Gloucestershire Integrated Care Board Meeting

To be held at 1.30pm to 3.50pm on Wednesday 26th March 2025

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

Chair: Dame Gill Morgan

No.	Time	Item	Action	Presenter
1.	1.30 – 1.32pm	**Welcome and Apologies** *Welcome: Claire Procter (deputising for SF), Gemma Artz* *Apologies: Siobhan Farmer, Benedict Leigh, Ellen Rule*	Information	**Chair**
2.	1.32– 1.33pm	**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.	1.33 – 1.35pm	**Minutes of the meeting held 29th January 2025**	Approval	**Chair**
4.	1.35 – 1.40pm	**Action Log & *Matters Arising - updates***	Discussion	**Chair**
		Business Items		
5.	1.40 – 1.45pm	**Questions from Members of the Public**	Discussion	**Chair**
6.	1.45 – 2.05pm	**Patient Story – Virtual Ward TBC**	Discussion	**Gemma Artz**
7.	2.05 – 2.20pm	**Virtual Ward Programme Update**	Discussion	**Gemma Artz**
8.	2.20 – 2.35pm	**Chief Executive Officer Report**	Discussion	**Mary Hutton**
9.	2.35 – 2.45pm	**Board Assurance Framework**	Discussion	**Tracey Cox**
10.	2.45 – 3.05pm	**Integrated Finance, Performance, Quality and Workforce Report**	Discussion	**Mark Walkingshaw, Tracey Cox, Marie Crofts, Cath Leech**
		Decision Items		
11.	3.05 – 3.15pm	**ICS Data Strategy**	Approval	**Dan Offord Paul Atkinson**
12.	3.15 – 3.25pm	**Joint Commissioning Strategy for SEND**	Approval	**Ann James/Zoe Riley/Emilie Dawson**
13.	3.25 – 3.35pm	**Public Sector Equality Duty: Equality Delivery System 2 Progress Report**	Approval	**Tracey Cox**
14.	3.35 – 3.45pm	**Budgets (Revenue and Capital) 2025-2026**	Approval	**Cath Leech**
		Information items		
15.	3.45 – 3.50pm	**Chair's verbal & ARAC report from the Audit Committee** held on 6th March 2025 and approved minutes from December 2024	Information	**Julie Soutter**
		Chair's verbal report on the Primary Care & Direct Commissioning Committee held on 6th February 2025		**Ayesha Janjua**
		Chair's verbal report on the System Quality Committee 5th February 2025 and approved minutes from December 2024		**Prof Jane Cummings**
		Chair's verbal report on the Resources Committee held 6th March 2025 and approved minutes from January 2025		**Prof Jo Coast**
16.	3.50pm	**Any Other Business**	Information	**Chair**

Time and date of the next meeting

The next Board meeting will be held on Wednesday 28th May 2025 – 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)

Gloucestershire Integrated Care Public Board Meeting

To be held 2.00 to 5.00pm on Wednesday 29th January 2025

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
Dr Ananthakrishnan Raghuram	AR	Chief Medical Officer, NHS Gloucestershire ICB
Ayesha Janjua	AJ	Non-Executive Director, NHS Gloucestershire ICB
Cath Leech	CL	Chief Finance Officer, NHS Gloucestershire ICB
Ellen Rule	ER	Deputy CEO & Director of Strategy and Transformation, NHS Gloucestershire ICB
Kevin McNamara	KM	Chief Executive, Gloucestershire Hospitals NHS Foundation Trust
Jo Coast	JC	Non-Executive Director, NHS Gloucestershire ICB
Prof Jane Cummings	JCu	Non-Executive Director, NHS Gloucestershire ICB
Julie Soutter	JS	Non-Executive Director, NHS Gloucestershire ICB
Jo Coast	JC	Non-Executive Director, NHS Gloucestershire ICB
Karen Clements	KC	Non-Executive Director, NHS Gloucestershire ICB
Marie Crofts	MCr	Chief Nursing Officer, NHS Gloucestershire ICB
Siobhan Farmer	SF	Director of Public Health, Gloucestershire County Council
Sarah Scott	SS	Executive Director, Adult Social Care, Wellbeing & Communities, Gloucestershire County Council
Rosanna James *(for Douglas Blair)*	RJ	Director of Improvement and Partnership, Gloucestershire Health and Care NHS Foundation Trust
Participants Present:		
Carole Allaway-Martin	CAM	Cabinet Member for Adult Social Care, Gloucestershire County Council
Ann James	AJ	Executive Director Children's Services, Gloucestershire County Council
Benedict Leigh	BL	Director of Integrated Commissioning, Gloucestershire County Council
Mark Walkingshaw	MW	Director of Operational Planning & Performance, NHS Gloucestershire ICB
Helen Goodey	HG	Director of Primary Care & Place, NHS Gloucestershire ICB
Richard Smale	RS	Interim Director of System Coordination, NHS England, South West
Dr Paul Atkinson	PA	Chief Clinical Information Officer, NHS Gloucestershire ICB
Dr Emma Crutchlow	EC	GP and Director for Gloucester Inner City PCN
Martin Holloway	MHo	Senior Independent Director and Non-Executive Director, South Western Ambulance Service NHS Foundation Trust (SWAST)
Nicola de Iongh	NdI	Deputy Director, Gloucestershire Health and Care NHS Foundation Trust
Nina Philippidis	NP	Deputy Chief Executive and Executive Director of Corporate Resources, Gloucestershire County Council
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHS Foundation Trust
In Attendance:		
Christina Gradowski	CGi	Associate Director of Corporate Affairs, NHS Gloucestershire ICB
Ryan Brunsdon	RB	Corporate Governance Secretary, NHS Gloucestershire ICB
Dawn Collinson	DC	Corporate Governance Administrator, NHS Gloucestershire ICB
Lucy White	LW	Manager, Healthwatch Gloucestershire
Sarah MacDonald	SM	Senior Public Health Officer, Gloucestershire County Council
James Mitchell	JM	Senior Commissioning Manager, (Rehabilitation), Clinical Lead Therapist and Programme Lead for Neurology, NHS Gloucestershire ICB

1. Welcome and Apologies

1.1 The Chair opened the meeting by acknowledging the pressure that had been placed on the health and care system over the past two months dealing with pressures in Urgent and Emergency Care. She noted the phenomenal way in which the workforce had come together, to effectively manage a very difficult situation. The Chair extended thanks for this, with the hope that pressures would be relieved further and that the situation in the system would continue to improve.

1.2 The Chair then welcomed members present, including Nina Philippidis from Gloucestershire County Council. Apologies had been received from Douglas Blair, Graham Russell, Jo Bayley, Tracey Cox and Mark Cooke. There were two members of the public in attendance and the meeting was declared to be quorate.

2. Declarations of Interests

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

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

3.1 The minutes from the meeting held on 27th November 2024 were approved by the ICB Board members. The Chair and CGi had earlier discussed a process of effective management of the Action Log for future Board meetings.

4. Action Log and Matters Arising

4.1 The Chair and CGi had met to go through the action log with regard to all open actions and to ensure that as many of those actions were completed or had a short summary provided at the next Board meeting so that that could be reviewed and closed, where possible.

4.2 **27/11/24 Action 42: IPR. January 2025:** Item on January ICB Board agenda. **This item was closed.**

5. Questions from Members of the Public

5.1 One question from a member of the public around patient and public concerns and how the Board responded to them, had been received and was read out by MW, followed by a short response. A more detailed response would follow and would be published on the ICB public website:
https://www.nhsglos.nhs.uk/about-us/how-we-work/theicb-board/

"What assurance, and re-assurance, does the Gloucestershire Integrated Care Board, with all the sector partners, have that the patients/residents and public feel, be it actually or perceived, safe to speak up when they are in receipt of inadequate (perceived or actual) services, provided by all the partners within the Gloucestershire Integrated Care Board.

What robust measure(s) and demonstrable impact/outcome evidence does the Gloucestershire Integrated Care Board, with all the sector partners, have that patients/residents and the public feel, be it actually or perceived, actively seek/have from interventions, policies, strategies, programmes, plans, to provide this assurance and re-

assurance, internally and externally, that it is totally safe to speak up, at the time of their concern(s) and/or at any time thereafter?

How does Gloucestershire Integrated Care Board, with all the sector partners, confidently know their action(s) on this matter are making a positive and measurable difference to the lives of the patients/residents and public on how they do, or don't, confidently choose to speak up?"

5.2 MW stated that similar enquiries had been received by the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and the Board was pleased to have this opportunity to inform on some of the arrangements currently in place to enable members of the public to be able to speak up and raise any concerns:

1. **The Patient Advice and Liaison Service (PALS)** and customer care teams across the system were a well-used service and valued by the public.
2. A systemwide **Complaints Team and a Complaints Advocacy Team** was available to help the public address any concerns.
3. **Healthwatch Gloucestershire** looked at the experiences of local people and provided regular feedback to this Board and Committees across the system.
4. **Insight Outreach** work helped underserved communities to identify issues.
5. **The Friends and Family Test (FFT)** gave direct, timely feedback from service users.
6. **Local and national surveys** provided the ICB Board with helpful population feedback.
7. **The One Gloucestershire People's Panel** represented people who experienced greater health inequalities in Gloucestershire and encouraged people to speak up.
8. **Freedom to Speak Up Champions** helped with any issues raised by NHS staff.
9. **Quality** reporting was reviewed by the System Quality Group, the System Quality Committee and ICS partners for consistency and assurance.

5.3 DE commented that one other recently established route, through which people could raise concerns was "Martha's Rule" where Gloucestershire had been a successful pilot site. Further thought was needed as to how people could be empowered to raise concerns and to speak out when they felt they were not getting the best service, or receiving the right care. The acute trust would therefore be working closely with the ICB Board on this.

6. Patient Story on Parkinson's Disease

6.1 The patient story circulated in the pack of papers about Parkinson's Disease was read out by Lucy White from Healthwatch Gloucestershire, whereby a number of themes had been identified.

1. People had told Healthwatch that there was a lack of information being provided at the point of diagnosis, and at their follow-up appointments.
2. People had concerns about access and frequency of appointments, particularly with their neurologist.
3. People felt that the lack of coordinated and holistic care affected their overall experience and outcomes.

6.2 Actions to improve care for everyone:

- Patients and their carers should be signposted early on to gain appropriate information, help and advice about what to expect following a diagnosis of Parkinson's. Carers had said they often felt isolated and overwhelmed.
- Provision of a leaflet on 'What is Parkinson's' listing support groups, as well as the importance of diet and exercise would help. People could also be signposted to trusted websites or resources, enabling self-research.
- A simple leaflet listing contact details for professionals and organisations supporting people with Parkinson's would be beneficial. This should also include support with completing benefits applications.
- Appointments needed to be streamlined and needed to clarify the purpose, and who would be seeing the patient.
- It would be helpful if people could be given contact details of someone to talk to if they had any concerns in between their appointments.

6.3 KM responded that this feedback had been helpful and had enabled more thought about outpatients as a system regarding communications, expectations and efficiency, particularly around Patient Initiated Follow-Ups (PIFU). Some transformation workstreams were under review, one of which was Outpatients, that had shown that there were opportunities for improving utilisation and productivity and this along with others, would be examined over the next couple of years by the trust. KM offered to pick up some of the navigational aspects of the patient story offline if these had not yet been resolved.

6.4 AR would like to examine more formalised ways of ensuring appointments became more effective for patients, to enable them to control the management of their disease, many of which would involve long and complex journeys, thus their experiences needed to be as positive as they could be, during this time.

6.5 KC confirmed that she also had experienced inconsistency around the cancer pathways. Quite a lot of it had been around information provision, in particular the management of the condition; what happened when chemotherapy finished, and appointments became fewer and what the patient could do to support themselves. The patient journey needed to be examined from the patient perspective, as well as the clinical aspect.

6.6 Because research had shown that people were always worried about the unknown and it was knowing how to build this in ubiquitously for patients. People, according to their condition, would require different amounts of information and would have different needs. Certain levels of information were available for some conditions and not others and should become developed and standardised.

Resolution: The ICB Board members noted the Healthwatch patient story on Parkinson's Disease.

7. Neurology Clinical Programme Group (NCPG)

7.1 James Mitchell from the NCPG spoke about neurology (the presentation had been circulated prior to the meeting) and gave some background information on figures of those people nationally and locally who were living with neurological conditions. JM also detailed what Gloucestershire's acute and community services could deliver for neurology patients.

7.2 JM spoke about the aims of the NCPG, which were to have:

- More people having a positive experience of the care they received;
- More people assessed and diagnosed in a timely way;

- Lower waits for specialist neurological rehabilitation and nursing needs;
- A shorter hospital stay for people with a neurological condition;
- More people able to manage their condition (therefore a reduced need for emergency care services / crisis calls).

7.3 Neurology patients had mirrored the concerns of patients living with Parkinson's Disease and those key areas had been, or were currently being addressed:

- A simple leaflet listing contact details for statutory and voluntary organisations was now available to patients in outpatient clinics.
- The Parkinson's nurses and the integrated neurology specialist practitioner team were currently working with the appointment booking systems team in establishing good communication to ensure that patients were kept updated.
- Integrated group sessions, physiotherapy and signposting would be offered for those who were newly diagnosed with Parkinson's Disease, enabling people to manage their physical health.
- The Patient Engagement team and Healthwatch had already been working to co-ordinate a Patient Engagement activity, to understand and find the gaps around the broader experiences of those living with Parkinson's Disease.

7.4 JM spoke about some of the things that had been done to address neurology issues for patients, including the implementation of a multidisciplinary (MDT) countywide team, a dedicated point of referral, improved and consistent information resources, an offer of home-based therapy, telephone appointments, group therapy, virtual consultations as well as a proactive use of outpatient facilities.

There was also a formal collaboration with the voluntary sector with referrals often coming from and going into that service. JM had also led and co-ordinated the repatriations for those who were being treated out of county with brain or spinal cord injuries, and there was a dedicated budget to support high-level rehabilitation for those patients.

7.5 Patient experience feedback had been collated by the service since it started in October 2023, with 85% of people having rated the service as "very good" (42 responses in total so far). Other comments had been around how they had been treated with respect and kindness, time had been taken to assess their condition, and that they had felt safe and intrinsically part of their therapy.

7.6 Questions/Comments/Information

Q. What impact had chronic fatigue arising from Long Covid on the work being done **A.** *This was an area of work to be picked up in shortly with more deep dives to understand the longer term impacts, and would be reflected in the forthcoming Five Year Plan.*

Q. What was the baseline starting point for measurable programme outcomes and objectives? Would there also be leaflets for some of the other conditions such as Huntington's Disease and Multiple Sclerosis?

A. *The programme outcomes were in development and would become more refined, detailing better metrics around outcomes. The same would apply to trajectories over the next five years. Leaflets for all other conditions were hoped to become available for all relevant outpatient clinics. The Chair observed that although useful, the logistics of keeping leaflets relevant were often difficult.*

Q. EC asked what was the demand for unmet appointments within general practice? Was community neurological service available to primary care for referrals as it was unable to be found on G-Care. (To be picked up following the meeting). How was primary care involved in the MDT aspect?

A. *There was still some work to do around unmet demand, the pathway of which*

was starting to be scoped to map the journey, with primary care being involved in this. GPs were able to refer their patients to the service, which was relatively new, leading to a build-up of provision. It was hoped to receive recurrent funding for the service.

7.7 ER observed that questionnaires were available which patients could use to prepare prior to a consultation with a clinician, enabling a more fulfilling outcome, and addressing some of the data mismatches seen in the data. JM said Gloucestershire had been selected to be a pathfinder system based on some of the work done with the community and specialist practitioner neurology services. Work was much further ahead than that of other parts of the country and would be shared later on in the year, as part of the national guidance.

7.8 Discussion Points

- Stroke was a service by which consolidation of those services could quantify the impact on patients. In mainland Europe, intensive rehabilitation was a real model in the support of neurological conditions and employment, which would support the work already being undertaken by CPGs.
- Data depended on the type of contact that patients were receiving, most of which was led by the needs of the patient. It was good to see the multidisciplinary and psychological aspects of input for the service.
- Separately speaking to patients and carers following a Parkinson's diagnosis was important, as relationships between relatives often became abusive. This would enable further support for carers, who could choose potentially *not* to be a care-giver. JM said this was being examined with various groups and organisations, but he would note that important point, and ensure it was incorporated into the model.
- Impact and outcomes - could these also be examined from a cost benefit analysis, efficiency and effectiveness aspect.
- Thinking around where the ICB and specialist commissioning should work together.
- Evidence showed the best time to deliver life-changing information was a week following diagnosis. This was of benefit to both consultant, around appointment time and to the patient in terms of greater understanding.
- Children transitioning into adulthood often experienced gaps in services so how could those two strands of activity be linked? JM said a recent workshop was finalising the themes, recognising the importance of information sharing and ensuring clinicians and specialists were knowledgeable about their patients, who were likely to be at very different stages in their neurological journeys.

Resolution: The ICB Board members noted the information and presentation on the Neurology Clinical Programme Group.

7.9 The Chair requested that an integrated report on homelessness be brought to a future Board meeting. NdI said that she fully supported this having heard a very moving and inspiring story at the GHC's Board last week. There were so many aspects of homelessness, including those experiences of children and young people, which the Chair wished to explore at a future Board meeting. **Action: SF and BP to bring a report on Homelessness in the county, to a future Board meeting.** **SF/BP**

8. Chief Executive Officer (CEO) Report

8.1 The report included details of the recent Critical Incident declared on Wednesday 8th January 2025 in Gloucestershire. This decision was made following sustained pressure within the Urgent and Emergency Care (UEC) services experienced by both main hospitals, community services and South West Ambulance services. The system was experiencing significant winter pressures, and a full debrief would be concluded very shortly. All partners across the health and care system worked to the agreed Operational

Pressures Escalation Level (OPEL) 4 actions, alongside additional actions to enable the system to recover and continued to do so, after the Critical Incident had been stood down.

Other areas of note in the Report (which had been circulated prior to the meeting) were:

- Planning (Strategic Planning and Operational Planning)
- Reforming Elective Care for Patients
- Interim Procurement Strategy (for approval)
- Suicide Prevention Strategy 2024-2029 (for approval)
- 10 year Plan Engagement
- Working with People and Communities Update

8. Included in the CEO report were two important requests for approval from the ICB Board members:

1. Permission was sought from the ICB Board, responsible for approving the ICB Procurement Strategy, for a three month extension of the ICB's interim Procurement Strategy, from 31 March 2025 to 30 June 2025;
2. The ICB Board was asked to adopt the Suicide Prevention Strategy 2024-2029.

Resolution: The ICB Board members:

1. ***Approved a three month extension to the ICB Board's interim Procurement Strategy from 31 March 2025 to 30 June 2025.***
2. ***Approval given to adopt the Suicide Prevention Strategy 2024-2029.***

9. Board Assurance Framework (BAF)

9.1 MH reminded members that Committees each had a cut of the BAF and Corporate Risks so that their meetings could set the frame and tone to ensure that those risks were being cross-checked and dealt with as the agenda items in the meetings.

9.2 Following this, the BAF would be updated, and this would be ready for the March 2026 Board. Proposed amendments had been annotated in red with changes outlined with one change in the risk score and a number of changes due to reviews which were set out in the body of the Report.

9.3 JS had been party to some excellent discussions around the BAF mapped to individual Committees who could then give their respective assurances to the Board. The Audit Committee went through the BAF and Corporate Risk Register in a very robust way every quarter, to make the BAF more meaningful. Some of the feedback would be examined in March from the Committees which would be forming some of the discussions going forward and would enable the Audit Committee to pick things up and to follow things through.

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

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

10.1 *MW updated on Performance:*
Before commenting on the main Performance Report, MW highlighted the National ICB Capability Assessment Pilot which Gloucestershire had taken part in. It was noted that this was a new way of assessing the performance of ICBs across England. The pilot phase had been completed and confirmation was awaited around the shadow rating, as a system. Early informal feedback had been very positive, although there were some areas of improvement which had been identified which would be addressed in advance of the national launch of the new process.

10.2 Other Performance highlights:

- Planning guidance was awaited which would provide the national performance standards for the coming year.
- Dementia Diagnosis Rates Performance – It was the aim, as part of performance recovery since the pandemic, to increase dementia diagnosis rates with targeted work underway in localities to increase those rates.
- Units of Dental Activity (UDA) delivered showed that 70% of contracted volumes had been delivered in 2024/2025 to date, thus meeting the operational planning target recognising that there is much work to deliver on dental access.
- There had been some stabilisation in UEC services which had seen significant impact from the usual winter viruses and seasonal infections. It was noted that this had affected bed capacity across the system. Ambulance handover performance reporting also indicated that the position had begun to stabilise.
- The national focus upon elective recovery meant the ICB needed to continue to reduce the overall waiting list size whilst delivering against the ICB's financial plan. It was recognised that this would be challenging.

10.3 *MW updated on Workforce*

- There had been a number of events across the county as set out in the report with some promising numbers attending the "We Want You" campaign.
- There had been a recent appointment of a Housing Officer who was developing a local staff housing needs survey, to understand the demand for housing amongst all staff groups across the system.
- A further £90k had been allocated as part of the national "Work Well" initiative which was about offering support to those living with a disability and those with long term health conditions to start, stay and succeed in work.

10.4 *MCr updated on Quality*

- The Quality Improvement Group (QIG) was continuing to meet every two weeks and was chaired by MCr with stakeholders across the system including KM and leaders in the maternity service. Significant progress had been made and two out of seven workstreams had been stepped down to Business as Usual. A new regional Chief Midwifery Officer had been appointed in November and had visited the acute trust, linking in with the Director of Midwifery and others.
- A new Primary Care Patient Safety Strategy had been launched with Hein Le Roux leading on this. One of the local practices had offered to pilot this to see what this means to Primary Care, which would be supported by the ICB and NHSE.
- There had been an increase in Quality Alerts, so a process is being developed around where these are dealt with, and they will link in with the new Patient Safety alert system as it progresses.
- A national report which came to the last System Quality Committee meeting around the Patient Safety Incident Response Framework (PSIRF) which detailed recommendations and insights over the last year since it had been developed. It was intended to examine individual organisational plans which were in place, to see what the system as a whole should be focussing on.
- A QIG chaired by AR was continuing to examine the Summary Hospital-Level Mortality Indicator (SHMI). AR informed that good progress was being made and levels had continued to drop for three consecutive months. While the data remained outside of control levels and the impact on the 12 month rolling data was small, the monthly data showed that in August the SHMI was 1.07. This much lower SHMI will pull through to the official data over the next 12 months. Coding and care aspects were being examined to try to make the changes in the county.

10.5 DE asked whether there was some value in using an after event review perspective to think about the Safety Patient implications around the Critical Incident review; particularly around operational pressures, where there were long waits and increasing mortality rates. There could be some value in adding a patient safety lens into the review.

10.6 AR responded this had been raised at the QIG. The hospital examiners would be looking at deaths during the critical incident. Deep dives would examine particular areas of impact. There was certainly an increase in mortality but the questions were:

- What was it about that wait that was causing that mortality?
- What could we do whilst that wait had to be reduced?
- Were there aspects of care that needed to be done to reduce mortality?

10.7 ER replied that reviews used a focus of Delay Related Harm and Quality, which would also be the lens for this latest review.

10.8 *Maternity Update*

KM stated that it would be important following a review of the critical incident that the sysem did not become complacent as some very long waits were still contirbuting to harm, not only in the acute trust but in other areas of the system. Some work around a dynamic risk assessment had started during the critical incident, to adapt risk appetite and thresholds, when high risk of harm was being seen. There were further opportunities to be able to develop this.

10.9 MH reported that a recent Health Overview and Scrutiny Committee (HOSC) meeting including the ambulance service, had discussed the critical incident. It had been important to understand the triggers which showed that the system was entering a difficult delivery position and what could be actioned to aid recovery. MH thought that the focus of the review should be on those key issues only, and not to try to encompass everything that had happened during that particular period.

10.10 The Chair observed that Christmas was always a problem for the health service and the dynamics of what was happening around those public holidays and when they fell, needed to be better understood and mitigated, which could help with future planning.

10.11 ER gave assurance around comprehensive winter planning. What was being tested and to what extent those plans fully materialised, which was where some of the gap analysis would come in. Events had arisen for varying reasons, and this was what the review would be examining.

10.12 KM reported that the Trust had been asked if it wanted to be part of a national programme to go further faster around Elective Recovery. Last week the number of those waiting for 52 weeks was down below the 1000 mark which was a significant milestone, with the aim of holding onto that momentum going into next year, conscious of all the constraints which might come out in the planning guidance.

10.13 KC commented that she had read the paper from the Government on Elective Care, saying it would be good to hear what the ICB could do next, as guidance from the centre did not appear to be suggesting that the ICB do anything further than that which had already been put in place. The Chair suggested bringing some of the work on productivity and how this could be approached differently, to the Board at a future meeting. A future Board Development session would take some time to explore a recent document for ICBs from centre about reporting on these sorts of things. Another similar document had also come out and the Chair wanted to explore whether they were coming from the same perspective.

10.17 *CL updated on Finance*

- As at Month 9, the ICB was forecasting a break even financial position, but this was contingent on continued close management of the position, in Continuing Health Care (CHC), placements budgets and other contracts. Ongoing mitigations continued to be progressed with the risk to delivering the break even position remaining high.
- Agency expenditure was £1,374k. The year-to-date expenditure vs. the total pay bill was 2.7% for GHFT and 2.1% for GHC, so well within the cap, which would be even lower in the new financial year.
- Although significant issues were not being seen as a system, GP Collective Action remained a risk and it was likely that financial issues would be seen arising from this, next year.
- The Elective Recovery Fund (ERF) was under-delivering – the ICS plan was 118% and the forecast was currently 115%. ERF for next year would be capped so it was important to improve performance both within the independent sector and out of county providers as well as in GHFT, working within maximum tariff to improve the position.
- The year-to-date system cash position was positive against the plan. The GHC position was close to plan, the GHFT position slightly better than planned. There would be a focus on cash in one of the the Audit Committee meetings in the new financial year.
- In terms of 2025/2026, planning would be rolled forward from 2024/2025, although planning guidance had not been received. There were a number of recurrent cost pressures coming through which had automatically worsened the financial position going into that year.
- Delivery of savings would be a key focus to manage demand and avoiding cost growth.
- Two new significant NICE Technology Appraisals (TAs) were in progress and would lead to large financial costs for all ICBs both in terms of drug and service costs. A new mental health White Paper would also bring significant costs.

10.18 KC referenced The Working as One (WaO) programme savings which were now forecast to slip. KC asked if this could be realised or whether it had already gone. CL responded that this was being worked through and would not be delivered in this financial year; however there was ongoing work within the programme to see whether it could be realised next year, and if so, what the value would be. The Chair confirmed that there would be a session on WaO whereby a cash conversation needed to be set alongside the other benefits conversation.

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

11. Health Inequalities Framework

11.1 Mark Walkingshaw (MW), Sarah MacDonald (SD) and Siobhan Farmer (SF) presented slides on this subject.

11.2 MW stated that the Joint Forward Plan clearly articulated the ICB's commitment with Health Inequalities (being one of the 10 strategic priorities aligned to the 3 pillars of the Integrated Care Strategy) was to improve health equity. Additionally, the existing plan set out the commitments, including introducing the Health Inequalities Framework and embedding work to reduce health inequalities into the transformation programmes.

11.3 This presentation described a framework for tackling health inequalities in Gloucestershire through a two-step process.

Step One:
This was described in Slide 5 which incorporated three components (contributory activity, targeted intervention to improve health and remove barriers and improving the equity of mainstream service delivery).

This would seek to:

- Support a more strategic and systematic approach to tackling health inequalities.
- Identify the different 'categories' of activity needed to deliver transformational change and ensure health equity is embedded across all we do.
- Enable the system to understand the contribution that different parts were making to health inequalities.

11.4 **Step Two:**
The second step was a Health inequalities strategic planning and review process which encompassed strategic self-assessment and objective setting and a review of progress and learning.

The purpose would be to:

- Support implementation of the Framework and prioritisation of activities to address health inequalities.
- Assess and understand contribution to the wider system approach for addressing health inequalities.
- Provide assurance to Board that each part of the system was contributing to the Heath Inequalities Framework.
- Identify where progress is being made and where there were opportunities to stretch further.

11.5 SM reported that feedback had been received from organisations and partnerships to give their key objectives around health inequalities and what they would be focussing on over the coming year. Responses were received at the end of October 2024 and some time was spent reviewing those.

11.6 SM stated that it was important to have this framework and process to ensure that the ICS were embedding the full range of health inequalities work and that there was a balance across those three themes. Each partnership had been asked to identify four or five objectives but had chosen many more. Many had been operational rather than strategic, focussing on projects of pieces of work and it was difficult to make those objectives smart or measurable or to identify outcomes that would specifically link to the system health inequality outcome measures.

11.7 It would need further thought around supporting partnerships to be smarter when thinking about how to track their progress around what they were doing regarding health inequalities or whether there were more appropriate ways of monitoring effectiveness, which would relate more to Themes A and C.

11.8 The process had been successful so far in pushing health inequalities, but the process had also highlighted some areas which needed to be built on. The programmes and services needed to be engaged and represented in the returns and it would make sense to have some shared strategic objectives around the improvement of health equity. The Strategic Planning Review process tool needed to gather the right level and quality of information needed to provide assurance that each part of the system was contributing to collective efforts around improving health equity.

11.9 Rosanna James stated that colleagues would be happy to promote the work externally and that strategic lens for the framework was very much what Douglas Blair was seeking as opposed to the operational aspect. It was noted that Douglas Blair was fully supportive of the recommendations being made today.

11.11 Interest was expressed in the outcome measures mentioned, and a question was asked as to whether these were part of the Outcomes Framework being developed as a system. Another question was around the link between the outcomes that had been identified for the Health Inequalities, and the actions and objectives. Was a logic model approach being used and was the list going to be one of very targeted things being done to improve outcomes.

11.12 SM responded that the aim was to look at how those activities were achieving the objectives and how they would explicitly link to the system outcome measures. The information on the returns would be taken away and looked at prior to launching the process to ensure that enough of the right information was being received. Not everything could be linked to a quantitative indicator, but it was about examining and monitoring whether those differences were being achieved.

11.13 DE thought this was very encouraging, and discussions had been taking place at GHFT about priorities and actions. Development work needed to be cross-cutting and would involve different organisations. DE spoke about Foetal Alcohol Syndrome for example, where any baby born with this would have lifelong issues. DE was sure that differences could be made in early interventions in raising awareness of different health issues if resources in the system could be used more constructively.

11.14 SF pointed out that Theme C spoke about capacity in the services being delivered day to day and although not everything could be picked up, SF had spoken with colleagues and alcohol was one area to be examined, which did connect into Foetal Alcohol Syndrome.

11.15 MCr mentioned people with Severe and Enduring Mental Illness (SMI) where high numbers of people were still smokers and felt this group should be targeted. In terms of maternity, Black women and their babies in particular had much worse outcomes compared to any other groups. Children in care also often had multiple disadvantages.

11.16 The Chair summarised by saying it was important for the process and the people making decisions around the content to be trusted in this co-creation model. It needed to be understood what people's responsibilities co-creation and there were around would be learning from this process around how the ICB worked as a system and what mutual obligations were. This work would be developed collaboratively, the learning would be collaborative but the things that did work could be applied to other joint working across the system.

11.17 The Chair was very pleased with this strategic approach around Health Inequalities which was putting all parts of the system in the right place rather than any one organisation assuming primacy. The Chair thanked all those involved for their work.

<u>Resolution</u>: The ICB Board members :

- ***Confirmed the level of detail needed from the strategic planning (objective-setting) process, e.g. high-level strategic versus operational objectives;***
- ***Championed the Health Inequalities Framework, strategic planning and review process, to ensure engagement with programmes/services to obtain a clearer picture, enabling the process to be become embedded.***

12. Audit Committee Terms of Reference

12.1 The updated version of the Audit Committee's Terms of Reference had already gone through the December Audit Committee and reflected that the Audit Committee reviewed items on procurement on a regular basis, which was the main change.

Resolution: The Board members approved the updated Terms of Reference for the Audit Committee.

13. Committee Meeting Updates

13.1 **Chairs verbal and ARAC report from the Audit Committee** held on 5th December 2024

13.1.1 KC had chaired the September meeting and JS had been happy with those minutes. The discussion in December's Audit Committee discussed BAF 5 with a request for Executives to review this. CGi had been working with governance leads in each of the trusts to look at risk ratings and how risk management was progressing. The Chair noted that County Council mechanisms around risks were very different and suggested CGi and CAM discuss this following the meeting.

13.2 Chair's verbal report on the Primary Care & Direct Commissioning Committee held 5th December 2024 and approved minutes from 3rd October 2024

13.2.1 A deep dive had taken place on risk and the length of time risks had been recorded on the Corporate Risk Register. The Committee discussed and agreed actions arising from this around mitigations and controls for risks and it had been a very positive exercise.

13.3 Chair's verbal report on the System Quality Committee held 5th December 2024 and approved minutes from 2nd October 2024

13.3.1 Risks were discussed at the meeting. The Infection Prevention and Control Action Plan was reviewed and approved as well as the LeDeR Annual Report, which had included a presentation from Experts by Experience which had been valuable.

13.4 Chair's verbal report on the Resources Committee held 5th September and approved minutes from 7th November 2024

13.4.1 There was a virtual meeting in January which AJ had chaired. There had been discussions around the Health Inequalities internal audit report which highlighted issues around governance and reporting. It had been agreed that the Committee would have this as a standing item on the agenda. The ICS Data Strategy was discussed which had revealed gaps around where it had been shared. There had been an update on Specialised Commissioning recognising that this was the start of that exercise.

13.5 Chair's verbal report on the People Committee held 16th January 2025 and approved minutes from 17th October 2024

13.5.1 KC stated there was nothing to report from the October meeting. The January meeting focussed on workforce and productivity where the tool for this did not cover GHC only focussing on the acute sector, so more work would be undertaken to look at measuring productivity more proactively. The "We Want You" programme had received interactions

from nearly 1500 young people and KC had received unprompted positive feedback from an Academy Trust that had multiple schools in the county about the quality and thought about what was being delivered. There was a presentation around thinking about the widening of the pools that the ICB recruited from, and how perhaps the NHS application process could be streamlined.

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

14. Any Other Business

14.1 There were no items of Any Other Business brought for discussion.

The meeting concluded at 5.00pm. .

Time and date of next meeting

The next Board meeting will be held on Wednesday 26th March 1.30– 4.15pm
Virtually and at Shire Hall, Westgate Street, Gloucester GL1 2TG

Withdrawal of the press and public

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

(Commercial in confidence discussions)

Agenda Item 4

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

No.	Date Raised	Reference	Owner	Action	Due	Updates	Status
20	Jan 24	**Min 8.18 P2 beds/EoL/Dying Matters**	**SQC**	SQC to bring back a report on P2 beds/EoL to a future Board meeting.	**March 2025**	P2 beds/EoL/Dying Matters. To be reported through the SQC minutes in November / Feb minutes to be reported to the Board in March 2025. Action Open	**To be Closed**
21	Jan 24	**Min 10.12 LMNS membership and functionality**	**Marie Crofts**	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.	**Nov 24**	Review of LMNS remained ongoing which included the ICB CNO and Regional Colleagues. Review completed and there is a revised set of priorities agreed with LMNS with GHFT and ICB. This action is complete. Closed.	**To be Closed**
34	July 24	**Min 7.25 – Interface discussion -secondary and primary care**	**PMO**	Interface discussion to be tabled for a future Board Development meeting, date to be confirmed.	**April 2025**	This item is included on the April Board Development agenda.	**Open**
39	Sept 24	**Min 11.3 – Reporting for the One Plan for Children and Young People in Glos**	**Ann James**	AJ to confirm reporting arrangements for the One Plan for all Children and Young People in Gloucestershire at the next Board meeting.	**Nov24**	Verbal update to be given	**Open**
40	Nov 24	**Min 3.9 Asthma Friendly Schools**	**Siobhan Farmer**	SF to ask members of her team to link in with DF and GA to make connections with school nurses and DF to connect in with the Clean Air Officer in Cheltenham.	**Jan25**	SF has linked with Gemma Artz. **Action Closed.**	**To be Closed.**
43	Nov 24	**Min 10.6 IPR**	**Mark Cooke / Richard Smale**	MCo to raise the position of Out of County Placements in Gloucestershire at a forthcoming meeting with senior colleagues and report back to the next Board meeting in March 2025.	**March 2025**	MCo to provide a verbal update to the March ICB Board	**Open**
44	Nov 24	**Min 10.8 IPR**	**Mark Walkingshaw**	To include a concise and focused session on the Insightful Board in a Board Development session	**Feb 2025**	This item has been rescheduled for the April Board Development session.	**Open**

45	**Nov 244**	**Min 12.10 Review of Intensive and Assertive Community Treatment for People with SMI**	**Siobhan Farmer**	SF to bring an information item to the Board at a future meeting, along with a patient story around multiple mental health needs. SF also to recirculate The Kings Fund Report conducted about 18 months ago.	**TBC 2025**	Liaising about a date for a paper/presentation on multiple mental health needs and also to identify a patient story. The report was sent out with the papers for the meeting.	**Open**
46	**Nov 24**	**Min 14.13 EPRR**	**Marie Crofts**	EPRR to be placed on a future Board Development session**.**	**Autumn 2025**	This will be scheduled for the Autumn Board Development Session.	**Open**
47.	**Jan 25**	**Min 7.9 Homelessness**	**Siobhan Farmer**	SF and BP to bring a report on Homelessness in the county, to a future Board meeting.	**TBC 2025**	The Kings Fund Report into SMD in Gloucestershire also covers homelessness.	**Open**

One Gloucestershire
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NHS Gloucestershire

NHS Gloucestershire ICB Board
Wednesday 26th March
Agenda Items 6 & 7

Virtual Ward Staff and Patients tell their story
March 2025

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

Hear from the Virtual Ward Team

https://youtu.be/t-Ludxu5Z-I

2

Acute General Medicine Virtual Ward

Female aged 75 with recurrent UTI

Rapid Response contacted Virtual Ward Hub, who arranged Acute Medical Unit (AMU) admission for Hypokalaemia

Discharged from AMU supported by tech-enabled Virtual Ward & Rapid Response

Virtual Ward Stay

Shared care pathway with Rapid Response

Directly admitted to AMU

Regular communication between Virtual Ward Hub and patient supported by remote monitoring

Bloods take by Rapid Response in the patients own home

Learning

Coordinating care and communication was essential for a successful admission and stay.

If Rapid Response had not made contact with the Virtual Ward Hub, this patient may have ended up as an ED presentation and subsequent admission.

Discharge was supported by sharing care between VW and Rapid. The patient felt supported and fed back that they were grateful to the seamless care from all involved.

Acute General Medicine Virtual Ward

Male aged 82 with Dementia

Referred to Ambulatory Emergency Care (AEC) via GP Cinapsis

Referred to Virtual Ward from AEC

Patient's preference was to remain out of hospital

Virtual Ward Stay

Patient stayed on the acute general medicine virtual ward, remaining out of hospital and avoiding possible deterioration and deconditioning.

IV antibiotics and bloods were facilitated by Rapid Response in the patients own home.

Learning

Use of remote tech was difficult for this patient so home visits were imperative for monitoring.

Strengthening home visit options for Virtual Ward patients is central to Virtual Ward growth and holistic care.

Development of admission avoidance pathways from the community would have benefited this patient

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NHS Gloucestershire

Virtual Wards Update

ICB Board

26th March 2025

@NHSGlos
www.nhsglos.nhs.uk

Part of the One Gloucestershire Integrated Care System (ICS)

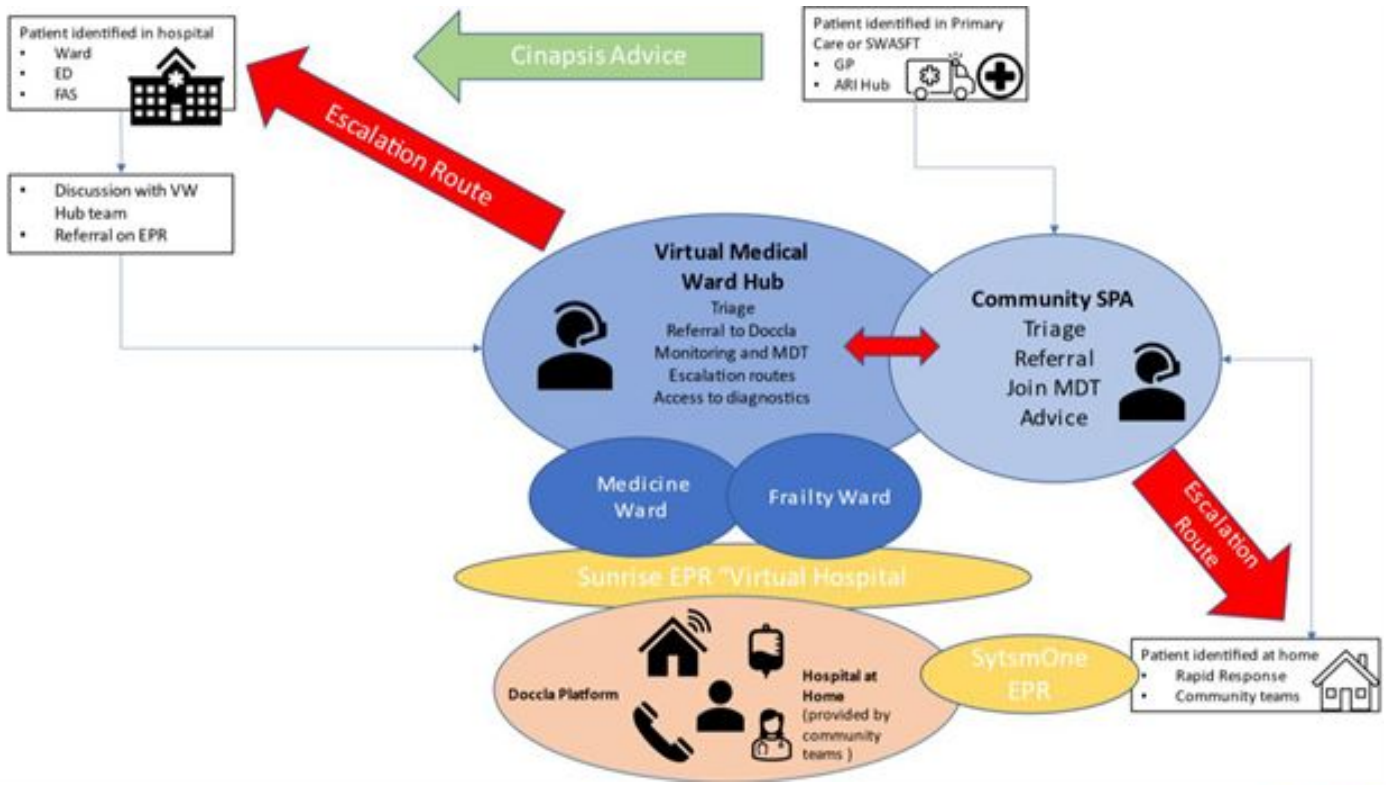
What is a virtual ward?

- A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology.
- Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home.

Functions	Why?	Who?	Referral sources	Core components across both functions	Key outcomes
Step-up Alternative to attendance or admission	• Alternative to hospital attendance/ admission, enabling provision of care ideally without individuals having to leave home	• Acutely unwell patients deteriorating in the community – may be known to services and would otherwise be (re)admitted to hospital	• Care homes • 999/111 • SPoAs/ ICC • UCR • Primary and community care • ED/SDEC	• Effective governance and clinical leadership, with consultant physician/consultant practitioner/GP oversight • Operating hours (8am-8pm, 7 days a week at a minimum) and out -of-hour provision • Clear admission criteria and assessment processes • Personalised care and support planning and shared decision-making • Daily board rounds incl. a senior clinical decision - maker, medical input and the wider MDT • Hospital-level diagnostics • Hospital-level interventions and treatment • Technology-enabled care, incl. remote monitoring • Pharmacy, medicine reconciliation and optimisation • Clear discharge processes, including monitoring of length of stay	• Hospital attendance and admission avoidance • High-quality comprehensive assessment, and treatment • Improved recovery following period of acute illness or injury • Positive experience of care at home • Patient safety and protection from avoidable harm
Step-down Earlier transfer from an inpatient ward	• Enables early discharge from inpatient wards when not medically optimised to go home without medical support	• Patients in hospital who are not medically optimised for discharge but on recovery trajectory that can be managed via a virtual ward	• Hospital inpatient wards • Transfer of care hubs	**Clinical pathways supported :** • Respiratory • Cardiac • Frailty • Paediatrics • General medicine	• Reduction in hospital length of stay • High-quality comprehensive assessment, and treatment • Improved recovery following period of acute illness or injury • Positive experience of care at home • Patient safety and protection from avoidable harm

Gloucestershire model development

- Sought to build on existing services.
- Prioritised the development of an integrated model that delivers patient-centred solutions
- Developed both medical and surgical pathways that have tech enabled and non tech options.
- Iterative approach employing a "test and learn" methodology



Growing service over winter 24/25

- Development of an integrated hospital at home service across Rapid Response and Virtual Ward Medical Hub teams to deliver a community component to the virtual ward pathways.
- Co-designed with the rapid response team and the virtual ward hub team it was agreed that there was real potential in developing a hospital at home team, who would deliver the community activity following specialist assessment either by the VW hub team or the rapid response practitioners.
- 73 patients supported by Hospital at Home in Jan & Feb 2025 most patients sat on the frailty and general medicine virtual wards
- Increased consultant cover to support over weekends to make the most of this opportunity and offer a genuine 7 day service.
- Consistency of service availability has been key to build the momentum of referrals to the virtual wards as a key service component.

Building a systemwide solution

- Moving towards a condition agnostic model will allow flexibility within the virtual ward capacity and will ensure that any patient who is suitable for care at home, is able to access the virtual ward.
- Integrating a community offer with this condition agnostic model to build on the learning from this winters pilot.
- Ensuring connection with existing services and how the virtual ward differs from current offers is clear.
- Clinical responsibility and governance within an integrated model is a key enabler.
- System access and visibility has been a barrier that are seeking a system solution for.
- Developing a systemwide pharmacy solution.
- Focussed on prevention in the long-term building a closer relationship between telehealth and virtual ward to provide a continuity of care.

