS spoke about the recent Post Office scandal and felt that there were “lessons learnt” for the ICB to benefit from. These would follow after their inquiry had finished, around governance, culture and processes that it would be really important around asking, knowing and following things up, for Boards and Committees. There were some parallels in some of the NHS inquiries that had happened elsewhere, with a responsibility for everyone to examine and learn from all aspects of those inquiries. JS thought that today’s discussion around maternity was a good place to start.

7.1.1 Maternity Deep Dive Presentation and Updates from GHFT

7.1.2 MCr said that several national maternity reports following inquiries into care, had been published; the Ockendon Report related to Shrewsbury and Telford Hospital Trust, and Dr Bill Kirkup’s report on Maternity and Neonatal Services in East Kent. NHS England’s Maternity and Neonatal Three-year Delivery Plan (3YDP) incorporated the requirements from the Ockenden and East Kent Reports with a range of actions to ensure safe and personalised care.

7.1.3 MCr went through the four themes incorporated into Slide 1. Ockendon had talked about the cultures, particularly in midwifery and obstetrics and how staff could learn and support each other. The Section 31 issued recently to GHFT was mostly around embedding and sustaining learning.

7.1.4 Maternity Services at GHFT were first rated as Inadequate in April 2022 and that rating still stood. The most recent inspection report from the CQC was still awaited by the

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Trust. Implementation of recommendations from CQC reports were being progressed in conjunction with support from NHSE Maternity Improvements Advisors (MIA's) for midwifery and obstetrics. MCr outlined the list of concerns on the Section 31 notice one of which was governance processes, ensuring that this linked with the rest of the Trust's governance and assuring the Board were aware of all issues in maternity and mitigation in place. . Other concerns such as induction issues owing to agency shift nurses changing thus affecting continuity, were being addressed.

7.1.5 Gloucestershire's Local Maternity and Neonatal System's role in oversight of Quality and Safety of maternity services in Gloucestershire had been evolving and increasing over the past year. From April 1st, 2024, oversight and assurance in relation to Quality and Safety, previously undertaken, by the regional Maternity Team was now devolved to LMNS's.

7.1.6 HF informed that Gloucestershire LMNS had a perinatal assurance and surveillance dashboard which brought together a range of sources of intelligence from maternity and neonatal services at GHFT. This did not include women that birthed out of county so out of around 6000+ women, there were about 500 that would go mainly to Great Western Hospital at Swindon, but some would go to Bristol, Worcestershire or over into the Welsh border.

7.1.7 The ICB gained access to the national maternity data set last year. Work was underway to improve the data quality which would support national, regional and per Trust benchmarking. More dedicated resource and expertise would be required to ensure the dashboard was developed and maintained, enabling analysis and deep dives to take place. Actions to improve and embed learning through robust governance processes was essential.

7.1.8 JS asked at what point would the ICB know when the data required was good enough. HF responded that a data person might be able to answer that, but it was clear that more dedicated and experienced resource was needed from the data and Business Intelligence (BI) colleagues in order to conduct this work robustly, to be assured that accurate data was being obtained and to maintain and develop analysis which would help with swift access to deep dives. A colleague within the ICB Bi team had looked into stillbirths, neonatal death rates and maternal mortality last year. The data had shown that Gloucestershire were not significantly different to the UK rates. A Quality Improvement Group, under the national Quality Board guidance of escalation, had commenced as a task and finish group to progress at pace those areas where traction and resolution were required.

7.1.9 MCrconfirmed that the Quality Improvement Group would initially escalate to the System Quality Group initially and then up to the System Quality Committee for oversight. There had been over 400 actions from the CQC and Maternity reports which has meant the focus was unclear. Following the last Section 31, it was decided to focus on the top 7-10 actions which leaders within GHFT and maternity services had found helpful.

7.1.10 HF described the top of focus:

- 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

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Kevin McNamara, CEO at GHFT, had recently commissioned an external review of Maternal Mortality, Morbidity and Neonatal Deaths. In addition, the ICB were meeting weekly with the Maternity Improvement Advisor from NHSE to ensure alignment of actions and concerns. Understanding the issues together was really important which had started two months ago.

7.1.11 The Chair said that although GHFT might have been aware of some of the issues, she had not been made aware and asked at what level had people become aware of things that may not have been reported higher up, as being of special significance why had these things not already been on the radar? If the data had been unavailable, what other sources of information around concerns could have alerted people? The Chair said that as a Non-Executive Committee member, this would not have given assurance. Information had not been made available when it should have been which was of concern to both JSo and JCu.

7.1.12 HF explained that a review of the LMNS was taking place to ensure that the right structure was there to fulfil the ICBs oversight role, including reporting lines within the ICB and would also cover what went out of the ICB and what would come back in. There was a buddying arrangement within Bath, Swindon and Wiltshire (BSW), one aspect is a safety learning forum and helped with information being brought back to be embedded in the ICB, detailing where this was being recorded and how it would be disseminated to the right people. MCr had discussed this approach with the Regional Chief Nurse, and a more formal arrangement of buddying up was being explored.