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Appendices

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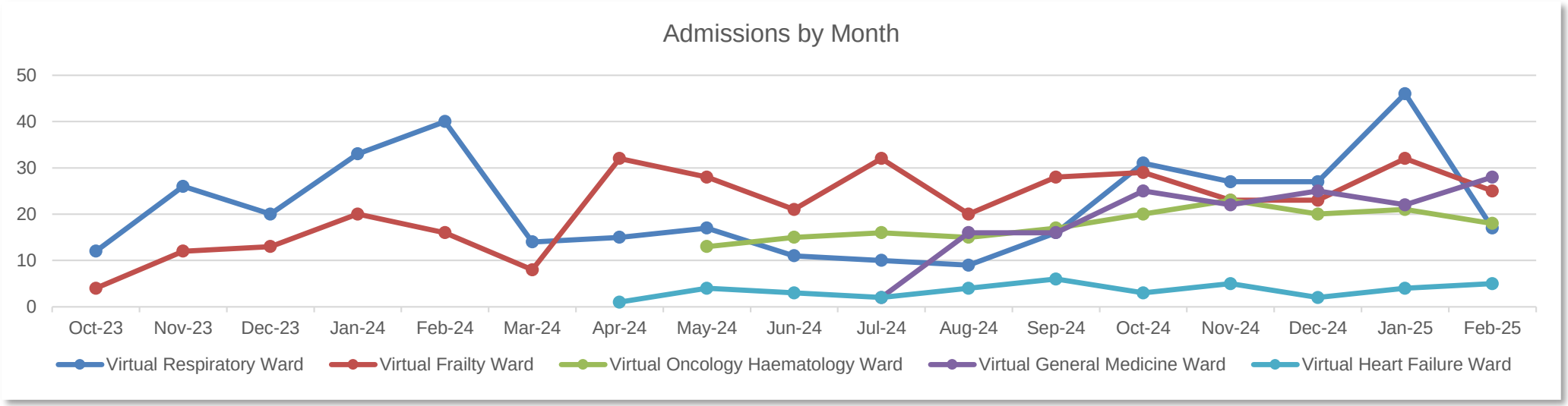
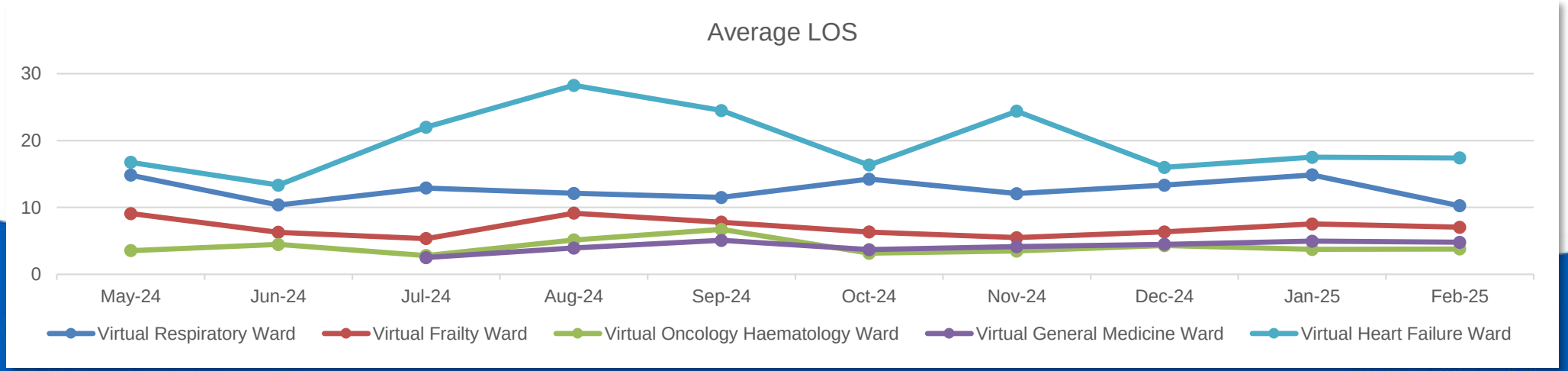
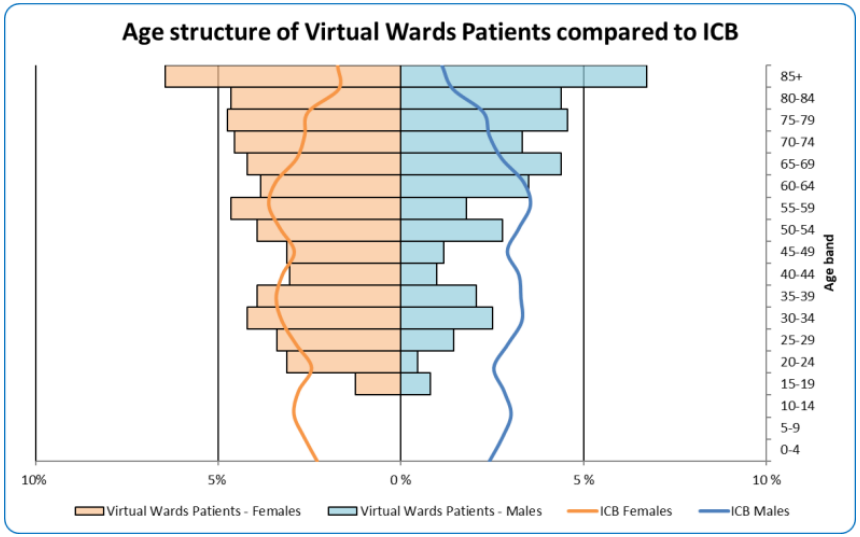
Part of the One Gloucestershire Integrated Care System (ICS)

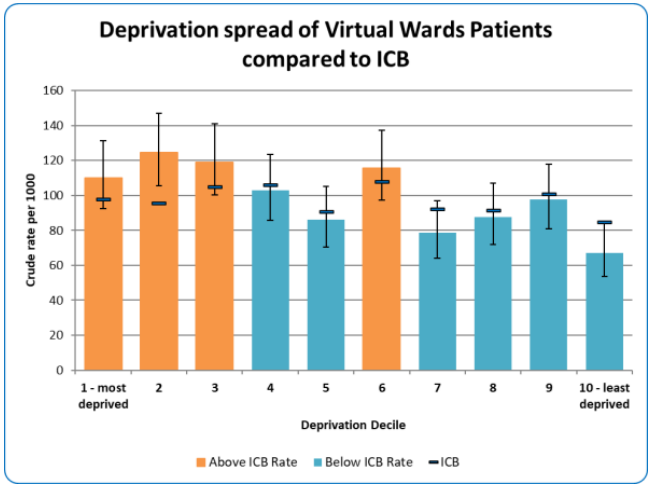
Activity

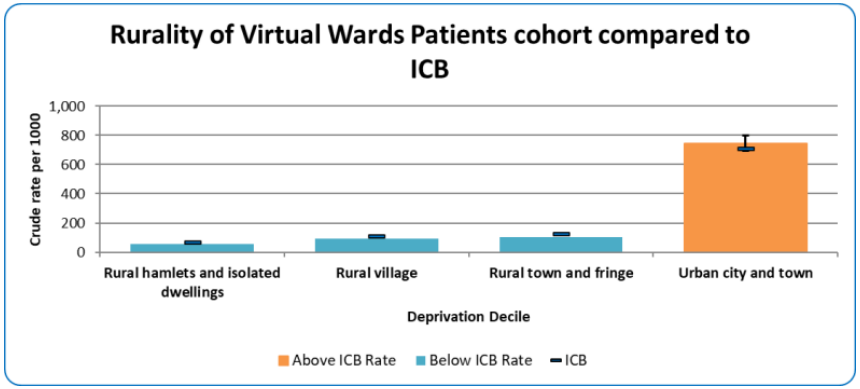

Admissions by Month
50
40
30
20
10
0
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Virtual Respiratory Ward
Virtual Frailty Ward
Virtual Oncology Haematology Ward
Virtual General Medicine Ward
Virtual Heart Failure Ward

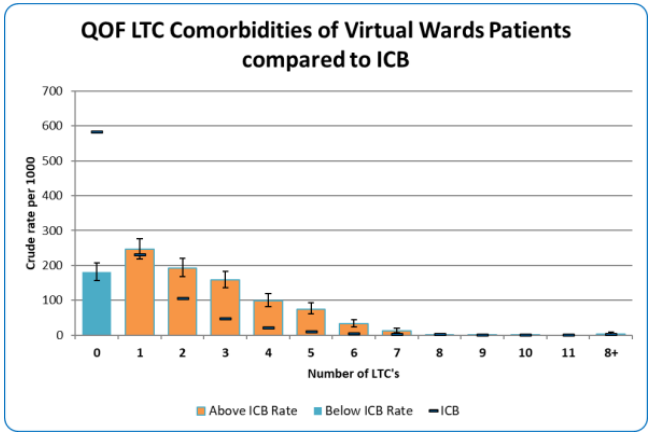

Average LOS
30
20
10
0
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Virtual Respiratory Ward
Virtual Frailty Ward
Virtual Oncology Haematology Ward
Virtual General Medicine Ward
Virtual Heart Failure Ward

Virtual Ward Demographics









The age structure of the cohort trends older than the ICB average with some additional spiked among females of younger ages.

There are higher rates of patients from deprivation deciles 1,2,3 and 6 though this is only significant in Decile 2.

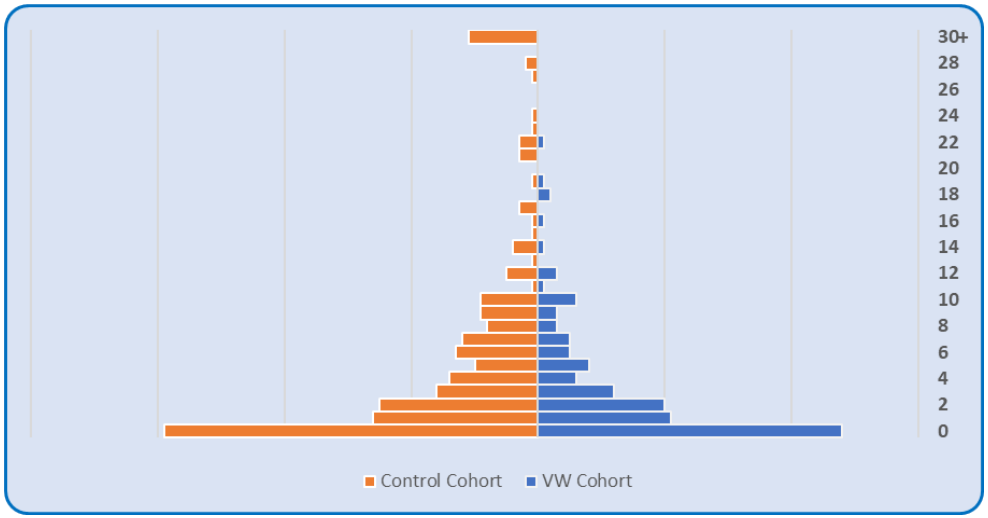
We are seeing patients in virtual wards at a higher rate from Urban and city backgrounds.

Typically, higher rates of patients with multiple long-term conditions are seen in the Virtual Ward.

7

Length of Stay analysis – Deeper look

	Number of admissions		Proportion of admissions	
	VW Cohort	Control Cohort	VW Cohort	Control Cohort
0 Days	48	59	31.8%	24.6%
1-7 Days	77	116	51.0%	48.3%
8-14 Days	17	37	11.3%	15.4%
15-21 Days	4	9	2.6%	3.8%
22-28 Days	1	8	0.7%	3.3%
> 28 Days	4	11	2.6%	4.6%
Total Bed Days	**718**	**1683**		
Total Admissions	**151**	**240**		



The virtual ward cohort has a significantly lower number of admissions in the 12 months following induction onto a virtual ward when compared with a control cohort, using a matched emergency admission as their start date. There was also a difference in the length of stay between the two cohorts. with 2.6% of the emergency admissions in the VW cohort being greater than 28 days compared with 4.6% in the control cohort.

A T-test conducted on the results shows a **Significant Difference** between the two samples. **P=0.0000201**

NHS at HOME
VIRTUAL WARDS

NHS

Patient Leaflet Virtual Wards

One Gloucestershire

Who is this leaflet for?

If you have been offered treatment on a virtual ward this leaflet explains the support and monitoring that you will receive.

What is the Virtual Ward?

A Virtual Ward allows you to get the care you need at home, safely and conveniently, rather than being in hospital. Being in familiar surroundings, with your own routine, whilst still receiving the monitoring that you require, supports your overall recovery.

Whilst on a virtual ward your care plan will be personal to you. You will receive an at-home monitoring kit. Depending on your care plan you may also receive regular phone calls, be visited in your home or asked to visit a health care setting.

Everything contained in your at-home monitoring kit will be used to submit readings and will keep us informed each day on how you're feeling. This helps health and care professionals to monitor your progress and ensure that you are getting better.

Our at-home monitoring kits are supplied by our partner Doccla. They will contact you by phone after you've received your kit to explain how everything works and will support you to set up and use the equipment for the first time.

Your clinical team

Whilst you are on the Virtual Ward you will be looked after by a team of health and care professionals from:

- **The Virtual Ward Hub Team** who will coordinate your care and are on the end of the phone 8am to 6pm 7 days per week.
- **Specialist Hospital Teams** who may have cared for you in hospital or as an outpatient.
- **Community Care Teams** who may have supported you at home before.
- **Doccla** who will help you set up your kit and contact you to check how you are.

These teams will work together to deliver your care and will contact you regularly to check that you are getting better.

Contact details

The Virtual Ward Hub Team
For queries or concerns on **0300 4223962** between 8am and 4pm or **07812 709855** between 4pm and 6pm, 7 days a week.

After 6pm or in an Emergency
Please contact **111** or **999**.

Doccla
If you have queries related to your Doccla kit, please contact the Doccla Customer Care Team on **0808 175 0832**.

Being discharged from the Virtual Ward

The decision about discharge from the Virtual Ward will be made between you and the teams supporting you and will only take place once it's clinically safe to do so.

Once you have been discharged from the Virtual Ward, Doccla will arrange to come and pick up the at-home monitoring kit from you. Your GP will receive a discharge summary about your time on the Virtual Ward and any ongoing care.

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9

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting

Wednesday 26th March 2025

Report Title	**Chief Executive Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X				**X**		
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.						
Executive Summary	This report summarises key achievements and significant updates to the Integrated Care Board. This report is provided on a bi-monthly basis to public meetings of the ICB by the Chief executive Officer.						
Key Issues to note	This report covers the following topics: • **Asthma + Lung UK ICS Respiratory Review 2024/25** • **We can move: Transforming Physical Activity and Health Across Gloucestershire** • **Joint Forward Plan** • **Operational Plan** • **Carers update**						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The report references a number of different services, schemes and initiatives with associated risks included on the project / implementation plans. The risk associated with not producing a CEO report that summarises key programmes is relatively small, as there would be other mechanisms to communicate with partners and stakeholders.						
Management of Conflicts of Interest	There are no conflicts of interests associated with the production of this report.						
Resource Impact (X)	**Financial**		**Information Management & Technology**				
	Human Resource		**Buildings**				
Financial Impact	The schemes and initiatives included in this report will have associated financial plans that have been approved through established groups and committees.						
Regulatory and Legal Issues (including NHS Constitution)	The ICB constitution includes specific requirements for the ICB to engage and involve its local communities in health services and has specific duties with regard to the public sector equality duty. s. 1.4.5(e) The public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35). s.1.4.7(f) section 14Z45 (public involvement and consultation).						
Impact on Health Inequalities	N/A						
Impact on Equality and Diversity							

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

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

Agenda Item 8

NHS Gloucestershire ICB Public Board Meeting
Wednesday 26th March 2025

Chief Executive Report

1. Introduction

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

2. Asthma + Lung UK ICS Respiratory Review 2024/25

2.1 Between September and December 2024 Asthma + Lung UK undertook a review of all 42 ICS's nationally. The review presents key metrics from publicly available data, equitably, for all systems and ranks them based on respiratory hospital admissions and deaths. Gloucestershire has demonstrated a significant improvement in outcomes compared to 2023 by improving **29 places** in the ranks.

2.2 We now stand at 8th in the country for our admission rate and 5th for our mortality rate which puts us 4th overall in the country. ICS Respiratory Review 2024/25 | Asthma + Lung UK
In addition to this, the review captured where innovative work is being carried out across the country including diagnostics, treatment and overall support for patients with a chronic respiratory condition. Gloucestershire has one of the highest respiratory diagnostic provisions in the country compared to over half of the ICSs' having insufficient spirometry capacity; we have been used as a model for others to follow and lead the field in access to spirometry (only 8 ICB had sufficient capacity). This is a great news story for the Respiratory CPG but we still strive to consistently improve.

3.1 **We Can Move: Transforming Physical Activity and Health Across Gloucestershire**

3.1.2 The We Can Move programme, part of the Enabling Active Communities portfolio, is a whole-system approach aimed at increasing physical activity levels across Gloucestershire. Led by the team at Active Gloucestershire, one of our trusted Voluntary, Community, and Social Enterprise (VCSE) partners, the programme is driving both cultural and practical change. By creating the right environment and infrastructure, We Can Move aims to make being active a natural part of daily life, while focusing on specific priorities that truly matter to our communities.

3.1.3 But this programme is more than just a plan—it's action in motion. We Can Move plays a vital role in delivering our local strategy to build healthier, more active communities. It's also central to supporting the Government's NHS reform agenda, particularly by aligning with key goals like moving from hospital to community care and shifting from treatment to prevention

3.1.4 Through its targeted initiatives, We Can Move is bridging the gap between healthcare services and community provision. The programme enables individuals to transition smoothly from medical care to community support, fostering healthy behaviours and promoting long-term wellbeing. This work is making a tangible impact, improving lives at an individual level while also strengthening system-wide collaboration across the healthcare, education, and physical activity sectors.

3.2.1 **Impact in Action: Activity on Referral**

A prime example of this work in action is the Activity on Referral project. Over the past year, this initiative has supported more than 300 children and young people (CYP) in primary and secondary education who are experiencing mild to moderate mental health challenges. Referrals come from healthcare or education professionals, and the programme tailors' activities to suit each child's interests and aspirations—be it dance, fencing, horse riding, or something else entirely. Each child receives 12 free sessions, providing not just a fun way to stay active but also the chance to discover new hobbies, build friendships, and improve mental well-being.

3.2.2 On an individual level, the impact has been transformative. On a system level, the project has forged stronger partnerships across sectors, creating new opportunities for collaborative development.

3.3.1 **A Parent's Perspective**

One of the most compelling demonstrations of the programme's impact comes from a parent whose child participated in Activity on Referral:

"I just wanted to say a big thank you to Active Gloucestershire for what you do. X has been fantastic with me and my child, getting to know them and arranging a gym pass at our local leisure centre.

My child struggled with mental health due to bullying at secondary school, developed panic attacks, and attempted self-harm. They said that physical activity at the leisure centre helped them find a distraction from negative thoughts and school challenges. I also managed to move them to a different school.

Their mental health has improved so much. As a parent, it makes me so happy to see my child positive again, just like they were in primary school. It has also had a positive impact on our family, as we were truly worried about their wellbeing.

We are planning to continue the gym membership, and I am also keen to join, so we can support each other.

Thank you to the entire team for helping not just my child, but all of us as a family."

3.4.1 **The Impact of We Can Move**

Other examples of the impact We can Move is having can be seen through the place and communities work, which has demonstrated the power of place-based approaches in tackling physical inactivity and health inequalities across Gloucestershire. This area of work has engaged over 1,300 residents in Cinderford through innovative programmes like Beat the Street, which

exceeded its 10% participation target by reaching 15% of the population and inspiring 10,680 miles of active travel. The Blackbridge Community & Sports Hub in Podsmead is another key project, building long-term community ownership of physical activity spaces and improving accessibility and quality of provision and for local residents.

3.4.2 At a community level in Gloucester City, some examples of impact are Ebony Carers, an organisation supporting ethnically diverse carers, who received funding and support to run chair yoga sessions, growing from 12 to 50-60 weekly participants. The initiative not only enhanced physical and mental well-being but also created a vital social hub, helping to combat isolation and connect members with health services that they might not otherwise access. Other successful interventions include 1-2-1 health coaching for those least active in Matson (supporting 34 individuals in six months) and the Walk and Talk initiative, which evolved into a self-sustaining social support network.

3.5.1 **Looking Ahead**

The We Can Move programme continues to evolve, demonstrating how integrated, community-led approaches can make a real difference in people's lives. As we move forward, our focus remains on expanding these successful initiatives, fostering deeper collaboration between healthcare, education, and community sectors, and ensuring that physical activity remains a cornerstone of preventative healthcare in Gloucestershire. Together, we're creating a healthier, more connected Gloucestershire—where moving more isn't just an option but a way of life.

4. Planning (Strategic Planning and Operational Planning)

4.1.1 **Joint Forward Plan 2025-2030**

NHS Trusts along with Integrated Care Boards have a statutory responsibility (as defined by the Health and Care Act 2022) to publish and refresh a 5-year Joint Forward Plan on an annual basis. The purpose of the plan is to set out how the NHS plans to exercise its functions over the next five years. The plan must be delivery focused (including specific objectives, milestones, and trajectories), build on existing local strategies and be aligned with partner ambitions.

4.1.2 A light touch refresh of our collective Joint Forward Plan has been undertaken this year. This is a similar approach that other systems are taking in recognition that the refresh of the plan next year will likely be wider, considering both the publication of the NHS 10 Year Plan as well as work being undertaken on Partner Trust Strategies. This Joint Forward Plan continues therefore with the same approach as last year – aligned to the 3 Pillars of the Integrated Strategy and setting out our progress and commitments against that 10 strategic objectives that we have established as partners together.

4.1.3 A draft of the Joint Forward Plan has also been shared with the Health and Wellbeing Board as part of their statutory responsibility to comment on the alignment of the plan with the Joint Local Health and Wellbeing Strategy. The plan is in final stages of development (taking into account changes agreed through NHS annual planning), will be submitted to NHS England at the end of March and formally published in May.

4.2 **Operational Plan 2025-26**

4.2.1 On 27th February Gloucestershire ICB submitted our Headline operational plan submission. This year's planning round in particularly challenging with all ICBs needing to strike the balance between financial sustainability and delivery of national performance objectives. At the time of submitting our Headline plan there still remained a gap of £36.3m to reach a balanced financial plan. This gap has since reduced to £27m, and work continues to identify savings and efficiencies to deliver a fully balanced plan for the Full Submission due on 27th March. Feedback on our Headline plan positioned us in the top half of ICBs within the region. All ICBs within our region reported a significant financial gap still to close. The Full Operational Plan submission is due on 27th March.

4.2.2 Alongside financial balance our biggest challenges in meeting the national performance objectives are within elective care. In previous years ERF (Elective Recovery Fund) investments have supported additional elective activity to enable us to achieve RTT targets and waiting list reductions. Gloucestershire is committed in seeking to deliver a financially balanced plan. A number of ERF schemes have been submitted through the priorities process, but investment must be considered alongside the need to have a balanced financial plan. Work is continuing to refine our plan and respond to the wider scope of planning detail required for the Full Submission that was outside of the scope of the initial Headline Submission.

5.1 **Care leaver Covenant Update**

5.2 The Care Leaver Covenant Working Group was established to oversee the programme's progress and ensure alignment with broader NHS objectives. It was understood early on that Gloucestershire would approach this systematically including social care. The programme began with a system-wide audit to understand the existing processes and identify areas for improvement. Collaboration with various stakeholders, including NHS organisations, local authorities, charities, and educational institutions, was crucial.

5.3 **Key activities:**
An audit of current provision and support for care leavers was conducted that enabled the working group to understand the different organisations that are involved in the education and employment support of care experienced individuals within the County.

5.4 **Findings:**
There are multiple entry points and overlapping services within the system for care leavers which can result in sporadic engagement and confusion for care leavers. This highlighted the need for a more streamlined and accessible pathway for care leavers to gain meaningful career/employment opportunities.

5.5 Step Forwards and the ICS We Want You (WWY) careers engagement team have been pivotal in the delivery of interventions to support care leavers within Gloucestershire to find work experience and employment. Working alongside our partner agencies and in conjunction with the University of Gloucestershire (UoG) we ran a healthcare taster day which provided care leavers with insights into various healthcare careers on offer at UoG and facilitated interactions between

care leavers and NHS staff with similar experiences. We had 2 care leavers attend and both had further follow-up conversations resulting in one pursuing a health and social care L2 qualification.

5.6 Referrals from Step Forwards, Youth support team, Out of County Social services, and schools have resulted in a number of career coaching conversations with young people and the WWY team. To date 3 have gone to secure employment within health and social care settings. The team continues to work collaboratively with our partners to support the education and employment needs of care leavers within the County. Two care leavers have gone onto gain work experience within the sector because of career conversations and support given.

5.7 GHC offer a fast-track work experience process for Care leavers with 1:1 advice and guidance on next steps, linking the care leaver back through to the WWY team or Step forwards if appropriate. They have supported a number of care leavers into work experience opportunities within the Trust.

5.8 GHFT has supported care leavers into several clinical roles. As part of national apprenticeship week in 2024 they recorded a powerful podcast with "Ella" a care leaver who explains her journey into a career within healthcare. '*Ella entered the care system following a challenging time at home when she was 16, during the pandemic. Ella ended up in supported living with other young people. This was hard for Ella, but her resilience has enabled her to succeed from a young age. She had an interested in health and social care and began her career as a health care support worker apprentice at GHFT. On successfully completing this Ella has continued to pursue her nursing dream by undertaking the nursing associate foundation degree apprenticeship. Ella has received support from her partner, social worker, work colleagues, university, and the apprenticeship team at GHFT which has been vital to enable her to feel valued and included. With reasonable adjustments and the guidance of those around her Ella has demonstrated that you can succeed and achieve your dream.'*

You can listen to the full podcast here - Podcast 3 Apprenticeships at Glos Hospitals/GMS (youtube.com).

5.9 **Next steps**

- The working group are developing a half day workshop, co-designed with care leaver ambassadors to enable a better understanding of the role of different agencies in the support of care leavers. The aim being to understand the role of different agencies, how they can work together effectively to support care leavers to navigate opportunities available and understand how to refer into Step Forwards/WWY. To facilitate the continued development of the One Gloucestershire referral process for care leavers wanting to pursue a career within health and care.

- Continue to meet with Care ambassadors to share ideas, gain feedback and work collaboratively.

- Engage with recruitment teams to explore opportunities for care leavers to gain employment without being disadvantaged. To include adaptations to the application

process, tailored application support, onboarding advice, mentoring/buddying by someone with lived experience and reasonable adjustments.

- Working with the Wellbeing line on “new to role” support mechanisms for care leavers to support with imposter syndrome and anxieties associated with joining the workforce for the first time (UoG research bid submitted to support this project).

- Develop an experience of the workplace model that is inclusive for all including care leavers.

- Ensure strong partnership working with initiatives such as 100 futures, Connect to Work programmes.

- Connect to Work an integral part of the Government’s “Back to Work Plan” to support 100,000 people with disabilities or health conditions, or those who have complex barriers to entering the labour market into paid work each year and support to help them to sustain their jobs. It is anticipated that Connect to Work will be supporting Care Leavers from October 2025, further details will be available later in the year.

6. Recommendation

6.1 The Board is asked to note the CEO report.

Agenda Item 9

NHS Gloucestershire ICB Public Board Meeting

Wednesday 26th March 2025

Report Title	**Board Assurance Framework**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	Risks are reviewed by Directorates and Executives each month.						
	ICB Internal	**Date**	**System Partner**	**Date**			
	ICB Operational Executive	04/03/2025	Strategic Executive	20/03/2025			
Executive Summary	The BAF was refreshed last year with the risks aligned to the three pillars, the strategic objectives, and priorities for 2024/25. For each of the sub-committees of the ICB • System Quality Committee • Resources Committee • People Committee • Primary Care & Direct Commissioning Committee A cut of the BAF risk and corporate risks related to that committee are included in the committee papers at each meeting. The discussion on those risks appears early in the agenda to set the frame and tone and to ensure that the committee cross checks the risks being discussed at the committee meeting with those that appear on the CRR and BAF.						
	Where modifications need to be made to the risks following the committee meeting these are followed up after the meeting and incorporated within the BAF and CRR. It should be noted that the Audit Committee receives the full BAF and CRR at each of its meeting and provides feedback on the risks, including the controls, assurances, and action plans. The BAF and the CRR were reviewed at the Audit Committee meeting that was held on 6th March 2025 and requests were made to update and refresh the BAF particularly UEC risk, which has been reviewed and updated since that meeting.						
Key issues	The BAF has been reviewed this March and the changes made to the BAF are marked in RED. The key changes for the BAF report are as follows There are 13 strategic risks on the BAF • 9 Red rated risks • 4 Amber rated risks. The following changes have been made:						

	• BAF 1 Health Inequalities risk has been reviewed, updates have been made to the controls, assurances, actions and Director's update • BAF2 community and locality focused approach to the delivery of care. Content updated in Controls, Assurances, Actions and Director's Update sections • BAF 3a workforce risk has been reviewed, System Partner Risks information updated. Content added into Director's Updates • BAF 3b Equality, Diversity, and Inclusion has been reviewed actions and Director's Report updated. The BAF risk was reviewed and discussed in detail at the People Committee 17th October 2024, with the risk score increased from 12 to 15. In March system partner risks information updated. Content added into Director's Updates and the risk appetite decreased. • BAF 4 Quality risk has been updated and there is a comprehensive report on SHMI. • BAF 5. UEC risk has been updated in terms of controls and Directors update along with an increase in score from 12 to 16 (noting the original risk had been 20) • BAF 6 Risk. There is no update for March. • BAF 7 Recovery and Productivity risk has been reviewed, the risk had previously been increased from 12 to 16. For this reporting period a significant update is given in controls, actions and the Director's report. • BAF 8. Mental Health Transformation risk has been reviewed and a change has been made to gaps in controls • BAF 9 Financial Sustainability: Financial Sustainability: this risk has been reviewed. There are no updates to the scoring with a detailed update to the Director's report. • BAF 10 Estates Infrastructure: There are no updates to the scoring, however this is a clearer explanation of cause and effect, and controls. • BAF 11 Emergency Planning Resilience and Response (EPRR) Risk reviewed a decrease in the current risk score to 12 (Amber) with a significant update to the actions and Director's report. • BAF 12 Risk has been reviewed against GHFT risk as shared IT service/systems and the risk rating has been reduced from 20 to 15 in January. There is an update on assurances and the Director's update.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The risk associated with not reporting risks is that key issues may not be identified and/or discussed at committee and board level. (4x3) 12 (4x2) 8
Management of Conflicts of Interest	There have been no conflicts of interest in producing this report. If there are conflicts of interest identified, they should be managed in line with the Standards of Business Conduct Policy.
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	Risk around finance have been included within this report.

Regulatory and Legal Issues (including NHS Constitution)	The ICB Constitution requires the ICB to have appropriate arrangements for the management of risk.		
Impact on Health Inequalities	There is a risk pertaining to health inequalities within the BAF see BAF 1.		
Impact on Equality and Diversity	An Equality Impact Assessment is included in the Risk Management Framework and Strategy		
Impact on Sustainable Development	No specific risks relating to sustainable development included in the BAF		
Patient and Public Involvement	There are no risks included in the BAF on Patient and Public Involvement		
Recommendation	The Board is asked to; • discuss the system wide strategic risks contained in the BAF • 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

March 2025 Summary **

Pillars	ID	Entry Date	Strategic Risk	Last Updated	Lead	Original Score (IxL)	Current Score (IxL)	Target Risk (IxL)	Committee	Note
1: Making Gloucestershire a better place for the future	**Strategic Objective 1:** *Increase prevention and tackle the wider determinants of health and care.* **Strategic Objective 3:** *Achieve equity in outcomes, experience, and access.*									
	BAF 1	13/11/23	The failure to promote and embed initiatives on health inequalities and prevention.	17/03/2025	Director of Op. Planning & Perf.	**12** (4x3)	**12** (4x3)	**8** (4x2)	Resources ICP System Quality	*Current score unchanged.*
2: Transforming what we do	**Strategic Objective 2:** *Take a community and locality focused approach to the delivery of care.*									
	BAF 2	14/11/23	The risk is that our delivery structures are unable to drive the acceleration required on community and locality transformation. This is also impacted by limited capacity to drive the change.	13/03/2025	Director of Primary Care & Place	**12** (4x3)	**12** (4x3)	**4** (4x1)	System Quality	*Current score unchanged.*
	Strategic Objective 4: *Create a One Workforce for One Gloucestershire.*									
	BAF 3a	01/11/22	Failure to provide a compassionate working culture, with the right levels of capacity, capability, training and development and well-being provision that enables us to recruit and retain staff to fully deliver our strategic plans which competes with requirements of the NHS Workforce Plan.	16/03/2025	Director of People, Culture & Engagement	**16** (4x4)	**20** (5x4)	**5** (5x1)	People	*Current score unchanged*
	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.	16/03/2025	Director of People, Culture & Engagement	**12** (4x3)	**15** (5x3)	**4** (4x1)	People	*Score increased. Appetite decreased.*
	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.	17/03/2025	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.	06/03/2025	Deputy CEO / Director of Strategy & Transf.	**20** (5x4)	**16** (4x4)	**8** (4x2)	Resources	*Score increased.*

	BAF 6	15/11/23	Risk of instability and resilience in primary care due to increasing costs and financial risk to delivery of core services. This is alongside high workload with increasing patient demand and reporting requirements as well as existing workforce and estates pressures.	16/01/2025	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.	**17/03/2025**	Director of Operational Planning & Perf.	**12** (4x4)	**16** (4x4)	**4** (4x1)	Resources System Quality	*Current score unchanged*
	BAF 8	01/11/22	Failure to sustain a transformational focus on mental health services hampered by multiple workstreams and lack of sufficient workforce to deliver sustained changes.	**17/01/2025**	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.	**07/03/2025**	Chief Finance Officer (CFO)	**16** (4x4)	**16** (4x4)	**8** (4x2)	Audit Resources	*Current score unchanged.*
	BAF 10	30/01/23	The estates infrastructure of the ICS and insufficient resources hinder our ability to provide a safe and sustainable estate and replacement programmes for equipment and digital infrastructure enabling deliver of high-quality care.	**07/03/2025**	Chief Finance Officer (CFO)	**16** (4x4)	**16** (4x4)	**8** (4x2)	Audit Resources	*Current score unchanged.*
	BAF 11	01/11/22	EPRR - Failure to meet the minimum occupational standards for EPRR and Business Continuity.	**11/03/2025**	Chief Nursing Officer (CNO)	**12** (4x3)	**12** (4x3)	**4** (4x1)	System Quality Audit	*Score decreased.*
	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.	**17/03/2025**	Chief Clinical Information Officer	**20** (5x4)	**15** (5x3)	**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 January 2025

1	Risk reviewed with updates to the controls, assurances, actions and Director's update.
2	Risk reviewed. Content updated in Controls, Assurances, Actions and Director's Update sections.
3A	System Partner Risks information updated. Content added into Director's Updates.
3B	System Partner Risks information updated. Content added into Director's Updates.
4	New control added. Director's report updated.

5	New content in Current Assurances and Known Gaps in Assurances. ‘Due to’ section updated. Risk score increased from 12 to 16.
6	No change.
7	Movement increase to 16. Updated controls, assurances, and actions. Directors Update on Actions updated.
8	This risk has been reviewed and gaps in controls updated
9	Risk reviewed. Aligned with new F&BI ICB risk. Directors Update added.
10	‘Due to’, impact and control sections updated.
11	Movement decrease. Updated controls, gaps in controls and actions. Director’s Update added.
12	Risk reviewed. Assurances edited and Director’s Update section updated.

**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:**	**17/03/2025**
Owner:	**Mark Walkingshaw, Director of Operational Planning and Performance**		
Committee	**ICP, Resources, System Quality**		
Aligned with System Partner Risk(s):	**GHC Risk ID 2** *There is a risk of demand out stripping supply for services and/or that services operate in a way which does not meet the needs of the population, potentially reinforcing health inequalities.* **(Red 12) May 2024**		
Aligned with ICB Risk(s):			

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

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

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

Key Priorities 25/26: *Continue to increase the focus on prevention for health and care – for people of all ages; Work with wider partners and communities to enable people to take an active role in their own health and care.*

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

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

Due to:	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):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Prevention Delivery Group and EAC-I oversight. 2. Health inequalities embedded in transformation programmes. This includes activity in Gloucester City ("Core20"), race relations as well as other inclusion health groups ("PLUS") and 5 nationally identified clinical areas. 3. Health inequalities is a standing item at the Planned Care Delivery Board. 4. Integrated Locality Partnerships take a place-based approach to identify priorities for addressing the root cause of health inequalities. 5. System representation at Regional Inequalities Group and links with local and regional networks. 6. Consideration of health inequalities as part of service development and change through application of Equality and Engagement Impact Assessments.	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	1. Health inequalities measures built into strategic outcomes framework with Board-level assurance. 2. Six-monthly updates on health inequalities objectives by system organisations and partnerships to ICB Board. 3. Updates on health inequalities objectives by system organisations and partnerships to ICB Board. 4. Regular reporting to System Resources Committee & Strategic Executive. 5. Quarterly activity reporting to NHSE. 6. Oversight by SROs.	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. Gloucestershire Health Inequalities Framework launched.
9. Organisational level health inequalities objective-setting tool.
10. ED&I Insights Manager ensures feedback and experiences of seldom heard communities informs service development & delivery.
11. Commitment to patient participation in all workstreams.

Actions to Mitigate Risk & Implementation Dates

1. Work with information teams to collate and analyse data related to the Core20PLUS5 for adults and children and young people to inform targeting of resources – roll out of demographic information to be included on all system dashboards. Collaboration with GCC on roll out of system Health Inequalities dashboard (throughout 2025), and internal ICB development of PowerBI reporting to cover all indicators required for the national statement on health inequalities (prior to publication of next statement – July 2025).
2. Further develop Statement on Inequalities to reflect progress in reducing inequalities over time, and widen the metrics and populations covered by the review. Next publication July 2025.
3. Project to increase and improve engagement with underserved communities continuing following the evaluation of the first phase. Funding for the remainder of 2024/25 is in place.
4. NHS Gloucestershire ICB was a test site for the development of the ICS Engagement Improvement Framework, which will enable systems to measure how well they listen to, and act on, the experiences and needs of people and communities to reduce health inequalities. The framework was launched on 12th February and we are working with SROs to implement the framework within the system during 2025/26.
5. Health inequality reporting to be scoped and developed as a regular standing item to System Resources Committee who are taking on the delegated assurance responsibility from the ICB board around progress to reduce health inequality in the Gloucestershire system.
6. Equality Impact Assessments are required to be completed and submitted with business cases being considered under the priorities process.

Directors Updates on Actions to Date (Updated Quarterly)

1. The returns on the Health Inequalities Framework for the ICS have been completed by system partners and key themes are being identified. Review of these has demonstrated some issues with the HI framework which will be addressed by the project group. including consideration of effectiveness/impact measurement and reporting. Full update went to Board in January 2025 and will be going to Health & Wellbeing Partnership in March 2025.
2. Health inequalities "champions" from system organisations and partnerships and ILP leads to codevelop a set of shared objectives, priority outcomes and metrics for addressing health inequalities across the system, aligned to the Health Inequalities Framework.
3. The Gloucestershire Statement on Health Inequalities has been presented at several system and internal meetings to raise awareness, a development group has met to steer the focus for additional reporting and analysis for the 2025 statement and we have agreed a cross-system approach to align the ICB and provider statements, with particular emphasis on the exemplar themes identified in Gloucestershire.
4. An 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. We are scoping next steps to take this work forward.
5. Specific focus on Gloucester Inner City in underway as Targeted Lung Health checks have commenced in January 2025 – 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. 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. This includes review of national publications which have highlighted health inequality such as the Darzi review and the "Reforming elective care for patients" plan.
7. We completed our testing of the ICS Engagement Framework in mid-November and fed-back on our observations and experiences of using the Framework at a number of action learning meetings. The Framework has been amended based on the feedback received from the test sites and was launched at an event on the 12th February. We were involved in filming a promotional video about the Framework. which was shown at the event. We have been invited to join a speaker panel at the NHS Confed Expo in June, which introduces the framework to a wider audience.

	8. Information on health inequalities and tools to support the design, delivery and evaluation of initiatives to improve health equity has been built into the ICB Project Management training.

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

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

Entry date:	**14/11/2023**	**Last updated:**	**13/03/2025**
Owner:	**Helen Goodey, Director of Primary Care & Place**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	*There are no correlating risks.*		
Aligned with ICB Risk(s):	*Risk of instability and resilience in general practice.*		

Pillar 2: *Transforming what we do.*

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

Key Priorities 25/26: *Continue to support improvements in outcomes for people at every stage of life – delivering care that is closer to home and person-centred*

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

Due to:	**Impact:**
Multiple and competing demands to transform services, coupled with increased demand for services and challenges in recruitment and retention. Delivery requires prioritisation across GHC and primary care as well as GCC teams to ensure progress is delivered in 24/25.	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 effectiveness):*	**Known Gaps in Assurances**
1. Provider-led INT Delivery Group in place (as adaptation of Neighbourhood Transformation Steering Group) to drive the development of INTs across the county and to ensure INTs deliver care as per the national INT definition. A new INT Oversight Group will report to ICB Board. Please see Director's update. 2. Board agreement to focus initially on cohorts of people living with moderate to severe frailty and health inequalities. Working with BI colleagues to further understand our cohorts and baseline. 3. Supported by 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 INT Delivery Group and INT Oversight Group Gloucestershire Neighbourhood Transformation Steering Group (GNTG). Changes to governance arrangements are anticipated. Please see Director's update. 2. Ongoing monitoring supported by clear baselining and outcomes measures. 3. Delivery supported by enabling subgroups with clear reporting function; digital, Business Intelligence, organisational Development and Estates.	1. Further development of the performance and benefits realisation trajectories required.

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

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. All PCNs/Neighbourhoods included within the programme (rather than the initial three pilot areas). 2. Bi-annual update to ICB Board due in June 2025 including implementation progress, outcomes, and performance metrics.	1. Further ongoing alignment and clear reporting of Enabler Subgroups of Digital, Business Intelligence, Organisational Development and Estates, to amplify the delivery opportunity, including in contributing to holding demographic growth and the resultant impact on urgent and emergency care. 2. Initial baselining exercise across all 16 INT footprints complete by May '25 to support ongoing evaluation. Alignment for the purposes of reporting efficiency to Frailty and Dementia Co-diagnosis model baselining exercise and NHS SW Digital Neighbourhoods Programme evaluation framework. Plans to concurrently carry out a mapping of system resource by organisation to inform resource allocation for consistent and systematised delivery of ambitions for system, workforce, and people. Resources allocated based on data informed need. 3. Continued system support to align resources to move from pilot projects to a cohesive, system-wide approach which is necessary for transformational change; to systematise INTs as our *way of working* at neighbourhood.

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

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

Entry date:	**01/11/22**	**Last updated:**	**16/03/2025**
Owner:	**Tracey Cox, Director of People, Culture and Engagement**		
Committee	**People**		
Aligned with System Partner Risk(s):	**GHFT SR16:** *Inability to attract and recruit a compassionate, skilful, and sustainable workforce (Culture & Retention)* ***(Risk rating 20, March 25)*** **GHFT SR17:** *Inability to attract and recruit a compassionate, skilful, and sustainable workforce (Recruitment & Attraction)* ***(Risk rating 20, March 25)*** **GHC ID3:** *There is a risk that we fail to recruit, retain, and plan for a sustainable workforce to deliver services in line with our strategic objectives* ***(Risk Rating 16, Nov 24)*** **GHC ID12:** *There is a risk the Trust does not invest strategically and sufficiently in colleague's development, meaning that colleagues do not develop the new skills or have the ability to undertake the transformational roles needed for the future, do not have a long-term relationship with the trust and that productivity is below target* ***(Risk Rating 16, Nov 24).***		

Pillar 2: *Transforming what we do.*

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

Key Priorities 25/26: *Increase staff retention, provide good training and development opportunities of our One Gloucestershire workforce, and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):	**PCE:** *Inadequate Workforce Supply* **PCE:** *Workforce Infrastructure Funding for 2025/26* **(Risks 15 and above)**

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. Risks to future staff pipelines e.g. apprentices and graduates in key staffing groups	Increased pressure on existing staff, impacting staff morale and wellbeing, impacting service delivery in key areas and future bank and agency targets

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectiveness):*	**Known Gaps in Assurances**
1. Utilisation of all available resources from NHSE monies for Continuing Professional Development and leadership development to support staff training & development. 2. Some leadership learning and development programmes in place. 3. People Promise Leads in both Trusts focusing on all aspects of People Promise elements and best practice. Both Trusts have staff experience improvement programmes	1. Lack of an adequately defined and resourced system-wide and medium-term plan for staff relating to leadership development (Mapping of current leadership development approaches and offers completed, options for future being explored in context of limited investment opportunities)	1. Reporting to the People Board, People Committee, and the Board of the ICB. 2. On-going monitoring of progress on key workforce metrics through Integrated Performance Report.	1. Implementation details relating to supporting delivery of NHS Workforce Plan and impact of operating planning guidance for 2025/26. 2. Reduced funding for workforce transformation in 2024/25 and in 2025/26. 3. Awaiting details of strategic workforce planning assumptions in response to 10-year plan.

4. System level delivery plans focusing on agreed priority areas for action in 24/25 for each Steering Group.
5. Robust organisational plans in place for EDI, retention and temporary staffing spend reduction.
6. Colleague Communications & Engagement.
7. System-wide careers and engagement team (2-year FTC) focused on promoting careers in health and care.
8. Apprentice Strategy developed.
9. Strategic Partnership Board with UoG.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. People Promise Leads and work programmes in both GHFT and GHC.	1. Peoples Promise Managers site visits with NHS England leads presenting on achievements (GHC, Nov 24, GHFT, 15 Jan 2025). Agreement and work in progress on areas where a system approach would be beneficial e.g. pension awareness and menopause policy and resources.
2. System wide EDI actions focusing on 3 areas, data, anti-discrimination & recruitment/career progression.	2. All organisations recently completed SW EDI audit. Proposal being developed for system wide EDI conference during 2025/26. Review of 2025 staff survey results. Provider level plans e.g. GHFT Board development programme and GHC Leadership & Culture Programme.
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.	3. Agency spend remains within agreed cap of 3.2% for 2024/25.
4. On-going recruitment activities at organisational level e.g. GHFT's Workforce Sustainability programme aimed at transforming its recruitment process. Roll out of system wide recruitment promotion campaign 'Be in Gloucestershire'.	4. Recruitment: We Want You project team continues to develop service offer including coaching and work placements. Be a GP in Glos Campaign now scheduled for launch May 25.
5. H&WB strategy and Learning & Development proposals to be developed and key initiatives for staff including proposed staff housing hub.	5. Regional conversations to establish housing hub have been paused. Housing Officer came into post November 24. Housing needs survey launched.
6. Continued focus on System Leadership with a programme of conferences and events for leaders across the system.	6. OD Delivery Group to confirm leadership offers for 2025/26.