7.1.13 The Chair said in the absence of a lot of good quality information and the fact that the dashboard for quality had been paused temporarily, if data was coming in for example around results from a staff survey for a maternity department, this might reveal perhaps 10 areas of dissatisfaction and JS had not seen any of that kind of information pulled together on the quality dashboard. It was that cross-cutting approach rather than examining things in silos which for her was the key to risk management and emerging risks being picked up. MCr said having a Provider Dashboard would be a good idea as there was a lot of information in silo which was not triangulated across the different domains and services. HF said that quite a lot of this information was available. Mcr stated the LMNS will work with the Trust to develop a set of information which enabled triangulation and 'hotspots.

7.1.14 MCr spoke about learning on the last slide of the presentation:

- Clear and robust governance at all levels
- Being clear on accuracy of data and having 'one story'
- Many actions from multiple places – have one place and one action plan
- Leadership
- Role of the LMNS – transformation v assurance
- Pace of change

GHFT had, in recent times, put in a number of senior posts both in governance and leadership with an expectation of them having clear lines of sight on what their responsibilities were. Having the right people round the table for the LMNS would give detailed assurance which would link to the quality improvement and transformation work. MCr's observation would be to have a pace of change so as to not allow things to slip and for swift actions to be taken with specific timelines.

7.1.15 MHo said that following receipt of the disappointing Section 31 notice, SC had started to pull issues together around the very first inspection which had led to the enforcement notice and some of these correlated and some did not. The underlying thread was the

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governance and learning running through the five issues. Some of the challenges had been in the dissonance of feedback received and possibly resulting in confirmation bias a few weeks prior to the Section 31 notice being served which was something being reflected upon.

7.1.16 MHo explained that maintaining compliance with the Maternity Incentive Scheme (MIS) was a requirement from NHS Resolution (NHSR). Examining the many different data sources whilst maintaining this compliance was an enormous challenge whilst maternity services were under such current scrutiny. This was a major piece of work to be done which would improve the pace and the top priorities would need to be examined and tackled in order to deliver the level of assurance required. Multidisciplinary working and collaboration across maternity services had improved and was evidenced in some of the Quality Improvement projects being put together.

7.1.17 There had been a good deal of support from the ICB, LMNS and region for GHFT to be able to concentrate on seven priorities rather than having to also work on the many other improvements. A risk assessed approach would have to be taken around those things of focus at any given moment to enable the maternity team to be supported.

7.1.18 SC gave an update on the Quality Improvement (QI) work now being undertaken in relation to all areas within the CQC Section 31 notice for maternity services which had led to a series of workshops where agreement had been made to use an established QI process. Teams, with clinical leads had been tasked with putting a 'Plan on a Page' supported by the specialist QI and Safety teams to examine the change ideas and the improvements process. Teams would be bronze QI and then silver trained and would be able to give feedback on their projects with ICB and executive colleagues present, discussing any blockers which would then be actioned and supported going forward. Governance systems would be a focus along with monitoring the seven key items without inadvertently adding additional actions to the list.

7.1.19 MCr said this was a way of sustaining and embedding long term improvements rather than temporarily solving problems with quick reactions however there was also something about ensuring quick immediate safety actions were put in place if necessary.

7.1.20 The Chair asked who the GHFT's Non-Executive Director (NED) Maternity Champion was, and how they were involved in some of the work. MHo informed members that Vareta Bryan was the new Maternity Champion NED and was new to the role, replacing Alison Moon who held the role previously. Vareta would be involved in the work moving forward but had not been involved in any of the workshops.

7.1.21 The Chair reflected that the maternity discussion had been a helpful use of time and would be captured in the minutes for a debrief with JCu when she returned to see how this could be taken forward through the System Quality Committee and how assurance from the System Quality Group and the Quality Improvement Group would be coming through along with updates on the work ongoing at GHFT. It would be important to build this in as a rhythm of reporting as things progressed.

<u>Resolution:</u> The Committee members noted the Maternity Presentation and maternity progress updates from GHFT.

7.2 <u>GHFT Exception Reporting</u>

7.2.1 MHo said one of the main parts of the report was the Regulatory Report which detailed GHFT's regulatory activity. The main difference this time had been around the Section 31 in maternity. Reporting would be changing around the Quality and Performance Report (QPR) moving to an Integrated Performance Report (IPR) which went live 6-8

weeks hence with Performance. The Quality aspect was being examined with the data warehouse with an anticipated go live date next month. This would be followed by Workforce and then finally, Finance, enabling delivery of a truly integrated performance view across GHFT. The papers today outlined the assurances from the Chair of Quality and Performance.

7.2.2 JSo queried the forward plan to deliver deep dives into the five key domains of operational performance and asked what those five domains were. A similar approach would be being developed on quality. **Action: MHo to send details of the five performance domains for GHFT to JSo.** **MHo**

7.2.3 JSo noted that the BAF for GHFT was to be updated and this was being progressed. JSo referred to the Never Event Task and Finish Group with two events being exactly the same and asked why these had not gone through the new Patient Safety Incident Response Framework (PSIRF) process. MHo explained that these events had taken place before the new PSIRF had been implemented and had involved a high number of wrong-sided blocks in theatres within GHFT. Consequently, a large-scale Task and Finish Group had been implemented with oversight from Mark Pietroni, CMO to review those Never Events and causative factors. Those events went back to zero for well over a year, but then the task and Finish Group had been stepped back up following two further unrelated incidents. No serious harm had arisen from these events however, both patients had to have blocks re-done. The work was continuing and would be reported back via GHFT's Quality and Performance as an update, within the next month or so.

7.2.4 AR reflected that a huge amount of work had gone into getting the Never Events down. It needed to be understood at how at a departmental and divisional level, this would be embedded into Business As Usual, so that the changes actually stayed embedded.

7.2.5 BP had checked the Fit For The Future (FFTF) decision making Business Case (the GHFT paper on p57 of 317), which referred to the Urology Assessment Unit (UAU) challenges around the 62 hour wait and reconfiguring staff to Cheltenham General Hospital. BP's request to GHFT colleagues was to ensure that the wording here was made very clear prior to presenting to the Health and Social Care Overview and Scrutiny Committee (HOSC) in July. **Action: MHo to check the wording around Urology in the FFTF Business Case.** **MHo**

7.2.6 The Chair asked MHo whether the key issues in the assurance report would still continue to come from GHFT's Committee. MHo said there were no plans to change things and all Committees produced one of those reports for Board.

7.2.7 MCr referred to and was anxious about water safety improvements being required and asked if there was any pace behind this as it was rated as Red. MHo shared MCr's anxiety and was around a risk assessment being undertaken which had now been resolved in terms of pace. Partners in General Medical Services (GMS) had previously not updated the Legionella Risk Assessment but had now done so.

7.2.8 MCr noted that there was nothing on GHFT's BAF around Maternity. MHo said that he and SC had discussed this earlier around describing this regulatory risk on the Risk Register. MHo's view was that this needed to be placed on the Trust's Risk Register, anticipating that the scoring would warrant a place there. SR2 on the BAF mentioned failures around quality where maternity was referred to but needed to be formalised into a specific risk assessment.

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7.2.9 MCr asked that when GHFT looked at the list of ten priorities, whether triangulation would be done across all potential harms and areas so that hotspots could be seen and would not be siloed into numbers or aggregated up. MHo said this was where the Integrated Performance Report was heading and would give GHFT the ability to look at the full suite of metrics albeit would take a while to get that granularity through the divisions down to specialities, but this work was beginning. The Chair was looking forward to seeing some of this from a system perspective and would enable conversations to be directed and support to be given. MCr hoped that the setting up of recent ICB Quality Governance meetings to give support to colleagues would also prove helpful.

Resolution: The Committee members noted the verbal update on the Exception Reporting from Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT).

7.3 Gloucestershire Health and Care Trust (GHC) Exception Reporting

7.3.1 HW said that the Trust was also moving to a more integrated approach around performance reporting. There was still further work to do regarding the triangulation and analysis perspective of data for the Trust's dashboard which would be taken forward. MCr said she would be happy to support the development of this for both Trusts if helpful.

7.3.2 HW spoke about the End of Year Summary on GHC's Quality Priorities of which the Trust was very proud of in terms of achievement.

- There were no backlogs of Multi Agency Risk Assessment Conference (MARAC) reports which needed uploading.
- There was a new Safeguarding Supervision offer for Children and Adults. Attendance for supervision was an area of concern for the Trust and new leads had been able to co-produce a different offer.
- Berkeley House – monthly submissions continued with data as requested by the CQC. These would continue until the Section 31 notice was lifted. The CQC were satisfied with the level of improvement and pace around discharges, which were continuing.

7.3.3 MCr recalled from the previous System Quality Committee meeting, that the reason for staff not receiving clinical supervision was due to this data not being recorded correctly and wondered if a system existed whereby this could be recorded this more accurately.

HW said regarding supervision reporting, this supervision paperwork has now to be uploaded onto the ESR system upon staff having completed this. AH queried rapid tranquilisation training and access to courses for Wotton Lawn staff. HW said reporting for rapid tranquilisation data was now around 8 weeks old. Colleagues were able to assure their own Board that numbers for rapid tranquilisation and resuscitation were now in a much better position. Rapid tranquilisation was a piece of work following the CQC inspection and whilst there was good reassurance around appropriate observations being taken following this, the recording of that was an area which needed to be examined and this was being undertaken.

There were some other areas where numbers were down due to long term sickness or maternity leave but all those on duty had been trained. HW said that there was probably some further work to be done internally to break down the data for training in a more meaningful way.

MCr also thought that as a system, it would be good to start working collaboratively on areas of Severe and Moderate harm and to dedicate some of the QI resource to this in

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order to reduce it. The Chair agreed that this was a good point. HW said she was sure that colleagues from the Trust would welcome this along with involvement from social care and voluntary sector partners.
***Resolution*: The Committee members noted the verbal update on the Quality and Performance Report from Gloucestershire Health and Care NHS Foundation Trust (GHCNHSFT).**

7.4 ICB Quality Report (Primary Care) Exception Reporting

7.4.1 The Chair thought there was more to be done around supporting data, which was qualitative and informative rather than data driven, and this would also be followed up in the Primary Care and Direct Commissioning (PC&DC) Committee meeting with improvements being seen going forward together with discussions around content.

7.4.2 BP confirmed that this would be discussed at the PC&DC meeting tomorrow to ensure that the relative quality metrics being reported on would be of most use to the relative Committees.