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

BAF 3b	**ED&I: Risk that as a system we fail to deliver on our commitments to having a fully inclusive, diverse, and engaging culture for staff we employ.**

Entry date:	**01/03/24**	**Last updated:**	**12/03/25**
Owner:	**Tracey Cox, Director of People, Culture and Engagement**		
Committee	**People**		
Aligned with System Partner Risk(s):	**GHFT SR17** *Inability to attract a skilful, compassionate workforce that is representative of the communities we serve, (Culture & Retention.)* **(Risk rating 20, March 25)** **GHC ID4** *There is a risk that we fail to deliver our commitment to having a fully inclusive and engaging culture with kind and compassionate leadership, strong values and behaviours which negatively impacts on retention and recruitment.* **(Risk rating 16, Nov 24)**		

Pillar 2: *Transforming what we do.*

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

Key Priorities 24/25: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):	**PCE:** Lack of Progress on ED&I – system partners do not make sufficient progress on ED&I priorities and against our commitment to creating a fully inclusive, diverse and engaging culture for our workforce. (Rated 16)

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

Due to:	Impact:
Insufficient strategic focus and actions that make a real difference to improving diversity and representation of staff across the pay grades including senior positions (clinical and non-clinical); and improves staff experience in the workplace ensuring compassionate leadership and a compassionate culture is in place.	The system does not benefit from cognitive diversity and fails to enhance opportunities to reduce the negative impacts on recruitment, retention, and poor staff workplace experience.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. One Glos People Strategy priority and commitment to ED&I as an underpinning theme 2. Reporting through the ICS People Governance Groups 3. Monitoring from the Equality and Human Rights Commission on the Public Sector Equality Duties. 4. Annual reporting against Workforce Race Equality Standards, Workforce Disability Standards & gender pay gap with corresponding action plans. 5. ED&I Task and Finish group.	1. Lack of systemwide targets for: a. Recruitment. b. Movement between pay bands. c. Insufficient frequency in metrics related to engagement and staff experience. d. Significant volume of data but more granular analysis required to support improvement plans.	1. Reporting to the People Board, People Committee & relevant Committees of providers. 2. Reporting to the ICB Board. 3. Audits undertaken by Internal Auditors.	1. People Committee requested further system wide focus and commitment to discuss improvement trajectories.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. All NHS partners engaged in Equality Delivery System framework. **2.** All NHS partners have action plans in response to 6 high impact actions in national EDI Improvement Plan. **3.** System wide commitment to support agenda prioritising: a. Data collation and presentation, b. anti-discrimination policy and practice & c. recruitment/career progression. **4.** Relaunch of SW Regional EDI work programme and action plan being developed with nominated CEO/HRD leads. **5.** Increasing Board level focus	**1.** EDS2 briefing and position statement submitted to March Board, followed by publication on ICB website. **2.** Individual organisational level action plans progressing focusing on anti-discrimination approaches and reporting of incidents and inclusive recruitment. **3.** SW Regional EDI audit took place in November with requirement for all providers and ICBs to participate in a regional questionnaire. SW EDI Regional workshop on 10th April 2025. **4.** Planning for future session at system NEDs meeting and proposal for system wide EDI conference for 2025/26 in Q1 aimed at middle managers. **5.** Review of 2024 staff survey March 2025 including progress and publication of WRES & WDES and gender pay gap position.

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:**	**17/03/2025**
Owner:	**Marie Crofts, Chief Nursing Officer & Ananthakrishnan Raghuram, Chief Medical Officer**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	**GHFT SR2** *Failure to implement the quality governance framework.* **(Risk rating 16)** **GHFT SR 5** *Failure to implement effective improvement approaches as a core part of change management (risk rating 16)* *GHFT SR1 Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System.* **(Risk rating 25)** **GHC ID 1** *There is a risk that failure to: (i) monitor & meet consistent quality standards for care and support; (ii) address variability across quality standards; (iii) embed learning when things go wrong; (iv) ensure continuous learning and improvement, (v) ensure the appropriate timings of interventions*. **(Risk rating 12) May 2024**		

Pillar 2: *Transforming what we do.*

Strategic Objective 5: *Improve quality and outcomes across the whole person journey.*

Key Priorities 25/26: *Increase support for people living with major health conditions – shifting to a more preventative approach and earlier diagnosis.*

Aligned with ICB Risk(s):

Integration 13: *Midwifery Staffing Levels.*

Integration 15: *Antenatal Screening*

Integration 28: CQC *community & mental health inspection reports*

Integration 30: *Paediatric Palliative Care Support at Home*

Integration 32: *Post Partum & Massive Obstetric Haemorrhage*

Integration 34: *Antenatal Scanning capacity*

Integration 37: *Reputational damage to the ICB and Childrens Continuing Care team of transferring long term complex packages of care to a new provider.*

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

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

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

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

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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. ID 27: Clinical Leads and Team Manager are completing regular caseload reviews to ensure throughput	1. New PSIRF will turn on the previously mentioned Patient Safety System Group. 2. Colleagues leading the work on the System Safety, Effectiveness and Experience groups	1. Reporting to the System Quality Committee. 2. Quality Assurance discussions.	1. There are gaps in some of the controls as stated and while there is a sound governance system in place for oversight, we will not have full assurances until we assess if the controls around PSIRF and alignment of groups (System Safety,

2. Reporting from and attendance at Provider Quality Committee. 3. Learning from Case Reviews. 4. System Quality Group. 5. System Effectiveness Group. 6. System IPC Group 7. System Mortality Group 8. Rapid Review and Quality Improvement 9. Groups where appropriate for specific service areas challenged. 10. Weekly safety huddle within ICB now routinely in place. 11. Internal ICB Quality and Clinical Gov group to bring together triangulated data more formally across the system to promote learning and ensure focus support on challenged areas. First meeting has taken place and TORs drafted.	will be meeting to ensure new groups are aligned. 3. Until groups are in place and functional existing control methods will continue as a risk mitigation. 4. Triangulation of data across the system through quality dashboards not in place currently.	3. Intelligence gathering through data relating to all aspects of quality. 4. Contract Management Boards. 5. Regulatory reviews.	Effectiveness and Experience groups) are working.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. NHSE supporting with development of the System Effectiveness Group by highlighting good practice from other systems. 2. System Safety and Learning Group to be instigate by 31st December. 3. PSIRF to be ratified by Quality Committee in February 2024. Continued focus on personalised care training across the system. 4. Established Quality and clinical gov internal ICB group – first meeting 30th May 2024. TOR to triangulate data drafted.	1. PSIRF now in place although early days of new approach. Some enhanced measures and reporting in place, beyond PSIRF oversight, with maternity services owing to the level of surveillance and concerns; working with providers to develop their plans. 2. Internal ICB Quality and Clinical Gov group to bring together triangulated data more formally across the system to promote learning and ensure focus support on challenged areas. First meeting has taken place and TOR drafted. 3. **System Mortality**: The national NHSE data tool shows that the Summary Hospital-Level Mortality Indicator (SHMI) for Gloucestershire Hospitals has reduced to 1.16. This is a 12-month rolling average covering the previous 12 months up to September 2024. This has remained above the expected limits but is improving. Other monthly data sources suggest that SHMI is now within control levels in Gloucestershire Royal Hospital (at 1.06) and has changed dramatically in Cheltenham General falling from 145.27 for September to 0.72 in October. There is still significant variation in Out of Hospital SHMI data between admissions through Gloucestershire Royal and Cheltenham General. However, the latter has now reduced monthly SHMI down to 128.21. While still outside of control limits, this is a positive change. The QIG continues to have a watching brief on these improvements. The system mortality QIG (with support from regional colleagues and external support from a colleague in another ICB) meets monthly. A regional mortality insights visit has been planned in May 2025 and agreed with the acute provider at the System mortality group meeting on 6th January 2025. The ICB is overseeing a number of actions looking at improving quality of depth of coding and improving clinical pathways. Early evidence is that the SHMI is on a downward trend in GRH and remains high in CGH mainly due to the post discharge deaths in CGH. 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:**	**06/03/25**
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 25/26: *Support improvements in the delivery of urgent and emergency care.*

Aligned with ICB Risk(s):

U&EC 1: *Risk of insufficient access to alternative pathways to ED*

U&EC 3: *Workforce & Delivery Priorities*

U&EC 6: *Risk of failure to meet core UEC performance metrics. Risk of failure to meet National Ambulance Response times, Risk of non-delivery of reduction in hospital length of stay & Risk of failure to meet National targets for UEC waits: Emergency Department (ED) and Ambulance Handovers [UEC ED Flow])*

U&EC 4: *Risk of insufficient system Resilience*

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Increase 12 (4x3) to 16 (4x4)
20 (5x4)	**16** (4x4)	**8** (4x2)	**Appetite**	**Zero/Minimal**

Due to:	Impact:
Significant pressure on operational capacity due to winter pressures, meaning performance has been impacted and improvement capacity is challenging to identify.	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. 5. Use of demand and capacity funding, additional capacity funding, discharge and BCF funds to deliver improvements within UEC system flow.	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. 5. Portfolio for UEC set up to ensure safe transition from working as one to new system working approach to ensure system oversight and grip. 6. New governance set up for intermediate care oversight (intermediate care board) and 'front door' oversight (community urgent care board) to ensure focus on improvement is maintained.	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. 3. Impact of planning round combined with system pressures on staff capacity to deliver.

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).	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. Benefits realisation being developed, Programme metrics to be finalised by December 2023.	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. Communication and Engagement plan developed, core narrative and supporting materials to be shared in November 2023 (action to remain open).	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. Improvement trials targeted to areas where performance improvements are needed (ongoing action with regular review at UEC CPG).	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:**	**16/01/25**
Owner:	**Helen Goodey, Director of Primary Care and Place**		
Committee	**Primary Care & Direct Commissioning**		
Aligned with System Partner Risk(s):	**GHC ID8** *There is a risk that the ICS prioritises acute care demand over the demands of Mental Health, Community, Primary Care and Learning Disabilities* **(Risk rating 9)**		
Aligned with ICB Risk(s):	**PC&P 7:** *Financial Challenges within Primary Care* **PC&P 10:** *Primary Care Sustainability* **PC&P 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 22***: National Community Pharmacy Collective Action* **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 25/26: *Support a resilient and accessible primary care for the public and increasing workforce recruitment and retention.*

Due to:

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

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

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

It should also be noted that general practice national collective action, commenced on the 1st of August 2024, following the BMA ballot results to proceed, this 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 Collective Action took place on the 16th September 2024. The National Pharmacy Association undertook a ballot which received near a unanimous vote in favour of Community Pharmacy Collective Action, expected in the early 2025.

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 patients and 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 Collective Action – for General Practice and Community Pharmacy - to determine	**1.** 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 unknown with regard to potential

2. Resilience and Sustainability of General Practice Sub Group (to the PC strategy group) taking place when required. 3. A Standard Operating Procedure (SOP) for practices requiring financial assistance and support has been developed to ensure a fair and consistent approach with good governance. 4. Finance Training Package procured and cohorts going through. 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) on monitoring impact of the national Primary Care Collective 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. 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.	which areas of work/system this will impact. 2. National Contract negotiations impending, which our outside of local control. 3. Significant Winter Pressures across System – Critical Incident declared January 2025 – major additional pressure on demand in Primary Care	support practices including workforce reports. 2. The Primary Care and Direct Commissioning Committee receives those reports from PCOG and provides oversight and scrutiny 3. The Primary Care Resilience and Sustainability subgroup has been established to further develop the ICB response to struggling practices 4. The Collective Action Task & Finish Group is monitoring the situation with regard to collective action 5. Working with the LPC to understand Community Pharmacy issues and community pharmacy held in November 2024 to support the community pharmacy voice within primary care across the system	Collective Action and Enhanced Services.

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Further Admin and Reception Staff Training Events planned on conflict resolution and customer service. 2. Primary Care Induction Sessions - supporting knowledge and training of those new to general practice	1. National announcement that General Practice will receive a 7.4% uplift to the GMS contract for 2024/25 - Further guidance awaited to understand the impact to practices' finances. 2. National announcement that newly qualified GPs will be claimable via ARRs with additional funding.

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.	**3.** Working closely with the LMC to understand the potential impact to general practice capacity, due to the sustainability challenges. Working with the LMC on the impact of GP Collective Action. **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:	**17/03/2025**
Owner:	**Mark Walkingshaw, Director of Operational Planning and Performance**
Committee	**System Quality, Resources**
Aligned with System Partner Risk(s):	**GHC 3** *There is a risk of demand for services beyond planned and commissioned capacity.*
Aligned with ICB Risk(s):	

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

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

Key Priorities 25/26: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

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

Due to:

Waiting list backlogs built up during COVID as elective services were stood down for long periods of time. On-going workforce pressures in key diagnostic and treatment specialties make recovery more difficult.

There has also been a growth in 2ww referrals across a number of big cancer specialties such as Lower GI and Urology which has diverted elective capacity towards seeing and treating them at the expense of routine patients.

Impact:

Most elective specialties have a level of long waiters >52 weeks but there are specific specialties with very high numbers e.g. ENT and OMF. The total waiting list size is also bigger than pre-covid. Clearance of non-admitted patients generates additional admitted patients, and the shape of the waiting list curve is such that waves of long waits come through at different times making PTL management challenging in nature.

The increase in cancer work for specialties such as Lower GI and Urology has made it difficult to maintain routine elective activity and so these patients continue to wait longer than we would want. Prioritisation of waiting lists for cancer and urgent P1-2 categories often pushes the P4 routine waits further and further back.

Follow up patients are also often very delayed for the appointments and largely go unnoticed as they are not reported in any national waiting time target but pose a significant risk of harm especially in specialties such as Ophthalmology or cancer follow ups.

Current Controls *(to mitigate risk):*

1. Clinical technical and administrative validation and prioritisation of system waiting lists plus regular proactive contact with patients to notify them of delays and what to do if clinical condition changes. Elective waiting list prioritised with P codes.
2. Weekly check and challenge meetings in place at GHFT to focus on longest waits by specialty and instigate immediate remedial actions.
3. Elective care hub undertaking patient level contact, validation, and link to social prescribers as well as escalation of any patients with a worsening condition to the relevant specialty.

Known Gaps in Controls

1. Stratification of waiting list based on other health and socioeconomic factors under development.
2. Specific plans for improving C&YP access to elective services in development.
3. Elective recovery plans for Gloucestershire patients treated at out of county NHS providers subject to further development.

Current Assurances *(of controls effectivity):*

1. Performance Reporting to the Planned Care Delivery Board, System Resources Committee and the ICB.
2. Elective recovery planning and oversight provided by the Planned Care Delivery Board (PCDB) with escalation via Programme Delivery Group and ICS Execs as required.
3. Monthly elective care delivery meetings with NHSE in place.

Known Gaps in Assurances

1. Limited data available for monitoring of Gloucestershire patients waiting at out of county providers and associated recovery plans.
2. Lack of visibility of delayed follow ups at ICB contract, performance and quality meetings.

4. Additional elective activity commissioned with Independent Sector providers both for new referrals and transfer of long waiters from GHFT where required. New providers entering the market via the Provider Selection Regime (PSR) process.
5. Additional capacity commissioned with GHFT in key long waiting specialties as part of annual planning process using ERF funding stream.
6. Work continues with primary care through the Referral Optimisation Steering Group (ROSG) to manage referral demand into secondary care. Increase in A&G services and access to Cinapsis as well as progress with "Advice First" approach and RAS role out. Expanded GP education programme and G-Care pathway content.
7. System interface group established to oversee improvements in the interface between primary and secondary care.
8. Operational and transformational delivery monitored by system Planned Care Delivery Board. Reallocation of ERF slippage undertaken here.
9. Regular analysis of waiting lists in place to ensure equity of access, waiting times and outcomes for our most deprived populations and ethnic minority groups. Weekly check and challenge meetings at GHFT to micromanage long waiters in place.
10. Clinical harm reviews undertaken for all long waits.
11. Ring fencing of elective capacity extended through bed reconfigurations and new daycase facility and theatres in CGH.
12. New payment models introduced at GHFT to support willingness of staff to undertake additional weekend activity.

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

4. Reporting to NHSE/I on forecast month end long-waiters weekly. Any elective cancellations reported to NHSE/I. System waiting times monitored through the WLMDS tableau report. Regular Elective Recovery COO and Performance Directors meetings with NHSE for the region.
5. Regular contract and performance management governance structures in place to review performance and associated recovery plans with all independent sector providers. Visibility of waiting times through WLMDS returns.

Actions to Mitigate Risk & Implementation Dates

1. Operational plans for 25/26 in development ahead of submission at end of March. Expectation is to agree activity and productivity improvements to meet the waiting times targets as per operational guidance.
2. Specific additional capacity investments to be agreed.
3. Additional elective activity being planned for the final quarter of 24/25 at GHFT in key specialties, focussing on new outpatient clinics and high volume daycase procedures such as Endoscopy.
4. Independent sector budget and activity plans to be agreed which support delivery of waiting times.
5. Patient Engagement Portal phased implementation underway.
6. Roll out of FDP within GHFT to improve productivity and efficiency.
7. Use of robotic automation in booking processes identified and due for implementation by April 25.
8. Elective and Diagnostic Portfolio developed to support delivery of transformation programmes including IP/DC/theatres, outpatients, waiting list management, referral optimisation and diagnostics.
9. Primary/secondary care interface group established and work programme underway.

Directors Updates on Actions to Date (Updated Quarterly)

1. Operational plan being delivered and monitored by PCDB. ERF achievement at M8 is 117.4% vs a plan of 118%. Inclusion of addition coding and specific activity commissioned for Q4 is expected to increase this to 118.3%.
2. Priority schemes identified in long wait specialties, including ENT, OMF, Orthopaedics, Spines, Endoscopy and Angiography to support waiting time achievement through 25/26.
3. Capped theatre utilisation at GHFT has deteriorated in the last 3-months such that renewed focus is required on short notice cancellations. Robotic automation and FDP are expected to help improved the situation.
4. Baseline assessment of community hospital theatre activity completed and to be presented to the T&F group this week. GHFT to present their options appraisal as to the best use of community theatres by creating centres of excellence. Recommendations to be put to Execs thereafter for consideration.
5. The ICB has received another accreditation application from an elective care provider (6 in total). This will add additional choice options for patients in Gloucestershire but also additional financial risk.
6. GHFT have appointed a primary care liaison role with admin support. The learning is being collated and further additions to interface principles guidance created. The Interface Principles document has also been shared with ISPs for their agreement and engagement.

Relevant Key Performance Indicators

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

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

Entry date:	**01/11/22**	**Last updated:**	**17/01/2025**
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 25/26: *Improve mental health support across health and care services.*

Aligned with ICB Risk(s): **Integration 06:** *Tier 4 Eating Disorder Beds*

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

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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. 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 released to support UEC MH programme/Right Care Right Person.	**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. **5.** CYP MH Lead for ICB currently away. Programmes that sat with her (Eating Disorders) have been	**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.

	transferred to Adult MH commissioning but from end of Feb 25 there will be limited capacity in team to support programme. 6. Shared care arrangements for ADHD prescribing between primary/secondary care.		

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Ongoing monitoring of the mitigations and engagement with service review around increasing demand upon the GHC CYP and Adults ED disorders service, due to an increase in referrals. 2. 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:**	**07/03/2025**
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* **F&BI 13** *- The ICS is not able to develop a breakeven plan for 2025/26 and is unable to deliver its control total in 2025/26*		

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

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

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

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

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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Governance in place in each organisation and System-wide Financial Framework in place 2. Monthly review of whole-system financial position by Directors of Finance, Strategic Executives with reporting into relevant Committee for ICB, GHFT, GHC. 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.	1. Longer term strategic plan which delivers sustainably for the system is in development and the supporting financial strategy for the ICS in development. 2. Methodology on realisation of productivity leading to cashable benefits not in place. 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	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.

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

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. GHFT internal financial improvement plan progressing and plans for new financial year being included, control review is ongoing. Reporting through to the GHFT Finance Committee. **2.** System savings plan for new year and longer term in development, monitoring of progress and delivery by individual organisation and at system level each month to Executives. **3.** 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.** Work on the medium-term plan including financial plan underway with a key focus on 25/26. Development of portfolio approach with clear terms of reference to transformation programmes to ensure prioritisation of projects and programmes within the overall medium-term plan. **4.** Workforce monitoring for budgeted and worked WTE progressing with monthly reporting and monitoring within organisations and to the system in development, initial reporting at M3 planned. **5.** Bi-weekly meetings with CEOs and DoFs to monitor progress of plans and progress for 2025/26 and 2024/25 financial position.

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

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

Entry date:	**30/01/23**	**Last updated:**	**07/03/2025**
Owner:	**Cath Leech, Chief Finance Officer**		
Committee	**Audit, Resources**		
Aligned with System Partner Risk(s):	**GHFT: SR10:** *Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.* **(Risk score 16)**		
Aligned with ICB Risk(s):	**N/A**		

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

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

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

Key Priorities 25/26: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Due to:	**Impact:**
- Increasing inflation on capital costs. - Inefficient systems and processes within the system leading to inherent inefficiencies in the way we do things leading to increased cost. - High level of backlog maintenance within GHFT (c£72m) and ageing estate leading to increases in maintenance work both planned and unplanned. - Additional capital allocations are not always cash backed leading to an impact on the cash position for the system and a potentially reduced ability to take full advantage of additional allocations. - Revenue costs of primary care rents increasing significantly leading to a slowdown in the development of replacement premises for surgeries which have estate issues or where the population served has increased significantly.	- Capital allocation "buys less" as a result of increasing inflation and System may be unable to live within its capital resource limit. - Inability to reduce the level of high-risk backlog maintenance, to replace equipment when due or to refurbish facilities across the system in a timely manner leading to down time for unplanned maintenance and reduced productivity across the system. - Inability to progress with primary care estate developments leading to GP surgeries with insufficient space to accommodate staff required to deal with increased numbers of patients and/or GP surgeries with estates issues that impact on operational performance.

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 and taking forward actions from the draft infrastructure strategy. **5.** EPRR in place, to support any critical infrastructure failures within provider organisations.	**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.

6. Mature Provider estates planning forums to manage risk and capital planning oversight. **7.** Revised primary care infrastructure plan developed. **8.** This risk will form part of the ICB infrastructure plan.			

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 draft, finalisation in progress with support from NHSPS, and implementation plan in progress with key priorities identified to take forward first.

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:**	**11/03/25**
Owner:	**Marie Crofts, Chief Nursing Officer**		
Committee	**System Quality**		
Aligned with System Partner Risk(s):	**GHFT** *SR12 Failure to detect and control risks to cyber security* **(Risk Rating 20)** **GHC 8** *Cyber There is a risk of inadequately maintained and protected the breadth of IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care etc* **(Risk Rating 20)**		

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

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

Key Priorities 25/26: *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	Decrease 16 (4x4) to 12 (4x3)
12 (4x3)	**12** (4x3)	**4** (4x1)	**Appetite**	**Zero/Minimal**

Due to:	Impact:
Lack of oversight, the ICB being rated as 'partially compliant' and new resource in the EPRR team taking time to embed.	Unable to fulfil our responsibilities as a Category One responder, and effectively lead a robust, effective and coordinated system response to a major incident.

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. EPRR on-call manager training. 2. EPRR exercises. 3. Oversight of EPRR through the Local Health Resilience Partnership. 4. ICB EPRR Policy and Business Continuity Policy. 5. ICB EPRR Training Needs Analysis.	1. Insufficient internal debriefs have been performed for exercises that the ICB has participated in or that lessons learned have not been embedded. 2. Lack of progress on the implementation of the cyber security exercise action plan points relating to the joint working and processes required with the cyber and EPRR teams. 3. Lack of take up of strategic training offered and lack of attendance and representation at local and regional exercises. 4. Band 7 EPRR T&E Manager is leaving the organisation and therefore there will be a gap in organisational T&E provision whilst we recruit to the post.	1. Reporting to Quality Committee. 2. NHS England system assurance review and provider assurance process against national standards. 3. BDO Internal Audit Report (November 2023) moderate assurance for design and effectiveness. 4. Peer review and sharing good practice through the new SW EPRR Collaborative group	1. BDO Internal Audit Report which rated the ICB as moderate for design opinion and moderate for design effectiveness, with four medium recommendations (November 2023). NHS System Assurance all but two of the Partners has achieved a submitted standard of at least "Substantially Assured" with one (PPG) achieving Fully Assured. A great deal of work has been undertaken to improve E-Med's score and they have moved to "Substantially Assured" from "Non-Compliant" last year. The ICB itself has seen its overall rating remain static and again whilst a self-assessment of "fully compliant" was submitted, we have been rated as "partially assured" by NHSE).

Actions to Mitigate Risk & Implementation Dates	**Directors Updates on Actions to Date (Updated Quarterly)**
1. Sign off of the ICB T&E Strategy through Ops Exec and then System Quality Committee – mid April 2025 2. Full roll out and further testing of the new mass notifications system for incident alerts – end of March 2025 3. Recruit to the post of EPRR T&E Coordinator (which will become vacant 3rd April) – May 2025	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)

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.	plans /Business impact analysis with local departmental walkthrough /discussion of what they would do for a loss or partial loss of service. **3.** Board Development Session is planned for later in the year to reiterate Cat 1 responder duties and responsibilities and update. **4.** A new Business Continuity Policy has been developed and signed off at System Quality Committee in February. This includes enhanced steps for monitoring and evaluating BCPs across the organisation. In addition, the EPRR Manager has met with some departmental leads re BCPs and updated the departmental leads list. The ICB EPRR Policy has also been reviewed and signed off by System Quality Committee. **5.** A new ICB Training and Exercise Strategy has been produced and is due to be approved by System Quality Committee in April. The policy contains a detailed training prospectus for all incident response and EPRR functions across the organisation and commits the organisation to running and participating in a certain number of exercises per year. **6.** EPRR team now attend Cyber Ops meetings and have been working with the Digital team in terms of delivering a cyber workshop and exercise event in June 2025. **7.** Significant work has been underway to capture lessons identified in the January System Critical Incident response. The learning will be embedded in the review of the ICB Incident Response Plan and Health Community Response Plans. A report on the CI incident will go to Ops Exec and then Patient Delivery Board. **8.** With admin support in the team, the EPRR team have already created a folder structure to collate evidence for this year's NHSE EPRR Core Standards assurance and evidence is being uploaded through the year to meet the September deadline.

Relevant Key Performance Indicators
N/A

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

Entry date:	**15/02/24**	**Last updated:**	**17/03/2025**
Owner:	**Paul Atkinson, Chief Clinical Information Officer**		
Committee	**Audit Committee**		
Aligned with System Partner Risk(s):	**GHFT SR12** *Failure to detect and control risks to cyber security.* **(score Amber 15)** *Key threats include malware, phishing, and potential physical breaches, with the National Cyber Security Centre emphasising the increasing sophistication of cyber-attacks on the NHS. (14th November 2024)* **GHC ID 8 Cyber** *There is a risk that we do not adequately maintain and protect the breadth of our IT infrastructure and software resulting in a failure to protect continuity/ quality of patient care, safeguard the integrity of service user and colleague data and performance/monitoring data (**score 28 November2024**)*		

Original Score (IxL)	Current score (IxL)	Target Risk (IxL)	Movement	Unchanged
20 (5x4)	**15** (5x3)	**10** (5x2)	**Appetite**	**Zero/Minimal**

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

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

Key Priorities 25/26: *Increase recruitment and retention of our One Gloucestershire workforce and build an inclusive and compassionate culture.*

Aligned with ICB Risk(s):

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

Current Controls *(to mitigate risk):*	**Known Gaps in Controls**	**Current Assurances** *(of controls effectivity):*	**Known Gaps in Assurances**
1. Cyber Security action plan in place, reviewed annually. Gaps in security and investment identified.	1. Insufficient in-house expertise in cyber security team.	1. External audit completed by BDO identified no new/unknown risks or issues. Next audit scoping in progress	1. Annual schedule and scope of penetration testing for coming years to be agreed.
2. Monitoring systems in place via dedicated countywide NHS cyber security team hosted by GHFT.	2. Disaster recovery planning around support systems (out of IT control) not consistently in place.	2. External penetration testing conducted annually by GHC and ICB and findings managed.	2. Not all third-party suppliers provide multi-factor authentication in line with national policy.
3. Backup systems and disaster recovery in place and regularly updated.	3. Operating model of cyber-technical & cyber-governance currently not optimal.	3. GHFT/CITS penetration test completed in June and findings being managed	3. Risks associated with software supply chain difficult to evaluate.
4. Rolling cyber security delivery programme to improve position.	4. Volume of cyber-security issues requiring resolution.	4. Annual ICB board cyber development completed at February 2025 session and associated online training to follow.	
5. Investment in cyber tools and software.	5. ICS-wide incident response processes not fully operational.	5. GHFT reduced their BAF risk score from 20 to 15 to reflect work undertaken to mitigate cyber risk.	
6. Regular phishing tests and firewall tests (planned system hacks.)			
7. Regular security updates and patches.			

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

Actions to Mitigate Risk & Implementation Dates	Directors Updates on Actions to Date (Updated Quarterly)
1. Board level awareness of risk and issues. **2.** Rationalisation of detection and prevention tooling. **3.** Introduction of targeted monitoring and alerting across key systems and entry points. **4.** Contract monitoring third party suppliers to ensure that there is sufficiently robust data security and protection software and safeguards in place as well as reporting. **5.** Removal of all end-of-life software and hardware.	**1.** Progress continues to be made towards protecting from cyber-attack however the external environment means the threat continues to evolve and is likely to remain. Gloucestershire's cyber security strategy has been through organisation reviews and due for approval at ICB board in March. Good progress continues to be reported by our NHS ICS cyber service on removal of end-of-life software and hardware, building our asset registers and monitoring. **2.** GHFT have reduced their BAF score to 15. As hosts of our NHS ICS cyber service this is positive news.

Relevant Key Performance Indicators

N/A

Risk scoring:

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

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

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

Agenda Item 10

NHS Gloucestershire ICB Board, Public Session

Wednesday 26th March 2025

Report Title	**Integrated Performance Report**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
			X				
Route to this meeting	N/A						
	ICB Internal	**Date**	**System Partner**	**Date**			
Executive Summary	This is the Integrated Performance Report (IPR) for NHS Gloucestershire ICB for March 2025. The report brings information together from the following four areas: • Performance (supporting metrics report can be found here) • Workforce (supporting metrics report can be found here) • Finance (ICS and ICB M11 reports) • Quality The report includes assurance pages from each of the relevant ICB Committees relating to their part of the IPR, a headline summary from each of the areas above and a more detailed breakdown of progress within the remainder of the document. There is a supporting metrics document that lists performance on the individual metrics that can be found here.						
Key Issues to note	Areas of key exceptions have been included at the front of the Integrated Performance Report.						
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The Integrated Performance Report (IPR) provides an overall summary of the current position of health and social care in Gloucestershire. Issues in delivery will have an impact on our ability to deliver against the priorities for the health and care system that we have committed to. Our performance also feeds into the NHS Oversight Framework and influences segmentation decisions made by NHS England. There is a close link between the risks within the BAF and delivery of our objectives through the Integrated Performance Report.						
Management of Conflicts of Interest	None						

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

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

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Integrated Performance Report

March 2025

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Integrated Performance Report Contents

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Feedback from Committees

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

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System Resources Committee

Accountable Non-Executive Director	Jo Coast
Meeting Date	6 March 2025

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Performance Report	**SIGNIFICANT**	Committee have requested further work to be done on the Performance element of this report and greater insight into metrics and activity.	Performance team to review and work with system teams to develop the report, incorporating the suggested changes.	May 2025
Investments and Benefits Review	**LIMITED**	A small set of strategic schemes was brought before members to consider the impact of investments. The Committee agreed further work was to be carried out on the review process with criteria drafted.	Draft review criteria to be brought back to the Committee and impact of schemes to continue to be monitored.	May 2025
Planning Updates	**SIGNIFICANT**	The Committee received updates on the Joint Forward Plan, Operational Planning and 2025/26 Planning Guidance.	No actions required	N/A
Operational Pressures	**LIMITED**	Committee reviewed the Risk Report, particularly BAF5. It was agreed that the risk should extend its scope to cover Integrated Urgent Care Service (IUCS). Emphasising the importance to ensure that there is strong co-ordination and synchronisation across system risks.	Board Assurance Framework entry to be updated by lead directors as per usual process.	April 2025

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

Issues referred to another committee

Topic	Committee
None	None

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People Committee

Accountable Non-Executive Director	Karen Clements
Meeting Date	16 January 2025

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 presented their work programmes to the Committee.	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.	Ongoing as part of revised work programme for 2025/26
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 Board development session TBC
Equality, Diversity & Inclusion	**LIMITED**	Review of BAF and strategic risk relating to ED&I, decision to raise score	Participation in SW Leading for Inclusion SW EDI Work programme and delivery group – Regional workshop proposed for 10th April 2025. Revised work programme being developed for 2025/26	Ongoing as part of revised work programme for 2025/26
Oliver McGowan training	**LIMITED**	Difficulty in sustaining training across the system without appropriate levels of financial investment beyond current funding allocations. This would contravene guidance and could put patients at risk.	Business case completed as part of operational planning process. Re-prioritisation of places to NHS partners.	Funding provision in place until October 2025

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
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	5 February 2025

Issues identified at the Committee

Key Area	Assurance	Committee Update	Next Action(s)	Timescales
Complaints process at GHNHSFT	**LIMITED**	GHNHSFT continues to experience delays with responding to complaints. A Quality improvement (QI) project is underway to embed a new Complaints Standard Operating Procedure (SOP) within the Trust to clear the large backlog.	Recruitment of two new administrators in the team are expected to help with this improvements.	Update in April with trajectory requested.
CQC Adult Social Care Inspection	**LIMITED**	The CQC report for Adult Social Care was published on Friday 31st January 2025 with the service rated as 'Requires Improvement'. This reflected the council's self-assessment published last July.	Adult Social Care continuing to implementing changes with the service three years into a five-year transformation programme.	Ongoing.
GHNHSFT 2 week wait Breast service	**LIMITED**	The GHNHSFT Breast service has not been able to meet the national performance target of 93% since August 2023. The Trust has worked hard to improve and has now reached 86.5%. Despite the non-achievement of the 2 week wait target, the specialty maintained 62-day performance over the period ensuring the right patients were prioritised.	The recovery is fragile with substantive posts to be filled. Saturday clinics would be implemented until a reduction in the backlogs had been demonstrated	Review progress at next system Quality committee (23 April)
SHMI	**LIMITED**	While the SHMI remains outside control levels and the impact on the 12 month rolling data small, the monthly data revealed that in August and September 2024, the SHMI was 1.07. This much lower SHMI will pull through to the official data over the next 12 months.	Quality Improvement group remains in place (see Effectiveness slide for more information)	Ongoing

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

Issues referred to another committee

Topic	Committee
Updates on the new IUC service and systemwide impact to go to UEC Board with Quality elements coming to Quality Committee	UEC Board.

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Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Summary of Key Achievements & Areas of Focus

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Our Performance

Key Achievements

- The NHS in Gloucestershire has made significant progress in reducing the longest waits for treatment with the number of people waiting more than 52 weeks cut by almost two thirds in the last twelve months from 3,000 in March 2024 to 1,047 in January 2025. System performance against the Referral to treatment target (% of patients waiting under 18 weeks) is 67.4% in January, compared to 58.9% nationally. The total size of the waiting list is now at just under 77,500, reduced by 3,600 from its highest levels in 2023.
- In January, the total number of diagnostic tests carried out was once again the highest number recorded for the system (the third time this record has been broken this year).
- The Pharmacy First offer has helped over 35,000 local people to access assessment, advice and medications (where appropriate) for the seven conditions and other minor illnesses covered by the scheme in the first 12 months since its launch. The most common presenting illnesses for adults have been sore throat and uncomplicated urinary tract infection, and for younger people, earache and impetigo. The service is continuing to expand as more and more local people are choosing their local pharmacy as their first point of contact.

Areas of Focus

- The system performance against the Cancer Faster Diagnosis target is currently not meeting our plan with performance in January at 70.4% – this is due to staffing challenges in pathology and increased reporting turnaround times. There is a national shortage in this staff group so alternatives, especially for outsourcing and digital solutions, are being explored by GHFT and the cancer CPG.
- Dementia diagnosis rates have continued to decline, reflecting seasonal challenges. Performance in December 2024 saw 65.2% of the estimated population with dementia having a formal diagnosis and this has declined again in January to 64.8%. Significant work is ongoing in the system, in particular review of the Memory Assessment Service to reducing waiting times for assessment.
- Urgent and Emergency care performance continues to fluctuate, with the end of February seeing a deterioration in Emergency Department waiting times and ambulance handover time as demand increased. Work around system plans for 25/26 including maximising the use of out of hospital care and improving support for patient discharge are continuing as part of the operational planning process.

Our People (Workforce)

Our People

Please note: The Workforce report is updated bimonthly.

Key Achievements

Strategy & Planning
- 25/26 annual operational planning headline submission completed and submitted on 27th February.
- Following publication of 25/26 ops planning guidance have been reviewing and revising the draft Joint Forward Plan and Steering Group priorities.
- Due to the above, review of People Workstream governance structure to support required work to achieve ops plan targets for 25/26.
- Business case for Oliver McGowan remains under review as part of 25/26 Strategic Delivery Priorities process, however, the ICS lead role (Advanced Practice and AHP workforce lead) business case was unsuccessful.

Education & Training
- System-wide apprenticeship cohort 1 for project management commenced.
- Increase in non-clinical T-Level industry placements across the system.

Retention
- ICS staff housing needs survey launched with deadline for completion by end March. Housing providers now regularly sharing available accommodation.

System-wide Development Programmes
- Agreed focus for next ICS leadership conference will be EDI with external speaker/facilitator Tracie Jolliff.

EDI
- EDI dashboard developed in response to EDI board reporting recommendations (from Roger Kline).

International Recruitment & Pastoral Support
- Cultural awareness programme completed – five on-line sessions and two in-person train the trainer sessions enabling future in-house delivery.

Health & Wellbeing
- Review concluded and first draft of report circulated for review and feedback received.

Areas of Focus

Strategy & Planning
- 25/26 annual operational planning final submission to be submitted on 27th March.
- Review of AHP and Advanced Practice priorities required to ensure priority areas picked up.

Education & Training
- System level work experience offer being developed.
- Universal family (Care leavers) conference day planned
- Attendance at SW Virtual Careers day in May 2025

Recruitment
- Discuss and agree shorter TRAC application form for support workers, including neurodiverse stakeholders.

Retention
- Health and Social Care Support Worker appreciation event(s) being planned for existing staff in 25/26.
- Stay & Thrive event being planned to support existing international educated staff.
- Analysis of staff housing needs service.

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

Health & Wellbeing
- Second draft of review report to be circulated, taking on board feedback.
- Workshop to review recommendations and agree implementation plan and timescales.

Quality – Safety, Experience and Effectiveness

Quality

Please note: The Quality report is updated bimonthly.

Key Achievements

- **SHMI** - The latest official data shows that the Trust's SHMI has now dropped to 1.16 for the 12 months to September. Local monthly data (which stretches into October) shows that it has further reduced to 0.99 for the month of October.
- **Addressing Health Inequalities through Engagement with People and Communities:** A self-assessment and improvement framework for Integrated Care Systems national launched on 12 February 2025. Gloucestershire has been one of four national pilot sites, the only site to involve VCSE partners, and people with lived experience during the testing. The ICS is currently identifying opportunities to apply the Framework to programmes and projects. It is not mandatory to apply the framework. However, the data the framework collects will be useful evidence for future ICS CQC assessment.
- **CQC Maternity Patient Survey 2024** – Women/Birthing People report a positive experience of maternity care in the recently published report. Areas where feedback was particularly positive was around partners, induction of labour and mental health support. Areas to focus on in 2025 were care at home after birth and infant feeding support.
- **GHC** - The number of complaints acknowledged within the national 3-day requirement returned to 100% in January.

Areas of Focus

- Campaign to raise awareness of the public about the importance of baby's movements in pregnancy and the danger of using home dopplers in pregnancy – launch 17th March includes social media, information on local buses, and other resources.
- We want to better understand out of hospital mortality to ensure there are no care quality concerns.
- GHFT are focusing on improving complaint response times.
- Implementation of the Primary Care Patient Safety Strategy

Finance and Use of Resources

Finance

Key Messages: Month 11

Statement of Net Income & Expenditure Position (£'000)							
Month 11 2024/25 – February	**Month 11 Plan Surplus / (Deficit)**	**Month 11 Actual Position Surplus / (Deficit)**	**Month 11 Variance to Plan Favourable / (Adverse)**		**Full-Year Plan Surplus / (Deficit)**	**Forecast Outturn Actual Position Surplus / (Deficit)**	**Forecast Outturn Variance to Plan Favourable / (Adverse)**
Gloucestershire Hospitals NHS Foundation Trust (GHFT)	(2,342)	(2,133)	209		0	0	0
Gloucestershire Health and Care NHS Foundation Trust (GHC)	34	177	144		(0)	295	295
Gloucestershire Integrated Care Board (ICB)	0	0	0		0	0	(0)
System Surplus / (Deficit)	**(2,308)**	**(1,955)**	**353**		**(0)**	**295**	**295**

- The system financial plan included a significant amount of financial risk to achieve breakeven including a high savings value. Savings delivery including Working As One has slipped and a number of pressures have emerged in year, predominantly in non pay within GHFT, Continuing Health Care (CHC) and high cost placements. A number of mitigations, including improvements in run rate in GHFT and slippage from a number of programmes, have been and are continuing to be progressed and the year end forecast for the system remains at breakeven.
- The year to date income and expenditure position is a positive variance of £0.4m versus plan. This is attributable to non-recurrent benefits within GHFT, including balance sheet releases, prior year income and some planned savings delivered earlier than anticipated. GHC is also reporting a small surplus versus plan.
- The year end forecast is for a small surplus. Work is continuing to manage the financial position. Measures are mainly non recurrent and identification of recurrent savings is ongoing as part of planning for the Joint Forward Plan and 2025/26 operational planning. The forecast assumes delivery of elective recovery funding.
- Year to date capital expenditure is £19.8m behind the plan due in a number of schemes. Mitigations are in place to recover this position, and the full year forecast is £287k below capital allocation. NHSE is advised of this underspend.
- Agency costs for both GHFT and GHC remain below the 3.2% national cap.

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Detail of Key Achievements & Areas of Focus

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Improving Services & Delivering Outcomes

ICP Dashboard

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

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Overarching	0.1*	Life Expectancy	Life expectancy at birth (male)	79.7	81.4	79.3	77.9	81.0	81.1	80.0
	0.2*	Life Expectancy	Life expectancy at birth (female)	84.1	84.6	83.6	81.8	83.9	84.6	83.8
	0.3*	Premature mortality	Under 75 mortality rate from all causes rate per 100k	314.9	253.6	311.6	405.3	281.4	283.1	308.4
	0.4*	Infant mortality	Infant mortality rate	2.8	2.4	4.5	4.9	3.3	3.8	3.7
Pillar 1: Health and Wellbeing Board	1.1	Physical Activity	% of physically inactive adults	16.3	15.2	23.9	19.0	14.8	23.6	18.5
	1.2	ACEs	% of Children reporting 'When you are worried about something, is there a trusted adult you can go to for help?'	86.8	86.1	85.0	81.7	81.5	86.8	84.3
	1.3*	Mental Wellbeing	Emergency hospital admissions for intentional self-harm RATE per 100k	67.8	103.4	75.7	127.2	87.7	85.6	92.2
	1.4*	Social Isolation & loneliness	% of adults who feel lonely often/always	N/A	N/A	N/A	N/A	N/A	N/A	6.3
	1.5*	Healthy Weight	% Year 6: Prevalence of obesity (including severe obesity),	17.9	16.3	23.0	22.5	18.1	20.5	19.9
	1.6*	Early Years and Best Start in Life	Infant mortality rate	2.8	2.4	4.5	4.9	3.3	3.8	3.7
	1.7	Housing	% of households which are overcrowded in terms of bedrooms	1.9	1.2	1.8	3.5	1.6	1.4	2.0

Updated metrics indicated with *

Improving Services & Delivering Outcomes

ICP Dashboard

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

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 2: Transforming what we do	2.1	Health equity	Inequality in life expectancy at birth (male)	9	1.1	5.8	13.5	4.7	6.5	7.6
	2.2	Health equity	Inequality in life expectancy at birth (female)	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	N/A	N/A	N/A	N/A	N/A	N/A	538.2
	2.4*	Health equity	% School Readiness	69.1	73.3	69.0	65.6	67.2	71.7	68.2
	2.5	Employment exemplar theme	Gap in the employment rate between learning disability and overall employment rate	N/A	N/A	N/A	N/A	N/A	N/A	76.4
	2.6*	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage	16.7	15.4	24.7	17.0	17.1	13.2	16.7
	2.7*	Smoking exemplar theme	Smoking Prevalence in adults (18+) - % (three year average)	12.7	7.3	12.9	14.3	11.9	9.5	11.7
	2.9	Blood pressure exemplar theme	% of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	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

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

				Cheltenham	Cotswolds	Forest Of Dean	Gloucester	Stroud	Tewkesbury	Gloucestershire (against national)
Pillar 3: Improving Health and Care Services Today	3.1*	Improve access/ reduce backlogs	Numbers/breakdown of waiting lists by locality – rate per 1000	99.6	105.9	118.5	103.0	100.4	99.5	103.3
	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	21.1	12.7	14.4	23.0	13.3	16.6	18.1
	3.5*	Support Improvements in delivery of UEC	Emergency admissions – rate per 1000	10.0	9.0	11.8	11.1	8.9	10.7	10.2
	3.6*	Support Improvements in delivery of UEC	Long lengths hospital stay (proxy of availability of out of hospital support – rate per 1000).	0.62	0.67	0.51	0.48	0.59	0.78	0.58
	3.7	*Improve access to care: Cancer*	*% of cancers diagnosed at Stage 1 and 2, 2020*	54.0	53.7	54.1	52.6	46.8	54.2	52.4

Updated metrics indicated with *

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

Improving Services & Delivering Outcomes

ICP Dashboard – narrative

0.1 Life expectancy at birth (male)

Gloucestershire's life expectancy at birth (male) has been significantly better than the England average since at least 2010-2012 (when comparable data became available). The latest data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).

At district level Gloucester has a significantly worse life expectancy at birth (male) than the county and national average. It has had a significantly worse rate than the county average since 2010-2012 (when comparable data became available), and a significantly worse rate than the national average since 2013-2015.

Cotswold, Stroud and Tewkesbury have significantly better life expectancy at birth for males than the county average.

0.1 Life expectancy at birth (female)

Gloucestershire's life expectancy at birth (female) has been significantly better than the England average since at least 2010-2012 (when comparable data became available). The latest data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).

At district level Gloucester has a significantly worse life expectancy at birth (female) than the county and national average. It has had a significantly worse rate than the county average and national average since 2015-17.

0.3 Under 75 mortality rate from all causes rate per 100k

The Under 75 mortality rate for all causes has been significantly better than the England average since at least 2001-2003 (when comparable data became available). The latest data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).

At district level Gloucester has a significantly worse Under 75 mortality rate from all causes than the county and national average. It has had a significantly worse rate than the county average since 2001-2003 (when comparable data became available), and a significantly worse rate than the national average since 2013-2015.

Stroud and Cotswold have a significantly better Under 75 mortality rate from all causes than the county average.