***Resolution*: The Committee members noted the verbal update on the Integrated Care Board (ICB) Quality Report.**

7.5 Verbal update from System Quality Group (SQG)

7.5.1 The forthcoming CQC inspection of Adult Social Care around Mortality and Safety would be aspects moving to PSIRF. The Chair would like to see in future the minutes and a slide and would be checking with JCu about this.

7.5.2 There were a lot of quality issues noted in the care provider market which the Chair noted were being closely monitored but were not necessarily improving. MCr said this could be taken back to the System Quality Group for Cheryl Hampton to look at as some of the context was not known, especially around Care Homes. **Action: MCr to bring data on Care Homes back to a future System Quality Committee via the System Quality Group.** **MCr**

***Resolution*: The Committee members noted the verbal update on the System Quality Group.**

7.6 Childrens Social Care Exception Reporting

The Chair said she was not proposing to go through the Gloucestershire Children's Services Ambition Plan in detail as there was no representative here today. The Chair was happy to accept the report as was at the moment and then examine what requirements would be for future meetings. It was noted that there were high rates of school exclusions for this county which was a concern and rates of home schooling had increased since the pandemic which would need further examination and more discussion time.

***Resolution*: The Committee members noted the verbal update on Children's Social Care.**

8. PSIRF Policy and Plan for Ratification – Tetbury Hospital Trust

8.1 RM said that arrangements for this Trust were different to that of GHFT and GHC in that it was a smaller Trust and PSIRF had recommended a smaller document for such providers however, this did contain everything necessary for Tetbury Hospital

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8.2 JS queried the staff huddles and how these were conducted in a smaller organisation. RM said that staff came together from different parts of the Trust. The PSIRF had been used in one incident and had proved to be a really good learning opportunity with staff being able to demonstrate some good team work around this incident. Daily huddles had been taking place for quite some time prior to the incident and new processes around PSIRF were being adopted.

8.3 RM updated generally on PSIRF saying all things considered around this huge culture change, things were moving in the right direction and this new system was much more focussed around patient safety incidents, examining after action reviews and conducting the swarm huddles. The new tools were moving the system into designing things that went right in the first place and looking forward proactively. There had been a few Patient Safety Incident Investigations (PSII) opened, six in GHFT, five in GHC and one in SWAST. The Trusts reported the incidents themselves with oversight from their Boards for final sign off.

8.4 Both Trusts were reporting into the Learn from Patient Safety Events service to enable data to come through which was a really good new tool, although data was currently presented on one huge spreadsheet and would have to be turned into something far more accessible. The ICB had now started Patient Safety weekly huddles which were going well with a lot of ideas and input. Social Care colleagues had been invited for future meetings to bring information together and to triangulate the work being done.

8.5 The Patient Safety Learning Review Group's first meeting had been held today, which was attended by the QI Lead. MCr observed that good governance and oversight was essential in embedding the PSIRF. RM referred to the to the Patient Safety Partners mentioned in the PSIRF policy who should all be in place, but these could be 'borrowed' if necessary. Most ICBs had two but Gloucestershire currently only had one and until PSIRF became embedded, it was not known how those people would be utilised, which would need formal resolution going forward.

8.6 MHo agreed with MCr's observations with governance and oversight being essential in order to move well across the PSIRF. The drive and timescales around PSIRF did not always allow for this which was quite challenging and may not be the same across an organisation. Some parts of GHFT were further advanced than others and having a nuanced approach was not always straightforward. MHo mentioned that he would be happy at a future Committee meeting to give further updates on where GHFT were with the PSIRF rollout. HW said that any After Action Reviews (ARRs) needed to be conducted correctly and these took time and should be done face to face in order to learn from those experiences. GHC were embedding this process but there were sometimes unintended elements and impacts on corporate nursing.

Action: RM to discuss the review meeting with JCu and bring back a progress update to the meeting in October. **RM/JCu**

***Resolution**: The Committee members approved and ratified the PSIRF Policy and Plan for the Tetbury Hospital Trust.*

9. End of Life Care Presentation

9.1 JH informed the Committee members that following the GHC and GHFT Chair's visit on End-of-Life care which took place in December 2023, a concern was raised at the ICB public board meeting on the 31st January 2024 regarding choice of place to die. Insights shared as part of the visit seemed to highlight patient choice was being reduced due to financial constraints on the Continuing Health Care (CHC) budget. The purpose of this report was to provide an overview of some of the work within the palliative end of life and bereavement care programme in response to this question.

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9.2 The Chair wanted the End-of-Life team to talk to the public and staff and evidence had been gathered from five areas:

1. Results from a recently conducted staff and feedback from the public
2. End of Life dashboard data
3. Continuing Health Care Fast Track deep dive and benchmarking analysis
4. Findings from the Rapid Home to Die Discharge Facilitator pilot in GHFT
5. Update re the End-of-Life Strategy and system collaborative

9.3 LB explained the CHC Fast Track Gloucestershire ICB Benchmarking Analysis element where three aspects had been examined:

- GICB looked at where it benchmarked against other ICBs
- A deep dive was conducted around the patient journey looking at those people who were discounted from CHC Fast Track
- A clinical audit was still under way examining 100 cases

From April 2022 to June 2023, there was a sustained increase both in new referrals and in those eligible for Fast Track which had been followed by a dip for a three-month period in eligibility which sat outside the expected range and also meant that the ICB had fallen below the median range for our peer group. Since then, this had returned to the expected range.

The early findings from the clinical audit suggested that the CHC team were complying with the eligibility framework, but the quality of referrals varied significantly, and the findings had pointed to a training need, where staff were unclear on the criteria for CHC, especially within hospitals.

The deep dive examined around 2000 individuals who were reviewed and 277 of those were discounted and 89% died within five weeks. This indicated that had paperwork and criteria been completed and understood, a different decision perhaps could have been made for that cohort of people. A similar percentage of people who had been eligible had not died within 12 weeks.

9.4 The public survey was launched in conjunction with the Dying Matters week in early May 2024. The two most important issues coming from the survey concerned training with 34% of people having attended End of Life training or awareness in the last 12 months. There was also a low confidence level in there being enough care for people leaving hospital if they wished to die at home. 88% of the public felt that health and care staff were caring and compassionate. Medical Examiner feedback was also contained within the report.

9.5 Rapid Home to Die Discharge Facilitator (RHTD) – the key messages from the six-month pilot was an understanding of CHC Fast Track processes and a training need had been identified.

9.6 A collaborative, systemwide meeting was held at the end of May 2024 where there were over 60 representatives from across the system who attended this online and face to face networking event. The feedback was that people had really valued that opportunity to make connections and take work forward to enabling a refreshed strategy that would go beyond 2025 to be produced.

9.7 JH spoke about the low uptake on training saying it was desired to incorporate alternative pathways for End of Life in the CHC training as people did not understand

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those pathways very well. Conversations had already taken place with some Acute colleagues in the Discharge Hub who had requested that training.

9.8 The findings from the Discharge Facilitator (although this had only been a pilot) had added a lot of value and the person involved had worked in frailty for a long time so this had been really useful, and it was hoped to produce a Business Case in order to take that forward. One area of delay picked up was completion of Care Diaries following assessment. It was also hoped to continue working with the Medical Examiner to ensure that feedback was received from all settings.

9.10 JSo queried that given End of Life had been raised at Board, whether the Report should go to Board following the audit report. JSo said that writing up the findings and producing an executive summary with an appendix for detail would be helpful before the Report went to Board. AR said the Chair was keen to see next steps and recommendations. The Chair's visit had coincided with a dip in the figures and understanding referrals. MCr thanked JH and her team for this valuable work and for organising and facilitating the collaborative. JH fed back that there had been a lot of openness and willingness to really make improvements and to take them forward. The focus would be on training and education and ensuring that staff were released to attend training which would increase numbers.

9.11 HW queried the broader End of Life training and asked how many had engaged with the system funded training or the provider specific training. When HW had compared it with the End-of-Life dashboard in GHC, this was showing a score in excess of 90%. Following the CQC inspection, one of GHCs commitments was to move more towards mandatory training, so HW was happy to allow the team to have oversight of GHC's training dashboard. LB confirmed that GHC had performed well compared to other organisations around numbers trained.

9.12 HW referred to the three-month dip and this may have been influenced by some of the feedback from staff. HW wanted to know what had caused the dip to prevent it from happening again. LB did not have a specific answer; the data and what it was revealing was the focus at the time. MCr said she would speak to Rebecca Barrow in CHC about this. JH said the important things was that levels were now back to where they had been prior to the dip.

9.12 SS said that it would be good to take this work back to the Board in order to close that loop and to validate the Committee's role in having overseen the work that had been requested. JH said that the audit results would enable focus on priorities, one of which was the CHC training across the system. The Chair extended her thanks for the valuable work that had gone into the End-of-Life report.

Resolution*: The Committee members noted the verbal update on the End-of-Life Care Report.*

10. One Gloucestershire Research, Audit and Evaluation Strategy

10.1 The Research, Evaluation and Audit Strategy had been co-designed with the Research for Gloucestershire (R4G) Group which comprised members from the ICB Research and Evaluation and Patient Insights teams, GHFT, GHC, GCC (social care and public health), University of Gloucestershire, VCSE Alliance, National Institute of Health and Care Research (NIHR) and Health Innovation West of England. R4G and Gloucestershire ICB Operational Executive Team had approved this version of the Strategy being submitted to the System Quality Committee for review and approval.

10.2 The development of this Strategy would be the next step of the Research, Evaluation and Audit journey for Gloucestershire ICS. The ICB would like to celebrate all the

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diverse research activities that had already taken place in the county and develop and encourage others to take part in research. Any actions taken to deliver the Strategy would be achieved by working together in collaboration as a system.

10.3 Some of the proposed actions had already been pulled together into an operational delivery plan where R4G are keen to see progress being made against the Strategy. The request today was for the Committee to approve the adoption and implementation of the Strategy.

10.4 AR confirmed that this was consistent with other research policies in other organisations and there had been a vision many years ago to have something akin to this across the county and unfortunately at that time things did not move forward. However, now there was a real option and vision to enable a systemwide Strategy for the county to be progressed, especially involving Primary Care. ES said that there was evidence to suggest that organisations that took part in research had better retention and improved outcomes for their patients.