Improving Services & Delivering Outcomes

ICP Dashboard – narrative

0.4 and 1.6 Infant Mortality
The Infant mortality rate has been similar to the England average since 2009-2011. The latest data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).At district level all districts have a similar infant mortality rate to the county average.

1.3 Emergency hospital admissions for intentional self-harm RATE per 100k
Gloucestershire's rate of emergency hospital admissions for intentional self-harm has been significantly better than the England average for 2 consecutive years. The latest data for 2023-2024 shows the rate has **significantly improved** since the previous period (2022-2023).
At district level Gloucester has a significantly worse rate of emergency hospital admissions for intentional self-harm than the county average, but a similar rate to the national average. It has had a significantly worse rate than the county average since 2010-2011 (when comparable data became available).
Cheltenham has a significantly better rate of emergency hospital admissions for intentional self-harm than the county average.

1.4 % of adults who feel lonely often/always
Gloucestershire's percentage of adults who feel lonely often/always is similar to the national average. The latest data for 2021-2023 shows there has been **no significant change** at a Gloucestershire level since the previous period (2020-2022).
Data is not currently available at district level.

1.5 % Year 6: Prevalence of obesity (including severe obesity)
The prevalence of obesity amongst year 6 pupils has been significantly better than the national average since at least 2007/08 (when comparable data became available). The latest data for 2023/24 shows there has been **no significant change** at a Gloucestershire level since the previous period (2022/23).
All districts have a similar prevalence of obesity amongst year 6 pupils to the county average. This marks a change from the previous year when the prevalence of obesity in Gloucester was significantly worse than the county average, and the prevalence of obesity in Cotswold was significantly better than the county average

Improving Services & Delivering Outcomes

ICP Dashboard – narrative

2.4 School Readiness: percentage of children achieving a good level of development at the end of Reception

Gloucestershire's percentage of children achieving a good level of development at the end of Reception has been similar to the national average for the last two years, in 2021/22 it was significantly better than the national average. The latest data for 2023/24 shows there has been **no significant change** at a Gloucestershire level since the previous period (2022/23).

In Cotswold, the percentage of children achieving a good level of development at the end of Reception is significantly better than the county average, while in all other areas the districts are similar to the county average.

2.6 Proportion of employee jobs with hourly pay below the living wage

Gloucestershire's proportion of employee jobs with hourly pay below the living wage is similar to the national average. All districts have a similar proportion of employee jobs with hourly pay below the living wage as the county average

2.7 Smoking Prevalence in adults (18+) - %

Gloucestershire's smoking prevalence in adults is similar to the England average. The latest data for 2021-2023 shows there had been **no significant change** at a Gloucestershire level since the previous period 2020-2022.

All districts have a similar smoking prevalence in adults to the county average.

3.1 – Waiting list (rate of people on elective waiting list per 1000 population)

There has been a reduction in the overall rate of people on the waiting list, and Gloucester has reduced to be no longer significantly different to the county average (there were previously significantly more people waiting in Gloucester for elective treatment than the county in general).

The Forest of Dean is now the only locality to have a rate significantly above the county average for people waiting for elective treatment.

Improving Services & Delivering Outcomes

ICP Dashboard: Indicator full description & source

No.	Indicator	Full indicator name and hyperlinked to source where available	Latest Data/Time period
0.1*	Life Expectancy	Life expectancy at birth (male)	2021-2023
0.2*	Life Expectancy	Life expectancy at birth (female)	2021-2023
0.3*	Premature mortality	Under 75 mortality rate from all causes	2021-2023
0.4*	Infant mortality	Infant mortality rate	2021-2023
1.1	Physical Activity	Percentage of physically inactive adults	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)	2023/2024
1.4*	Social Isolation & loneliness	Percentage of adults who feel lonely often/always	2021/2-2022/23
1.5*	Healthy Weight	Year 6: Prevalence of obesity (including severe obesity)	2023-24
1.6*	Early Years and Best Start in Life	Infant mortality rate	2020-2022
1.7	Housing	Percentage of households which are overcrowded in terms of bedrooms	2021
2.1	Health equity	Inequality in life expectancy at birth (male), 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,	2023/2024
2.5	Employment exemplar theme	Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	2022/2023
2.6	Employment exemplar theme	Proportion of employee jobs with hourly pay below the living wage	2024
2.7*	Smoking exemplar theme	Smoking Prevalence in adults (18+) (three year average)	2021-2023
2.9	Blood pressure exemplar theme	Percentage of patients 18+ with GP recorded hypertension & bp reading in last 12m is below the age appropriate treatment threshold.	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).	January 2025
3.2*	Improve access to care – primary care	Primary care: GP headcount per 100k population (General Practice Workforce - NHSD) – *note quality concerns have been raised with this metric – exploring with BI and primary care*	May 2024
3.3	Improve support for people with mental health conditions	SMI physical health check uptake	March 2024
3.4*	Support Improvements in delivery of Urgent and Emergency Care	A&E attendances - Rate per 1000 population	January 2025
3.5*	Support Improvements in delivery of Urgent and Emergency Care	Emergency admissions - Rate per 1000 population	January 2025
3.6*	Support Improvements in delivery of Urgent and Emergency Care	Long lengths of hospital stay over 21 days rate per 1000 population	January 2025
3.7	Improve access to care: Cancer	Percentage of cancers diagnosed at Stage 1 and 2, 2020	2020

ICP notes and caveats

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

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

Improving Services & Delivering Outcomes

Urgent & Emergency Care

- In February Gloucestershire Hospitals NHS Foundation Trust (RTE) saw 60.6% of patients within 4 hours of less in a Type 1 setting. Gloucestershire ICB saw 75.5% of patients in all settings within 4 hours. Compared to last month, GHFT's & Gloucestershire ICB's performance decreased for Type 1 from 62.8% and for all settings from 77.0%. Of the 122 providers with Type 1 A&E service, GHFT ranked 45th . This is lower than last month's ranking of 26th. Gloucestershire ICB ranked 12th out of 42 ICBs in overall percentage of attendances within 4 hours and 13th of the 42 ICBs with type 1 activity. Last month the ICB ranked 3rd for overall attendances and 7th for Type 1. There have been several challenging days in February, particularly at the end of the month which has put pressure on performance.
- Ambulance response times have improved in February with Category 2 incident response times averaging 40.2 minutes (over 10-minute improvement on January's average), and Category 1 response times averaging 9.6 minutes (30 second improvement on January performance).
- The Operational Plan for 2025/26 focuses on timely care in the UEC area, with particular emphasis on reduction of long waits that contribute to patient harm (12 hour waits in ED), as well as holding the national interim 4-hour target at 78% (as per the 2024/25 plan). The plan also asks for a reduction in hospital ambulance handover delays to help support improvements in ambulance response times.
- The number of patients who have a discharge ready date has remained stable, despite seeing improvements in the most recent weeks for the number of patients with stays over 21 days. Focussed work is continuing around the length of stay in discharge beds (Pathway 2) as there are high levels of variability seen.
- A "Call before convey" trial will be running for 10 weeks (commencing , where paramedics responding to calls in nursing or residential care homes for patients with new confusion or delirium will call the Single Point of Clinical Access before conveying the patient to hospital to maximise admission avoidance opportunities where not in the patient's best interest.

Improving Services & Delivering Outcomes

Elective Care

- In January, there were 67.4% patients waiting under 18 weeks for treatment or elective care against the RTT target, while GHFT have achieved 66.9%. Comparative national performance is currently 58.9%. Performance is currently stable and based on the November 2024 position, the ask for Gloucestershire is to achieve 72.1% as an interim RTT recovery target by March 2026. This is in line with the national expectation of a 5% improvement in RTT throughout 2025/26. Additionally, the operational plans sets out expectations around the time patients wait for their first appointment – current performance is that 68.1% of patients are waiting under 18 weeks for their first appointment, and the expectation is that this will improve to 73.1% by March 2026. The national recovery plan for elective care sets out the longer-term ambition to meet the 92% RTT standard by March 2029.
- There has been a further decrease in overall numbers of 52 week waits for the ICB to 1,047 from 1,378 last month with ENT remaining a particular pressure area with 334 in January. ENT accounts for 32% of all 52 week waits in the system, however this has come down from 38% of 52 week waits in December. There were 20 over 65 week waits for Gloucestershire patients in January – GHFT accounted for 11 of the total 65 week waits – eight in Ophthalmology and three in Trauma and Orthopaedics. Those waiting over 52 weeks in Gloucestershire make up 1.4% of the total waiting list – half that of those waiting nationally (2.8% of total waiters).
- Actions to support performance are focussed on patients with the longest waits – in particular use of additional capacity to support ENT from the independent sector and general focus on booking all patients with waits of over 52 weeks to ensure none reach 65 weeks. Delayed follow up lists have remained stable, which is an area of focus for GHFT, with the elective care hub validating overdue follow ups to ensure resource is used appropriately.
- Performance against the Elective Recovery Fund (ERF) target at Month 10 (January) is currently 107% against a target of 117%. This is a FLEX data position, so is likely to increase – if all uncoded activity is accounted for the month, this would increase to 115.7%. The YTD performance to month 9 (December) is currently 117.4% (compared to 2019/20 activity adjusted for cost weighting). An Independent sector provider has moved to sending data to SUS and we are now starting to see this data flow through to our ERF position so there is a positive change in our forecast position.

Improving Services & Delivering Outcomes

Cancer

- Faster Diagnosis Standard (FDS) performance has dropped in January to 70.4% (people receiving a diagnosis or all clear following a cancer referral within 28 days of the referral being made), reflecting capacity constraint and patient choice over December (Lower GI and Upper GI performance in particular both dropped compared to previous months). A recovery trajectory is in place to support overall 28-day performance which includes additional capacity and a focus on diagnostic pathology turnaround times, as well as modelling to support services offering first appointments by day 7 following referral (rather than 14 as has been the average through 24/25).
- 31-day treatment performance decreased from 97.2% in December, to 91.7% in January, again driven by seasonal challenges. Gynaecological and Kidney cancer are particularly challenged, however several larger specialties also saw a drop in performance due to capacity or patient choice including Upper and Lower GI and Breast.
- 62-day performance had improved in December, and reached the 70% interim recovery target (patients treated within 62 days of referral), with overall performance at 72.7%, but this declined slight in January to 68.1%. The three main areas with larger numbers of breaches were Prostate, Lower GI and skin – higher volume specialties, where additional resource has been deployed to help reduce the backlog of patients waiting beyond 62 days.
- Surgical capacity is constrained by consultant workforce, particularly across gynaecology and urology pathways. Increased nurse/practitioner led clinics are being implemented to free up consultant resource and increase surgical capacity. Locum support and additional theatre lists are in place which will help to deliver the interim national recovery target of 70% against the 62-day standard in March 2025. Work is currently underway to agree performance expectations for our operational plan for 2025/26, with national targets set to 80% for the FDS standard and 75% as a further interim recovery target for 62 day treatment.

Improving Services & Delivering Outcomes

General Practice

- 364,453 appointments were delivered in general practice in Gloucestershire in December 2024. Same day appointments made up 44.0% of these – 160,761 appointments across the month reflecting high demand for primary care with high volumes of seasonal illness circulating in the county. Appointment activity continues to be well above the operational plan for 2024/25, and was 10% higher than for December 2023.
- A new GP contract has been provisionally agreed nationally with uplift to funding.
- The Autumn Winter vaccination campaign concluded on 31/01/2025 with 160k booster doses of Covid-19 vaccines given in Gloucestershire. The ICB finished with the highest uptake rate of all ICS in the country. Uptake in the age related (>65) and Care Home resident cohorts was particularly strong with over 82% of our over 80s and Care Home Residents boosted. The Spring campaign is due to commence on the 1st April 2025.

Dental

- Dental Market Engagements - The ICB will be carrying out a series of market engagements in March 2025, which is part of the development of the Gloucester City based new dental access centre.
- Dental Commissioning Plan Stocktake - The ICB team have undertaken an internal Dental Commissioning Plan Stocktake to review dental priorities and outstanding actions, to look ahead into 2025/26 at the next steps required and a workplan.
- National Operational Planning Guidance - shared with ICBs in February 2025 confirms Urgent Dental Care as a priority and an additional 700,000 appointments to be commissioned across England for 2025/26. This equates to over 11k appointments for Gloucestershire. The ICB will be prioritising this work and subsequent actions once further detail has been received, to continue to increase Urgent Care provision in Gloucestershire.

Improving Services & Delivering Outcomes

Diagnostics

- Diagnostic performance in January has declined slightly compared with the December position, from 15.9% patients waiting over 6 weeks for a test to 17.4%. GHFT performance was 18.5%. Following the decline in activity seen in December, overall provision of diagnostic tests has continued to increase, with January showing the highest number of tests carried out on record for the third time in 2024/25. The waiting list has remained stable despite increased activity reflecting new demand seen in January following the festive period.
- Patients waiting over 13 weeks have increased to 679 patients in January – with Echocardiography, Peripheral Neurophys and MRI the three modalities with highest numbers. Echocardiography performance appears to be driving the overall DM01 fluctuations in performance throughout 2024/25. Additional capacity in this modality will be rolled out through the CDC in 2025/26 which will help to improve performance.
- For Endoscopy, additional evening and weekend resource has been agreed to support enhanced activity to the end of March – this will help to further improve performance and reduce the backlog of patients waiting for these diagnostic tests, building on the consistent reduction in the waiting list seen throughout 2024/25 to date. Gastroscopy performance has stabilised, with the waiting list now at a sustainable level. Colonoscopy saw the lowest number of patients waiting over 6 weeks (155) in January since December 2022 – showing the impact of the recovery work that has been taking place.
- Diagnostics was identified as a key enabler in the national “Reforming elective care for patients” published at the start of January. With expected focus on increased use of Community Diagnostic Centres, innovation of diagnostic pathways and increasing straight-to-test and direct access diagnostics where possible, it is likely that demand across most modalities will continue to increase. The Clinical Programme Group is considering the implications of future growth on existing services and beginning to plan for the next phase of transformation work in diagnostics to support operational services.
- CDC activity continues to deliver at expected levels, with no concerns for 24/25. The CDC benchmarks well against other sites, particularly for imaging activity levels. The activity plan for 25/26 has been submitted.

Improving Services & Delivering Outcomes

Mental Health

- Dementia diagnosis rates have continued to decline, reflecting seasonal challenges. Performance in January 2025 saw 64.8% of the estimated population with dementia having a formal diagnosis – down from 65.2% in December 2024. Significant work is ongoing in the system, in particular review of the Memory Assessment Service to reducing waiting times for assessment.
- Access to perinatal mental health services continues to exceed targets, with a rolling 12-month access rate of 672. Latest 12 month access is 835 across Gloucestershire. Performance against the 2-week assessment threshold was 48% in January, missing the 50% target for the first time in 4 months. Breaches were generally due to patient DNAs or cancellations, but staff sickness also restricted capacity in the team. The team hosted the recent South West Perinatal network meeting where they shared examples of the pilots currently running and successes with reaching women who are harder to engage. This is being shared nationally as best practice by NHSE following the event.
- Out of Area placement days remain lower than in previous years and Gloucestershire has been held up as the best performer across the South West in this area. There have been no patients remaining out of county at the end of the month cross Q3 of 2024/25.
- CYP access continues to be strong across all providers, with latest national data showing access exceeded our target (8985 against the 7340 target in December 2024). Compliance with the 4-week waiting time target has dropped slightly in January 2025, with 68% of referrals receiving their initial appointment within 4 weeks (below the 80% target). The LD CYP service met the 80% 4 week wait threshold, with 100% of referrals receiving their first appointment within 4 weeks in January.
- The Talking Therapies service continues to demonstrate strong recovery rates, achieving 68.5% in January 2025 well above the target of 67%. The reliable recovery rate (for patients meeting caseness at the start of their therapy course – i.e. patients whose clinical anxiety or depression exceeds a defined threshold, as measured by talking therapy outcome measures specific to their symptoms) was 48.9%, meeting the target of 48%. The service has continued to reduce the “in-step” waiting time, i.e. the time between first and second appointment for treatment, in line with national ambitions.

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(System Resources Committee)

Detail of Key Achievements & Areas of Focus

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Education, Training and Development

- First cohort of the level 4 Associate Project Management apprenticeship has started with 28 apprentices from across the system, including Social Care, Primary Care, GCC and NHS Organisations. This is a closed cohort for Gloucestershire with Corndel training provider. Looking to run a second cohort in October 2025
- Developing career pathways with the ICB PMO team to support project management career development across the system.
- Exploring a closed Gloucestershire cohort for L3 and L5 leadership and management apprenticeships to run in September 2025
- Healthcare Science and AHP careers event attended at Cleeve Secondary school in conjunction with the Medical Science and Engineering department at GHFT. Over 120 people attended with stands from multiple professional groups across the NHS, showcasing different professions and routes in.
- Continued career conversations with a range of individuals seeking support and guidance on application processes, personal statements, and career choices.

Arts Health & Wellbeing Centre

- Small Grants in Research and Evaluation – Round 2
    - 32 applications received for 2nd round of small grants in research, evaluation and innovation.
    - 14 proposals have been shortlisted with a Dragons Den taking place on 28th March and 4th April 2025.
- Launch of the Research Hub on 6th March 2025 with attendance from GHFT, GHC, GPs, social care, ICB and some from the VCSE sector representing underserved communities.
- Positive Risk Taking Film wins a South West Personalisation Award
    - Risking Happiness 2 film (funded by the AHWC grant monies) won in its category of 'Giving confidence' in the NHSE SWIPC Awards in February.
    - This is a great piece of creative health work and there are some great plans to embed the work in the system and in education and training.

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Please note: The Workforce report is updated bimonthly.

Our People (Workforce)

Our People Strategy: Focussed Pillars

Valuing and looking after our people

- The Health and Wellbeing review (HWB) data collection and analysis phase was completed and a first draft of the report circulated to HRDs and Health and Wellbeing leads for review.
- Feedback has been received; a second draft is being written, and a workshop being planned to bring together stakeholders to agree recommendations and an implementation plan
- The review found many HWB services offered across the partner organisations (in scope of the review) with a high potential to collaborate to provide more consistent services across all the partners. The review found many good examples of interventions although data relating to impact and cost-effectiveness is challenging to extract (one of the recommendations pertain to improving this)
- An area which needs greater focus is development for managers to support the HWB of their staff, whilst a number of good programmes are available to address this, the take-up remains variable.

Retention

- A system wide Support Worker appreciation and upskilling event is being planned for 25/26 Q2 to include networking and upskilling opportunities.
- £3k was successfully bid for from NHSE to hold a system wide learning and networking event for our international colleagues :
    - the event will focus upon connecting people and diasporas from within the system to build better belonging and networks in the county
    - it will cover two of the four 'pillars' – building belonging and maximising personal and professional growth
    - there will be a morning and afternoon session, repeated, to allow a larger cohort of internationally educated colleagues to attend
    - colleagues will be able to "pick and mix" what they would like to participate in and choose their area of development or learning. This could include picking a revalidation session, or information about local events or activities, leadership development opportunities or cultural aspects of UK working.

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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

Leadership and Culture:

- The third Leadership Conference is being planned for spring 2025. The focus for this will be EDI and Tracie Jolliff will be facilitating this for us.
- The system-wide coaching platform (My e-coach) has been extended for a further 12 months pending outcome of a review of need and collaboration appetite to share coaches and mentors.

EDI

- A further cohort of the Inclusion Allies Programme is being planned by the ICS Partners. This will likely run in 2025/26
- Following a review of EDI Board reporting recommendations, (Are you serious? Thirteen questions for Boards to ask about NHS race equality data in your organisation, by Roger Kline) an EDI dashboard has being developed.
- A Cultural awareness programme “Building a Culture of Conscious Inclusion (BCCI)” commissioned by Independent Sector Staff and run by the SWC CSU; this was also extended to NHS staff . Five on-line workshops (30 attendees) were held and two face-to-face Train the Trainer workshops (17 delegates) that will allow partners to run the programme themselves in the future.

Digital, Data and Technology

- Digital workforce strategy in has been developed with four areas of focus:
    1. Development of Digital Skills and Education offer for all staff to develop and enhance digital literacy
    2. Support and develop digital specialists (including clinical informaticians) across the ICS
    3. Delivery of Technology Enhanced Learning (TEL) as a key enabler for training both digital skills required and innovative methods of education
    4. Development and optimisation of current workforce systems for the ICS

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One Gloucestershire
Transforming Care, Transforming Communities

NHS

Improving Services & Delivering Outcomes (Our Performance)

(System Resources Committee)

Our People

(People Committee)

Quality (Safety, Experience and Effectiveness)

(Quality Committee)

Finance and Use of Resources

(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

Maternity

- The Quality Improvement Group (QIG) chaired by the CNO continues following the CQC section 31 warning notice issued in May 2024. The inspection report was published 10th January 2025. The service remains rated inadequate and on increased surveillance, under the National Quality Board guidance. The QIG remains bi-weekly with progress being seen in the five workstream/areas of concern identified by CQC. Two workstreams have become business as usual to be monitored through Trust governance processes. The QI programme also includes two other areas identified as a concern for the maternity & neonatal service; antenatal screening and scanning capacity.

- There has been a focus on ultrasound scanning capacity for reduced fetal movements, as national standards of a scan within 24 hrs are not being achieved, Progress is being made however pregnancy USS remains on the Trust and ICB risk register and is being closely monitored through the QIG. A second still-birth review is currently underway with oversight from the MIA's. The service remains on the NHSE Safety Support Programme with Midwifery and Obstetric Improvement Advisors continuing to support the service. The Trust also reports all progress monthly to the CQC. The Trust have now redesigned the Maternity governance structure & this is being implemented with Trust senior oversight reporting escalations of concern to the Maternity Delivery Group chaired by the Trust CNO. Midwifery staffing has significantly improved with recruitment to establishment expected by end of March 2025. This will now be downgraded on the Trust and ICB Risk Register

Maternity Interface with GPs

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

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Assurance

Pharmacy, Optometry and Dentistry (POD)

- The POD Q3 Quality Report has been received from the SW Collaborative Commissioning Hub (CCH). There were 5 GPhC inspections for GICB in Q3 – all standards were met. Action plans are in place for 2 pharmacies inspected in Q2 where standards were not met. 1 dental safeguarding investigation continues.
- 5 pharmacy, 1 optometry and 4 dental complaints were received by the CCH in Q3.

Community and Mental Health

- GHC have made a sustained improvements in the quality and safety of the care being provided at Berkeley House in line with requirements of the CQC Section 31 notice from October 2023. An Enhanced Oversight Group, is now in place to retain the system commitment to supporting Berkeley House, to successfully discharge the remaining patients into the community. Once there is confidence in Discharge dates GHC will consider their application to the CQC regarding the lifting of the section 31.

- An increase in Pressure Ulcers has been seen across the trust, prompting a review of the risk level. Next steps are to look at standardizing data reporting slides and looking at thematic findings over time.

- Progress is being made to improve safeguarding performance involving the provision of training such as the continuation of older person's Domestic Abuse training for Charlton Lane Hospital and the first sessions of Adult Supervision taking place in January. The number of complaints acknowledged within the national 3 day requirement returned to 100% in January.

Migrant Health

- Beachley Barracks is still planned to return to 1st Rifles by March 31st and the draw down continues. RSOM is now closed with a small number of families remaining in Transitional Service Families Accommodation (TSFA).There has been a small increase in the number of local properties being matched to families. Numbers remain steady in our contingency accommodation.

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 January and February 2025 six PSIIs have been opened; one for GHC and four for GHFT. These four PSIIs will go forward for a full investigation with the respective Trusts' boards holding oversight, as is policy under PSIRF.
- All relate to potentially avoidable deaths.

Quality Alert

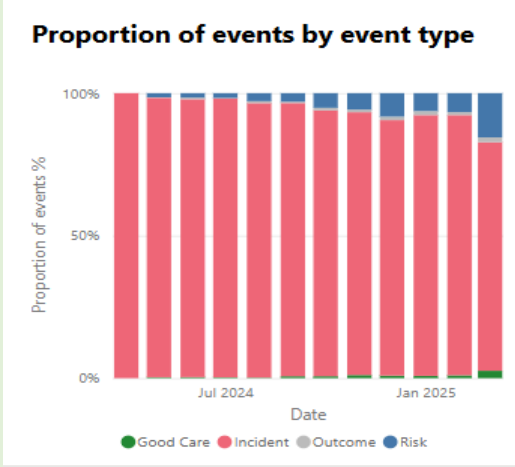
- We received 15 Quality Alerts during January and February from six different practices. While the volume is too low to consider reports a trend, there appears to be on ongoing theme to alerts around communication and administration.
- All alerts and investigated with reports now going back to the reporter.

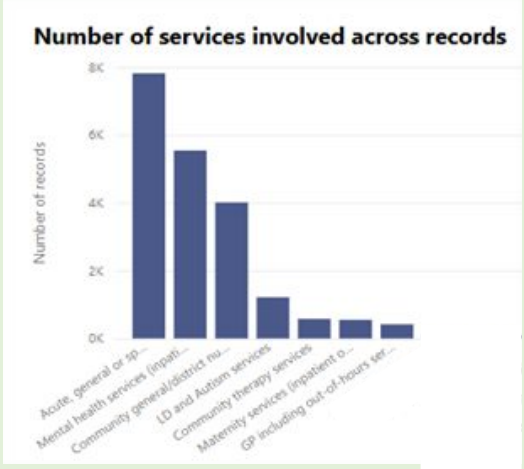
Primary Care Patient Safety Strategy

- NHS England recently launched the new Primary Care Patient Safety Strategy
- We have now started to work with Churchdown practice to explore how this can be implemented.

Learn from Patient Safety Events (LFPSE)

- NHS England have updated the tool that will eventually enable ICBs to look at whole system LFPSE data. While it cannot yet be used for planning or official statistics (due to lack of data validation) it is starting to show what might be possible in the future.
- As the tool adds more data, Gloucestershire is looking a little different than other ICB areas. Alongside the reporting of incidents, we are seeing an increase in the identification of risks, and the reporting of good care. (Risk is shown as a blue bar and 'good care' as green in the top chart). Other areas appear to be categorising everything as an incident, which is contrary to the intention of Patient Safety Strategy.





Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Experience

Friends and Family Test (FFT) April – December 2024 (latest available data)

		Apr-24 Provider	May-24 Provider	Jun-24 Provider	Jul-24 Provider	Aug-24 Provider	Sep-24 Provider	Oct-24 Provider	Nov-24 Provider	Dec-24 Provider	Jan-25 Provider	Feb-25 Provider	Mar-25 Provider	
GHT Inpatients	% Positive	92%	92%	93%	94%	93%	92%	93%	93%	94%				
	% Negative	4%	3%	4%	3%	3%	4%	3%	3%	3%				
GHT A&E	% Positive	79%	78%	76%	79%	81%	77%	76%	79%	77%				
	% Negative	14%	16%	16%	14%	13%	15%	16%	14%	15%				
GHC Mental Health	% Positive	86%	80%	94%	81%	89%	86%	81%	90%	90%				
	% Negative	6%	9%	3%	10%	7%	5%	11%	6%	5%				
GHC Community	% Positive	95%	93%	86%	94%	95%	94%	94%	94%	94%				
	% Negative	2%	3%	8%	2%	2%	3%	2%	3%	3%				

The Friends and Family Test (FFT)

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

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

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

There are three key metrics we pay close attention too:

- The **Crude Mortality rate** is not adjusted for age, sex or other demographic factor and so caution must be taken when looking at it in isolation. Crude percentage mortality for elective admissions is currently at 1%, against the English average of 1%. For non-elective it is currently at 3.1%. This is below the English average of 3.4%.

- The **Summary Hospital-Level Mortality Indicator (SHMI)** has reduced but remains outside of control levels. The latest official data shows that the Trust's SHMI has now dropped to 1.16 for the 12 months to September. Local monthly data (which stretches into October) shows that it has further reduced to 0.99 for the month of October. This much lower SHMI will pull through to the official data over the next 12 months.

- **In Hospitals deaths** are relatively low at 65% compared to the England rate of 69%.

SHMI for **Out of Hospital deaths** following an admission to Cheltenham has been a cause for concern. Local data for October suggests an improving picture. This is currently being investigated.

Please note: The Quality report is updated bimonthly.

Quality – Safety, Experience and Effectiveness

Effectiveness

The Quality Improvement Group (QIG) set up to support our system remains in place and focuses on:

- Improvements in coding
- Reduction in variation
- Improvement in condition specific coding

Improvements in Coding
Most non-elective patients who contribute to SHMI are coded on admission by AMU. A Quality Improvement Project has been set up to improve coding by clinicians. This is making good progress and has contributed to the reduction in monthly SHMI rates. Local data for October 2024 shows that the Trust matched 'Expected' and 'Observed' mortality for the first time. This improvement is a remarkable transformation but must be sustained to return the official SHMI statistic to within control levels.

Reducing variation and improving condition specific coding
Some diagnosis groups including pneumonia, septicaemia, COPD and 'other' Gastrointestinal appear to be outliers with statistically higher SHMIs. The Trust are investigating this issue which appears to link to admission coding.

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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NHS

ICS Finance Report

Month 11 2024/25 – February 2024

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Finance and Use of Resources

Key Financial Performance Indicators : Dashboard (1)

	Month 11			Previous Month Variance	Month 11 Actual		
	Plan	Actual	Variance		GHC	GHFT	GICB
Overall System Financial Performance			Surplus / (Deficit)				
Year to Date (£m)	(2.308)	(1.955)	**0.353**	**0.32**	0.177	(2.133)	0.000
Year End Forecast (£m)	(0.0)	0.3	**0.3**	**0.0**	0.3	0.0	0.0
Efficiency Plan Status							
Year to Date Delivery (£m)	83.7	80.6	**(3.1)**	**(2.7)**	12.3	32.4	35.9
Year to Date Delivery (%)	100%	96%	**(4%)**	**(4%)**	102%	100%	91%
Forecast Outturn Delivery (£m)	93.24	91.23	**(2.0)**	**(2.53)**	12.98	37.39	40.86
Forecast Outturn Delivery (%)	100%	98%	**(2%)**	**(3%)**	100%	100%	95%
System Capital			Over / (Under)				
YTD spend against total CDEL (£m)	50.95	31.16	**(19.8)**	**(20.90)**	3.04	27.16	0.96
FOT spend against total CDEL (£m)			**(0.3)**	**0.60**			

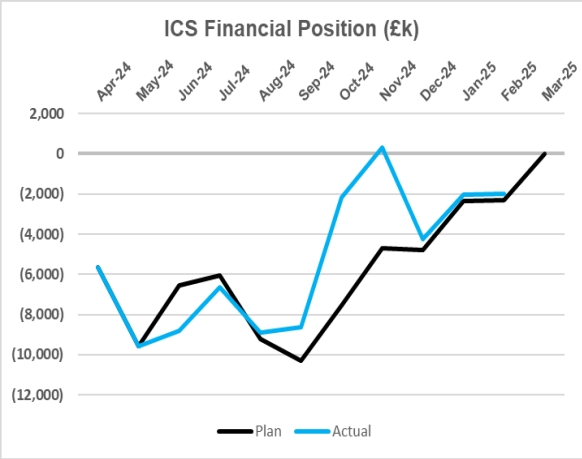
Finance and Use of Resources

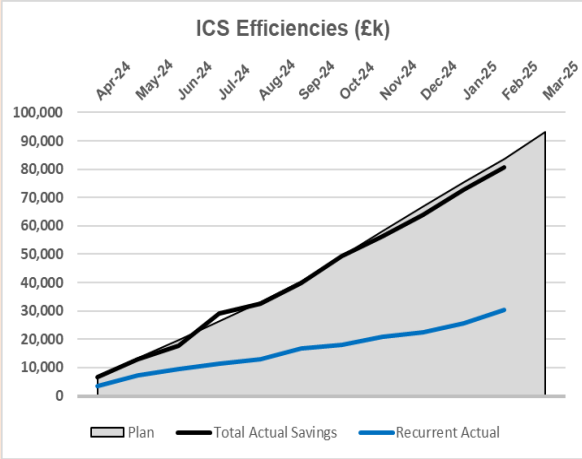
Key Financial Performance Indicators : Dashboard (2)

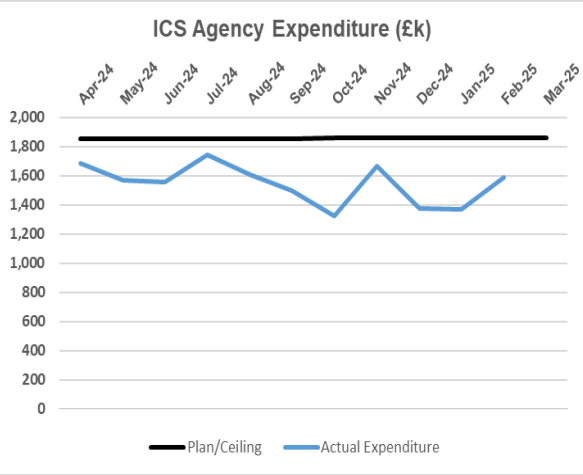
	Month 11			Previous Month	Month 11 Actual	
	Plan	Actual	Over / (Under)		GHC	GHFT
Workforce						
Year to Date Agency expenditure v Cap (£m)	20.5	17.0	(3.5)	(3.2)	4.8	12.2
Forecast Outturn Agency expenditure v Cap (£m)	22.3	18.2	(4.1)	(4.6)	5.3	12.9
YTD Agency spend as % of total Staff costs	3.2%	2.5%	(0.7%)	(1.0%)	2.2%	2.6%
Liquidity (Cash)						
Year to Date Cash Balance v Plan (£m)	83.0	99.4	16.4	(0.7)	52.3	47.1
Forecast Outturn Cash Balance v Plan (£m)	81.2	91.8	10.7	9.8	54.8	37.0
Other Key Financial Indicators						
Better Payment Practice Code (no. organisations not complying with 95% payment volume and value targets)			1	1		
Elective Recovery Fund fully coded flex performance v 19/20 baseline			118.2%	116.6%		

Finance and Use of Resources

ICS Financial Performance Overview: Analysis (1)







Key risks to delivery of the financial plan:

- Increased CHC and Placement costs
- Delivery of the system savings plan.
- Under delivery of elective activity leading to a reduction in ERF income and a shortfall in the system plan.

System Financial Position
The System set a challenging plan to deliver financial breakeven. Savings schemes have progressed, however, there is under delivery and the value of recurrent savings lower than needed to maintain or improve the underlying financial position: This will impact on the position for 2025/26 and has been included in the 2025/26 plan.

The year to date position is a positive variance to plan of £0.4m. This is due to non-recurrent benefits within GHFT. The GHFT benefits are offsetting other overspends in nursing pay, non pay in the medicine division drugs and clinical supplies. The ICB has overspends in continuing health care & placements which are under review. All organisations forecast breakeven by year end. Recovery actions are in place within organisations to manage spend in line with plan and identify further savings.

Efficiencies: Working as One savings will not be delivered in 2024/25, work is continuing to assess the level of recurrent savings based on updated trajectories and non recurrent mitigations are being progressed. The forecast outturn recurrent level of savings is 37.6% of total savings which is below the value required to maintain the underlying financial position.

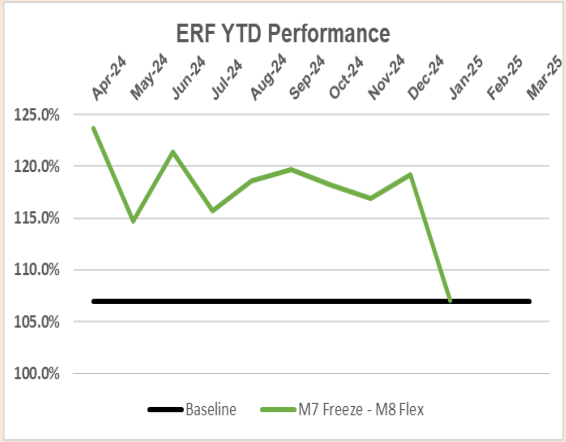
Agency: M11 agency expenditure was £1,588k. The year to date expenditure v total pay bill is 2.6% for GHFT and 2.2% for GHC.

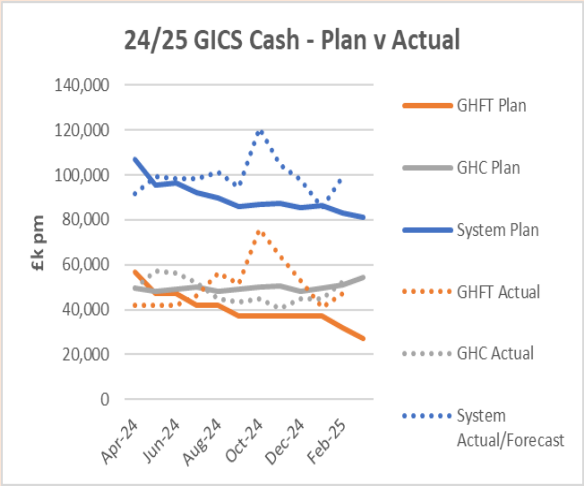
Finance and Use of Resources

ICS Financial Performance Overview: Analysis (2)

Full Year Charge Against Capital Allocation (£m)

System Capital Allocation	45.1
Disposal	0.0
Nationally Funded Schemes	3.8
IFRS 16 Leases	4.5
Operational Capital Allocation	**53.4**
Forecast System Capital expenditure	(44.8)
Disposal	0.0
Forecast NHSE Schemes expenditure	(3.8)
Forecast IFRS 16 Leases expenditure	(4.5)
Forecast Capital Expenditure	**(53.1)**
Forecast Variance to Capital Allocation	**0.3**





Better Payment Practice Code (BPPC)
Target = 95%

Organisation	YTD Volume %	YTD Volume Achieved ?	YTD Value %	YTD Value Achieved ?
GHC	82.0%	N	90.7%	N
GHFT	98.5%	Y	96.1%	Y
GICB	97.1%	Y	99.7%	Y
System Average	**95.2%**	**Y**	**97.6%**	**Y**

Capital
Capital expenditure is forecast to be £287k below the capital allocation. This underspend has been communicated to NHSE.

Elective Recovery Fund (ERF)
The national target for Gloucestershire 107% value weighted activity (VWA) compared to 19/20 activity. The ICS plan is 118% VWA of 19/20 activity.
Within the M10 flex position there are a number of uncoded episodes of care which once coded may generate an additional c£1.3m to ERF achievement and improve the position at 115.7% VWA. Work is underway to look at non recurrent activity that can be delivered prior to year end to improve the position.

Cash
The year to date system cash position is £16.4m favourable to plan. Cash forecasts are under regular review by organisations given the challenging financial position. The GHC position is slightly ahead of plan, whereas the GHFT position is significantly more positive to plan.

Better Payment Practice Code
The system is achieving target in respect of YTD volume and value of invoices paid. GHC is below target due to a focus on clearing old invoices, and tightening up on procedures for receipting. This is impacting short term performance. There is an action plan in progress within GHC to improve its BPPC achievement. GHC BPPC performance forecast to improve to 93% by March 25.

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. The Working as One programme savings are now forecast to slip by £5.7m - £6.2m.	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 the impact of non delivery of recurrent savings.
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. There is a forecast range of activity, depending on the final activity delivered of between £0.6m under to full delivery..	The 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. Additional focus on ensuring that all activity delivered has been coded..
Two new significant NICE TAs are in progress and 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 in 2025/26.	The potential impact on services and costs is being reviewed to assess the most appropriate service model, the system is responding to consultations as they are issued. A budget has been allocated in the 2025/26 plans, works continues to assess the risk against this budget
Primary Care: high risk of contract handback due to growing operational & financial pressures. Indicative direct costs £0.6m-c£1m per practice.	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices is underway to identify issues early and work with practices on mitigating actions which can include investment in training and additional support.
Publication of new MH White paper; this is assessed to impact now in 2025/26	Circa £1m of additional costs in respect of more staff to deal with new processes outlined in paper.

Finance and Use of Resources

System Savings Delivery Summary

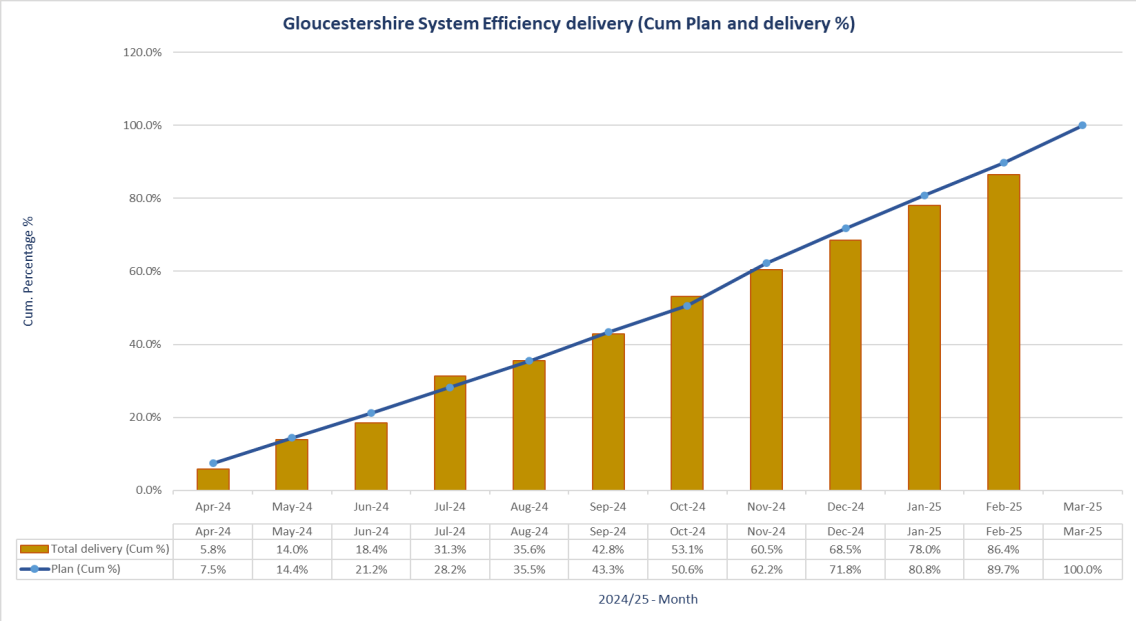
GLOUCESTERSHIRE SYSTEM SAVINGS SUMMARY

	PLAN	FORECAST								
Organisation	Savings requirement	Forecast Savings	Forecast Savings Variance	Unidentifed	Identified Schemes Total	High	Medium	Low	Recurrent	Non-Recurrent
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gloucestershire Hospital's NHS Foundation Trust	37,389	37,389	- 0	66	37,322	66	527	36,795	10,865	26,524
Gloucestershire Health & Care NHS Foundation Trust	12,980	12,980	-	1,333	11,647	1,332	822	10,826	6,139	6,841
ICB	29,578	31,740	2,162	-	31,740	-	1,069	30,671	15,856	15,884
System-Held - (Incl. part of £15m Recovery)	13,293	9,120	- 4,173	-	9,120	-	1,457	7,663	1,457	7,663
Gloucestershire System Financial Savings Plan - 2024/25	**93,240**	**91,229**	**- 2,011**	**1,399**	**89,829**	**1,398**	**3,875**	**85,955**	**34,317**	**56,912**
Percentage (%) of Forecast identified					**98.5%**					
Percentage (%) of Forecast - Risk Rating						**1.5%**	**4.2%**	**94.2%**		
Percentage (%) of Recurrent v Non-Recurrent									**37.6%**	**62.4%**

Finance and Use of Resources

System Efficiencies: Performance

	System Plan	System Actual	Over / (Under) Delivery	GHC	GHFT	GICB
Efficiency Plan Delivery (YTD £k)	83,658	80,583	**(3,075)**	12,306	32,398	35,879
Efficiency Plan Delivery (YTD %)			**96%**	102%	100%	91%
Efficiency Plan Delivery (FOT £k)	93,240	91,228	**(2,011)**	12,980	37,389	40,860
Efficiency Plan Delivery (FOT %)			**98%**	100%	100%	95%



System Savings
System savings for the Working as One (WaO) Programme will underdeliver in year, by circa £5.7m - £6.2m.
Non recurrent mitigating actions being identified by all partners. The focus remains delivery of the full recurrent savings into 2025/6.

ICB
The medicines management programme is forecast to deliver additional savings of £2.7m via national price changes for Rivaroxaban, thereby partly offsetting WaO under delivery.

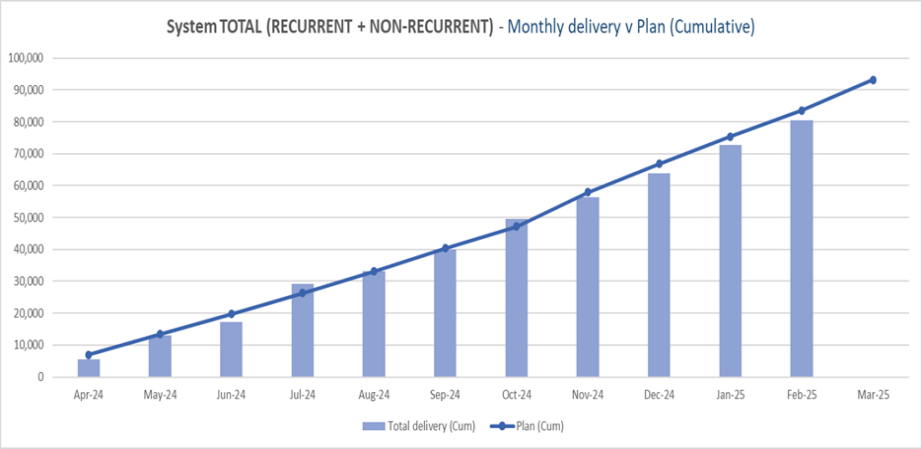
GHC
GHC are on plan with overall delivery of efficiencies at M11. Cumulative recurrent savings delivered at month 11 were £5,465k, an increase of £936k on last month, but behind plan by £1,120k. Non recurrent savings delivered year to date were £6,841k, ahead of plan by £1,304k. Overall FOT efficiencies remains breakeven versus plan although some recurrent savings targets will be carried forward into 25/26.

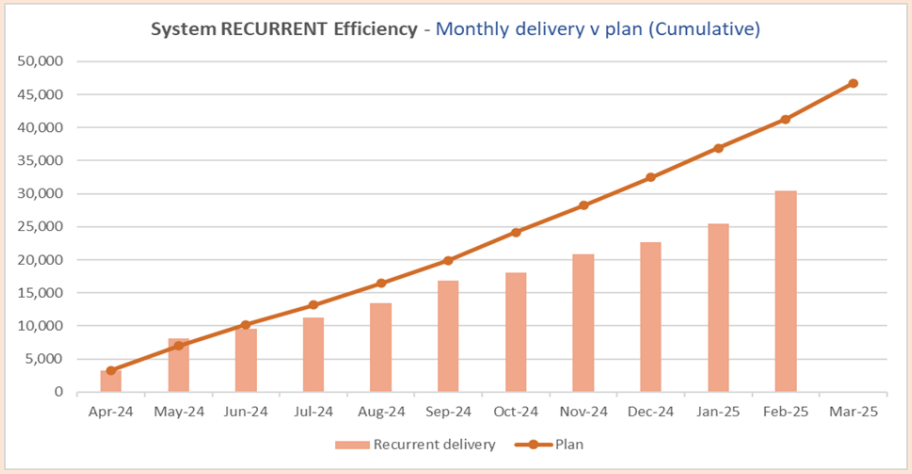
GHFT
Year to date ahead of plan by £0.2m, mainly due to earlier than anticipated delivery on cross-cutting workstreams. GHFT continues to forecast 100% delivery of the full Financial Sustainability Plan (£37.4M). As at month 11, 70% of the forecast delivery is non-recurrent. The majority of the forecast is RAG rated Green, and the level of Amber risk has reduced to £0.5M, down from £1M in M10. GHFT continues to engage with Divisions and Transformational colleagues to scope efficiency programmes to support a longer-term recurrent financial sustainability agenda.

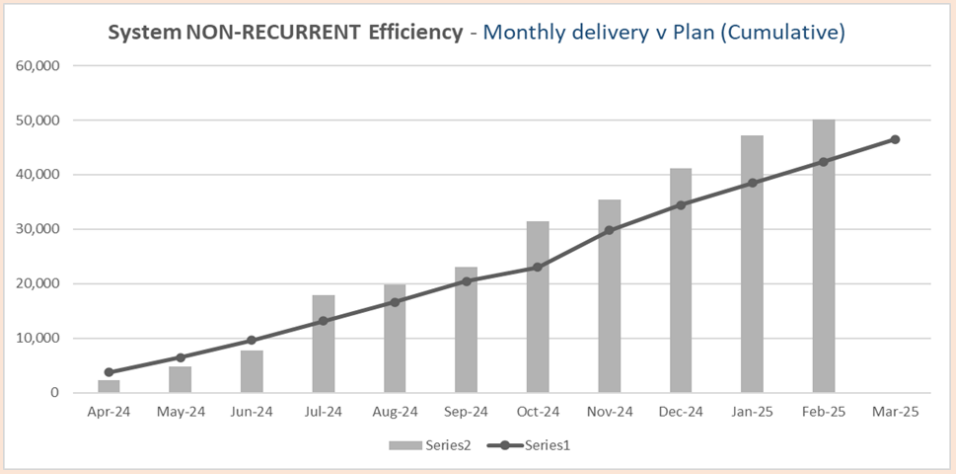
Finance and Use of Resources

System Efficiencies: Recurrent Performance

- These charts show how recurrent system savings delivery is cumulatively lower than planned. Non-recurrent savings delivery is cumulatively higher than plan, currently supporting the in-year system position.







Finance and Use of Resources

Cash Management: Provider Cash Holdings

System Cash Holding (£'000)		
	February 2025	March 2025
GHFT Plan	32,000	27,000
GHC Plan	51,046	54,152
System Plan	**83,046**	**81,152**
GHFT Actual / Forecast	47,145	37,000
GHC Actual / Forecast	52,292	54,811
System Actual / Forecast	**99,437**	**91,811**
Above/(Below) Plan	**16,391**	**10,659**

- One of the system measures of effective cash management is the number of days cash cover for operating expenditure. A reasonable system target is 30 days cover.
- The GHFT cash balance as at M11 represents 21 days cash cover.
- GHC cash at the end of month 11 is £52.292m which is ahead of plan following the settlement of a number of invoices and contractual variations. GHC is below the BPPC target but is seeing a small improvement month on month following implementation of an action plan to address the issue.
- GHC cash balance represents 52 days of cash cover.

Finance and Use of Resources

System Capital: Performance

YTD CAPITAL EXPENDITURE				
	GHC	GHFT	ICB	SYSTEM
PLAN - NET CDEL	8,335	41,652	964	50,951
EXPENDITURE	3,035	27,156	964	31,155
VARIANCE	**(5,300)**	**(14,496)**	**0**	**(19,796)**

SYSTEM FOT (£k)	
TOTAL ALLOCATION	53,420
TOTAL CHARGE AGAINST ALLOCATION	50,584
VARIANCE TO ALLOCATION	**2,836**
TOTAL CHARGE AGAINST ALLOCATION (EXCL. IMPACT OF IFRS 16)	**45,080**
VARIANCE TO ALLOCATION	**(287)**
M11 CHANGES IN CHARGES	
GHC IFRS16	70
GHFT IFRS16	(231)
GHC SLIPPAGE REDUCTION	(348)
ICB REDUCTION IN MIG FORECAST	(6)
TOTAL CAPITAL DEPARTMENTAL EXPENDITURE LIMIT (CDEL)	**(515)**

GHC

- Capital spend is behind plan but is expected to catch up by year end. The Trust increased its capital forecast following confirmation of funding for Endoscopy scopes and washers, Cyber Security, and a National Energy Efficiency scheme, totalling £877k. Disposal proceeds were received in December. The Trust no longer requires any disposal income to be deferred into 25/26 as some asset disposals have now been moved back to 25/26.

GHFT

- To achieve breakeven on the Capital programme, a number of high priority equipment scheme mitigations are being progressed. These offset an assessed forecast underspend position of £2.4m with further known risks included within the forecast. The delivery of these schemes will be carefully managed through the remaining months of the financial year.

ICB

- The ICB capital plan relates to GP IT and minor improvement grants is planned to take place from quarter 3 onwards.

- The system is forecasting a marginal variance to breakeven against the system capital resources. The original system plan was an underspend of £2m against the CDEL with a plan to carry this forward.

Finance and Use of Resources

Elective Recovery Fund (ERF): Overview

- An Independent sector provider has moved to sending data to SUS and we are now starting to see this data flow through to our ERF position so there is a positive change in our forecast position.
- The January flex position is 107%, if the uncoded activity is coded, the position would improve to 115.7%.
- The total potential ERF currently generating UZ codes is £1.6m (~£1.1m GHFT, ~£333k OOC Providers, ~£90k ISP)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD Total
Actual 2019/20	£ 13,073,406	£ 14,079,242	£ 13,198,195	£ 14,913,532	£ 13,202,191	£ 13,733,489	£ 15,420,194	£ 14,765,797	£ 12,456,296	£ 14,619,566	£ 139,461,906
Glos System Plan (incl A&G) 118%	£ 15,426,619	£ 16,613,505	£ 15,573,870	£ 17,597,968	£ 15,578,585	£ 16,205,517	£ 18,195,829	£ 17,423,640	£ 14,698,429	£ 17,251,087	£ 164,565,049
2024/25 (Excl. A&G)	£ 15,748,653	£ 15,777,981	£ 15,671,108	£ 16,867,778	£ 15,348,245	£ 16,069,862	£ 17,842,083	£ 16,924,332	£ 14,554,866	£ 15,454,761	£ 160,259,671
Advice & guidance	£ 578,635	£ 524,154	£ 510,222	£ 547,299	£ 468,286	£ 527,727	£ 533,358	£ 497,397	£ 451,930	£ 335,999	£ 4,975,008
Total System Achievement	£ 16,327,288	£ 16,302,136	£ 16,181,329	£ 17,415,077	£ 15,816,532	£ 16,597,590	£ 18,375,441	£ 17,421,729	£ 15,006,797	£ 15,790,761	£ 165,234,679
System variance to plan	£ 900,669	-£ 311,370	£ 607,459	-£ 182,891	£ 237,947	£ 392,073	£ 179,613	-£ 1,911	£ 308,367	-£ 1,460,327	£ 669,630
Performance	123.6%	114.7%	121.4%	115.7%	118.6%	119.7%	118.2%	116.9%	119.2%	107.0%	117.4%

- ERF data reported in month 11 is based on the month 9 freeze (fixed), and month 10 flex (interim) position.
- 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.

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**
February (M11) 24/25	**4,715.1**	**8,263.9**	**770.6**	**9,034.5**		**13,749.6**

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 11 reflects an overall progressive increase in worked WTE since a baseline of March 2023.

GHC WTEs were 57 below plan at month 11.

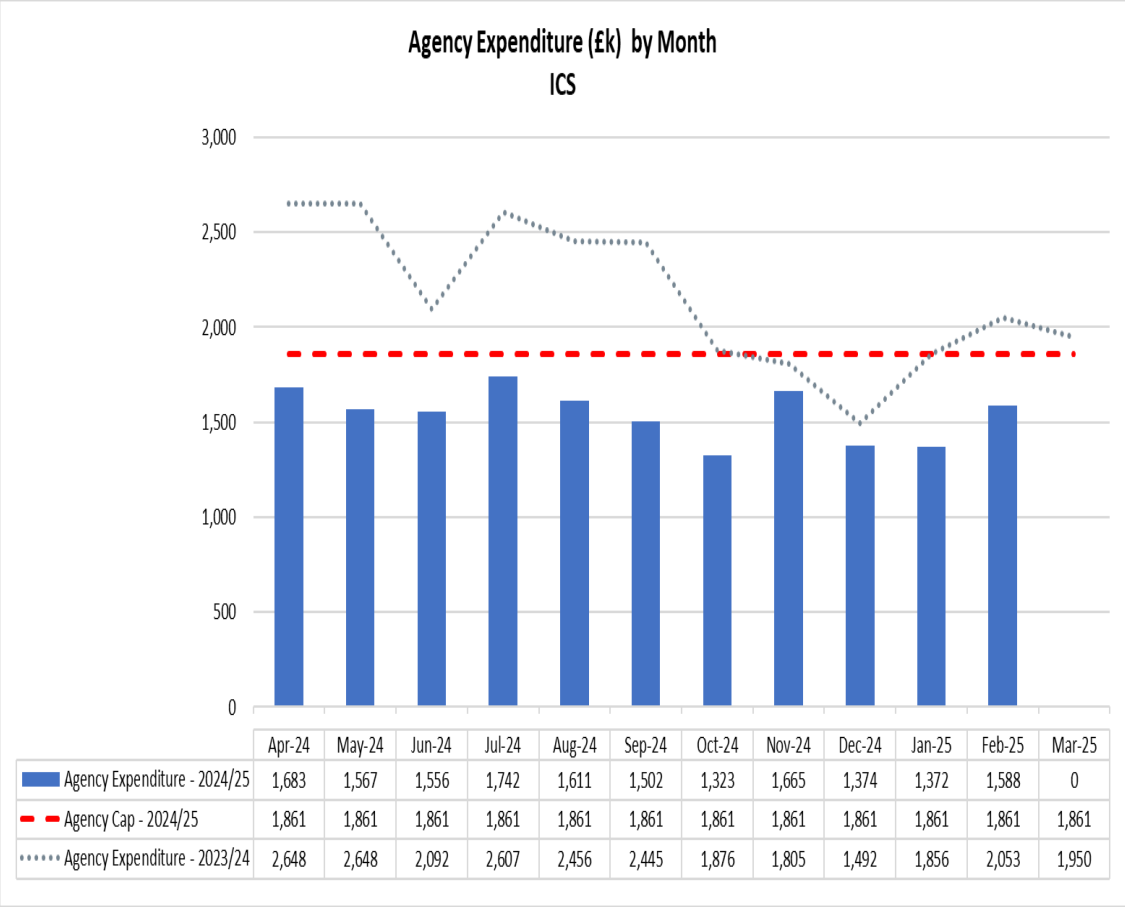
The GHFT position is 208 WTE over plan and includes some longer term increases due to specific investments increasing WTE usage.

The Nursing aspects of WTEs used has seen a reduction in 2024/25, this is as a result of two key factors:

- Robust & on-going reviews of roster v funded establishment.
- Improved monitoring system in management of roster and bank/agency usage.

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	1,502	1,323	1,665	1,374	1,372	1,588	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

Agency spend of £4.8m for GHC remains below the 3.2% national cap at 2.14% of total pay costs ytd.

Off framework shifts for M11 total 29 (64 lower than M10) driven mainly by opening of escalation beds.

The Trust has a strong process in place to ensure all requests for agency go through due governance, in particular the use of off framework agencies.

GHFT

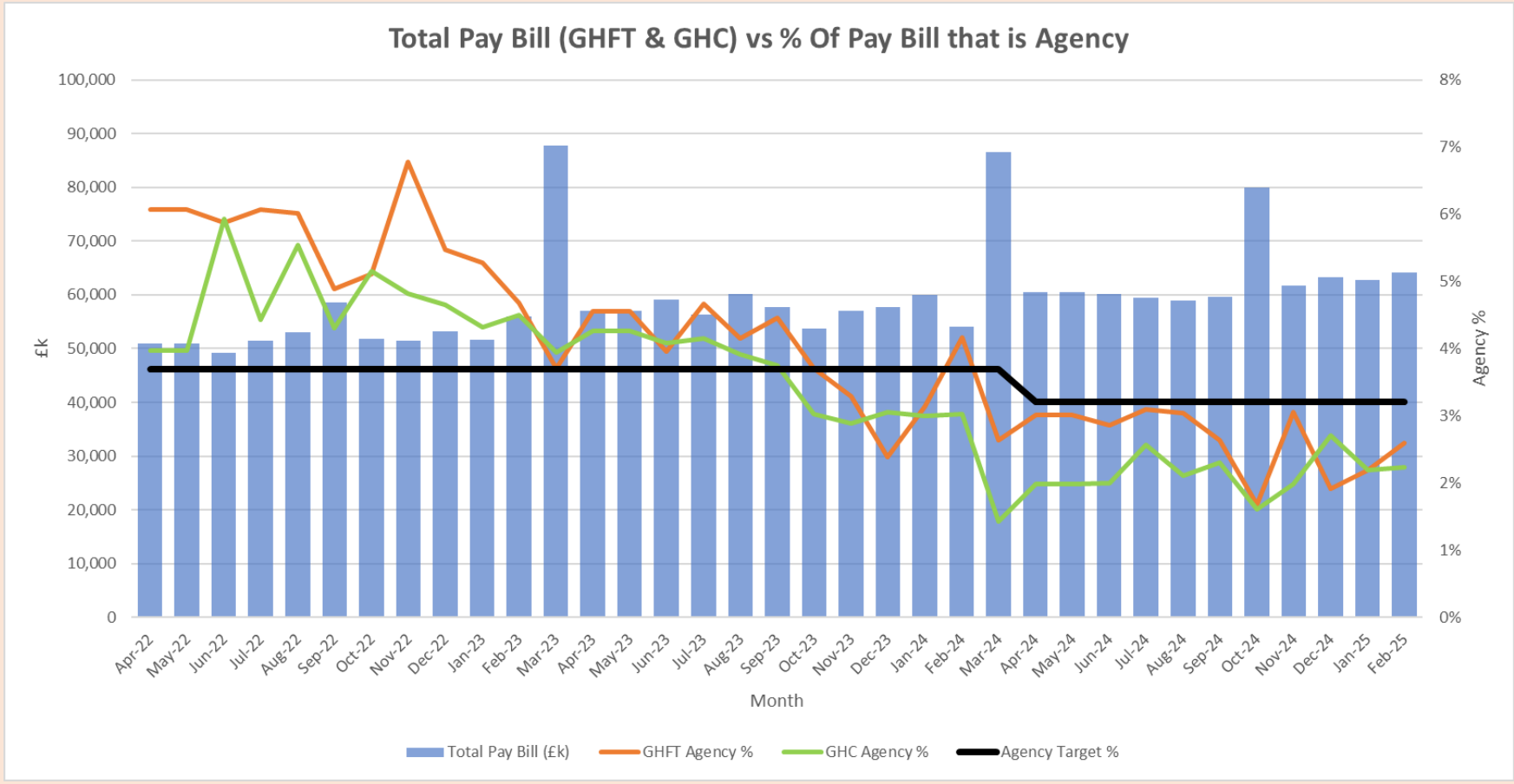
M10 agency cost is £1,116k and has increased from prior month by £179k. Agency shifts filled are represented by Medical & Dental, Nursing & Midwifery, Non Clinical, and AHP/HCS.

The Trust has processes in place to ensure agency requests are approved alongside wider workforce controls overseen by the Workforce Impact Group.

Off framework shifts used were for Nursing via Thornbury.

Finance and Use of Resources

System Workforce: Agency Spend



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
GHFT Agency Spend (k)	£ 2,148	£ 2,148	£ 1,949	£ 2,171	£ 2,212	£ 1,977	£ 1,804	£ 2,362	£ 1,984	£ 1,774	£ 1,782	£ 2,296	£ 1,766	£ 1,766	£ 1,616	£ 1,818	£ 1,747	£ 1,744	£ 1,350	£ 1,304	£ 969	£ 1,323	£ 1,515	£ 1,561	£ 1,306	£ 1,179	£ 1,171	£ 1,252	1208	1043	921	1259	819	937	1116
GHC Agency Spend (k)	£ 618	£ 618	£ 953	£ 693	£ 903	£ 782	£ 852	£ 799	£ 785	£ 777	£ 808	£ 1,020	£ 777	£ 777	£ 748	£ 726	£ 709	£ 702	£ 526	£ 501	£ 523	£ 533	£ 538	£ 389	£ 377	£ 388	£ 385	£ 490	403	459	402	406	555	435	472
Total Agency Spend (k)	£ 2,767	£ 2,767	£ 2,902	£ 2,864	£ 3,116	£ 2,759	£ 2,656	£ 3,161	£ 2,769	£ 2,551	£ 2,589	£ 3,316	£ 2,543	£ 2,543	£ 2,364	£ 2,544	£ 2,456	£ 2,446	£ 1,876	£ 1,805	£ 1,492	£ 1,856	£ 2,053	£ 1,950	£ 1,683	£ 1,567	£ 1,556	£ 1,742	£ 1,611	£ 1,502	£ 1,323	£ 1,665	£ 1,374	£ 1,372	£ 1,588

One Gloucestershire
Transforming Care, Transforming Communities

NHS

ICB Finance Report

Month 11 2024/25 – February 2025

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Finance and Use of Resources

Financial Overview and Key Risks

- As at month 11, the ICB is forecasting a break even financial position, within this there is continued close management of the position, including maintenance of the current savings trajectory and managing overspends in continuing health care (CHC), placements budgets and variances in other budgets.
- The prescribing budget is forecast breakeven (M9 data). The rivaroxaban price reductions are expected to offset growth and current NCSO Pressures. The year to date growth is currently 1.56% higher compared to same period last year.
- Elective Recovery Funding - the Gloucestershire target is 107% with the system operational plan value set at 118% value weighted activity of 19/20. There is a risk to delivering the elective activity planned and the current range is between c£0.6m under delivery to delivery against plan, this is due to a number of reasons, including estates issues and escalation pressures impacting on delivery. Additional non recurrent activity has been commissioned to reduce the shortfall.
- Continuing Health Care & Placements including Children's Services- The forecast is £8.3m overspend as at M11. included in this are several high cost placement, increasing numbers of domiciliary care packages and increase in provisions.
- Within the position, there are overspend on ADHD assessments from private providers, discharge to assess beds and community equipment, these are being offset by slippage in a number of other budgets.
- Agenda for change pay award costs are covered by the in year allocation. However, the ICB has a recurrent pressure of c£1.2m as recurrent costs on contracts exceed the recurrent allocation.
- The Mental Health Investment Standard (MHIS) for 24/25 is £114.327m and is forecast to be delivered.

Finance and Use of Resources

Financial Overview and Key Risks

Key Financial Risks	Mitigating Actions
Additional slippage in savings programmes, leading to a worsening of the financial position. The working as One programme savings are now forecast to under deliver by c£5.7m. - £6.2m	Savings monitored monthly through the Programme Delivery Group and Strategic Executive meetings as well as internal governance routes, monitoring being strengthened. Working as One Programme Board focus on the delivery of cashable savings and implementation plan. 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. System deliver is forecast to be slightly below the original plan by c£0.6m including the impact of the additional activity commissioned.	The 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. Additional focus on ensuring that all activity delivered is coded may improve the reported position
Significant NICE TAs are in progress which if issued will lead to high costs for all ICBs both in terms of drug and service costs. The risk of impact in this financial year is reduced with more significant impact in 2025/26.	Potential impact on services and costs is being reviewed based on available information, the ICB is responding to consultations as they are issued. The 2025/26 plan includes some provision for additional NICE TA costs.
Increasing high cost placements, particularly children's and learning disabilities are a key financial issue and ongoing risk for the ICB.	Regular monitoring in place. Review to identify additional support for the team in progress.
Primary Care: high risk of contract handback due to growing operational & financial pressures. Indicative direct costs £0.6m -c£1m per practice	Monitoring and active working with practices by the primary care team to gain early information and enable work with practices

Finance and Use of Resources

ICB Allocation – M11

- The ICB's confirmed allocation as at 28th February 2025 is **£1,474m**.

Description	Recurrent £'000	Non-Recurrent £'000	Total Allocation £'000
BALANCE BROUGHT FORWARD M10	**1,348,723**	**96,986**	**1,445,709**
DOAC		308	308
ERF		10,481	10,481
Frontline Digitisation Connecting Care Records		110	110
Glos Digital Champions		10	10
Oliver McGowan		62	62
PC Uplift		43	43
PCT – Community Pharmacy Contractual Framework		2,862	2,862
PCT – Pharmacy First		540	540
PCT GP ARRs		**3,328**	3,328
PCT Independent Prescribing Pathfinder Programme		28	28
Primary Care Access Recovery Plan (PCARP)		259	259
Revenue Bonus		10,660	10,660
Developing Digital Champions and Networks		30	30
TOTAL IN-YEAR ALLOCATION 24/25 @ M11	**1,348,723**	**125,707**	**1,474,430**

Finance and Use of Resources

ICB Statement of Comprehensive Income

Statement of Comprehensive Income (£'000)						
Month 11 2024/25 - February	M11 Plan	M11 Actual Position	Year To Date Variance to Plan Favourable / (Adverse)	Full-Year Plan	Forecast Outturn Actual Position	Forecast Outturn Variance to Plan Favourable / (Adverse)
Acute Services	631,889	630,745	1,143	688,443	689,344	(900)
Mental Health Services	129,095	129,061	35	140,885	140,838	47
Community Health Services	118,642	119,226	(584)	129,934	131,809	(1,876)
Continuing Care Services	80,551	84,200	(3,650)	87,987	96,265	(8,279)
Primary Care Services	186,565	184,067	2,498	202,899	203,482	(583)
Delegated Primary Care Commissioning	122,964	124,758	(1,795)	134,609	136,128	(1,519)
Other Commissioned Services	38,025	38,095	(70)	41,406	41,894	(488)
Programme Reserve & Contingency	35,602	33,165	2,438	35,869	22,259	13,610
Other Programme Services	4	20	(15)	70	82	(13)
Total Commissioning Services	**1,343,337**	**1,343,337**	**(0)**	**1,462,102**	**1,462,102**	**(0)**
Running Costs	11,454	11,454	0	12,328	12,328	0
TOTAL NET EXPENDITURE	**1,354,791**	**1,354,791**	**(0)**	**1,474,430**	**1,474,430**	**0**
ALLOCATION	**1,354,791**	**1,354,791**	**0**	**1,474,430**	**1,474,430**	**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** - £8.2m savings requirement within the system of which £6.2m is within the ICB savings plan. These savings are not now forecast to deliver in 2024/25. Non recurrent mitigations to this slippage have been identified within the ICB and system organisations. Further work continues in respect of recurrent savings delivery in 2025/26..

- **Medicines savings** - forecast savings at month 11 includes £2.7m in respect of national price changes for Rivaroxaban. December data continues to support this higher level of price change benefits which will also provide part year effect benefits in 2025/26. Overall, oral Anticoagulation drugs show a trend of reduced costs alongside increased rate per 1,000 items. There is continued focus on 2025/26 scheme implementation to support project development and delivery in 2025/26. There continue to be significant cost and growth areas within primary care medicines.

- **CHC / Placements** – in-year savings delivery to date has primarily been from Electronic Call monitoring and CHC LD reviews. There are still shortfalls in capacity, both within the ICB and GCC to carry out additional adult CHC reviews and re-assessments and this presents an ongoing financial risk. At month 11, savings delivery is supported by non-recurrent cost recovery from Personal Health Budgets.

- **ERF - Elective Recovery** - £1.5m shortfall is now forecast against the planned overperformance. Non recurrent mitigations against this shortfall have been identified. There continues to be some areas of uncertainty including uncoded activity levels.

- **Non-recurrent slippage** – The position includes £4.2m of non-recurrent slippage. There may be risk that some elements are required to be paid to NHS England. This is being further assessed and discussed with NHSE, the overall risk within this is c£1m.

Finance and Use of Resources

ICB Savings Summary: Month 11

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD (ICB)
2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 11

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	4,582	6,434	1,852	5,000	7,162	2,162	143.24%	GREEN - Low Risk
	Home Oxygen	138	138	0	150	150	0	100.00%	GREEN - Low Risk
PRIMARY CARE MEDICATION OPTIMISATION - TOTALS		4,720	6,572	1,852	5,150	7,312	2,162	141.98%	
CONTINUING HEALTHCARE (CHC) & PLACEMENTS	Individual Personal Commissioning - Continuing Healthcare (CHC) / Joint Placements	1,465	1,465	0	1,600	1,600	0	100.00%	GREEN - Low Risk
CONTINUING HEALTHCARE (CHC) & PLACEMENTS- TOTALS		1,465	1,465	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.)	6,363	6,363	0	6,944	6,944	0	100.00%	GREEN - Low Risk
OTHER RECURRENT EFFICIENCIES - TOTALS		6,363	6,363	0	6,944	6,944	0	100.00%	
OTHER - NON-RECURRENT	ICB Non Recurrent Efficiencies	14,559	14,559	0	15,884	15,884	0	100.00%	Amber - Medium risk
OTHER NON-RECURRENT EFFICIENCIES - TOTALS		14,559	14,559	0	15,884	15,884	0	100.00%	
2024/25 ICB SAVINGS PROGRAMME - TOTALS		27,107	28,959	1,852	29,578	31,740	2,162	107.31%	Amber - Medium risk

Finance and Use of Resources

System-Held Savings Summary: Month 11

NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD - SYSTEM HELD EFFICIENCIES 2024/25 EFFICIENCIES PROGRAMME - AS AT MONTH 11									
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	4,743	-	(4,743)	5,175	-	(5,175)	0.00%	RED - High Risk
URGENT EMERGENCY CARE SAVINGS - TOTALS		4,743	-	(4,743)	5,175	-	(5,175)	0.00%	
DISCHARGE	P2 Bed savings (System)	918	0	(918)	1,000	-	(1,000)	0.00%	RED - High Risk
DISCHARGE SAVINGS - TOTALS		918	-	(918)	1,000	-	(1,000)	0.00%	
ELECTIVE	ERF Productivity	2,750	800	(1,950)	3,000	1,457	(1,543)	48.57%	RED - High Risk
ELECTIVE SAVINGS - TOTALS		2,750	800	(1,950)	3,000	1,457	(1,543)	48.57%	
OTHER	Non-Recurrent slippage	2,011	4,196	2,185	2,194	4,196	2,002	191.25%	GREEN - Low Risk
	Other Non Recurrent Savings	1,524	0	(1,524)	-	1,543	1,543		RED - High Risk
	Unidentified Savings - Non-recurrent	1,763	1,924	161	1,924	1,924	0	100.00%	GREEN - Low Risk
OTHER & UNIDENTIFIED SAVINGS - TOTALS		5,298	6,120	822	4,118	7,663	3,545	186.09%	
2024/25 ICB SAVINGS PROGRAMME - TOTALS		13,709	6,920	(6,789)	13,293	9,120	(4,173)	68.61%	RED - High Risk

Agenda Item 11

NHS Gloucestershire ICB Public Board

Wednesday 26th March 2025

Report Title	**One Gloucestershire Draft Data Strategy**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	Since September 2024, ICS partners have co-designed a system-wide data strategy for Gloucestershire. This follows the ICS Digital Strategy (2022-25) highlighting the pressing need for a data strategy and Digital Executives agreeing the commissioning of Health Economics Unit (HEU) to undertake the work. The One Gloucestershire Data Strategy has been developed through interviews, surveys, workshops and Boards, with multiple system-wide partners. This process has captured input from multiple ICS partners, articulating Gloucestershire's collective ambition to use data insights and the sharing of information to benefit our citizens. The final draft of the Data Strategy is attached (appendix a), while partners' comments and feedback can also be accessed via a SharePoint link, shared later in this paper.				
	ICB Internal	**Date**	**System Partner**	**Date**	
	Op Ex (ICB) Strategic Executive System Resources Committee Presented at ICS Boards & Forums: • PHM Delivery Board, • Gloucestershire Information Governance Group (GIGG), • Data and Information Sharing Board, • Whole System intelligence Group and • Digital Executives	03.12.24 19.12.24 09.01.25	Information Board (GCC) Executives meeting (GHfT) Resource Committee (GHC) Finance and Resouces Committee (GHFT)	28.11.24 06.12.24 19.12.24 25.02.25	

Executive Summary	The proposed strategy addresses the pressing need for a system-wide data strategy, as identified by the ICS Digital Strategy (2022-25), which surfaced multiple examples where better data sharing could improve service users' experience, staff efficiencies and system wide performance. Areas highlighted included direct care, Population Health Management (for direct and indirect care purposes), system demand and capacity, commissioning and system performance, among others. The Data Strategy takes a clear steer from the ICS Digital Strategy's key transformation themes and aligns its ambitions with the numerous subsidiary digital strategies (digital workforce, infrastructure, empower the person). Its vision 'To become an intelligence led system; using data and sharing information to wrap care around the person and enable our *One Gloucestershire* ambition" is drawn from engagement from across all ICS partners. Reflecting the need to articulate the real-life experiences of health and care staff, the strategy includes high level use cases for Complex Needs, Discharge to Assess (D2A) and Urgent Care & Workforce. These outline the positive implications of a successfully implemented vision, particularly for clinicians, practitioners, patients and citizens as well as managers and commissioning staff. The core of the strategy draws on 6 strategic themes; each explored regarding their goal, importance, alignment with the vision and key deliverables. To ensure the strategy can be implemented effectively, a section on delivery includes principles of how we will collaborate, engage staff and citizens, deliver through action and measure our success. Finally, a roadmap outlines the key deliverables along a short, medium and longer term trajectory.

Key Issues to note

A full list of partners' contributions and comments can be found at the following SharePoint location or are available on request.
Data Strategy feedback log - excel.xlsx

With these contributions being extensive, the following responses represent a summary of those comments provided and accommodated within the final draft strategy:

Feedback	Response
More focus on Gloucestershire's opportunities and challenges	Updated in the introduction: particularly opportunities of a small system
More focus on insights/intelligence as a driver of strategic change	Title now: *One Gloucestershire's Data Strategy: Sharing information and insights for our citizens*, plus changes throughout document
Clarity on how citizens will be engaged	Now greater emphasis on resolving questions re: ethics and citizen access
Recognise need for investment planning – particularly 25/26	Short/medium/longer-term road map now included
Varying ambition for alignment: some reticent about convergence and standardisation at every opportunity.	Highlighted high level principle of alignment, but recognise solutions still need to be resolved
Consistent ask for greater OD and relational investment to establish a collaborative approach & enable delivery	Need for OD activity flagged within strategy and is in scope for the next phase
Establish clear metrics to measure progress	National metrics reviewed (DMA and Cyber Essential etc)
Not realistic to produce a single SOC for whole Data Strategy	Breakdown OBCs and work packages into constituent parts

One response consistently recognised by all parties is the requirement for additional relational activities to address different partners' comfort with data sharing and technical convergence. Following the strategy's approval, investment in organisational development will explore partners' diverse views and seek to overcome data related barriers to system-wide service transformation.

In addition, various financial and planning assumptions were surfaced through the preparation of the strategy, which have been captured below:

- Some activities can be fast tracked (e.g. a joint controllership agreement), while others require greater consideration and development (e.g. enterprise architecture)
- National funding arrangements are not commensurate with local ambition. Therefore, delivery of the strategy will require prioritizing and likely diverting of limited resources to higher priority activities.
- Investment in strategic outline cases will be required to draw out options and costs/ROI of the various strategic themes.

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- Greater upfront insight to capture feasible data and digital requirements, solutions and costs is required to enable more effective service transformation activities, from day one.

Undertaking the OD activities described and resolving these outstanding assumptions will be the priority focus of work in the first part of 2025, following the ICB Board's approval of the strategy.

By recognising the Data Strategy's role in surfacing these remaining challenges and assumptions, the four core ICS organisations (GCC, ICB, GHFT & GHC) and the ICS Strategic Executive have endorsed the draft strategy, enabling its presentation to the ICB Board for approval, before it is socialised with other ICS partners' forums.
</td></tr>
<tr><td>Key Risks:

Original Risk (CxL)
Residual Risk (CxL)</td><td>

1. The strategic aims and governance for data sharing remain at organisational level, hindering the development of a fully integrated ICS strategy. Leading to a reduction in benefits for citizens, patient's, staff and clinicians.
2. Executive stakeholder engagement fails to achieve full organisational commitment, which leads to piecemeal implementation that fails to deliver the significant benefits (as above).

On both risks 12 (likelihood 3 x impact 4)
</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>No conflicts of interests have been identified during the development of this overarching strategy.</td></tr>
<tr><td>Resource Impact (X)</td><td>
<table>
<tr><td>Financial</td><td>x</td><td>Information Management & Technology</td><td>x</td></tr>
<tr><td>Human Resource</td><td>x</td><td>Buildings</td><td></td></tr>
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</td></tr>
<tr><td>Financial Impact</td><td>No funding decision is sought at this stage.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td>Regulatory: Commissioners and providers have a legal duty to share information and to meet safeguarding obligations.</td></tr>
<tr><td>Impact on Health Inequalities</td><td>The driving purpose of the data strategy is the ambition to better able to serve our population by sharing data more effectively. To achieve this, "use cases" that demonstrate a variety of health inequalities (that are either directly or indirectly exacerbated by data sharing) are included throughout the strategy. This ensures health equality and diversity considerations are baked into the purpose of the strategy.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td>Equality and Impact assessments will be undertaken once the draft strategy is approved and workstreams start to form.</td></tr>
<tr><td>Impact on Sustainable Development</td><td>Long-term effective data sharing has the capability of streamlining services thereby reducing unnecessary travel, holding one version of data instead of multiple reduces the requirement for multiple solutions and servers, which hold a carbon footprint.</td></tr>
<tr><td>Patient and Public Involvement</td><td>Direct engagement with the public was outside the scope of the project, (as approved by ICS Digital Executives), although existing public insights were drawn upon to help shape the strategy. Engagement and the views of the public will be part of the development of workstreams and implementation.</td></tr>
</table>

Recommendation	**To Approve the Data Strategy for One Gloucestershire**		
Authors	**Daniel Offord** **Haydn Jones**	**Role Title**	**ICB Head of Digital / Programme Manager** **ICB Associate Director BI**
Sponsoring Director (if not author)	**Cath Leech (ICB Chief Finance Officer)** **Paul Atkinson (ICB Chief Clinical Information 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
PHM	Public Health Management
Op Ex ICB	ICB Operational Executive
OD	Organisational Development
ROI	Return On Investment

One Gloucestershire
Transforming Care, Transforming Communities

One Gloucestershire's Data Strategy

Sharing Data and Insights for our Citizens

2025 - 2030

@One_Glos

Contents

Welcome

We are proud to present *One Gloucestershire's* first Data Strategy. This marks a bold step forward for our Integrated Care System, drawing together our collective strengths to transform how data is used to improve the health and care outcomes of our population.

Across Gloucestershire, significant achievements are already taking place within individual organisations, with partners demonstrating a commitment to harnessing data for better care. However, this strategy represents a much bigger ambition: a unified vision that transcends organisational boundaries to create a truly integrated and data-driven system of care.

Gloucestershire is uniquely positioned to achieve this ambition. The shared objectives of our health and care organisations, coupled with the shared geographical boundary of our county, provides us with a solid foundation to foster collaboration, build trust, and unlock the transformative potential of data sharing. Years of joint working between our key organisations have brought us to this point, ready to take the next step toward seamless, holistic, and citizen-centred care.

This strategy is not just about technology or infrastructure; but about fundamentally changing how we work together as a system. With Gloucestershire's citizens at its heart, it sets out our collective direction of travel, demonstrating how data sharing and insights will drive real, positive change in health and care delivery. Through ambitious use cases and a clear roadmap, we aim to turn this vision into action—ensuring that the benefits of integrated, data-driven care are felt across every part of our health and care system.

Together, we are embarking on a journey to create a system that is greater than the sum of its parts, with this strategy laying the groundwork for a future of truly integrated, innovative, and high-quality care for all.

XXX person
Chief Executive
Gloucestershire County Council

XXX Person
Chief Executive
Gloucestershire Health and Care Foundation Trust

XXX person
Chief Executive
Gloucestershire Hospitals Foundation Trust

XXX person
Chief Executive
Gloucestershire Integrated Care Board

About Gloucestershire

Since 2018, Gloucestershire has been collaborating through an Integrated Care System (ICS) known as *One Gloucestershire*. This partnership aims to provide integrated, coordinated care across the region.

The partnership brings together key health and care providers, including

- Gloucestershire Integrated Care Board (ICB)
- Primary care (GPs)
- Gloucestershire Health and Care NHS Foundation Trust (GHC)
- Gloucestershire Hospitals NHS Foundation Trust (GHFT)
- South Western Ambulance Service NHS Foundation Trust
- Gloucestershire County Council (GCC; responsible for social care and public health), borough councils, city councils and districts
- the Voluntary, Community and Social Enterprise sector (VCSE).
- Healthwatch

One Gloucestershire Integrated Care System became a legal entity in 2022 but has a long history of good working relationships across the county, something that this data strategy is designed to capitalise upon.

The ICS serves a population of 660,000. The relative small size of the ICS partnership, combined with its shared geographical boundaries with Gloucestershire County Council, create opportunities for ICS partners to be ambitious in our data sharing approach.

These include fostering closer collaboration, enabling interoperability between clinical systems and achieving better integration (in this context, the seamless sharing of data between care professionals and coordination of business intelligence (BI) across organisations to improve our services and outcomes for citizens).

This Data Strategy will also enable *One Gloucestershire* to further improve its digital maturity. NHS England's 2024 Digital Maturity Assessment (DMA) highlights our Shared Care Record (JUYI) as an advanced area of digital maturity.

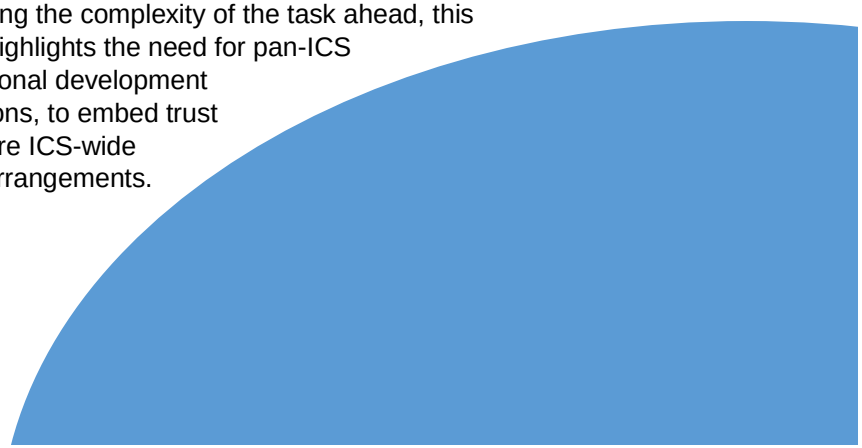
JUYI provides a rich source of individual level data for direct care, supporting health and care staff across different organisations and culminating in better support for citizens.

The ICB also has a well-defined central data repository with linked clinical and non-clinical data from various organisations within the ICS and is in the process of developing fully automated and regular analytics and reporting tools.

To improve, we need to make greater use of analytics to redesign pathways and evaluate their success by comparing them to other models. In addition, converging the sharing of data via agreed platforms will enable our staff to access the information they need to support our population.

The DMA also highlighted the need for greater collaboration with research centres and to provide appropriate access to data for research. The most advanced systems are using AI, machine learning and Secure Data Environments for research. This strategy will support the continued development of the digital maturity of *One Gloucestershire*.

Recognising the complexity of the task ahead, this strategy highlights the need for pan-ICS organisational development interventions, to embed trust and explore ICS-wide working arrangements.



The ICS has established digital governance with digital executives drawn from all four organisations (GHC, GHFT, GCC and ICB) providing accountability for the delivery of the Digital Strategy.

They are supported by an engagement process, bringing together experts in their field from across the county, to promote integration, consistency, security, and lawfulness (e.g. Data and Information Sharing Board, Clinical Systems Safety Group, Gloucestershire Information Governance Group & Whole Systems Intelligence Groups).

One Gloucestershire is well-positioned to achieve its goals but recognises the remaining barriers to addressing our shared challenges. For example, there is an 11-year gap in healthy life expectancy between the wealthiest and least wealthy parts of the county. These differences are unacceptable and preventable.

By transforming services based on data insights and sharing data effectively, our ICS aims to improve health and ensure fairness for everyone in the system.

Our five-year ICS strategy

This data strategy is aligned to the ICS strategy and is designed to help us achieve it. We have three strategic priorities in our five-year strategy:

1. **Making Gloucestershire a better place for the future –** focusing on the range of things that can impact of health and wellbeing including existing priorities like physical activity, healthy lifestyle, adverse childhood experiences and housing.
2. **Transforming what we do -** supporting prevention at a local level, joining up services close to home, reducing differences in people's experience, access to care and health outcomes and a *One Gloucestershire* approach to developing our workforce.
3. **Health and care services today -** improving access to care and reducing waiting times for appointments, treatment and operations, improvements in urgent and emergency care and supporting people's mental health.

Our population

Population Growth: Our population is expected to rise by 50,291 by 2028, especially among those aged 65+. However, there will continue to be drops in the population aged 0-19.

Life Expectancy: Our life expectancy is higher than the national average (80 years for males and 84 for females). However, disparities exist. The difference between the most and least deprived areas is 7.4 years for men and 5.4 years for women.

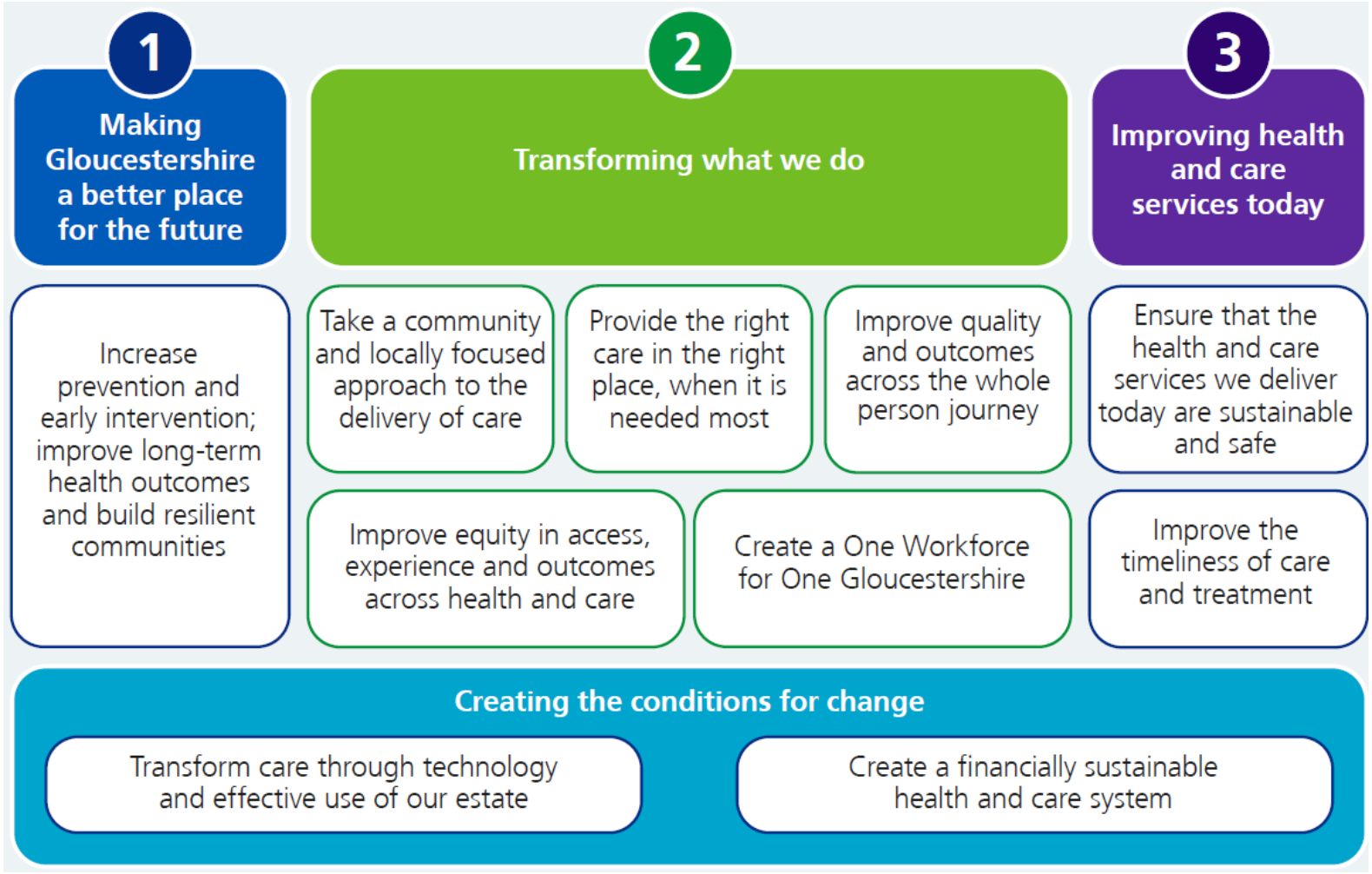
Ethnicity: Gloucestershire is predominantly white British (91.6%), with a small but growing minority population.

Health and Mortality: The leading causes of death include cancer (27.9%), cardiovascular disease (26.8%), and respiratory conditions (14.2%).

Deprivation: Gloucestershire is relatively affluent. But, 12 of our neighbourhoods are among the 10% most deprived nationally, with health inequalities persisting.

The ICS strategy for One Gloucestershire

The below infographic summarises the key vision, objectives and enablers of the wider ICS strategy. This data strategy aims to help enable this vision.



The national context

The NHS is undergoing a significant digital transformation, driven by a suite of national initiatives and policies that emphasise the critical role of data in healthcare. These initiatives reflect a collective effort to modernise care delivery, improve health outcomes, and streamline operations through better use of data and digital tools. At the heart of these efforts is a commitment to using data ethically, transparently, and effectively to build public trust, ensure data security, and promote collaborative working across health and social care services.

One key focus is fostering public trust in how health data is used, as highlighted in the Data Saves Lives publication. By involving citizens in decisions about their data and clearly communicating the benefits of data-driven care, we can create a foundation of confidence and engagement. This is essential to encourage citizens to use digital tools such as patient portals and care apps, ultimately enhancing data-driven insights and improving health outcomes.