10.5 SM said it would be good, given that it was a three-year Strategy, to have some of the detail of what the milestones might look like coming back to a future meeting enabling an evaluation of progress. SM felt this should really get maximum traction now across the system to enable wider pathway to buy in, preventing siloed approaches, and giving real opportunities for clinical transformation.

10.6 MAE assured the Committee that members would receive an annual report from R4G would formally report into this Committee and regular progress updates would also be provided throughout the year against the delivery plan.

10.7 The Strategy bears out that there is much more of a coming together in the county; at the moment it was very siloed and fragmented both organisationally and professionally. The whole idea was to base research around the people of Gloucestershire and not just around individuals and a paper would be going at some point to Strategic Executive meeting.

10.8 It was intended to examine research on creative health as Gloucestershire was quite unique on the way that social prescribing was delivered; there was very little research on this so it would be an area of collaboration with R4G. GHC had fortunately had some funding from the Clinical Research Network (CRN) to encourage Primary Care Networks (PCNs) to have Primary Care Champions and to develop their skills.

10.9 A recent report went to NHSE on research, and it was quoted as saying that ICBs were not doing enough to drive the research agenda. Out of 42 ICBs, only three had published their Strategies and two were in draft, one of which was Gloucestershire, so the ICB were in an advantageous position and had a lot to look forward to in progressing this. There was a real commitment and excitement from all partners to really deliver on this Strategy with some being further forward than others.

10.10 MCr recognised that this was a Strategy about building capacity and capability and a future conversation around how we use research into transforming practice and services would be needed at some stage. MAE also stated that research would be of little value should it not be put into practice and should support innovation. The ICB had been involved in the development of GHFT's new Research and Innovation Strategy as it would be essential that this dovetailed with that of the ICB's. A lot of learning about innovation would also unfold as things progressed.

<u>**Resolution**</u>***: The Committee members noted the development and content of the Research, Evaluation and Audit Strategy and gave their approval for adoption and implementation.***

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11. Policies for Approval

11.1 Intellectual Property Rights

11.1.1 This Policy had been updated and refreshed to reflect the ICS Research Policy and EU guidance, roles and responsibilities, and alignment to GHFT's Intellectual Property Rights Policy. There had been a need to check for any conflict between a contractor's policy and contractual arrangement between the ICB and a contractor. GHC currently did not have such a Policy and should they wish to develop theirs, then the ICB was willing to share a final copy of theirs. The Policy had previously been discussed at an Audit Committee meeting in March 2024.

***Resolution**: The Committee members approved the Intellectual Property Rights Policy.*

11.2 Maternity and Neonatal Independent Senior Advocate Policy

11.2.1 JG said this was a new Policy for the ICB and the new role sat within the ICB. It was largely an operational and nationally guided document as part of the pilot. MCr was the SRO for this programme, and it had already been to the LMNS Board, coming today for ratification.

JSo referenced 11.3.1 where wording needed to be Gloucestershire ICB rather than Gloucester ICB.
Section 13.3 – reporting quarterly to LMNS and the Trust Maternity Delivery Group and onwards to the Quality & Performance Committee. MCr confirmed that reporting to the System Quality Committee would be via LMNS and could be added in.
Page 309 Appendix 4 – reporting structure. Trust Board by exception on right hand side and on left hand side ICB *Executive* Board – unsure as to what that meant in the governance structure. Needed to just say ICB Board.

JG would make the necessary amendments to the Policy.

***Resolution**: The Committee members approved the Maternity and Neonatal Independent Senior Advocate Policy subject to amendments being made.*

12. Meeting Review, Items for Escalation to the Risk Register and Any Other Business

12.1 There were no items of Any Other Business to discuss. RB had given a Forward Plan to JSo, and she would be discussing this with JCu upon her return.

The meeting formally closed at 16.50pm.

Time and date of the next meeting:

Wednesday 7th August 2024 – 2.00-5.00pm
Shire Hall, Westgate Street, Gloucester GL1 2TG

Withdrawal of the press and public

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

(Commercial in confidence discussions)

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NHS Gloucestershire ICB System Resources Committee

Meeting Held at 2.00pm on Thursday 4th July 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
Mary Hutton	MH	Chief Executive Officer, ICB
Ellen Rule	ER	Deputy Chief Executive Officer and Director of Strategy & Transformation, ICB
Julie Soutter	JS	Non-Executive Director, Member
Mark Walkingshaw	MW	Director of Operational Planning & Performance, ICB
Participants Present:		
Jaki Meekings-Davis	JMD	Non-Executive Director, GHFT
Karen Johnson	KJ	Director of Finance, GHFT
Jason Makepeace	JM	Non-Executive Director, GHC
Sandra Betney	SB	Deputy Chief Executive Officer & Director of Finance, GHC
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Dr Paul Atkinson	PA	Chief Clinical Information Officer, ICB
Kelly Matthews	KM	Programme Delivery Director, ICB
Kat Doherty	KD	Senior Performance Management Lead, ICB
Jenny Richards	JR	Finance & Assurance Manager, GHFT
Alex Webb	AW	Finance & Assurance Accountant, GHFT
Mark Golledge	MG	Programme Director- PMO & ICS Development, ICB
Shofiqur Rahman	SR	Deputy Chief Finance Officer, ICB
Chris Buttery	CB	Finance Programmer Manager, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members and others present.