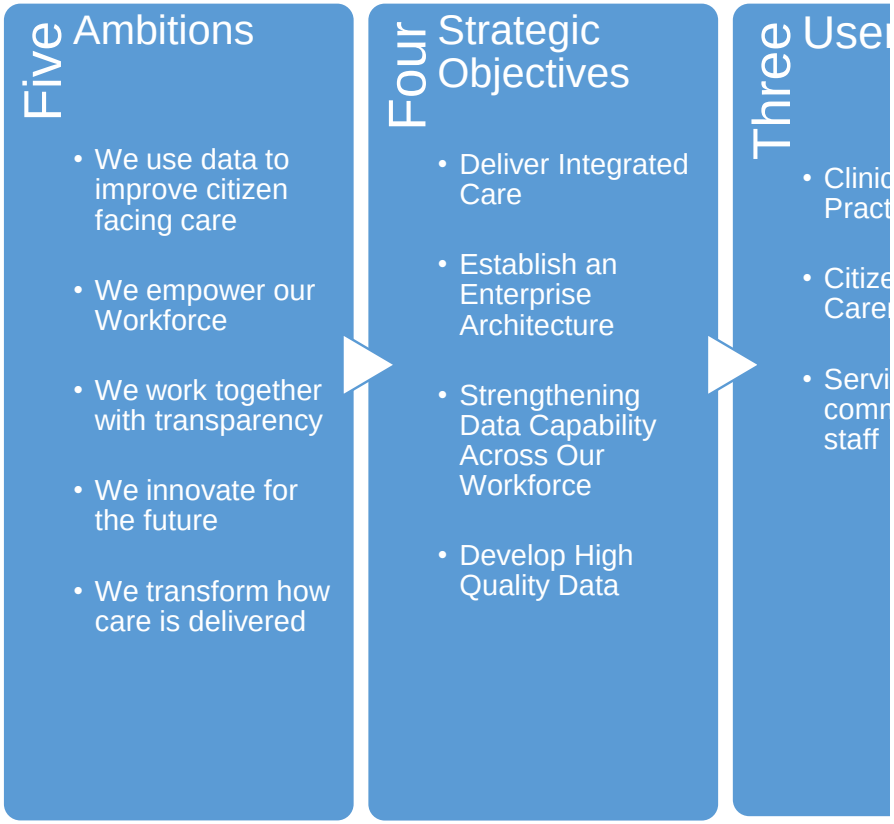
Efforts like Better, broader, safer: using health data for research and analysis, also known as the Goldacre Review, further underscore the importance of data security and ethical data handling. By promoting the use of Trusted Research Environments (TREs) and advocating for robust data governance practices, the review supports a balance between innovation and patient confidentiality. Such initiatives ensure that sensitive health data is managed in secure, de-identified environments, paving the way for responsible data use in research and operational improvements.

Another transformative initiative is the Federated Data Platform (FDP), which will enable NHS organisations to bring together data currently stored in disparate systems into one secure, unified environment. By preparing now to adopt the FDP, we can ensure a smooth transition that maximises its potential to enhance data accessibility, streamline care coordination, and enable real-time insights into system performance.

The Local Government Association's Better Use of Data Programme provide support to local authorities. This programme helps councils fully utilise data for decision making, service design and enhancing accountability and transparency. By fostering an evidence-informed culture, councils can better use data to improve outcomes for people and promote effective collaboration across services and with various partners. In social care, the drive for data transformation is also advancing, supported by the Government's Care Data Matters: a roadmap for better adult social care data, which is leading to changes in statutory collections and improvements in dataflows.

These national policies and initiatives reflect a rapidly evolving health and social care landscape where data serves as a cornerstone for improving care delivery and operational effectiveness. By aligning our local strategy with these guiding frameworks, *One Gloucestershire* can stay at the forefront of this transformation, driving better health and social care outcomes through data-informed care and collaboration.

Our strategy on a page



Our vision

Our vision for data

To become an intelligence led integrated care system; using data and sharing information to wrap care around the person and enable our ambitions for *One Gloucestershire*.

Using data and digital to drive change

This strategy complements and extends the ambitions set out in our 2022-25 digital strategy, Digital Health and Care Gloucestershire. Our digital strategy focuses on improving the digital infrastructure, embedding a digital-first culture, and enhancing citizen and staff experience through technology.

This data strategy ensures that data becomes a strategic asset, driving informed decision-making, improving citizen outcomes, and ensuring that care is delivered seamlessly across the system.

Together, these strategies provide a unified roadmap for leveraging digital technologies and data to transform health and care services across the county.

Our ambitions

This data strategy is built upon a set of key ambitions that reflect the priorities and commitments outlined in the digital strategy. This aligns the data strategy with our overall digital transformation themes: fostering collaboration, innovation, and continuous improvement.

We use data to improve citizen facing care

We want citizens' data to be shared appropriately, securely, legally, and seamlessly across health and social care services to reduce the need for individuals to repeatedly share their health and care history.

To do this, we need to build trust in the quality and security of data, so that citizens can be confident that their information is accurate, up to date, and available to all relevant professionals. This reduces administrative time and minimises the risk of harm by ensuring all relevant information is readily accessible.

Transparency is also key for our relationship with the public. Clearly communicating how we use people's data, who we share it with, and the safeguards in place is fundamental to meeting ethical and privacy obligations. By fostering public trust through transparency, we can ensure that data is used responsibly and in alignment with the values and expectations of the communities we serve.

We want services to be designed based on insights drawn from data, ensuring they meet the needs of citizens in the most effective way. We want data to be used to understand population health needs, optimise resource allocation, and deliver care that is equitable, proactive, accessible and convenient.

This ambition aligns with the Simplicity for the Citizen theme of the ICS' digital strategy.

We empower our workforce

Our workforce needs to be empowered for us to best use data for decision-making and care delivery. This includes all our staff, beyond only those who work in business intelligence. This will support the digital strategy's goal of having a workforce that is digitally enabled and capable of leveraging data to improve care.

We want to foster collaboration across the ICS and enable teams to work across organisational boundaries. We need to align data professionals across organisations to enable better use of shared data and expertise to solve system-wide challenges.

This ambition aligns with the Digitally Enabled Workforce theme of the ICS' digital strategy.

We work together with transparency

To achieve seamless data sharing, we need to prioritise interoperability and the integration of systems. By breaking down data silos and ensuring all organisations have access to shared, real-time data, we will harmonise care delivery and operational efficiency across the system. Achieving seamless data sharing requires both convergence onto key platforms to ensure a consistent and unified data infrastructure, and a commitment to ongoing interoperability between systems. This approach recognises that to drive innovation with services and partners, new platforms and solutions must continue to be integrated seamlessly.

This dual focus on interoperability and transparency will support the digital maturity of all organisations, enabling them to harmonise data usage and decision-making processes while maintaining public confidence.

This ambition aligns with the Levelling Up Maturity and Harmonising Pace theme of the ICS' digital strategy.

We innovate for the future

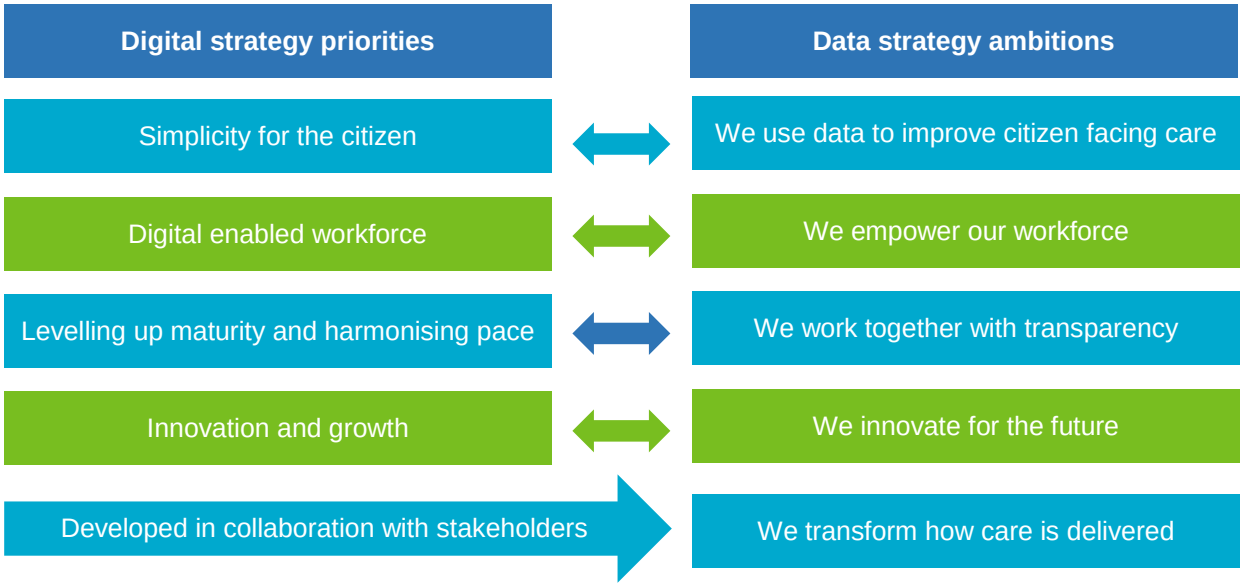
To drive innovation in care delivery, population health management, and operational efficiency, we need to harness the power of data analytics, AI and machine learning. Data systems and solutions need to be designed for scalability and future-readiness.

By encouraging the use of advanced analytics tools and predictive modelling, we will be equipped to leverage data for continuous improvement, fostering innovation and growth in digital healthcare. At the same time, we recognise the critical importance of ethics in the adoption of these technologies. Every step of our innovation process will include robust consideration of ethical implications, ensuring that data is used responsibly, equitably, and transparently, with respect for privacy and public trust. This ambition aligns with the Innovation and Growth theme of the ICS' digital strategy.

We transform how care is delivered

This ambition, which emerged through extensive stakeholder engagement and is distinct from the digital strategy themes, focuses on building the capacity and capability of our community partners. By strengthening collaboration across all organisations involved in community care, we aim to design and deliver pan-organisational pathways centred around the person, ensuring that data sharing and care delivery seamlessly follow the citizen's journey. This will support integrated, person-centred care, underpinned by Population Health Management (PHM) insights to proactively address health needs, reduce health inequalities, and improve outcomes for all citizens.

Our alignment between the digital and data strategies



Our users

Our data strategy will have direct benefits to our staff and citizens.

Currently, **clinicians and practitioners** often face fragmented systems that require them to navigate multiple platforms to access patient information. Data is not always available or accurate, leading to duplication of effort, increased workload, and challenges in coordinating care effectively across teams.

For **citizens and carers**, access to their health and social care data is often limited or inconsistent, making it difficult for them to fully understand or participate in their care. Care processes can feel disjointed, and there is limited visibility into how their data is used to improve outcomes, which can reduce trust and confidence in the system.

Service and commissioning staff, as well as decision-makers, frequently contend with data that is siloed, incomplete, or not timely enough to support dynamic decision-making. Reporting processes are often manual and time-consuming, limiting the ability to respond quickly to system pressures, monitor performance effectively, or plan strategically for future needs.

Summarised below are the benefits to our users we identified in the development of this strategy.

Clinician & Practitioner

- I record information once and trust it is accurate and up-to-date.
- I have all the information I need, when and where I need it, in a single place.
- I can see what other professionals have done with the person, enabling better decisions and easier care coordination.
- I share information seamlessly, improving collaboration and feeling supported by others providing care.
- My workflow is improved, and my workload is more manageable.
- I deliver care in the appropriate setting and focus more time on direct care delivery.

Citizen & Carer

- I feel listened to, understood, and confident in those caring for me.
- My care is coordinated and personalised, with streamlined processes and holistic support.
- I have access to my health and social care data, enabling me to make informed decisions about my care.
- I trust that my data is used securely and ethically to improve my health, my experience, and the health of Gloucestershire's population.
- I feel safe and supported by a network that understands my needs, helping me stay in my usual place of residence for as long as possible.
- Improved care processes and data-driven insights lead to better health outcomes and reduced disparities.

Service & Commissioning staff

- I use data insights to design, commission, and adapt services to meet the population's needs.
- I manage services dynamically in response to system pressures, using real-time data.
- I automate reporting and use intelligence to monitor performance, identify areas for improvement, and demonstrate value.
- I access information at population, service and user levels to inform strategic decisions.
- I improve care and population health through research and evidence-based planning.
- I drive accountability and transparency across the system, fostering a culture of trust, collaboration, and improved behaviours.
- As a board member or executive, I use high-quality data to make better strategic decisions, ensuring resources are allocated effectively.

Our Strategic Themes

Strategic Objective 1: Deliver Integrated Care

Our Goal

Our goal is to establish integrated care models that wrap care around the person via integrated case recording systems and digital solutions and use data analytics to predict, report, and proactively respond to our citizens' needs. This includes building an integrated intelligence function that encourages collaboration, leverages shared resources and expertise, and respects the unique contributions and integrity of local teams.

Our intelligence function will support multidisciplinary efforts to enhance the system's overall capability to deliver improved citizen outcomes, operational efficiency, and strategic foresight, while recognising and valuing the strengths of individual organisations within the system.

Why This Is Important

Despite the ambition to work as one through integrated neighbourhood teams, staff face the challenge of navigating multiple disconnected systems, resorting to workarounds to complete their daily tasks. This fragmentation leads to disjointed data flows, poor reporting capabilities, and increased risk (such as clinical, financial, and reputational), ultimately hindering the delivery of cohesive, person-centred care. Additionally, varying organisational cultures drive behaviours that further complicate collaboration, while legislation impacting care delivery—whether free or chargeable—adds another layer of complexity. This strategy aims to be an enabler, supporting cultural change and fostering a more unified approach to health and care delivery in Gloucestershire.

A coordinated approach helps bridge gaps between clinical, operational, and strategic analysis at a place level, ensuring that all layers of the system are aligned and informed by the same data and insights.

This function will align stakeholders, data professionals, and decision-makers to promote efficient, evidence-based practices. By fostering cross-organisational teamwork, we will ensure that data is shared and analysed effectively, creating a cohesive ecosystem where clinical, operational, and strategic decisions are informed by high-quality insights

Leveraging the ICS Intelligence Function Guidance Toolkit, we will foster a collaborative cross-system intelligence approach that supports decision-making at every level—from direct citizen care to high-level strategic planning. This toolkit emphasises collaborative working, ensuring that multi-disciplinary service teams are supported by BI professionals across multiple partners. This holistic approach to intelligence will facilitate the sharing of best practices, enhance resource use, and drive systemic improvements in care quality and efficiency.

Our intelligence function will align with the data strategy ambitions by:

- We use data to improve citizen facing care: By sharing data seamlessly, practitioners will access the data they need to support citizen-facing care. Individuals won't need to repeat their medical history. We will help reduce health inequalities through tailored campaigns that use population data and informed planning, reaching citizens who might otherwise be excluded.
- We empower our workforce: Enabling digitally integrated care will enable our staff to access information in all settings, saving time. Building an integrated intelligence function will empower not just data professionals but all staff to make data-informed decisions.
- We work together with transparency: Ensuring seamless data sharing and interoperability across organisational boundaries will promote consistent, real-time access to shared data for coordinated care delivery.
- We innovate for the future: Our integrated models of care will adopt innovative data analytics and predictive modelling tools, fostering a culture that is ready to leverage data for continuous improvement. It will ensure our systems and practices are designed for future scalability and readiness.
- We transform how care is delivered: By aligning data professionals and decision-makers, we will ensure that care pathways wrap around the person at a place level, facilitating seamless data sharing and enabling proactive, person-centred interventions within community settings.

Deliverables

Integrated Teams
We will establish cross-organisational, multidisciplinary teams that draw on skills from statistics, data science, epidemiology, and more. These teams will be formed with a clear focus on addressing strategic ICS challenges. Success will be measured through specific deliverables, regular reporting on progress against defined objectives, and demonstrable improvements in key system metrics."

Establishment of a Decision Support Unit (DSU):
We will establish a Decision Support Unit to enhance our capacity for strategic decision-making. A DSU is a network that supports the evidence-based decision-making by enabling knowledge exchange, training support, and large-scale analysis. This will be in partnership with regional and national bodies, including the Southwest DSU.

Standardised Analytical Methods and Tools
We will implement, where appropriate, standard analytical practices and tools to ensure consistent security, privacy, data handling, analysis, and output quality. This includes aligning with principles from the guidance toolkit to harmonise methods for decision-making and project evaluation.

Collaborative Platforms for Data Sharing and Communication
We will develop or adopt shared digital platforms that facilitate seamless data sharing and communication between organisations. These platforms will meet the system's needs for secure data transfer, compliance with data governance policies, and accessibility for all relevant parties.

Strategic Objective 2: Establish an Enterprise Architecture

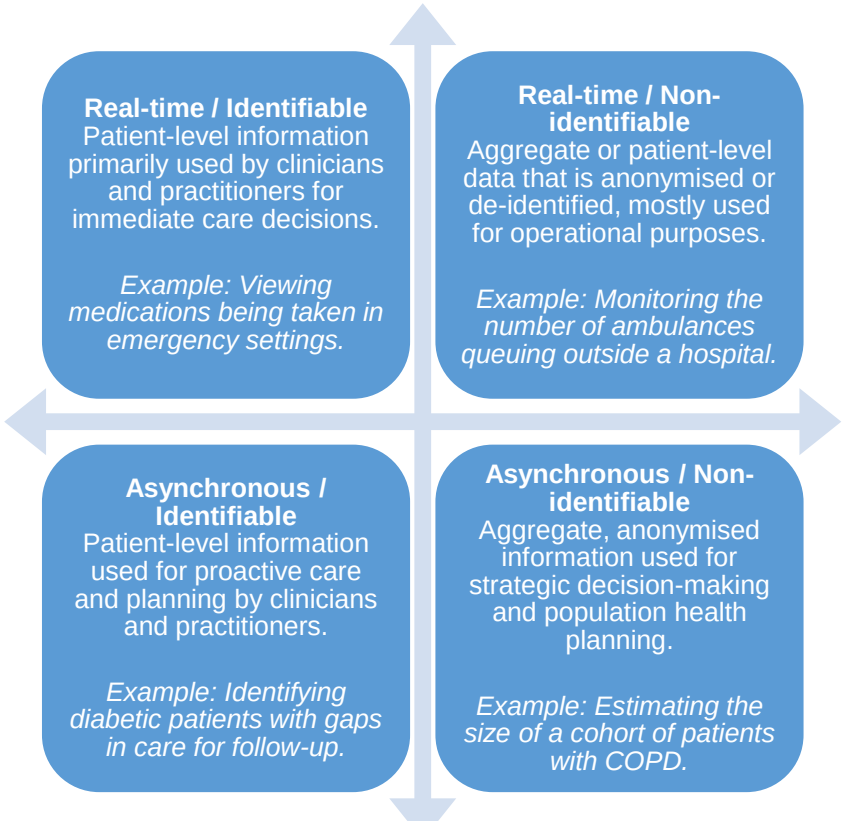
Our Goal

An Enterprise Architecture (EA) is a structured framework for organising the technology, data, and processes within an organisation to ensure they work together effectively. In health and care, this framework is essential for connecting systems, ensuring that data flows smoothly between them, and enabling efficient, secure, and reliable operations that support both citizen care and strategic planning.

As part of this process, we will explore architectural options, such as implementing single data platforms for direct and indirect care or adopting data mesh strategies. This exploration will ensure that our data architecture best supports the unique needs of our system, balancing flexibility, scalability, and efficient data use.

We will build a robust, flexible, and integrated EA across *One Gloucestershire.* This architecture will seamlessly connect our systems, platforms, and tools, leveraging on national and regional platforms where appropriate. This will enable efficient data flow across organisational boundaries and provide a “single version of the truth”.

Guided by the NHS England Architectural Principles, our EA will support both direct care, requiring real-time citizen-level information, and business intelligence (BI), which will mostly operate with aggregated or anonymised data. This dual approach will empower our clinical, operational, and strategic teams to make informed decisions, improve resource efficiency, and set a foundation for future digital growth. To illustrate how data will be used across different scenarios, we have categorised examples into the matrix below, based on whether the data is real-time or asynchronous and identifiable or non-identifiable.



Summary of the data types covered by this strategy

Why This Is Important

Our current enterprise architecture is fragmented, with systems often failing to communicate effectively or to support a unified data strategy. In some cases, legacy solutions are not fit for purpose, leading to data silos, inconsistent access, and duplication of efforts. This prevents us from realising the full potential of integrated care and data-driven decision-making, requiring a cohesive architectural framework.

In a health and care environment, where technology can greatly improve citizen care and organisational processes, a well-defined EA is essential for health and care delivery that is efficient, secure, and adaptive. A clear framework for aligning our technology and information processes with our clinical and strategic goals ensures we will deliver high-quality care while optimising resources and maintaining national policy compliance.

This will help us align with principles of interoperability, cloud adoption, and cybersecurity standards. In addition, our EA will directly support our ambitions:

- We use data to improve citizen facing care: By integrating systems to provide practitioners with comprehensive patient information, our EA will support localised care that is responsive, equitable and accessible, in every care setting.
- We empower our workforce: Our EA will provide a foundation for data access across all roles, ensuring our workforce is empowered to leverage data in both day-to-day care and strategic planning.
- We work together with transparency: By fostering interoperability and shared access to data, we will enable population insights and support unified decision-making and data consistency across our partner organisations.
- We innovate for the future: We will evolve our EA iteratively, developing platforms and capabilities that incorporate emerging technologies such as AI, predictive analytics and telehealth, while seeking to adopt national platforms and convergence.
- We transform how care is delivered: Developing a unified enterprise architecture supports the seamless flow of data across all care providers, enabling community partners to access accurate, real-time information. This ensures that data-driven care is consistently delivered along pan-organisational pathways, enhancing the capability of community services to provide holistic, person-centred care.

Deliverables

Unified Enterprise Architecture
We will develop a high-level data architecture framework that defines our core systems, platforms, and infrastructure. This will include adopting a “Public Cloud First” approach where appropriate, ensuring alignment with national standards, and supporting resilience and flexibility.

Consolidated and Integrated Systems
We will review our existing data tooling landscape to identify and rationalise redundant or overlapping systems. This integration effort will reduce complexity, eliminate silos, generate financial savings, and streamline our ability to share real-time information for direct care, as well as aggregated data for strategic uses.

Mechanisms for Direct Care and Strategic Uses
The EA will support real-time clinical applications, and strategic decision-making. It will enable timely, informed care decisions by linking key data across a citizen’s care journey. Simultaneously, it will support PHM by providing aggregated, non-identifiable insights. This structure will ensure secure, compliant and efficient data sharing across organisations.

Deploy Standards-Based Interoperability
We will implement and maintain open standards for data interoperability across our systems, in line with the NHS England Architectural Principles. This will facilitate seamless information exchange across a range of applications, from Electronic Health Records to business intelligence tools, ensuring all partners have access to the same information.

Ensure Security and Compliance
Our EA will integrate cybersecurity and data governance protocols throughout its design, including compliance with NHS guidelines. This will ensure that citizen data remains secure and private, adhering to regulatory standards. These measures will uphold public trust and protect against cybersecurity risks

Strategic Objective 3: Strengthening Data Capability Across Our Workforce

Our Goal

Our goal is to foster a data-literate workforce where all staff can confidently engage with data in ways that support citizen care and organisational improvement, building on the digital literacy ambition of our Digital Strategy and People Strategy.

Data literacy means equipping staff with the skills and knowledge to understand, interpret, and use data effectively in their day-to-day roles. For some, this might involve the ability to navigate dashboards and interpret visualisations to inform decisions, while for others, particularly data and analytics professionals, it will require advanced technical skills such as coding, statistical modelling, or machine learning.

Through improved data we will digitally enable frontline staff and commissioning, transformation, and data/analytics colleagues that support the effective running of services. Data and analytics professionals will receive structured support to access and use data effectively, progressing in their careers according to the National Competency Framework for Data Professionals. Meanwhile, all other staff members will be supported in developing foundational data literacy, empowering them to interpret, question, and apply data in their roles.

We will build a culture where data-driven insights are accessible, relevant, and embedded in evidence-based decision making at every level.

Why This Is Important

While some data is shared across the system, many staff are not equipped to fully exploit these resources. Analysts often struggle to effectively communicate insights, and many commissioners and boards make decisions without a comprehensive understanding of the data. This limits our ability to drive operational and strategic improvements.

A data-informed workforce is essential to achieving our goals of improved citizen care, operational efficiency, and strategic alignment.

By equipping our data professionals with the skills they need to excel and grow, we support advanced analysis, accurate forecasting, and enhanced decision-making capabilities. We will provide structured pathways for data analysts, data scientists, data engineers, database administrators, data warehouse developers, visualisation experts, and other specialists, ensuring our talent is developed and retained.

Enhancing data literacy means equipping all teams to use it confidently. This will improve the quality of care and boost operational efficiency by empowering staff to make informed decisions. Data and analytics specialists play a crucial role in generating actionable insights by analysing and interpreting data. Staff including clinicians, practitioners, and managers, rely on these insights to inform their health and care practices and planning.

By fostering collaboration, data specialists can better understand the real-world challenges faced by frontline staff and tailor their analyses to meet these needs. Simultaneously, staff not working in a business intelligence setting will be empowered to engage with analytical findings, ask the right questions, and apply data-driven insights effectively in their roles.

This theme aligns with our strategy's ambitions by:

- We use data to improve citizen facing care: With accessible and comprehensible data, teams can make informed decisions in citizen care and operations.
- We empower our workforce: Data literacy facilitates better dialogue, helping different parts of the organisation work towards shared goals with a common understanding of data.
- We work together with transparency: By making data tools and skills accessible to all, we enable a more inclusive approach to information sharing, promoting equity across roles and teams.

- We innovate for the future: a data informed workforce will feel confident to use PHM insights, ask questions and trial new care approaches that lead to informed decisions and improved services.
- We transform how care is delivered: By investing in data literacy and targeted training, we empower staff across community organisations to collaborate effectively and use data to improve care delivery. This strengthens the capacity and capability of our community partners, enabling them to contribute meaningfully to integrated care pathways that focus on the citizen's needs.

Deliverables

Aligned Job Descriptions across Organisations
We will work towards aligning job descriptions for data and analytics roles across all organisations within the ICS. This alignment aims to create consistency in role expectations, skill requirements, and career progression opportunities. This will help attract, develop, and retain talent more effectively.

Career Development Framework for Data Professionals
We will implement the National Competency Framework for Data Professionals, supporting data specialists from entry-level to senior roles. This framework will guide our data professionals through progressive stages allowing them to develop their skills in alignment with local and national needs.

Gloucestershire Data and Analytics Academy
We will create opportunities for mentorship and peer-learning across organisations in the ICS. This will facilitate the exchange of skills, best practices, and insights. This initiative will help bridge knowledge gaps, enhance problem-solving capabilities, and foster a collaborative culture centred around continuous learning.

Data Literacy Programme for all Staff
To promote foundational data skills, we will establish training and resources tailored for non-data-specialist roles. This programme will focus on basic data interpretation, statistical techniques, visualisation skills, and understanding data-driven insights. This will enable staff to confidently identify trends, compare with other systems and improve commissioning decisions.

Workforce Data Sharing to Support Service Planning and Staff Development We will enable the sharing of workforce data across the ICS to better plan services, identify skill gaps, and support staff development. By using data-driven insights, we can align workforce capacity with service needs, ensuring the right skills are in place to deliver high-quality care. This will also help identify areas for targeted support, inform workforce training priorities, and facilitate strategic planning for future staffing requirements.

Strategic Objective 4: Develop High Quality Data

Our Goal

Our goal is to enhance the quality, accessibility, and trustworthiness of data across *One Gloucestershire*. We aim to ensure that data assets are well-documented, easily discoverable, and reliable for use in clinical, operational, and strategic contexts. Surfacing data quality issues will ensure progress towards more reliable datasets can be tracked.

By improving data quality and transparency, reducing duplication of efforts, and identifying gaps, we can build a foundation of trust and collaboration that supports better decision-making and outcomes.

Why This Is Important

Currently, data quality varies widely across systems, with inconsistencies in data capture and a lack of reliable documentation. This undermines trust in data and leads to inefficiencies, as practitioners and decision-makers cannot always rely on the information available. High-quality, consistent data is essential to support effective care planning, coordination, and strategic decision-making across the system.

High-quality data is crucial for effective decision-making and the delivery of citizen-facing care. When data is reliable and comprehensive, partners—from frontline practitioners to strategic leaders—can make informed choices. Conversely, poor data quality or unclear data provenance can potentially cause significant harm, erode trust, hinder analysis, and lead to inefficient practices.

The more we share data across our integrated pathways and systems, the greater the risk that inconsistent data capture is exposed. We currently lack timely strategic visibility of the performance of many of our health and care services, and we lack confidence in understanding risk due to insufficient, and untimely intelligence. This hampers our ability to assess service quality risks, or predict and proactively respond to demand.

Additionally, limited access to accurate, timely intelligence could lead to an incomplete understanding of the populations we serve. This makes it difficult to effectively measure the performance or outcomes of our regulatory requirements, transformation efforts or other investments. These interconnected challenges related to data sharing, effective partnership working, and contract management further complicate our efforts to deliver high-quality care.

Improving data quality and making data more transparent and discoverable align directly with the strategy's ambitions:

- We use data to improve citizen facing care: By ensuring that data is comprehensive, accurate and up to date, we support the development of services tailored to citizen needs and improve the coordination of care across the system. High quality data which includes information on protected characteristics such as ethnicity can mean that health inequalities are observed and addressed.
- We empower our workforce: When staff know what data is available and can trust its quality, they can use it confidently for decision-making and care delivery, supporting the principle of a digitally capable workforce.
- We work together with transparency: Reducing duplication of efforts and sharing clear, reliable data promotes alignment between organisations and enhances system-wide collaboration.
- We innovate for the future: Highlighting gaps and being transparent about data quality fosters trust, reinforcing the commitment to an open and collaborative culture.
- We transform how care is delivered: High-quality, accurate, and accessible data supports effective collaboration and proactive care planning in community settings. By ensuring data is reliable and consistently shared, community partners can deliver integrated, person-centred care informed by robust PHM insights.

Deliverables

Data Quality Improvement Toolkit
We will establish clear roles for data stewardship to maintain data quality and promote accountability, complementing the responsibilities of existing Information Asset Owners (IAOs) within council and NHS bodies. Data stewards will focus on ensuring that data is accurate, consistent, and fit for purpose in day-to-day operations and strategic uses, while working collaboratively with IAOs, who retain their statutory and organisational responsibilities for data assets.

Centralised Data Catalogue
We will create and maintain a comprehensive data catalogue that documents all available data sources. This will help users easily discover and access data, understand its origins and limitations, and promote consistent use across different teams and organisations.

Data Stewardship and Ownership Model
We will establish clear roles for data stewardship to maintain data quality and promote accountability. Assigning data owners will help ensure that data is kept current, properly managed, and aligned with usage standards.

Map Activities to Reduce Duplication of Efforts
We will develop processes and collaborative tools that facilitate the sharing of data initiatives and projects. As-is and to-be maps will be developed, to baseline current constraints to data sharing and establish a transformation roadmap. This will prevent parallel efforts and ensure resources are allocated efficiently.

Strategic Enabler 1: Moving Forward Together

Our Goal

Our goal is to create an ICS where all partners—from clinical and operational teams to strategic leaders—work cohesively towards shared ambitions. This requires a collective commitment to transparency, collaboration, and continuous improvement. By fostering a culture of shared responsibility and decision-making, we aim to unify our efforts, streamline our processes, and ultimately deliver better health outcomes for the population we serve.

Why This Is Important

Currently, the lack of unified processes and fragmented collaboration across our ICS results in inconsistent data sharing and disjointed efforts. This limits the ability to align our shared ambitions and hinders the collective delivery of high-quality care. To overcome these barriers, we must create a culture of transparency, collaboration, and shared responsibility that bridges organisational divides and ensures consistent, patient-focused care.

Working collaboratively across the ICS is essential for harnessing the full potential of data and resources. Effective teamwork ensures that everyone contributes to, and benefits from, shared insights and strategies. This approach supports consistent and informed decision-making that aligns with our strategic ambitions.

Shared information governance agreements will play a critical role in achieving this cohesive approach. By establishing and maintaining robust agreements across organisations, such as the Joint Controllership Agreement being developed in a separate programme of work, we will ensure that data is shared securely, legally, and efficiently.

This approach supports consistent and informed decision-making that aligns with our strategy ambitions:

- We use data to improve citizen facing care: A unified approach ensures that every decision is made with the citizen at the centre, supported by comprehensive data and a collective focus on delivering high-quality care.
- We empower our workforce: Strengthening our collective approach promotes the effective use of shared data and expertise, addressing system-wide challenges and improving operational efficiency.
- We work together with transparency: Emphasising openness in our processes fosters trust, enabling better partnerships and smoother data sharing.
- We innovate for the future: Coordinated efforts allow us to explore and implement innovative solutions that push the boundaries of what is possible in healthcare delivery.
- We transform how care is delivered: Working cohesively across the ICS strengthens our ability to transform community care delivery. By fostering transparency, collaboration, and shared responsibility, we build the capacity of community partners to deliver coordinated care, reducing organisational silos and enhancing the citizen's journey across different care settings.

Deliverables

Joint Controllership Agreement
We will ensure that the ongoing review of information sharing agreements is completed and implemented, facilitating seamless, secure, and compliant data sharing. This will support the development of trust between teams and enable ICS colleagues to overcome existing organisational and cultural barriers to data and digital collaborations, fostering a more unified and cooperative approach across the system.

Integrate Strategy Principles into Decision-Making
We will adopt shared decision-making models that reflect the principles outlined in this strategy. This means that all future decisions about data in Gloucestershire will be evaluated on how they improve citizen-facing care, how they empower the workforce, how they improve transparency across organisations, and how they move us towards the future.

Continuous Stakeholder Engagement
We will establish a programme of regular engagement sessions with stakeholders at all levels, including frontline staff, community partners, and strategic leaders. These sessions will be designed to facilitate two-way communication, ensuring that all participants have a shared understanding of goals, challenges and progress. This will create a culture of open dialogue and drive collective action toward system-wide improvements.

Collaborative Procurement Strategy
We will implement joint procurement processes that enable all organisations to make coordinated purchasing decisions through aligned requirements, specifications, and commercial processes. This collective approach ensures alignment with shared goals, leverages collective bargaining power for cost efficiency, and fosters consistency in the tools and technologies adopted across the system. It will enable IG teams to better understand and advise on necessary controls.

Strategic Enabler 2: Preparing for the Future

Our Goal

Our goal is to ensure that we remain proactive and adaptable in the face of rapid technological change. This involves embedding a culture of horizon scanning, continuous evaluation, and early adoption of emerging technologies that can enhance care and efficiency. This is particularly the case for national platforms, where they are available and appropriate for local adoption.

To guide the adoption of new technologies and processes, we will employ a structured model of innovation. Innovations will be prototyped and evaluated for their impact on this strategy's ambitions. Successful solutions will then be scaled across the ICS, ensuring continuous monitoring, feedback, and adaptation. This will create an environment where innovations are tested, refined, and adopted sustainably.

By keeping up with technological trends and strategically integrating new tools and methods, we will future-proof our system and leverage advancements to benefit our population and our staff.

Why This Is Important

At present, the system's ability to adapt to rapid technological change is limited by fragmented processes, outdated infrastructure, and horizon scanning siloed within organisations. Without proactive engagement with emerging innovations, we risk falling behind in our capacity to deliver cutting-edge care, optimise operations, support staff, and adapt to changes in legislation.

In an environment where digital and technological advancements evolve at an unprecedented pace, health and social care systems must be forward-looking to maintain and improve care quality and efficiency. Horizon scanning allows us to identify emerging technologies and practices that could transform how we deliver services, ensuring we remain competitive and responsive to citizen needs.

An example of this is the Federated Data Platform (FDP). While there is still uncertainty over the full scope of what it will offer, it highlights the necessity of preparing for future changes in data tools. Keeping informed and ready for its rollout will enable us to adapt quickly and harness its capabilities to support seamless data integration and real-time analytics.

To ensure we remain proactive and adaptable in the face of rapid technological change, it is crucial to balance convergence onto key platforms with an ongoing focus on interoperability. This means building a consistent and unified data infrastructure while also maintaining the flexibility to integrate new platforms and solutions as they emerge. By enabling seamless connections between systems, we can foster innovation and responsiveness in our services, ensuring that technological advancements are effectively harnessed to enhance citizen care, optimise operations, enhances staff satisfaction and retention, and streamlines processes. This balanced approach helps future-proof our system, allowing it to evolve alongside emerging digital tools and methods.

This proactive approach aligns with the strategy's ambitions:

- We use data to improve citizen facing care: By staying ahead of technological trends, we can ensure that new tools and solutions support the development of more tailored and responsive citizen care.
- We empower our workforce: Keeping our workforce informed and skilled in new technologies ensures they are equipped to leverage data and digital tools effectively, supporting a digitally capable and innovative workforce.
- We work together with transparency: Engaging with partners, technology experts, and other ICSs to remain informed about advancements fosters collaboration and shared learning, contributing to system-wide improvements.
- We innovate for the future: Continuously preparing for and adopting emerging technologies enables us to drive innovation in care delivery, population health management, and operational processes.
- We transform how care is delivered: By embedding horizon scanning and fostering partnerships, we ensure that community care delivery remains adaptable to emerging technologies and practices. This proactive approach builds the capacity of community partners to leverage innovative solutions and stay ahead of changing health needs, ultimately improving outcomes for citizens.

Deliverables

Establish of Horizon Scanning Cycles
We will implement structured horizon scanning cycles to monitor, review, and assess technological trends and emerging innovations. This will involve collaborating with experts, industry partners, and research bodies to anticipate changes and plan accordingly.

Converge with National and Regional Strategic Platforms
We will maintain active engagement with updates and discussions about emerging national platforms and initiatives, such as the FDP and SDE, as they arise. By understanding their development and potential, we can position ourselves for early adoption when appropriate and ensure a seamless transition that maximises its benefits.

Strategic Partnerships and Collaborations
Working with Research4Gloucestershire, we will forge partnerships with technology providers, research institutions, and other ICSs to stay informed about new developments and share best practices for implementing innovative solutions.

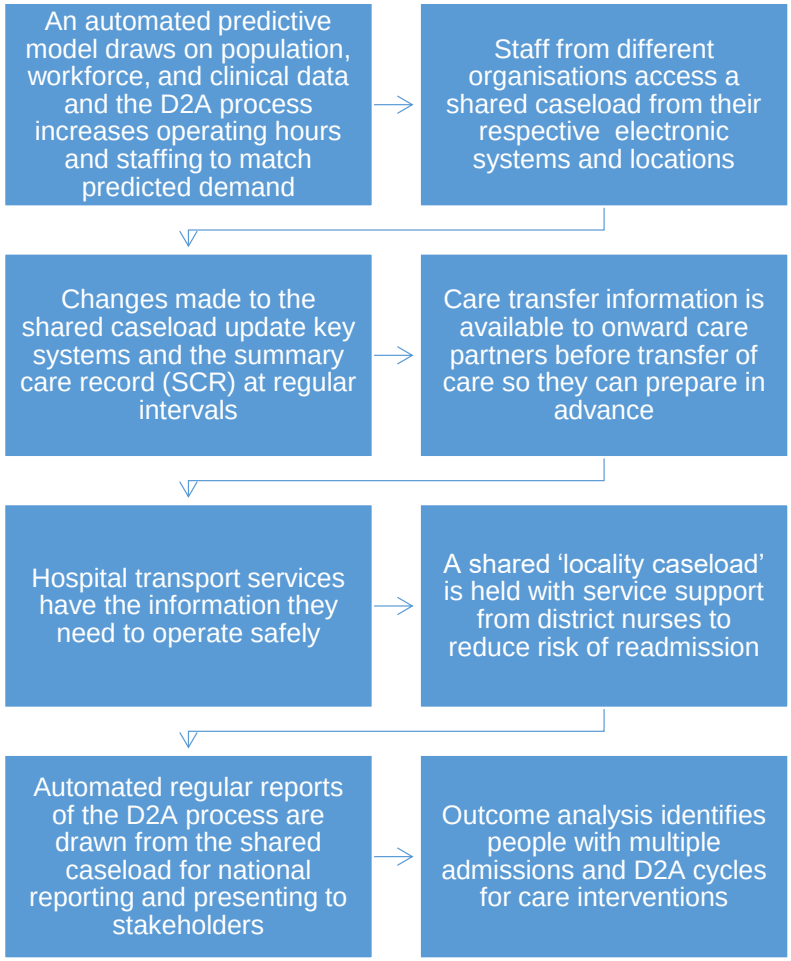
Establish an ICS-Wide Innovation Hub
We will create systems for gathering feedback on the implementation of new technologies and adapting based on lessons learned. This will ensure that new practices are refined and scaled effectively across the ICS, with training to enable staff to consider the full life cycle of innovation, from discovery, iteration, scaling solutions to feedback and adaption mechanisms.

Development of AI processes
We will leverage AI to enhance citizen engagement and advance PHM. This will enable us to identify high risk individuals and deliver proactive interventions, thus improving outcomes and the resource utilisation. Ultimately the use of AI driven tools will allow us to send tailored reminders, education and self-management resources giving the power to our citizens and enabling them to take control of their healthcare and supporting a truly citizen centred model.

Transforming our user journeys

The delivery of this strategy will require the mapping of key user journeys and pathways, to understand the needs and experience of our staff and citizens. The following “user journeys” demonstrate how practices and experiences will be improved by our investment in this strategy.

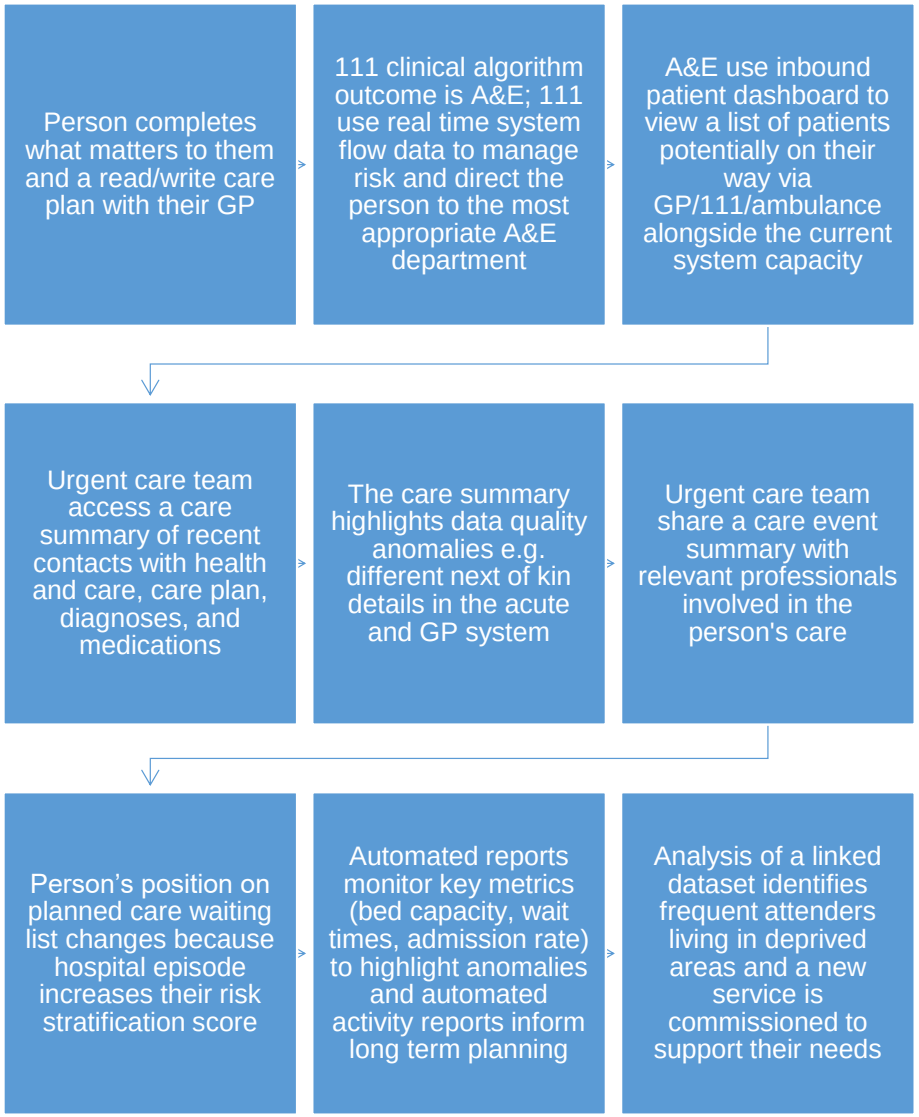
Discharge to assess (D2A)



Use cases

Deliver Integrated Care	Multidisciplinary collaboration supported by interoperable systems allows hospitals, community services and onward care to share and update caseloads. This ensures seamless transitions of care, minimising delays and errors in care transfers.
Moving Forward Together	Continuous feedback mechanisms will allow staff and stakeholders to agree how data usage is working and what needs improvement. This feedback loop will facilitate the continuous enhancement of data systems and tools, optimising how data is used to streamline care transitions, reduce delays, and enhance efficiency.
Establish an Enterprise Architecture	An integrated EA will facilitate shared access to a single, up-to-date caseload across hospitals, community care, and onward care partners. Real-time care transfer information will be available to all, enabling proactive planning for care transitions and reducing readmission risk. Updates to the shared caseload automatically synchronise across systems, enhancing efficiency.
Strengthening Data Capability Across Our Workforce	A well-trained BI workforce, supported by career pathways and mentorship opportunities, will have the skills to create advanced tools to analyse and address discharge delays. Predictive models and dashboards will provide actionable insights that help frontline staff anticipate and resolve issues in real-time.
Develop High-Quality Data	Accurate and reliable data ensures that predictive models can forecast demand for D2A services accurately, enabling optimal service capacity and proactive staffing. High-quality data also ensures timely updates to shared caseloads and care plans.
Preparing for the Future	Horizon scanning for emerging technologies will ensure the adoption of predictive models and new data-sharing platforms to enhance care transitions, reduce readmissions, and optimise service delivery.

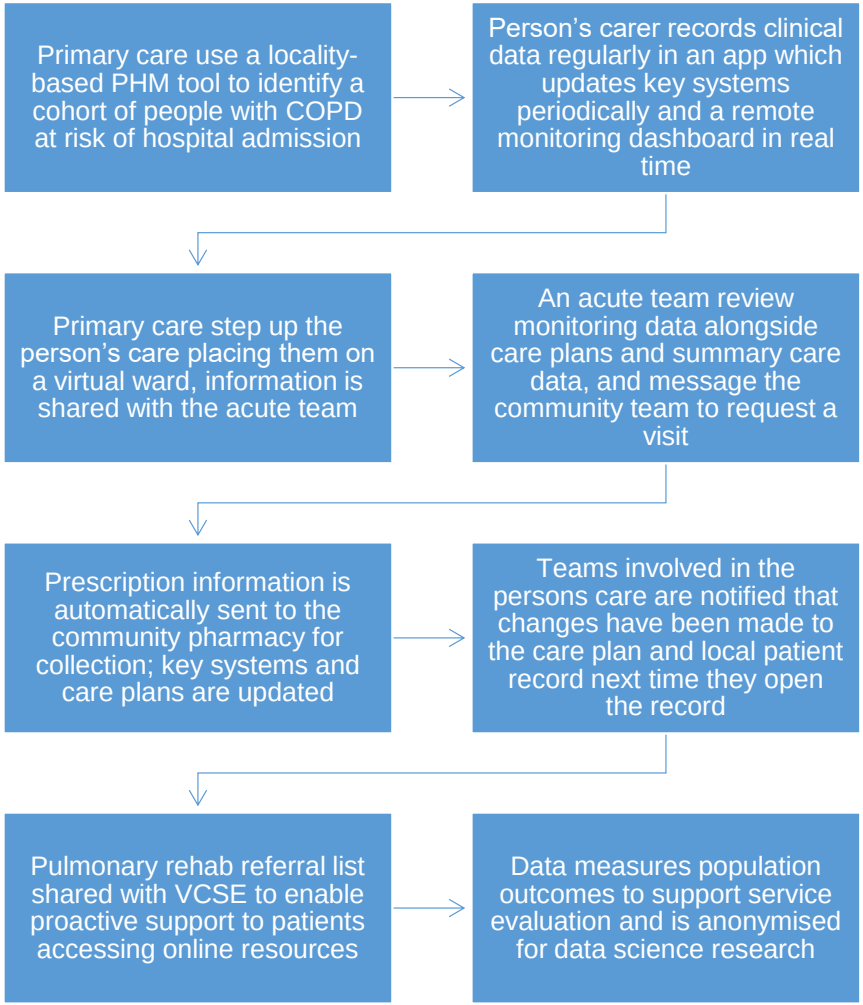
Urgent care



Use cases

Deliver Integrated Care	Urgent care data will enable the identification of frequent attenders. By sharing data and collaborating across care pathways, coordinated and tailored interventions can be offered, addressing underlying health and social issues. This reduces reliance on emergency care by providing consistent support in the community.
Moving Forward Together	Data-sharing agreements will mean that, in urgent care settings, staff can access accurate and timely citizen information. This might be care summaries and recent contact history, and will enhance decision-making and citizen outcomes through coordinated care delivery.
Establish an Enterprise Architecture	Urgent care teams will access real-time system flow data from sources like 111 and GPs. This allows for accurate, timely redirection of patients to the appropriate A&E department, reducing bottlenecks, improving patient flow and enabling better-informed care decisions.
Strengthening Data Capability Across Our Workforce	Clinicians and practitioners will benefit from enhanced data literacy training, enabling them to better interpret data. This will help identify bottlenecks within the urgent care pathway. Teams can redirect resources to address challenges, improving patient flow and reducing waiting times.
Develop High-Quality Data	High-quality data standards reduce inconsistencies in care records (e.g., different next-of-kin information) and support accurate patient care summaries. Performance reports generated from high-quality data enable effective long-term planning and operational decision-making.
Preparing for the Future	By forging partnerships with academic institutions, technology providers, and research bodies, urgent care services will gain access to the latest advancements and research findings. This will enable the implementation of cutting-edge practices, tools, and predictive analytics. This ensures that urgent care pathways remain responsive, innovative, and aligned with best practices.

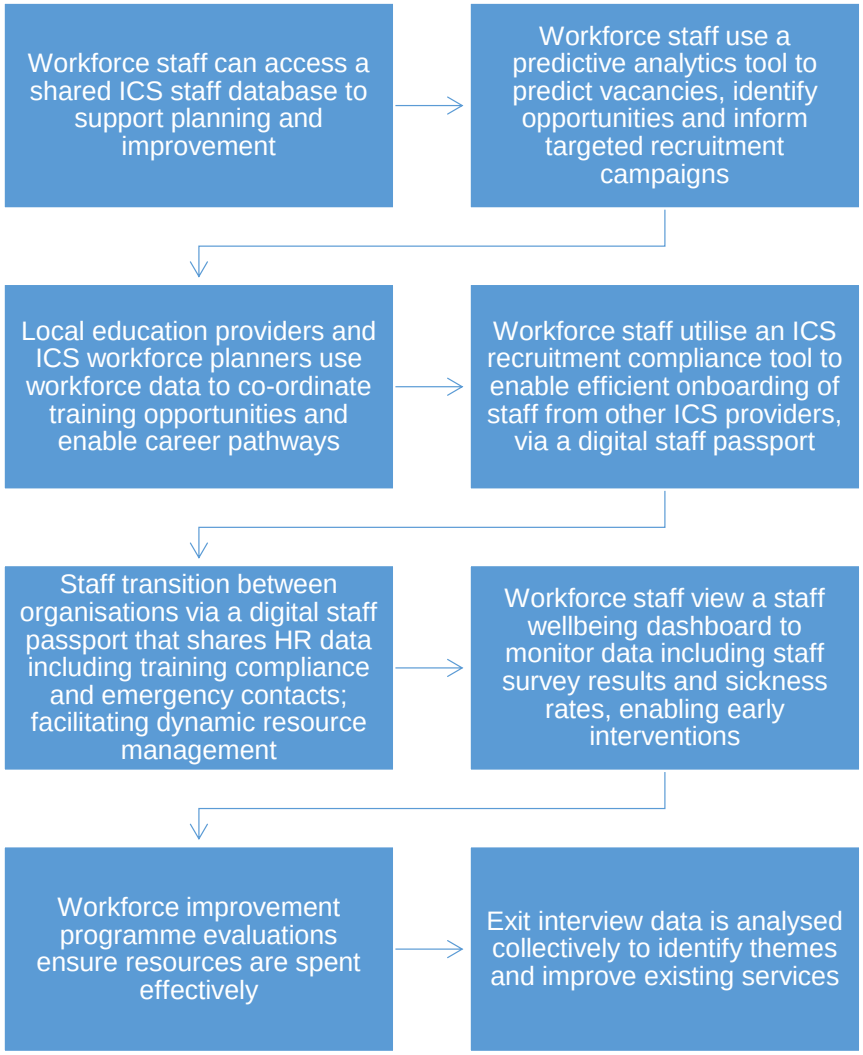
Citizens with complex needs



Use cases

Deliver Integrated Care	Collaboration between primary care, acute teams, and VCSE organisations will be supported by shared data platforms. These enable seamless communication regarding care plans, monitoring data, and care adjustments, improving patient outcomes and reducing fragmentation in care.
Moving Forward Together	Shared decision-making principles will guide the adoption and development of data platforms and approaches. By aligning on governance, interoperability standards, and data use strategies, solutions will be consistent, coordinated and fit-for-purpose
Establish an Enterprise Architecture	Data interoperability will allow primary care, acute teams, community pharmacies, and pulmonary rehabilitation services to access and update citizen information, ensuring continuity of care. For example, prescription updates automatically trigger notifications and care plan changes across the system.
Strengthening Data Capability Across Our Workforce	Alignment of job descriptions and competencies will support analysts to transition between roles. This fosters the exchange of skills, enhancing the system's analytical capability. Analysts can apply their experience from multiple care settings to develop innovative solutions for complex care pathways.
Develop High-Quality Data	A centralised data catalogue will allow BI teams to access and integrate information collected by different organisations. BI teams can develop more tailored and effective analytical products that address the needs of citizens with complex conditions, improving care coordination and outcomes.
Preparing for the Future	Future readiness will involve adopting advanced tools for PHM and real-time monitoring. For example, AI-powered tools will enable predictive risk assessments, supporting proactive care for citizens at risk of hospitalisation.

Workforce



Use cases

Deliver Integrated Care	Collaborative platforms and shared workforce data facilitate consistent workforce planning and coordinated training. By working together, different organisations can share resources, provide joint training opportunities, and flexibly deploy staff.
Moving Forward Together	A collaborative procurement strategy will ensure that digital tools and technologies are adopted consistently. This reduces friction when staff move between organisations, promoting efficiency, flexibility, and a unified digital experience.
Establish an Enterprise Architecture	An EA will support workforce planning by consolidating data on headcounts, retirements, and flexible staffing needs. Interoperable systems will allow for seamless updates to workforce deployment records, transferable training, and accurate planning in response to changing workforce demands.
Strengthening Data Capability Across Our Workforce	Targeted workforce development initiatives, such as flexible deployment and skills audits, ensure staff readiness to respond to emergencies. For example, transferable training records and data literacy programmes will enable staff to be redeployed quickly and effectively during crises.
Develop High-Quality Data	By mapping activities to reduce duplication of effort, staff will spend less time on repetitive administrative tasks. Streamlined data processes and shared tools will minimise redundant work, freeing up capacity for staff to focus on citizen care, strategic initiatives, and skills development. This enhances job satisfaction and improves system performance and responsiveness.
Preparing for the Future	Preparing for new technologies in workforce planning, such as AI-driven workforce optimisation and scenario planning tools, ensures adaptability and resilience in the face of changing demands.

How we will deliver this strategy

This strategy sets out an ambitious vision for transforming how we use data across the ICS, with the aim of improving outcomes for the people of Gloucestershire. To achieve this, we must focus not only on technical and operational improvements but also on fostering a culture of collaboration, trust, and shared responsibility across the system. Our approach is structured around four key areas: Principles, Engagement, Action, and Evaluation.

Principles

A successful ICS depends on shared values and a collective commitment to delivering better outcomes for citizens. To achieve this, we must support staff, enable them to make informed decisions based on timely and accurate data, and prepare them to meet future challenges. This strategy is underpinned by principles that promote collaboration, transparency, and mutual accountability. These principles encourage all partners to think as one system, ensuring that decisions reflect the best interests of the people we serve rather than individual organisational priorities.

Trust and openness will be central to how we work together. Partners will be encouraged to share data, insights, and expertise freely, recognising that our collective impact depends on breaking down silos and working as a unified system. This will require significant organisational development efforts, which may include leadership development programmes, cross-boundary team-building initiatives, and training to embed system-first thinking and collaborative behaviours. By fostering a culture where information flows easily, and collaboration is prioritised, we will ensure that everyone—from clinicians to strategic leaders—has access to the data they need to make informed decisions.

However, it is equally important to safeguard data privacy to protect the rights of individuals, especially where they may not fully understand how their data is used or shared with other organisations. Ensuring that data is handled responsibly and transparently will help build public trust and confidence in our use of data to support improved care.

Transparency will guide our decision-making processes, ensuring that they are open and inclusive. Organisational development (OD) efforts will focus on equipping staff at all levels with the skills and understanding needed to contribute effectively to this approach, fostering an environment where shared goals drive individual actions. By embracing these principles and investing in OD initiatives, we can create a system where the ICS acts as a cohesive and effective partnership, delivering meaningful improvements for the people of Gloucestershire.

Engagement

Engagement is critical to the delivery of this strategy, ensuring that all stakeholders are heard, valued, and involved in shaping the future. Traditional methods of engagement, such as boards, working groups, and structured consultations, will remain vital. These forums provide essential governance and structure, enabling stakeholders to align on priorities and contribute to decision-making.

However, this strategy also emphasises the importance of more innovative and inclusive approaches to engagement. By adopting frameworks like the Design Council's "double diamond" model, we can take a more generative approach to co-design. This involves deeply exploring challenges, ideating creative solutions, and testing new ideas collaboratively. Encouraging this kind of engagement across the ICS will unlock fresh perspectives and ensure that our solutions are tailored to the diverse needs of our system.

Citizens must also be engaged throughout this process. This must be meaningful, ensuring they are brought into the centre of the delivery of this strategy. This includes engaging citizens in how we want to share data. This is essential to build trust in how data is used, and to ensure that this strategy improves health and care in a way which is aligned to our citizens' values and expectations.

Engagement must also be ongoing. Regular dialogue between stakeholders - whether through formal workshops, informal networking opportunities, or digital platforms - will help to build trust and foster relationships. Transparent communication about progress, challenges, and successes will ensure that everyone feels connected to and invested in the strategy. Feedback mechanisms, including surveys and consultation exercises, will enable stakeholders to influence and refine our approach over time.

Leadership and staff involvement are essential to fostering a culture of engagement that supports the delivery of this strategy. Effective leadership will create an environment that values learning, dedicating resources such as time and expertise to enable meaningful participation. Leaders will also play a critical role in identifying the right metrics to measure impact and take actionable steps to drive improvement.

Engagement must extend to all staff, fostering their commitment to a system-wide culture of collaboration. Involving groups such as the One Gloucestershire People's Panel will be key to embedding this culture, ensuring that the voices of citizens and staff are central to how we design and implement solutions. By prioritising leadership, inclusivity, and staff involvement, this strategy will nurture an engaged community unified around shared goal.

Through a combination of traditional and innovative engagement methods, we will create an environment where collaboration is natural, ideas flow freely, and stakeholders are united by a shared vision for improving outcomes.

Action

Delivering this strategy requires translating our ambitions into practical, impactful actions. A clear and collaborative governance structure will ensure that decisions are aligned with system-wide goals and are made inclusively. Partners will work together to develop shared priorities, supported by transparent processes that make it easy to see how and why decisions are made.

Strengthening relationships across the ICS will be a key focus. By creating opportunities for staff to work across organisational boundaries - whether through secondments, joint projects, or shared training - we can build mutual understanding and trust. Leadership programmes will help to embed collaborative behaviours and system-first thinking, ensuring that our leaders set the tone for a unified and effective ICS.

We will also prioritise aligning incentives and metrics with system-wide objectives. Performance measures will reflect our shared ambitions, encouraging partners to work together rather than in competition. Early successes, such as joint initiatives or pilot projects, will demonstrate the value of collaboration and build momentum for further progress.

Good communication will underpin the success of this strategy, ensuring that data is understood and used effectively by all stakeholders. Building a shared language across organisations will help drive common understanding of what data insights mean and the communications needed for different audiences, including staff, leaders, citizens, and politicians. This clarity will ensure that data and intelligence are actionable and meaningful across the system.

To support teams in using data effectively, we will establish accessible mechanisms for advice and local guidance. Staff and managers will have access to expertise, enabling them to analyse and apply data to drive continuous improvement.

Addressing cultural barriers is another critical aspect of our approach. While the ICS already has a strong foundation of collaboration, there is room to deepen partnerships and strengthen relationships. Initiatives such as team-

building workshops, coaching, and targeted interventions will help to embed a culture of trust and openness across the system.

It is likely that the ambitions in this strategy require greater funding and resources than are available, at least in the first years. Therefore delivering this strategy will require careful resource planning to ensure we have the capacity, capability, and infrastructure to achieve our goals. We will work collaboratively across the ICS to identify and allocate the necessary resources, including funding, time, and expertise. This includes aligning workforce capacity with strategic priorities, ensuring staff have protected time to engage with data-driven initiatives, and investing in the tools and systems needed to support effective data use.

Evaluation

Continuous evaluation is essential to ensure that this strategy delivers meaningful and lasting change. We will assess progress against both technical and cultural dimensions, recognising that success depends on achieving improvements in both areas.

Evaluation will be underpinned by the What Good Looks Like (WGLL) framework, the key national benchmark for digital transformation in health and care. WGLL provides a structured set of success measures across seven key areas: Well-led, Smart Foundations, Safe Practice, Support People, Empower Citizens, Improve Care, and Healthy Populations. This framework will guide our approach to aligning governance, citizen engagement, and service delivery with national expectations.

The Digital Maturity Assessment (DMA) complements WGLL by providing a comprehensive view of digital capabilities across the system. Covering domains such as digital leadership, electronic patient records, citizen engagement, and predictive analytics, the DMA captures a wide spectrum of capabilities that contribute to operational excellence and citizen outcomes. Crucially, the DMA evolves over time, reflecting advancements in technology and shifting priorities, ensuring it remains a relevant and robust tool for assessing progress.

Transparency and assurance are foundational to creating a culture where staff feel encouraged to flag risks and opportunities, fostering an environment of reflection and continuous learning. Establishing strong links with quality and improvement teams across the system will help embed these practices, ensuring alignment with broader goals for system improvement. Benchmarking data will be used to identify areas of strength and those requiring improvement, driving system-wide progress.

By using data to understand root causes of emerging issues and develop solutions, we will foster a culture of continuous improvement. Reinforcing the benefits of data-driven performance management, including celebrating successes and demonstrating tangible outcomes, will enhance its credibility among staff and leaders.

To strengthen this approach, we will integrate data into our risk management systems, enabling us to link insights with mitigating actions. This will allow us to baseline changes to risk and ensure that evaluation directly informs strategies for improvement and adaptation. Through these efforts, we will create a system that is transparent, reflective, and focused on continuous progress.

By embedding evaluation into every stage of the strategy, we will create a feedback loop that drives continuous improvement. This will ensure that our approach remains responsive to the needs of the ICS and its stakeholders, enabling us to adapt to new challenges and opportunities as they arise.

Developing a roadmap

This roadmap suggests a prioritisation of key deliverables to be deployed.

Theme	Short Term	Medium Term	Long Term
Deliver integrated care	• Cross-Functional Teams	• Establish a DSU • Standardised Analytical Methods and Tools	• Collaborative Platforms for Data Sharing and Communication
Establish an Enterprise Architecture	• Map Strategic Uses • Ensure Security and Compliance	• Unified Enterprise Architecture • Consolidated and Integrated Systems	• Deploy Standards-Based Interoperability
Strengthening Data Capability Across Our Workforce	• Career Development Framework for Data Professionals • Data Literacy Programme for all Staff	• Gloucestershire Data and Analytics Academy	• Aligned Job Descriptions across Organisations
Develop High Quality Data	• Map Activities to Reduce Duplication of Efforts • Data Stewardship and Ownership Model	• Data Quality Toolkit	• Centralised Data Catalogue
Preparing for the Future	• Establishment of Horizon Scanning Cycles	• Strategic Partnerships and Collaborations • Establish an ICS-Wide Innovation Hub	• Converge with National and Regional Strategic Platforms • Development of AI processes
Moving Forward Together	• Joint Controllership Agreement • Shared Understanding through Engagement	• Strategy-led Decision-Making Model	• Collaborative Procurement Strategy

Abbreviations

AI	Artificial Intelligence
BI	Business Intelligence
COPD	Chronic Obstructive Pulmonary Disease
D2A	Discharge to Assess
DMA	Digital Maturity Assessment
EA	Enterprise Architecture
GCC	Gloucestershire County Council
GHC	Gloucestershire Health and Care NHS Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
ICS	Integrated Care System
ICB	Integrated Care Board
PHM	Population Health Management
TREs	Trusted Research Environments
VCSE	Voluntary, Community and Social Enterprise sector

Engagement and acknowledgements

This strategy was developed by Gloucestershire Integrated Care Board with support from the Health Economics Unit. It reflects the invaluable input and collaboration of stakeholders across Gloucestershire Health and Care NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, and Gloucestershire County Council.

To shape this strategy, we engaged extensively with our stakeholders. We conducted 16 in-depth interviews, received insights from 19 survey respondents, and facilitated discussions with 26 participants in a dedicated workshop. We gained feedback from 10 ICS and organisational boards and received direct contributions into the strategy from over 25 individuals (representing all ICS organisations and multiple professions), enabling a co-designed strategy that represent the priorities of our ICS partners.

We extend our sincere gratitude to everyone who contributed their time, expertise, and perspectives. Your input has been instrumental in creating a strategy that is both comprehensive and reflective of the diverse needs and priorities of our system. Together, we are building a stronger, data-driven foundation for integrated care in Gloucestershire.

Agenda Item 12

NHS Gloucestershire ICB Public Board

Wednesday 26th March 2025

Report Title	**Joint Commissioning Strategy for Special Educational Needs and Disabilities (SEND) – ICB Sign Off**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	Engagement with a wide range of stakeholders was carried out between May and June 2024 by external consultants, People too. The original draft of this strategy was shared with the ICB SEND Board where feedback was provided. A subsequent draft did not address these concerns and as such a re-work was undertaken by ICB colleagues. After agreement on moving forward with the new version – between GCC's Head of SEND, and the ICB's Associate Director for Children's – the strategy was shared at ICB SEND Programme Board, where some amendments were requested and made. It went to the SEND and Inclusion Local Area Partnership (SILAP) – which has a wide range of stakeholder representation. A number of amendments were requested at this point (particularly around aligning it with pre-existing strategies) and these amendments were also made. The strategy was agreed at ICB Op exec, and agreed at JCPE. Following this, some small amendments were requested by GCC's Director of Education, around the current landscape (to ensure it remained future-proof). These too have been made and agreed.				

ICB Internal	Date	System Partner	Date
SEND Programme Board OP Exec JCPE	06/01/2025 11/02/2025 24/02/2025	SILAP (SEND and Inclusion Local Area Partnership)	03/02/2025

Executive Summary	Gloucestershire County Council (GCC) and NHS Gloucestershire Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND in Gloucestershire. In December 2023, the Gloucestershire SEND Local Area Partnership was inspected by Ofsted and the Care Quality Commission (CQC). There were many areas of good practice identified. However, overall, the inspection found that the local area partnership's arrangement led to ***inconsistent experiences and outcomes*** for children and young people with Special Educational Needs and/or Disabilities. Ofsted and the CQC asked that the partnership updates and publishes its strategic plans based on the recommendations set out in the report *(see Appendix One).* Within the inspection report, the local area leaders gave assurance to Ofsted and CQC that some of the areas of weakness would be addressed by developing a consistent and coherent plan through a Joint Integrated Commissioning Strategy. In the inspection report it was documented that this was due to commence in January 2024 although work began in April 2024, when People 2 were commissioned by the Local Authority (jointly funded with ICB) to begin this work. May and June were used by People 2 to engage with stakeholders and an initial strategy was shared in July. The original draft of this strategy was shared with the ICB SEND Board where feedback was provided. A subsequent draft did not address these concerns and as such a re-work was undertaken by ICB colleagues. **What is Joint Commissioning in relation to SEND?** Joint Commissioning is detailed within the SEND Code of Practice and within this is described as a strategic approach where different organisations across Gloucestershire – including our local authority and our health services, will work together to plan and deliver services for children and young people with SEND. This collaborative effort aims to ensure that services are holistic, efficient, and tailored to meet the specific needs of these individuals. The key aspects of joint commissioning for SEND include: 1. Analysis of need 2. Collaborative Planning 3. Shared Resources 4. Improved Outcomes 5. Governance and Accountability 6. Review: assessing and measuring outcomes and impact 'Joint Commissioning' is one of the ICB's five workstreams within the SEND Programme. **DfE and NHSE monitoring visits** Due to the inspection finding we received, the DfE and NHS carry out regular monitoring to ensure progress is being made across the improvement plan. Their last visit was on **March 10th 2025.** **System-wide sign off timeline**

	Please see *Appendix Two* for the groups that the SEND Joint Commissioning Strategy needs to go through/has been through to go to Gloucestershire County Council Cabinet in June 2025.
Key Issues to note	Our intention is to receive systemwide sign off, of the Joint Commissioning Strategy *(Appendix Three)* ○ *Please note that the final appearance of this strategy can be altered to ensure it fits within both GCC and ICB visual identities; this current version has been drafted to ensure it is easy to read, based on strategies in other areas of the UK.* We do not have a joint commissioning strategy for SEND; this is a key issue. Within the strategy we are proposing five strategic priorities for joint commissioning: ○ **Ensure outcomes for children and young people with SEND are ambitious and achievable, with the right support and information accessible when needed.** ○ **Across the partnership, embed a graduated approach to meeting needs, providing children and young people with help and support at the earliest opportunity** ○ **With data showing us rising need in these areas, understand the interconnections between Moderate Learning Difficulties; Speech, Language & Communication Needs; Social, Emotional & Mental Health Needs; & Neurodiversity.** **Improve access to education through Multi-agency working for these groups.** ○ **Provide tailored support for/in mainstream settings through a multi-agency inclusion toolkit, and through workforce development across the partnership.** ○ **Ensure the local area is able to respond to a rising complexity in the needs of children & young people.** It is accepted that whilst the strategy details the first steps towards achieving our goals, a more detailed plan needs to be developed with a wider group of stakeholders. This is in motion. Our intention is also to work on ensuring the enabling principles outlined in the strategy are in place and therefore work will be required to ensure this is achieved.
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	**Risk to a future inspection:** *as one of the areas for improvement mentioned in the Inspection Report – and as a key workstream within the improvement plan – there is a risk to not implementing a joint commissioning strategy for SEND.* Original Risk: 3x5 = 15 Residual Risk:3x2 = 6 **Risk to our statutory SEND duties:** *without the strategy, there is a single risk to our statutory duty which links specifically to joint commissioning* Original Risk: 3x5 = 15 Residual Risk:3x2 = 6
Management of Conflicts of Interest	There is no conflict of interest identified.

Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource		**Buildings**	
Financial Impact	At this point, there is no financial resource requested within the approval of this strategy. The initial plan has highlighted that some of the necessary work is already covered in existing workstreams; some can be moved into existing workstreams; and that some will need implementation. If additional finance and resource is needed, it will be requested through the usual ICB or GCC routes.			
Regulatory and Legal Issues (including NHS Constitution)	Section 3 of the Children and Families Act (2014) and the SEND Code of Practice (2015) sets out the commissioner duties of ICBs; this includes jointly commissioning services for children and young people with SEND, with local authorities. There is not currently a joint commissioning strategy for SEND in place between the ICB and the local authority.			
Impact on Health Inequalities	The aim of the strategy is to improve services for children and young people with special educational needs and disabilities by committing to the priorities within the strategy, and the enabling principles. This strategy aims to ensure that services are holistic, effective, and tailored to meet the specific needs of these individuals. Therefore, the aim is to have a positive impact on health inequalities.			
Impact on Equality and Diversity	As part of its final sign off route to cabinet, the Head of SEND at the Local Authority is completing an EIA.			
Impact on Sustainable Development	The proposed Joint Commissioning Strategy for SEND aligns with following United Nation's Sustainable Development Goals: **3. Good Health and Wellbeing** **4. Quality Education** **10. Reduced Inequalities** **17. Partnerships for the Goals** Additionally, within the ICB's Green Plan, Objective 7 described sustainable models of care delivered through four principles. This strategy aligns with 2 of the principles: **Prevention** (linked to early intervention) and a **Lean Delivery Service** (focused on streamlining care to avoid waste and duplication).			
Patient and Public Involvement	When signed off by cabinet, the report will be published – it is likely this will sit on GCC's Local Offer pages as our central Hub for SEND Information, with a link through from the ICB SEND Page. The Gloucestershire Parent Carer forum was involved in the initial stakeholder engagement stage, and the views of children and young people were fed through via Future Me Gloucestershire. Additionally, school representatives, SENDIASS representatives, and the parent carer forum are on the board of SILAP. The strategy is due to reach cabinet in June 2025, giving further opportunity for patient and public engagement.			
Recommendation	**The Board is requested to:** • **Approve the Joint Commissioning Strategy for Special Educational Needs and Disabilities (SEND)**			
Author	Emilie Dawson	**Role Title**	**SEND Programme Manager**	

Sponsoring Director (if not author)	**Marie Crofts**

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

SEND

JOINT COMMISSIONING STRATEGY

EXECUTIVE SUMMARY

Our vision as a local area partnership is to provide high quality, inclusive services and to use our collective resource effectively; promoting inclusion and achieving the best possible outcomes for children and young people with Special Educational Needs and Disabilities.

Gloucestershire COUNTY COUNCIL

One Gloucestershire
Transforming Care, Transforming Communities

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Gloucestershire COUNTY COUNCIL

One Gloucestershire
Transforming Care, Transforming Communities

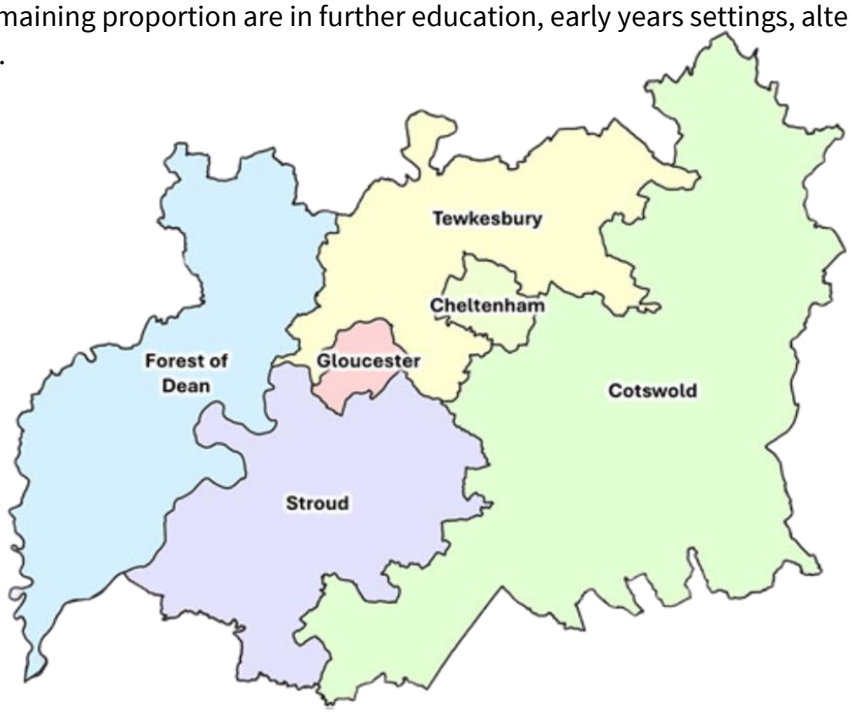
SEND in Gloucestershire & the National Landscape

In Gloucestershire, we are ambitious for all our children and young people, including those with additional or special educational needs and disabilities.
Gloucestershire benefits from coterminosity of the Integrated Care Board and County Council, and commissions a single hospital trust and single community health trust.
Our education landscape is more varied, with academies and maintained schools, special schools and independents schools, plus two further education college providers, and an array of training providers.

Our localities are diverse and varied; this creates intra county challenges and opportunities; these need to be recognised throughout all county-wide plans and strategies, including those considering children and young people with Special Educational Needs and Disabilities (SEND). For example, children in Gloucester locality might have access to very different social interaction than those who live in a more rural locality, such as Cotswolds.

The number of children and young people receiving SEND support in Gloucestershire has been increasing over the last 5 years, as has the number of children and young people with an Education, Health and Care Plan (EHCP).

Locally, 46% of children and young people with an EHCP attend a mainstream school; 25% attend a maintained special school; the remaining proportion are in further education, early years settings, alternative provisions, and independent settings.



The SEND National Landscape

The SEND Landscape is ever-changing. There is a recognition that the 2014 SEND reforms have not been successful; this is reflected across a number of national reports.

Nationally, challenges in the SEND system could be broadly summarised as:

- *Significant increases in the number of children identified as having SEND, especially those with EHCPs*
- *Despite an increase in high needs funding, the system is failing to deliver improved outcomes for children and young people with SEND.*
- *The system has become financially unsustainable.*
- *Parents' confidence in the system is in decline.*

Root causes of these issues and challenges are described as systemic and it is widely considered that reform of the SEND system is both essential and unavoidable.

Where We Are Now

Gloucestershire County Council and NHS Gloucestershire Integrated Care Board are jointly responsible for the planning and commissioning of services for children and young people with SEND in Gloucestershire.

In December 2023, the Gloucestershire SEND Local Area Partnership was inspected by Ofsted and the Care Quality Commission.

There were many areas of good practice identified such as our Local Offer, co-produced with families through the Gloucestershire Parent Carer Forum; provision for children's additional needs in early years; and the SEND Inclusion Local Area Partnership Board, amongst others.

The inspection also identified four areas to address, as set out below, if we are to achieve our ambition to deliver consistently good experiences and outcomes for children and young people with SEND. Ofsted and the Care Quality Commission asked that the partnership update and publish its strategic plans based on the inspection report.

Our SEND improvement plan incorporates our response to the recommendations and was published in April 2024.

The Local Area Partnership Board oversees the delivery of the improvement plan.

1. Leaders in the ICB & the Local Authority (LA) should strengthen **multi-agency working** between education, health, & social care providers in order to:

- *Identify/assess needs more quickly*
- *Improve education transitions*
- *Help children and young people (CYP) access provision that meets their needs*
- *Improve Preparation for Adulthood (PFA)*
- *Communicate decision-making processes with all stakeholders*

2. Leaders should work together to strengthen & embed the **quality assurance framework** around all EHCPs, including:

- *Quality & depth of all contributions*
- *Reducing health assessment waits*
- *Increasing timeliness & quality of needs assessments*
- *Increasing timeliness & quality of EHCPs & annual reviews*
- *EHCPs should consider information shared by all services providing support*

3. Leaders in education should continue to review the breadth & offer of **specialist places** for children with SEND, in order to inform **commissioning & investment** in **specialist provision** to improve the experiences & outcomes of children & young people & their families

4. The partnership should further develop their **strategic plans** to include families in partnership projects to embed their voice & create a model of true **co-production**.
The monitoring of projects & interventions should be more **inclusive** & **effectively communicated** with stakeholders, to create a shared culture of driving improvements for children, young people with SEND and their families

SEND Governance in Gloucestershire

SEND and Inclusion Local Area Partnership Board
Co-Chairs: **Kirsten Harrison** (*Director of Education*), **Helen Ford** (*Deputy Director, Integrated Commissioning*)

SILAP Programme Management Group

1. Developing Inclusive Communities and a Local Education System	2. Ensuring CYP are able to access the right support at the right time	3. Delivering Better Value in SEND	4. SEND AP Change Programme
Early Intervention & Assessment	Joint Commissioning	Whole school SEND & Inclusion Programme	Transforming Alternative Provision
Workforce Development	SEND Quality & Performance	Improving Post-16 Commissioning & Advice	Improving Transitions & Preparation for Adulthood
Access to Education / SEND Exclusions	Co-production & Communication		Local Area Inclusion Plans
			Advisory Tailored Lists
			National Bands & Tariffs
			Education, Health & Care plan Reforms
			National Standards
			Early Language Support for Every Child

In Gloucestershire, our overarching SEND and Inclusion work is governed by our SEND and Inclusion Local Area Partnership.

This board is co-chaired by the Director of Education from the Local Authority, and the Deputy Director of Integrated Commissioning from the Integrated Care Board. The board has diverse representation from across the partnership, including from health providers, schools and educational settings, parent-carers, children and young people's voice, and from the local SEND Information, Advice and Support Service, alongside colleagues working in education, health and social care.

The SEND and Inclusion Local Area Partnership has oversight and governance of the local area's SEND Improvement Plan. The Improvement Plan has 16 workstreams that sit under four over-arching pillars: developing inclusive communities and a local education system; ensuring children and young people are able to access the right support at the right time; delivering better value in SEND; the SEND and Alternative Provision Change Programme.

A dedicated group sits between full board and individual workstreams to ensure leaders have robust oversight of activity. Additionally, the Integrated Care Board has a dedicated SEND Programme Board which allows them to feed up and into the individual improvement plan workstreams.

Assessment of Need

In developing this strategy, we consulted with a range of stakeholders including our Parent Carer Forum, Future Me Gloucestershire, Education Services, social care colleagues, the designated social care officer, allied health professionals, service leads, commissioners, finance teams, and our Designated Medical Officer.

Consultations were conducted through 1 to 1 conversations that included structured questions and the flexibility for free-flowing discussions.

We brought the views of parent carers, partners and stakeholders alongside our SEND data to develop our needs analysis which underpins the priorities we have set out in this joint commissioning strategy.

In Gloucestershire there were

6,411

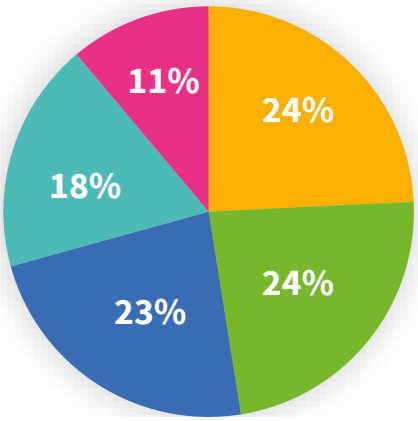
children and young people with an **EHCP** as of January 2025. This was an increase of 9% since July 2024

In 2023 there were

1436

requests for statutory assessment. This was an increase of 28.7% since 2022.

PREVALENCE OF NEED IN EHCPs



- **Moderate Learning Difficulties**
- **Speech, Language and Communication Needs**
- **Social, Emotional and Mental Health Needs**
- **Autistic Spectrum Disorder**
- **Other**

*Data for the SEN 2 Census will only record the primary & secondary needs: children sometimes have **multiple** needs.*

Children in Care

23% of children in care in Gloucestershire have an EHCP.

26% receive SEN Support

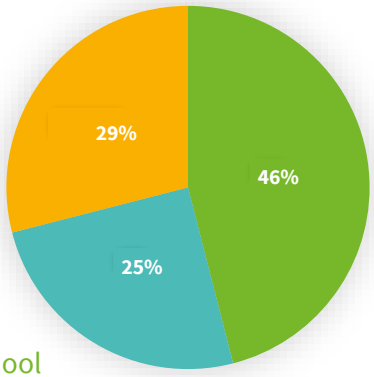
Adult Social Care

In March 2024 there were

342 young people receiving support from Adult Social Care in Gloucestershire.

72% were recognised as having learning disabilities and were receiving payments for supported living or direct payments to finance their daily care.

EDUCATION SETTINGS FOR CHILDREN AND YOUNG PEOPLE WITH SEND



- Mainstream School
- Special School
- Other: *Early Years; Further Education; Alternative Provision; Independent*

REFERRALS TO COMMUNITY HEALTH SERVICES

Children's Speech and Language Therapy

In 2023/2024 the service had **3758** referrals and **3415** children and young people on the service caseload.
Safe waiting is supported through a digital app service called **SHARE**

CAMHS Learning Disability

The CAMHS Learning Disability team supports children with a range of learning disabilities including ASD who attend specific special schools.
In 2022/23 there were **189** referrals to the service this rose to **232** in 2023/24.

Children's Occupational Therapy

In 2023/2024 referrals reduced to **1673** (following a peak at **3627** in 2021/2022).
The number of children and young people on the service caseload fell to **1484** in 2023/2024 due to improved flow and reduced waiting times.

Children's Physiotherapy

There were **3476** referrals into the service in 2023/2024, a slight decrease on the previous year's **3588**.
There were **10,583** contacts made with children and young people – and their families – in 2023/2024

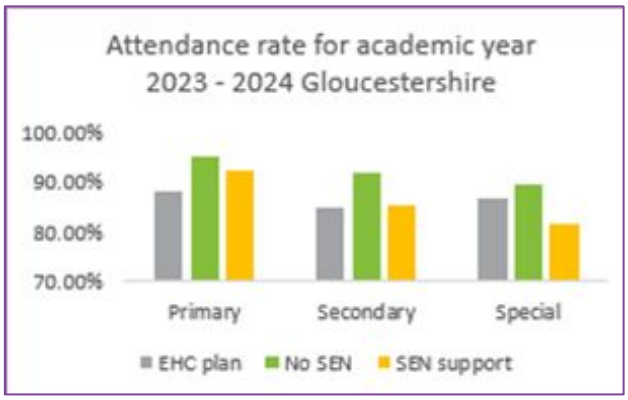
Educational Outcomes	Children with SEND Support (local)	Children with SEND Support (national)	Children with an EHCP (local)	Children with an EHCP (national)
Early Years *% of children meeting the "Good Level of Development"*	21.7	24.3	5.2	3.8
Key Stage 2 *% of children achieving expected level – or higher – in reading, writing, maths*	20	26	10	9
Key Stage 4 *Attainment 8 Scores*	33.5	33.3	13.5	14

Attendance and Exclusions

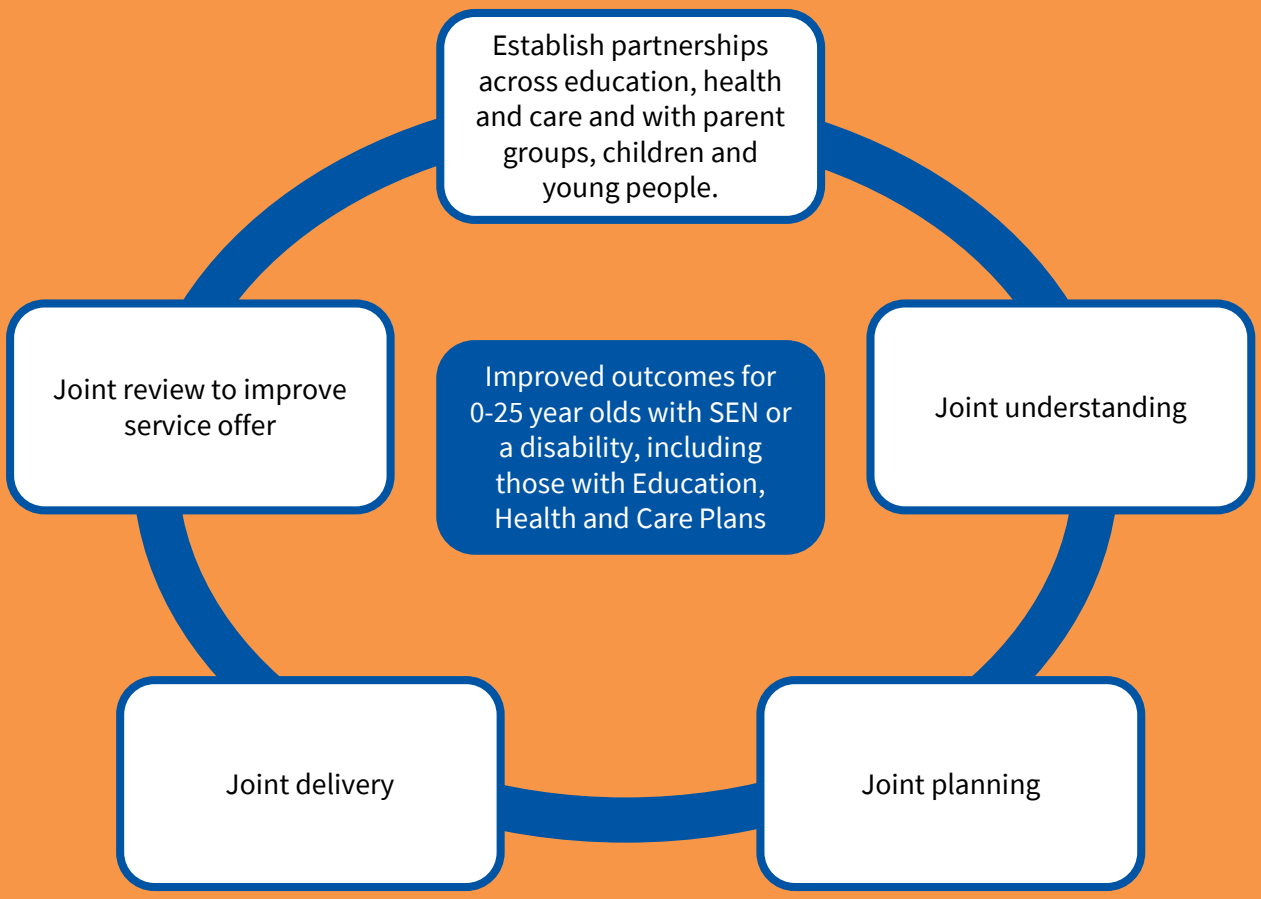
A higher rate of children and young people with SEND are persistently absent from a school or setting.

In 2022-2023, the overall persistent absence rate for pupils without SEN was **17.0** compared to **35.0** for children with an EHCP and 30.7 for children accessing SEND support. This is similar to the national averages at 36.0 and 31.1 respectively.

Children and young people with additional needs are more likely to receive an exclusion that those with none. This has increased for children with both an EHCP and SEN support in recent years.



Joint Commissioning for SEND



Joint commissioning for Special Educational Needs and Disabilities (SEND) is a strategic approach where different organisations across Gloucestershire – including our local authority and our health services, will work together to plan, purchase and deliver services for children and young people with SEND.

This strategy aims to ensure that services are holistic, effective, and tailored to meet the specific needs of these individuals.

For us, the key aspects of joint commissioning for SEND include:

Analysis: *Using data sources to understand and assess what is needed locally.*

Collaborative Planning: *The Local Area Partnership is committed to co-production. As such, we will come together to plan services that address the comprehensive needs of children and young people with SEND.*

Shared Resources: *By pooling resources and expertise, we will provide more effective and coordinated support.*

Improved Outcomes: *The goal is to deliver better outcomes for children and young people with SEND in Gloucestershire by ensuring that services are well-integrated and responsive to their needs.*

Governance and Accountability: *Strong leadership and clear governance structures are essential to ensure that joint commissioning efforts are effective and accountable.*

Review: *Assessing and measuring the outcomes and impact of our work to inform ongoing planning and priorities*

Strengths, Weaknesses, Opportunities and Threats in our Local SEND System

Through use of available data – including the voice gathered in consultation for this strategy and from the inspection report – the following have been identified across the partnership:

Strengths

- Leaders have a shared vision of excellence
- There are ambitious plans for improvement across the local area partnership
- The partnership has set out clear priorities and robust arrangements for governance
- There are a number of support measures in place whilst young people wait for assessments
- There are strong examples of effective partnership working and co-production across the area

Weaknesses

- More support is needed for young people with SEND to access social interactions
- More needs to be done to create open, supportive, trusted relationships using shared language
- Our young people need more support to gain autonomy, resilience and independence
- Increasing demand for special school places with limited places available
- More support is needed with Social, Emotional and Mental Health; Moderate Learning Difficulties; Speech, Language and Communication; and Neurodiversity needs
- Mainstream schools need to provide tailored support for children with SEND
- Poorer educational outcomes and attendance, and higher exclusions for young people with SEND
- Better SEND support is needed for children in care
- There are system-wide gaps in early intervention and use of a graduated approach to meeting need
- The needs of children and young people are becoming more complex
- Improved joint working between organisations
- Challenges of children with complex needs and who is responsible for supporting them in school
- There are inconsistent transition arrangements across the local area

Opportunities

- Support to gain autonomy, resilience and independence including preparation for adult life
- Providing our children and young people with help and support at the earliest opportunity
- Ensuring the local area is able to respond to a rising complexity in the needs of children and young people
- Delivering services to support Moderate Learning Difficulties; Speech, Language and Communication Needs; Social, Emotional and Mental Health needs; and neurodiversity needs
- Providing tailored support in mainstream settings
- Developing clear pathways and processes for multi-agency decision making and partnership working

Threats

- Workforce strain
- Financial unsustainability
- System becomes adversarial
- Rising youth unemployment rates
- Limited social opportunities in some communities
- Regulatory and Compliance Risks
- Cost of living crisis and post-COVID challenges

Strategic Priorities for Joint Commissioning

As a local area partnership, we recognise that children and young people with SEND are – first and foremost – children and people.

They come from all backgrounds, cultures, faiths and ethnicities, as well as having a diverse range of SEND that intersect.

We recognise that – for some people – those factors will be protective and enabling and, for others, they will amplify the challenges they face.