2. Apologies for Absence

2.1 An apology was received from Cath Leech (Shofiqur Rahman was acting as Deputy).

2.2 The Chair confirmed that the System Resources Committee meeting was quorate.

3. Declarations of Interest

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3.1 There were no Declarations of Interest (DOI) received other than those presented by way of the Register.

4. Minutes of the System Resources Committee Meeting Held on 2nd May 2024

4.1 Minutes of the meeting held on 2nd May 2024 were approved as an accurate record of the proceedings.

5. Action Log & Matters Arising

5.1 Matters Arising

5.1.1 MW and KM presented on the outcome of the 'Working as One' workshop held. KM explained that the workshop had a strong focus on workflow and decision making workstreams. KM added that the workshop had helped to strengthen joint working in progressing discussions on savings initiatives. KM described specific metrics employed to measure performance of pathways and provided comparative data relating to pathway performance.

5.1.2 KM expressed a need for system and organisation governance to support benefits realisation. KM also cited the Benefits Assurance & Oversight Group as a good example of providing an enabling governance group. KJ added that transformation premised on 'Working as One' factored-in skills development and workforce flexibility. This enabled system level transferability and movement of workforce from areas experiencing less pressure to areas in need of more support.

5.1.3 MW outlined the operational planning process, and he explained that the year 2024-25 Workplan was completed within target time and the ICB was awaiting final close down letter from NHS England. MW reassured that it was anticipated that no significant issues would be raised by NHS England. MW added that focus had now shifted to medium term planning.

5.2 Action Log

5.2.1 **16/01/2024, Action 30.** Investments & Benefits Review. A small set of strategic schemes was brought before members to consider the impact of investments. It was suggested that a proposed list should be brought back to the System Resources Committee, and criteria should be developed on what schemes would be considered. Members continue to monitor the impact of schemes. **Item remains open.**

5.2.2 **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 finalised at the 4th July 2024 meeting. **Item closed.**

5.2.3 **02/05/2024, Action 35. Register of Interests.** There was a request that the DOI log be reviewed and updated accordingly. The DOI Log was updated. **Item closed.**

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5.2.4 **02/05/2024, Action 36.** Terms of Reference Review. MG presented an updated draft of TOR. Members requested a few more amendments. Amendments were made. **Item closed.**

5.2.5 **02/05/2024, Action 37.** Working As One Programme (Urgent & Emergency Care). KM stated that a half day workshop would be held to review hospital flow. Members asked for further update. Members received the update on 4th July 2024. **Item closed.**

6. Risk Management Report

6.1 MG presented the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF) before members showing scores that were above 12 and were within the remit of the System Resources Committee. MG highlighted the importance of project delivery and benefits realisation, and he emphasised that projects and programmes benefit should clearly be stated. MG reiterated that realisation of benefits could be compromised either if clear plans were not in place to deliver the benefits, or due to projects and initiatives being delayed. MG emphasised that information/data should be made readily available to support the monitoring and delivery of benefits.

6.2 MG added that an Evaluation Task and Finish Group had been established to provide support and approach to benefits realisation and evaluation. The Group brought together a wide range of system partners and provided support to specific projects. JS stated that the Audit Committee was re-modelling the BAF and the Corporate Risk Register to re-align them with a system view and enhance capability to detect emerging risks.

6.3 JS expressed a concern that Risk Owners and Risk Leads were not demonstrating adequate commitment to supporting mitigation processes. JS reiterated that not enough effort was being made to provide data and information to support risk mitigation, and she cautioned that the resulting slippage could prejudice re-modelling of risk management processes.

6.4 Deep Dive: Project Delivery and Benefits Realisation

6.4.1 MG presented and described system level risks associated with project delivery and benefits realisation; and these constituted:

- risk that benefits were not clearly stated in projects and programmes;
- risk that sufficient information was not available to monitor delivery of benefits;
- risk that benefits would not be realised due to projects being delayed.

6.4.2 MG outlined processes and controls in place to support risk identification, mitigation, scale of risk, and monitoring of benefits. These included:

- standardising and agreeing project approval process for all new projects;
- upskilling of staff;

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- investing in the Task & Finish Group to support project evaluation;
- providing plans detailing financial and non-financial metrics within their programmes.

6.4.3 AJ stated that it would be beneficial if the re-modelling of above-mentioned project delivery and realisation efforts were structured in ways which enhanced assurance by way of channelling specific data and information relevant to the PC&DC and other committees of the Board. Members discussed and were of the view that such remodelling would support assurance efforts specific to partner organisations too.

RESOLUTION: The System Resource Committee noted the Risk Management report and the Deep Dive.

7. Sharing and Learning from Productivity

7.1 JR described GHFT's approach to measuring productivity and presented comparative data and statistics relating to workstreams and overall productivity. JR explained that the GHFT model generally deviated from the NHS England productivity model to accommodate specific local needs. JR acknowledged that the NHS England model had the benefit of nationally standardising the calculation of productivity, but she reiterated that the GHFT model had the benefit of factoring in greater detail, the local dynamics. KJ re-emphasised that the GHFT model was informed by requirements specific to GHFT and the local system.

7.2 KJ reassured that GHFT model was comprehensive and reliable, and it had been endorsed by NHS England. AW highlighted that the methodology employed by GHFT included improved coding and extra productivity metrics. JR described the governance aspect associated with measuring productivity. This included oversight by the GHFT Finance & Resources Committee and other delegated sub-committees. JR highlighted that the GHFT model was a shift from the traditional silo method of managing productivity toward a more joined-up approach supporting system integration.

7.3 AW stated that GHFT was an active participant in the South West Productivity Working Group, and it helped shape the work of other Providers in the region. JMD commended GHFT's model and the sharing of information and knowledge promoted. SB stated that GHC employed a different model of measuring productivity, but the model still favoured a joined-up approach to HealthCare services and the harvesting of benefits deriving from information sharing within the system. SB promised to present the GHC productivity model at a future meeting. **Action: SB to present the GHC productivity model in December 2024.** **SB**

7.3 RESOLUTION: The System Resource Committee noted the GHFT Productivity report.

8. September 2024 Workshop

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8.1 JC introduced the discussion and stated that a full workshop would be held in September. She reminded members that the workshop would be preceded by a 45-minute System Resource Committee meeting. MG outlined the proposal for the workshop and clarified that the proposal was being brought back before members for further review. MG suggested that the workshop should investigate how the local system should best employ its resources.

8.2 JC also stated that the workshop provided members an opportunity to widen their perspective of system resource planning. JC emphasised a need to swiftly identify current sources of funding and prevailing resource allocation. JC added that this would be followed by realigning resource allocation with the Long-Term Plan and resulting annual plans.

RESOLUTION: The System Resource Committee noted preparations for the 5th September 2024 Workshop.

9. ICS Finance Report inc. Savings Plan & System Financial Risk Share

9.1 KJ presented and stated that the system's final Financial Plan submitted on 12th June 2024 showed a system breakeven, and this was comparatively better than the initial Plan which had projected a system deficit. KJ added that the change in planned position was underpinned by several planned actions to reduce expenditure, increase income, and increase elective recovery funding. KJ reassured members that all organisations continued to identify actions to mitigate slippage in Savings schemes and overspends in the budgets.

9.2 KJ stated that system performance was improving post-Covid, and this extended to areas of clinical coding. KJ highlighted partners' commitment to increased focus on Elective Recovery Fund (ERF). KJ stated that receipt of ERF remained key in system financial planning. KJ emphasised that good performance would not only de-risk the financial planning but could result in additional funding.

9.3 KJ stated that savings for the system were higher than they have been in previous years. KJ added that partners were further looking for unidentified Savings in each organisation to further reverse slippage. KJ described workforce as a significant driver of financial performance. KJ reassured that additional workforce controls were being implemented by each partner organisation and this included changes to processes to bring substantive staff into posts quickly, and better planning for bank and agency staff.

RESOLUTION: The System Resource Committee noted the ICS Finance report.

10. Items of Escalation from System Partners

10.1 There were no items to escalate.

The Chair proposed a five-minute break and members welcomed the break.

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The meeting adjourned at 3:45pm and reconvened at 3:55pm

11. Performance Report

11.1 MW stated that the system achieved year 2023-24 Elective Recovery Fund target and year 2024-25 performance was encouraging. MW also stated that NHS 111 performance had been a concern, but it had recovered by June 2024 and call performance target was being met.

MW stated that 62-day cancer performance continued to be an area of concern, particularly in urology and lower gastrointestinal (lower GI). MW reassured that improvement plans were being development to reverse slippage. MW added that the Health and Overview Scrutiny Committee was supporting process and the effort to reverse slippage within the cancer programme.

11.2 MW stated that diagnostic performance remained stable against the 6-week standard. MW also stated that areas seeing the highest of 6-week breaches remained the endoscopies, echocardiography, and audiology assessment.

MW expressed a concern that Emergency Department 4-hour performance remained an area of concern. MW added that Ambulance Category 2 performance also remained an area of concern but mitigation to reverse slippage was progressing well. ER concurred and reassured that transformation programmes were identifying gaps and improving delivery of health services.

11.3 ER explained that one significant challenge faced in the transformation exercise was the limited standardisation of tools and platforms within the local system. ER highlighted that this was having some impact on integration plans. ER stated that there remained some challenges in the area of hospital discharge but work continued with partners. ER described how the transformation programmes were expanding Home-based Care to mitigate hospital bed pressures.

11.4 MW reported good progress in reducing out of area mental health placements. MW explained that the system was experiencing increased waiting times for child and adolescent mental health services. He reassured that measures were being taken to reverse the slippage. KD concurred and added that local mental health check capacity was expanding, and this had been commended by NHS England.

RESOLUTION: The System Resources Committee noted the Performance report.

12. ICB Finance Report

12.1 SR presented and explained that the Annual Accounts for the ICB were signed off by the Board on 26th June 2024. SR highlighted that the Accounts received auditors' unqualified opinion. Members discussed the report and commended the Finance team's hard work.

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RESOLUTION: The System Resources Committee noted the Finance report.

13. Any Other Business

13.1 **There was no other business.**

The meeting ended at 5:00pm

Date and Time of Next Meeting: 5th September 2024

Minutes Approved by: System Resources Committee Signed (Chair): Prof Jo Coast Date: 5th September 2024