We will use our equalities data and impact assessments to ensure that our joint commissioning approach is aimed at maximising access, inclusion and equity for all groups.

Our Strategic Priorities for Joint Commissioning have been set based on the data from our Joint Strategic Needs Assessment; the views of stakeholders gathered through consultation; and with a focus on aligning with the priorities identified in our ***2022-2025 SEND Strategy***, and our ***2022-2025 Inclusion Strategy***.

Priority 1

Ensure outcomes for children and young people with SEND are ambitious and achievable, with the right support and information accessible when needed.
Links to SEND Strategy Priority 1, 2, 3

Priority 2

Across the partnership, embed a graduated approach to meeting needs, providing children and young people with help and support at the earliest opportunity.
Links to Inclusion Strategy Priority 2

Priority 3

With data showing us rising need in these areas, understand the interconnections between Moderate Learning Difficulties; Speech, Language & Communication Needs; Social, Emotional & Mental Health Needs; & Neurodiversity.
Improve access to education through Multi-agency working for these groups.
Links to Inclusion Strategy Priority 3 and 4

Priority 4

Provide tailored support for/in mainstream settings through a multi-agency inclusion toolkit, and through workforce development across the partnership.
Links to Inclusion Strategy Priority 1 and 4

Priority 5

Ensure the local area is able to respond to a rising complexity in the needs of children & young people

Strategic Priorities for Joint Commissioning: *from Objectives to First Steps*

With the strategic priorities planned out, we will develop detailed plans for each of the priorities and will form working groups to deliver the actions we agree to take.

A Joint Commissioning workstream is already included within the local area improvement plan and will govern the progress of the planning group.

Key to each group will be the following first steps, and the accompanying enabling priorities.

1. Ensure outcomesEncour for children and young people with SEND are ambitious and achievable, with the right support and information accessible when needed.

Ensure seamless transitions across all services and stages.	Development of county-wide transition pathways across services; a shared understanding of what transition means.
Ensure young people have the skills to prepare them for adult life and all potential independence at an early stage, ensuring appropriate adult social care support where needed.	An agreed position on Preparation for Adulthood (PFA) with clear roles, responsibilities and sign-up from required organisations.
Ensure children and young people can engage in social interactions.	Learning from young people about current barriers to accessing social interaction; building the right support and opportunity.
Help children & young people with the resilience & support they need to access & attend their education, employment or training. Encourage and enable them to share their views and shape the support they need.	Review the approach to the commissioning of supported living and employment and education of young people with SEND.

2. Across the partnership, embed a graduated approach to meeting needs, providing children and young people with help and support at the earliest opportunity.

Develop a system-wide understanding of universal, targeted, specialist support, providing families with confidence in LOI.	Develop the levels of intervention guidance for the partnership and ensure strong, shared local area ownership and use.
Have a more systematic approach to recognising, and responding to, external factors that can impact on a child or family, such as trauma.	Equip colleagues with a robust understanding of contributors to behaviour; ensure signposting, support and services are available to support.
Strive to ensure needs are identified when emerging, with provision available in a timely manner.	Whilst working to improve waiting times, explore innovative waiting list initiatives for providing support.
Use the graduated approach robustly, consistently & with confidence, to build resilience and sustainable outcomes for children without the need for an EHCP.	Ensure settings use a Graduated Approach at the earliest opportunity and are given the skills and knowledge to use it flexibly.

3. With data showing us rising need in these areas, understand the interconnections between Moderate Learning Difficulties; Speech, Language & Communication Needs; Social, Emotional & Mental Health Needs; & Neurodiversity. Through Multi-agency working, improve access to education for these groups.

Develop improved partnership understanding of the interconnections between these areas to better inform our joint commissioning.	Conduct a research project and report, with a gap analysis following.
Upskill the workforce to understand these connections and their ability to support them, ensuring trust & relationships.	When the above is completed, feed this into workforce development across the system.
Empower CYP & families with strategies to meet need, ensuring we have communication channels & signposting to support this.	When above is completed, develop training, resources, support for families, place on the local offer; ensure it is shared through comms.
Ensure services are joined-up and well connected to meet a range of diverse needs.	Gap analysis of where services are not currently able to meet need. Analysis of total resources from each area to inform commissioning.

4. Provide tailored support for/in mainstream settings through a multi-agency inclusion toolkit, and through workforce development across the partnership.

Ensure children feel supported to access mainstream education as much as possible.	Through the Inclusion Framework, help schools create inclusive learning environments which remove unnecessary barriers.
Ensure the workforce feel empowered, supported & knowledgeable about meeting SEND needs.	Develop a robust training offer for schools so everyone understands their responsibilities within SEND.
Help families to better understand Ordinary Available Provision & have trust in it within their child's setting.	Through clear comms, resources and training, develop clear understanding of ordinarily available provision and reasonable adjustments for families.
Ensure services are available in the places where they can have maximum impact.	Jointly commission initiatives – using current pilots as examples – to give mainstream settings support when they need it.

5. Ensure the local area is able to respond to a rising complexity in the needs of children & young people

Make special school places available to those who need them.	Through strategic priority 4, raise confidence in the ability of mainstream settings to meet needs and provide reasonable adjustments.
Ensure roles & responsibilities for children with complex needs are clear system-wide; this includes financial responsibilities.	Review current decision-making groups/processes/policies; use these to produce a jointly-owned position on individual level funding.
Enable services to work collaboratively to meet rising complexity, streamlining processes for joint decision making.	Use data to inform joint commissioning decisions; define opportunities for joint commissioning of services.
Ensure complex health needs are not a barrier to accessing education.	Allocating of service or individual health resources to meet identified health needs to access education.

Enabling Principles

This strategy, the underpinning plan, and the work behind it cannot be successful without a partnership wide commitment to the following key enablers:

Co-Production

Design, develop and commission services in partnership with children, young people, and families to ensure commissioning decisions reflect their experiences, ambitions, and expectations.

Commitment to Tri-Working

From the start, education, health, and social care are committed to working together – alongside the Voluntary/Community Sector and other partners -to ensure shared responsibility for each strategic priority.

Resource and Finances

Allocate and use resources efficiently to gain maximum value and benefit to children and young people.
The partnership will identify and plan resource allocation and additional investment for subsequent years.

Governance and Accountability

This strategy, and the delivery of it, will be governed through the local area improvement plan; the SEND and Inclusion Local Area Partnership will monitor progress of its delivery.

Monitoring and Evaluation

We will embed a continuous cycle of monitoring, assessing, planning, doing, and reviewing to ensure high-quality, evidence-based activities under each priority.

Escalation Routes

Each strategic priority needs a clear, agreed-upon escalation process to resolve disagreements quickly and professionally. These routes will form part of the Joint Commissioning Plan.

Gloucestershire COUNTY COUNCIL

One Gloucestershire
Transforming Care, Transforming Communities

GLOUCESTERSHIRE SEND

- Gloucestershire County Council Education Inclusion Strategy
- Gloucestershire County Council SEND Strategy
- ISOS Partnership Research Paper on Pressures in the SEND System
- NAO – Support for Children and Young People with SEND
- Public Accounts Committee: Support for Children and Young People with SEND
- Education Select Committee: Solving the SEND Crisis

VISIT THE GLOUCESTERSHIRE SEND LOCAL OFFER WEBSITE

Glosfamilies Directory | Support for Families with SEND - Gloucestershire's Local Offer for Parent & Carers

1

Local Area Partnership report

Area SEND inspection of Gloucestershire Local Area Partnership

Inspection dates: 11 to 15 December 2023

Dates of previous inspection: 13 to 17 June 2016

Inspection outcome

The local area partnership's arrangements lead to inconsistent experiences and outcomes for children and young people with special educational needs and/or disabilities (SEND). The local area partnership must work jointly to make improvements.

The next full area SEND inspection will be within approximately three years.

Ofsted and the Care Quality Commission (CQC) ask that the local area partnership updates and publishes its strategic plan based on the recommendations set out in this report.

Information about the local area partnership

Gloucestershire County Council and NHS Gloucestershire Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND in Gloucestershire.

There have been significant changes to the senior leadership of Gloucestershire's SEND services since the previous inspection. These include the recent appointment of a new director of children's services, a newly appointed director of integrated commissioning and a director of safeguarding and care.

The commissioning of health services changed across England in 2022. On 1 July 2022, NHS Gloucestershire ICB became responsible for the commissioning of health services in Gloucestershire.

The local authority has recently merged three schools as alternative providers (AP) for children or young people who have been, or are at risk of being, permanently excluded, to The Altus School. This is aimed at providing a consistent AP offer across the county. The local authority commissions a range of provision, including unregistered provision, to meet the needs of children and young people who are educated other than at school.

What is it like to be a child or young person with SEND in this area?

Too many children and young people's needs are not being identified swiftly enough in Gloucestershire. The education, health and care (EHC) plan and annual review processes, in terms of quality and timeliness, mean that too many children and young people do not access the support they need. Referral processes and delays in referrals to services mean that providers often work in silos, doing the best job they can to meet needs. For example, at key transition phases, some children and young people move on without an agreed final plan or with an appropriate support package in place. This can put the education placement at risk. As a result, an increasing number of children and young people are missing from education, electively home educated, on part-time education packages or not in education, employment or training.

The timely and effective identification of children and young people's needs is a variable but improving picture in children's early help and social care. The threshold of need is understood and applied appropriately. Early help and social care assessments analyse the vulnerabilities of children and young people with SEND, taking into account family and social care history to inform child-focused multi-agency plans to address need. Timely referrals are made by practitioners, often for mental health support or neurodiverse assessments. However, due to the wait for children and young people to receive these services, assessments and plans often progress without this information or support.

Children and young people wait too long to access some therapeutic services, such as occupational therapy and child and mental health services (CAMHS). However, there are a number of support measures available for children and their families to access while awaiting assessments for CAMHS or autism. This includes social, emotional and mental health support from 'on your mind Glos'. The multi-agency 'team around the locality cluster' and navigation hub pilot ensure timely provision of services for children whose needs may not be met by a single service, helping to ensure that children don't 'bounce' between services or spend extended periods waiting for a service without support. The learning difficulty (LD) CAMHS initial assessment team regularly reviews children and young people when they are on the waiting list, and the 'navigation hub' pilot project is helping to signpost some children and young people who fall within the pilot scheme's scope to appropriate agencies so that care and support can be accessed during the 18-month wait for CAMHS.

The views of children, young people and their families are frequently sought, where possible, to help inform care planning in early help and children's social care. Observations and descriptions of children and young people are used to build a picture of their experiences and progress. They are supported to understand the choices that are available to them. However, too often, this information is not included in EHC plans.

Some children and young people talk positively about their experiences in special schools and at college, specifically about individual staff members who know and understand

their needs and support their aims and aspirations. However, not all children and young people are supported well to prepare for adulthood. Too many providers are not positive about the transition processes, whether from early years into primary, or from secondary to post 16. Where annual reviews and plans are passed on to new settings, they do not always provide a true reflection of the current needs of the child or young person. Many parents say that their child does not receive the right help and support to prepare them for their next steps, with too many EHC plans lacking input from partners in health and social care so as to plan and prepare for adulthood.

When communication between all partners is effective, the voice of children, young people and their families is heard, and their wishes reflected in their 'my plans' and EHC plans. For example, health practitioners advocate for the children and young people awaiting assessment for attention deficit hyperactivity disorder (ADHD), to ensure they are supported to co-produce coping strategies, which are then presented to the school to better understand their needs. However, communication between some settings and services is inconsistent, and this sometimes results in information being missed, which and leads to poor experiences and outcomes for too many children and young people.

Children and young people on the dynamic support register (DSR) are closely monitored by multi-agency practitioners through regular meetings, to ensure that young people are receiving the right support at the right time. This includes, for example, specialist adaptations being made to local area partnership-purchased properties in which young people can live with support. This in turn results in those young people not needing to be admitted to specialist hospital placements, reducing the 'revolving door' aspect of hospital admission and discharge. Young people who are young carers are readily identified by keyworkers so that appropriate multi-agency support can be accessed were necessary.

Children, young people and their families are informed of the community activities, support and short break services through children's early help and social care services as well as the local offer through the 'Glos families directory'. Children's interests and friendships are nurtured well in some settings. For example, children and young people attending LA commissioned AP have the opportunity to select learning and therapeutic activities that interest them and support their needs well. However, children, young people and their parents tell us that there is a lack of opportunities for activities and short breaks.

What is the area partnership doing that is effective?

- Leaders across the partnership have a shared vision of excellence. The local area's strategic plans are ambitious and designed to meet the needs of children and young people with SEND in Gloucestershire. The leadership structure is relatively new, with people appointed to key posts this year. As a result, many strategies and plans are in their infancy. There are many pilot projects underway, or due to start, to improve the identification of need and access to suitable provision. For example, the navigation hub scheme links multi-agency professionals, such as CAMHS, school nursing and young minds matter, to work collaboratively to review

referrals via a single route of access. However, leaders recognise that a previous lack of investment has resulted in reactive services that are not yet meeting the needs of children, young people and their families. They are committed to changing this and while there are 'green shoots' of progress being made, it is too early to measure the impact of these changes, as many projects are ongoing and yet to formally launch.

- Leaders have implemented a SEND and inclusion local area partnership board and improvement plan that sets out clear priorities with robust arrangements for governance and oversight. However, the impact of their work is only just starting to improve the lived experiences for children and young people with SEND and their families. There has been rapid improvement in some areas, such as the timeliness of some EHC plans where 86% of children in Year 10 have recently been issued with a final plan in preparation for transition to post-16. There is also an increase from 28% to 40% for issuing EHC plans within statutory time frames. This demonstrates the impact of the investment in 26 new staff in the casework team. But 40% completion of EHC plans is far from statutory timeframes. The long-term legacy of poor experiences of children, young people, and their families, along with the challenges faced by schools and colleges in working with out-dated information, is fuelling the dissatisfaction of parents and practitioners in Gloucestershire.
- The recently revised local offer is co-produced with families through the Gloucestershire Parent Carer Forum (GPCF). It is an example of leaders' commitment to actively working with families to deliver change. A new special school opened in September 2023, with a further planned, along with the merger of three schools to form the Altus School (AP), which are further examples of the partnership's understanding of the need for additional specialist places in Gloucestershire. Other early signs of impact include effective partnership working with colleges to create new programmes and pathways to better meet the changing needs of young people with SEND. However, the increasing numbers of children and young people with no allocated school place, those who are educated at home, on part-time packages or not in education or training, along with the increasing numbers of tribunals, suggest there is significant work remaining to be done.
- The early identification and swift and accurate provision for children's additional needs is resulting in children making progress in their early childhood development. The members of the early years team are supporting practitioners to improve their identification of SEND and subsequent adaptations through increased take-up of the two-year-old assessment. Nevertheless, when children reach the statutory school age, partner services are not routinely involved in the development and implementation of EHC plans. Health and social care partners do not consistently contribute to EHC reviews and plans. Insufficient school staff training on the graduated pathway results in provision recommended by other services not always implemented effectively.
- The investment of £10 million in additional funding for SEND by the local area partnership is beginning to reap benefits. Additional practitioners and improved

systems are positively impacting on the experiences of children and families. For example, access to applications online will enable families and practitioners to track the progress of assessments. However, there remains a lack of suitable qualified practitioners for some vacant posts, including educational psychologists (EP) and CAMHS workers, who are proving difficult to recruit. This means that the impact of investments already made is not yet felt by all those children and families awaiting assessment or support.

- The engagement and participation strategy, and the bi-annual pupil well-being reports, are examples of the local area partnership working together to better understand the needs of children and young people across Gloucestershire. Co-production of the 0 to 18 neurodevelopmental pathway, currently due to be implemented during 2024, was paramount to it being successfully planned and agreed. Representatives from the GPCF were involved in planning the new service, following many complaints from families that the current system was not working well. Practitioners told us that the benefits of working in co-production have made a tangible difference to the way they engage positively with families.
- The designated clinical officer has established positive relationships with, for example, the GPCF, the special educational needs information, advice and support service and children's social care. They have recently begun to sample and quality assure more recent EHC plans, to ensure that they are of a consistent and high quality. However, the inspection team could not be assured of a consistent methodology of EHC plan quality assurance across the local area partnership at the time of our visit.
- Leaders recognise that effective multi-agency working is core to improving the lived experiences of children, young people and their families. The local area partnership has worked together to commission some services that meet the needs of children and young people across the local area, for example voluntary sector social, emotional, mental health and well-being services, online counselling and digital support. These services are actively providing support to young people in formats that often best meet their needs at an early stage, therefore helping to prevent more formal CAMHS support measures needing to be put into place.
- Leaders across the partnership recognise the lack of investment in SEND following the previous inspection in 2016 up until more recently, which, along with the rise in numbers of children and young people with additional needs, has resulted in poor experiences for children, young people and their families in Gloucestershire. They have recently commissioned a local government association review to inform their strategic planning. The local area is also working with the Department for Education (DfE) through the delivering better value programme and more recently as a joint lead partner in the DfE's change programme. All provide opportunities for leaders to work with parents to evaluate services and ways of working to inform changes to their improvement plans. New appointments and investment in teams across the partnership will put leaders in a better position to focus on delivering improvements for children, young people, families and practitioners.

What does the area partnership need to do better?

- Parents and school leaders rightly describe a system that is not working well for children and young people with SEND and their families in Gloucestershire. A significant number of parents describe feeling desperate, and many practitioners say they are battling to be heard by local area leaders. Inspectors found systems that are too reactive, and, in some cases, this results in children, young people and families reaching crisis point before their needs are met. For example, we heard young people waiting too long for mental health assessments or not meeting the criteria for an assessment, even where health practitioners have supported their application. For some, hospital admission was the trigger for support. Leaders' strategies and plans are starting to impact positively on children and young people who are new to the system, but leaders recognise there is much work to do to improve the experience of children, young people and families who have had, or continue to have, poor experiences.
- Leaders are committed to working with children and young people with SEND and their families. There are examples of leaders using the voice of children, young people and families to improve provision and to engage them in co-production, such as the social communication and autism assessment service (SCAAS). However, co-production is too variable and not sufficiently widespread through the systems of planning and support across education, health and social care to make a difference. For example, evidence collected through surveys and meetings with parent representative groups and practitioners highlighted families' concerns about the inconsistencies in transport services, and schools reported children and young people frequently missing education as a result. The GPCF told us that they would welcome the opportunity to take part in the current review of transport services to support understanding of the impact of existing arrangements and co-produce solutions.
- Leaders sometimes positively engage with children, young people and their families to better understand their lived experience. However, through surveys, 68% of children and young people state explicitly that they do not get the help they need and that their needs are not understood. Parents praise some aspects of health support, such as speech and language and dynamic key workers, but too many parents say they are battling a system where they are made to feel that they are the problem. They say there is lack of understanding of SEND from leaders and poor communication regarding changes to the system. Over half of parents surveyed said their child does not get the right help to participate in universal and specialist activities. Some feel there is no support at all and face challenges such as securing transport, support and information for transition to adulthood. Many say that delays in the EHC assessment process, at all stages, prevent access to adequate provision that meets the needs of their child.
- Families appreciate the recent investment in the casework team and, as a result, recognise some early improvement in the timeliness of EHC plans. Nevertheless, an over-reliance on early years settings, schools and colleges to update plans is

done so at the expense of children's health and social care needs not being addressed and included within plans. This results in a lack of timely and appropriate support to prevent or minimise additional difficulties before they arise. Families say that agreed information is frequently missing from plans following annual reviews. They say the local area processes can cause delays to assessment, as it sometimes feels that the needs and behaviours of their child is attributed to their poor parenting. This causes anxiety for families and is a barrier to the early identification of their child's needs and access to the right support at the right time to improve their experiences and outcomes.

- The local partnership's oversight of the quality of EHC plans across education, health and social care is having little impact. The partnership's recent audits of EHC plans have increased the local area's understanding of the quality and constraints of processes. However, during the inspection, parents and practitioners expressed frustration at the time taken to issue final plans, saying that substantial changes to plans are frequently not reflected in the final plan. In cases sampled, this resulted in long waits for children to access the right support and specialist placements.
- Too many children and young people with SEND in Gloucestershire do not have a school or college place. Leaders recognise this and are proactive in analysing data to better understand the increasing numbers of children with no allocated place. Individual teams work well together to support children and young people who are educated other than at school and not in education, employment or training. Case coordinators and youth support team officers share support for young people to maximise the opportunities to re-engage individuals with education and/or training. However, the timeliness of consultations and updating of plans are resulting in some children and young people being out of education for too long. Cases sampled during the inspection, supported parent and practitioner concerns about the increasing numbers of children and young people missing education in Gloucestershire.
- Leaders recognise there is insufficient specialist provision to meet the increasing numbers of children whose needs cannot be met in mainstream schools. They are focused on developing consistent and coherent planning through the Joint Integrated Commissioning Strategy due to commence in January 2024. Some providers in early years and post-16 settings are positive about the work of the partnership in identifying gaps and commissioning provision. However, schools are most affected by the increasing demand for specialist places to meet the needs of children and young people. The new special school and changes to AP are showing signs of early impact, but leaders recognise that the partnership needs to invest further in schools and specialist settings to both alleviate the challenges that schools face, and to better meet the needs of children across the county.
- Leaders across the partnership understand that they have a lot of work to do to ensure that there is improvement to the lived experience of children and young people with SEND and their families. They recognise that providers are desperate for a coordinated and effective multi-agency approach across the partnership. Health, social care and education services are not yet working well enough

together, and providers want greater support from the partnership. For example, there is overwhelming evidence of schools leading the annual review and EHC plan process without input from partnership services, developing their own systems to monitor changes to plans in the absence of revised plans. Although this is permitted within the SEND code of practice, it does not enable a multi-agency approach to reviewing the changing needs of children and young people.

- Schools are being proactive and finding their own solutions to challenges in meeting the needs of children and young people with SEND. They value the recent allocation of EP support to schools in September but say the designated time is not enough. With limited hours and long wait times for services such as the over age 11 autism and ADHD assessments at 24-months, and 18-months for CAMHS, many commission their own services, such as EP, speech and language therapy, physiotherapy and occupational therapy. However, currently parents and providers say the partnership does not accept information collated from private practitioners to better support children and young people through assessment and review processes in swiftly identifying need and securing support.
- School leaders accept their responsibilities as commissioners of AP for individual children. However, they identify the need for further support from the LA. The long waiting times to access AP means schools are keeping children and young people in school, where they can no longer meet their needs. At best, this is through part-time timetables; at worst, they are being excluded due to deteriorating behaviours and breakdown of placements. Practitioners say they are drawing limited resources from other children and young people, in an attempt to meet the needs of those who would benefit from attending AP.
- Transition arrangements for some children and young people at different stages in their lives are not timely enough. Planning for children's futures as they reach adulthood does not happen quickly enough. This leads to children, young people and their families feeling anxious and unsettled about their future. For those young people entitled to care leaver services, the later allocation of personal advisers compounds this problem. When young people are referred to adult services in a timely manner, a period of joint working between adults' and children's social care enables the necessary assessments to take place to support effective planning for the smaller group of young people who are eligible for adult services. Some young people we spoke with told us of their negative experiences of transitioning to college, with some stating that they felt that their college had been ill prepared to meet their needs and, in some cases, placements had broken down.

Areas for improvement

Areas for improvement
Leaders in the ICB and the LA should strengthen multi-agency working across the partnership, between education, health and social care providers, so that:

▪ children and young people's needs are identified and assessed in a more efficient and timely manner; ▪ transitions for children and young people across phases in their education are improved; ▪ children and young people have access to education and training through placements that meet their individual needs; ▪ young people are better prepared for adulthood earlier; and ▪ communication with parents and practitioners supports all stakeholders effectively, to understand systems and decision-making processes.
Leaders in education, health and social care should work together to strengthen and embed the quality assurance framework around all existing and newly issued EHC plans. This includes: ▪ improving the quality and depth of contributions from health partners and children's social care into the plans; ▪ reducing waiting times for health assessments; ▪ increasing timeliness and quality of needs assessments; ▪ increasing timeliness and quality of EHC plans and annual reviews; and ▪ ensuring that EHC plans consider information shared by services providing support to the child, young person and their family.
Leaders in education should continue to review the breadth and offer of specialist places for children with SEND, in order to inform commissioning and investment in specialist provision to improve the experiences and outcomes of children and young people and their families.
The partnership should further develop their strategic plans to include families in partnership projects, to embed their voice and create a model of true co-production. The monitoring of projects and interventions should be more inclusive and effectively communicated with stakeholders, to create a shared culture of driving improvements for children, young people with SEND and their families.

Local area partnership details

Local Authority	Integrated Care Board
Gloucestershire County Council	NHS Gloucestershire Integrated Care Board
Ann James, Director of Children's Services	Mary Hutton, Chief Executive Officer
www.gloucestershire.gov.uk	www.nhsglos.nhs.uk
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Information about this inspection

This inspection was carried out at the request of the Secretary of State for Education under section 20(1)(a) of the Children Act 2004.

The inspection was led by one of His Majesty's Inspectors (HMI) from Ofsted, with a team of inspectors including two HMIs from education and social care, a lead Children's Services Inspector and a Children's Services Inspector from the CQC.

Inspection team

Ofsted

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Care Quality Commission

Daniel Carrick, CQC Lead Inspector

Claire Mason, CQC Inspector

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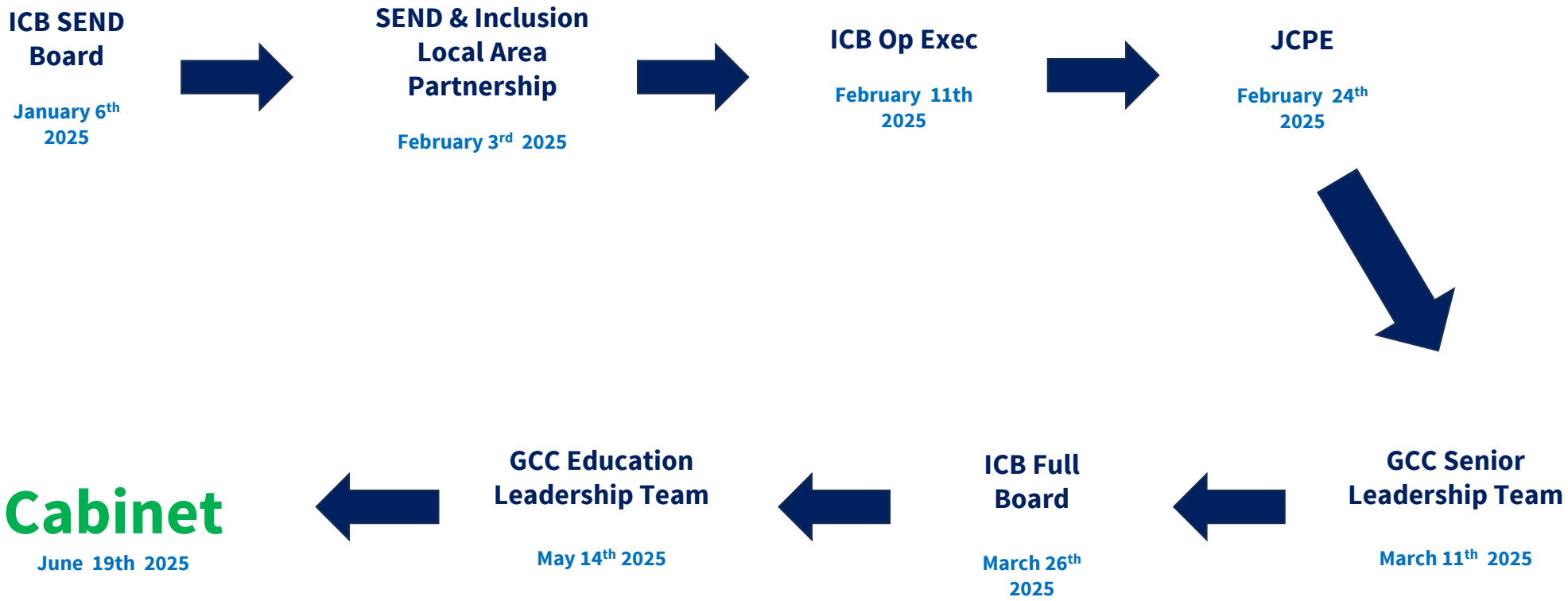
SEND Joint Commissioning Strategy: Sign-off Timeline



Agenda Item 13

NHS Gloucestershire ICB Public Board Meeting

Wednesday 26th March 2025

Report Title	**ICB Progress Report – Public Sector Equality Duty and our response to the Equality Delivery System**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
					X		
Route to this meeting							
	ICB Internal	**Date**	**System Partner**	**Date**			
			EDS Leads via OD Delivery Group	16/03/23			
Executive Summary	Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS), an improvement framework designed to assist organisations in assessing their performance and identifying future improvement actions. The PSED includes a requirement that the ICB will publish equality information about both the communities we serve and the staff we employ. It also requires ICBs to have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. The report sets out or response to these requirements and evidences the process we have undertaken to review our performance against the EDS framework and the eleven outcome areas spread across three Domains: • *Commissioned or provided services* • *Workforce health and well-being* • *Inclusive leadership.* We are required to undertake a self-assessment of our performance and independently verify our position with stakeholders and staff. As a result of this process, we also identify a range of improvement actions which are summarised in the main report and in Appendix 3.						

<table>
<tr><td>Key Issues to note</td><td>We have worked collaboratively with GHFT and GHC on Domain 1 and the outcome areas relating to Commissioned and Provided services

Whilst we have identified some good practice and continued improvement on last year’s performance, stakeholders reported the need to see further evidence of improvements in outcomes across a range of service areas not just those elected for the purposed of the Equality Delivery System.

The Working with People and Communities Advisory Group who supported a review of our self-assessment also found the national scoring system unhelpful and preferred to give some narrative feedback to the ICB.

During 2024/25 we:-
• revised our equality objectives,
• updated the ICB’s Equality Statement and Equality Action Plan
• published our first annual review of healthcare inequalities

(Please note:- links to these reports and plans are provided in the main report).</td></tr>
<tr><td>Key Risks:
Original Risk (CxL)
Residual Risk (CxL)</td><td>Failure to set out our position in support of external review. The Equality and Human Rights Commission (EHRC) continue to review ICBs relating to the PSED. There is a deadline for the annual publication of equality information (31st March 2025).

This process is also part of the System Oversight Framework for ICBs and NHS provider organisations and so failure to comply with these requirements would mean that we are potentially unable to show are commitment to addressing:
• equality of access;
• experience across the services we provide and commission; and
• how we treat our staff.

Risk rating 3x 2 – Low</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>There are no conflicts of interest identified through this process.</td></tr>
<tr><td>Resource Impact (X)</td><td><table>
<tr><td>Financial</td><td></td><td>Information Management & Technology</td><td></td></tr>
<tr><td>Human Resource</td><td>X</td><td>Buildings</td><td></td></tr>
</table></td></tr>
<tr><td>Financial Impact</td><td>There are no additional costs associated with carrying out this annual assessment.</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td>It is statutory obligation for public sector to evidence how they are meeting the Public Sector Equality Duty.</td></tr>
<tr><td>Impact on Health Inequalities</td><td>The outputs of this process highlight the potential gaps in service provision and experience for both patients and staff and areas where improvements can be made to address health inequalities.</td></tr>
<tr><td>Impact on Equality and Diversity</td><td>As above.</td></tr>
<tr><td>Impact on Sustainable Development</td><td>Not applicable.</td></tr>
</table>

Patient and Public Involvement	We have utilised information from patient and staff surveys as part of the evidence base to inform our response. The Working with People & Communities Advisory Group (WPACG) supported once again to independently assess our performance. The Staff Partnership Forum has reviewed and assessed Domain 2: Workforce health and well-being		
Recommendation	**The Board is requested to:** ICB members are asked to: i) Consider our assessment of our performance against the 11 outcome areas that make up the Equality Delivery System improvement framework, noting this assessment has been tested independently with the Working with People & Communities Advisory Group and the ICB's Staff Partnership Forum. ii) Note and approve the high level improvement actions set out in section 5. iii) Note the updates relating to our Equality Objectives and Equality Statement. Note that the EDS assessment will be published on our website on 31st March 2025.		
Authors	**Tracey Cox** **Christina Gradowski** **Caroline Smith**	**Role Title**	**Director People, Culture & Engagement** **Associate Director of Corporate Affairs** **Senior Manager, Engagement & Inclusion**
Sponsoring Director (if not author)	**Tracey Cox, Director People, Culture & Engagement**		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
EHRC	The Equality and Human Rights Commission
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
MNVP	Maternity and Neonatal Voices Partnership
PSED	Public Sector Equality Duty
VCSE	Voluntary, Community and Social Enterprise
WPACG	Working with People & Communities Advisory Group

ICB Progress Report – Public Sector Equality Duty and the Equality Delivery System

Contents

Appendix 1: Link to Infographic showing an overview of the Gloucestershire population

Appendix 2: *Membership of Working with People & Communities Advisory Group*

Appendix 3: *EDS Reporting Framework 2024/25*

1 Purpose of the Document

Integrated Care Boards have a vital role in tackling inequalities in access to and outcomes from health and social care services. Each year public sector bodies must demonstrate they have met the requirements of the Public Sector Equality Duty (PSED). This process is supported by the Equality Delivery System (EDS), an improvement framework and toolkit that is designed to assist organisations in assessing their performance and identifying future improvement actions. This paper reports on our progress against both the PSED and the EDS toolkit.

2 Public Sector Equality Duty & Equality Delivery System Toolkit

2.1 PSED Duty

The PSED is designed to support ICBs and other bodies to think about equality across our work programme, to identify the major challenges and to agree the actions we will take to tackle them.

The PSED consists of a general duty and specific duties. The general duty requires ICBs to think about how they can prevent discrimination, advance equality and foster good relations. This applies to the services that are provided and commissioned and to the employment of staff. The PSED requires a thorough consideration of the needs of people with each protected characteristics and is therefore different to the focus of the health inequalities duty which includes a focus on geographical inequalities and other non-protected characteristic inequalities.

The specific duty requires the ICB to be transparent about our work on equality and to show how we are meeting the requirements of the general duty. Each year we must publish equality information that demonstrates how we are thinking about equality across the services we provide and commission and the employment of staff.

ICBs should also have one or more published equality objectives, that are specific and measurable and cover a period of up to four years. The Equality and Human Rights Commission (EHRC) monitor the performance of ICBs and require the annual publication of equality information (31st March 2025).

2.2 Equality Delivery System Toolkit

The NHS Equality Delivery System is an accountable improvement tool for NHS Organisations in England. Updated EDS Technical Guidance was published August 2022. This is the third version, commissioned by NHS England and supported by the Equality Diversity Council and is a simplified version of EDS2. The EDS comprises eleven outcomes spread across three Domains:

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

Outcomes are evaluated, scored, and rated using available evidence and are designed to provide assurance or point to the need for improvement. Ratings are as follows:

Undeveloped activity – organisations score 0 for each outcome
Developing activity – organisations score 1 for each outcome
Achieving activity – organisations score 2 for each outcome
Excelling activity – organisations score 3 for each outcome

Completion of the EDS, and the creation of interventions and action plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the CORE20PLUS5 approach and annual Operational Planning Guidance. NHS organisations are expected to start to adopt a system approach to application of the EDS framework where possible.

3 Overview of Gloucestershire's Equality Information

As per last year, the 2021 Census data information provides us with information about the profile of our local population. The infographic at Appendix 1 shows our position across the nine protected characteristics.

4 Our Approach to EDS for 2024/25

Across Gloucestershire we have agreed that we will collaborate on a review of *Commissioned and Provided* services for the 2024/25 review and each organisation would review its own progress on *Workforce health and wellbeing and Inclusive Leadership.*

We have collated evidence to support a review of the requirements against the 3 Domains and 11 outcome areas and have engaged with both staff networks, the Working with People & Communities Advisory Group (WPACG) to review the information and to independently assess our performance. The membership of the WPAGAG is available at Appendix 2.

The next section shows our evidence and assessment against the framework. Whilst we have identified some exemplary practice and a continued improvement against the overall objective of advancing equality there is of course much more to do.

The Working with People & Communities Advisory Group also felt that the scoring system is unhelpful and preferred to provide some general feedback and commentary to the ICB.

5 Overview of Outcomes

5.1 Domain 1: Commissioned or Provided services

This year we have agreed across Gloucestershire to look at our work in 3 different areas: Respiratory Services, Blood Pressure & Children's Mental Health Services. For each service area we were required to test four outcomes:

- 1A: Patients (service users) have required levels of access to the service
- 1B: Individual patients (service user's) health needs are met
- 1C: When patients (service users) use the service, they are free from harm
- 1D: Patients (service users) report positive experiences of the service

Our assessment looked at focused work for each of the three service areas, gathering evidence which included statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans.

The evidence presented identified exemplary practice and demonstrates progress has been made. When people access services, they are able to report a positive experience and the services provided are safe. However, analysis by some protected characteristics remains challenging due to the incompleteness of data and members felt that there are some patient groups who are still underserved. Assessing services by protected characteristics does not recognise intersectionality and makes it difficult to establish whether the service delivery models meet the needs of all.

Further information about the evidence gathered is included in Appendix 3.

Our assessment rating: Developing
Improvement Actions: - • Continue to build a detailed understanding of our population and their health needs, through improvements in the quality of our data recording and robust use of Equality and Engagement Impact Assessments.

5.2 Domain 2: Workforce health and wellbeing (ICB employed staff)

The data and statistics we have on our workforce profile, including a breakdown of staff according to gender, ethnicity, age and disability was reviewed. Over the last year the ICB has provided a range of health and wellbeing initiatives and projects to support staff to manage their health conditions such as obesity, diabetes, asthma, COPD and mental health conditions.

The staff survey results for 2023 were assessed as well as more recently the staff survey results relating to 2024. The information was shared with the ICB Staff Partnership Forum on 27th February 2025 for their feedback and input.

The 4 outcomes areas for review of our approach in this area are as follows:

- 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source
- 2D: Staff recommend the organisation as a place to work and receive treatment.

Further information about the evidence gathered is included in Appendix 3.

Our assessment rating: Developing
Improvement Actions: -
• During 2025-26 the ICB will concentrate on supporting the health and wellbeing of staff during a time of change and transition. We will improve our staff offer around psychological support, resilience training and improve our policies and procedures with regard to wellbeing.

5.3 Domain 3: Inclusive Leadership

In completing the assessment, we collated an overview of organisational level and systemwide approaches to support senior leaders understanding of equality and health inequalities. A desk top review was completed of a number of meetings which have taken place since March 2024 to see how frequently the Board Members were discussing inequalities and issues relating to equality, diversity and inclusion.

We also reviewed how well the ICB (as an employing organisation) is using relevant tools such as the following:

1. Workforce Race Equality Standards (WRES)
2. Workforce Disability Standards (WDES)
3. Impact Assessments
4. Gender Pay Gap Reporting

The 3 outcomes areas for review of Inclusive Leadership are as follows:

- 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.
- 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.
- 3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

Our assessment rating: Developing
Future Improvement Actions: -
• System wide action planning on 2024 WRES and WDES results with a continued focus on recruitment and anti-discrimination. • A health inequalities dashboard is in development and will be available by May 2025 • A One Gloucestershire Leadership Conference on ED&I • Implementation of next phase of the Health Inequalities Framework

6 Equality Objectives

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

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

7 Equality Statement

Promoting equality, valuing diversity sets out our expectation that all staff will take responsibility for promoting equality; commissioning accessible services that respond to the diverse needs of communities in Gloucestershire.

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

Our Equality Action Plan sets out how the ICB will work towards achieving our organisational equality objectives.

8 Health Inequalities

The Gloucestershire Health Inequalities Framework, launched in August 2024, aims to provide structure to the work that we are doing to address health inequalities across the Gloucestershire system, and supports a more strategic, systematic, and evidence-based approach to improving health equity.

Alongside the Framework, we have developed an ICS Health Inequalities strategic planning and self-assessment process, requiring organisations to identify high-level objectives which will enable them to make the biggest impact on reducing health inequalities. As a system, this will allow us to see where progress against health inequalities is being made, where there are gaps or duplication in our collective response to health inequalities, and where we can go further in the work that we are doing.

Our first annual review of healthcare inequalities was published in July 2024, enabling us to monitor progress against a range of indicators that align to the Core20PLUS5 programme by deprivation and ethnicity, in line with the NHS England Statement on Health Inequalities. An ICS Health Inequalities Intelligence Group has been established to oversee and drive the development of the next review, due to be published in July 2025. Through this group, we are taking a collaborative approach to identifying areas of improvement that align to the Core20PLUS5 programme and to our system priorities, that will help us achieve our long-term system outcomes to achieving health equity.

We are currently working with:

- health inequalities champions from system organisations and partnerships to co-develop a shared ambition, and a set of shared objectives, priority outcomes and metrics for addressing health inequalities across the system, aligned to the Health Inequalities Framework.
- internal information teams to develop a PowerBI dashboard to cover all indicators required for the forthcoming health inequalities information reviews, which will help to inform service design and delivery, and to assess whether improvements are being made to different population groups in access, experience, and outcomes.

9 Recommendations

ICB members are asked to:

i) Consider our assessment of our performance against the 11 outcome areas that make up the Equality Delivery System improvement framework, noting this assessment has been tested independently with the Working with People & Communities Advisory Group and the ICB's Staff Partnership Forum.

ii) Note and approve the improvement actions set out in section 5.

iii) Note the updates relating to our Equality Objectives and Equality Statement.

iv) Note that the EDS assessment will be published on our website on 31st March 2025.

Appendix 1: **Infographic showing an overview of the Gloucestershire population**

Understanding our local population : NHS Gloucestershire ICB (nhsglos.nhs.uk)

Appendix 2: Membership of Working with People & Communities Advisory Group

The proposed 'lay' membership should be up to 12 individuals including the Chair. The WWPAC AG members should include individuals with recent and relevant experience of health and care services in Gloucestershire and have a mix of characteristics and interests:

- Chair (Jenny Hepworth, NHS Gloucestershire ICB Lay Champion)
- John Lane - Healthwatch Gloucestershire
- Vicci-Livingston-Thompson – Inclusion Gloucestershire
- Rupert Walters – 4orty2 – Black Business Network
- Jennifer Skillen – Expert by Experience
- Pat Eagle – Foundation Trust Public Governor
- Jan Marriott – Trust Non-Executive Director/Partnership Board Co-Chair
- Riki Moody – Gloucestershire Care Home Providers Association
- Matt Lennard / Gill Parker – VCS Alliance
- Emma Mawby – LGBT+ Partnership
- Becky Parish and Caroline Smith - NHS Gloucestershire ICB Engagement/Insight/Equality and Diversity Leads

Appendix 3: Equality Delivery System reporting 2024/25

Domain 1: Commissioned or provided services

We have collated information to support this assessment from NHS Gloucestershire ICB, Gloucestershire Health & Care NHSFT and Gloucestershire Hospitals NHSFT. The evidence gathered includes statistical data, policies, strategies, working protocols and procedures, service specifications and health inequalities action plans. The three service areas are Respiratory Services, Hypertension and Childrens' Mental Health services. These were selected based on work that is underway to tackle health inequalities, patient experience data and local community insight.

The evidence has been discussed and considered with the ICB Working with People and Communities Advisory Group, but members felt that attributing individual scores to services and/or domains was unhelpful. There was evidence of exemplary practice which demonstrated that the needs of certain groups of people were being met. However, limited data capture for some protected characteristics meant it was difficult for members to be fully assured.

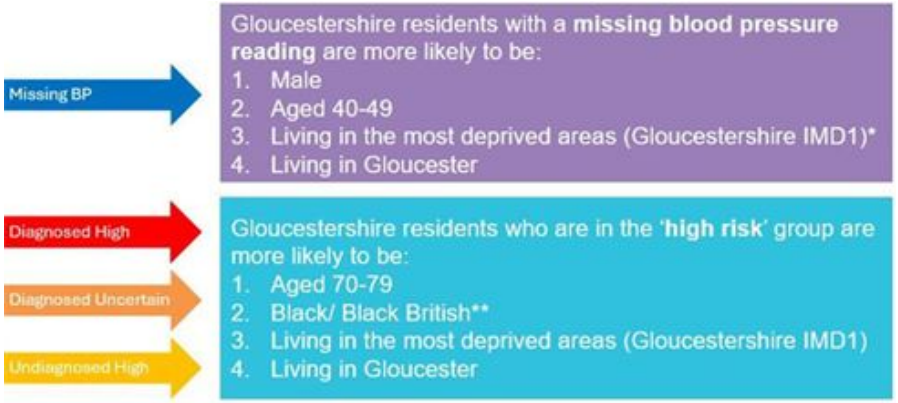
Domain	Outcome	Evidence	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Respiratory services:** There is good provision of respiratory services across primary care, acute and community services. A Population Health Management approach is being taken in the ongoing development of services, with a focus on providing earlier intervention and community-based support to avoid the need for acute admissions. Work is being progressed at a Primary Care Network level, involving a Consultant-led support and the development of Respiratory Champions/wider Voluntary Sector support. Improved access to services through Community Clinics and Acute Respiratory Infection Hubs potentially benefits all, but is particularly helpful in enabling access for working age adults, children, people who are frail and those with co-morbidities.	Respiratory Clinical Programme Board

		• There is ongoing work to improve data coverage and links across all health data sets, to improve the data completeness. Analysis by some protected characteristics remains challenging due to the incompleteness of data. • Targeted improvements for those living in our most deprived areas (CORE20). People living in our CORE20 areas are more likely to be from ethnic minority communities and/or will be living with co-morbidities. • We have implemented and funded a model of "Respiratory Champions" to promote and improve respiratory care at a PCN level; this has involved education and training, spirometry training and delivery, and "lung health" clinics for those at risk of respiratory disease. • Respiratory consultant collaborative community clinics are delivered in practices across the county. The clinics are delivered at a PCN level and are rotated across practices monthly to ensure equitable coverage. • Acute Respiratory Infection (ARI) Hub – Provides additional capacity particularly targeted to working age adults and paediatrics. If needed clinicians are able to talk to a respiratory consultant to get advice and guidance. They also have the added advantage of being able to refer patients directly the Respiratory Virtual Ward for continued remote monitoring. • Childrens' Asthma Service – Implementation of national bundle of care for CYP Asthma designed to help improve health outcomes for all children and young people with asthma. This has included: – Improved integrated working. – Liaison with district council Clean Air Officer re. system training – Asthma Friendly Schools (AFS) – ensuring a safe learning environment for CYP with asthma. – Work with county council to access schools – web portal, headteacher/SENCO/schools' HLL Leads – Extra-curricular reach – Glos FA, RFU, Girl Guides – Collaboration with local housing associations and system leads to work towards minimum standards for CYP asthma patients. • Patients admitted to hospital are offered a smoking assessment, with a range of support available from advice and Nicotine Replacement Therapy (NRT) to help		

		manage any cravings or withdrawal symptoms, to personalised behavioural support. On leaving hospital, patients who want to continue abstaining from smoking will receive NRT and a referral to the Healthy Lifestyles Service for ongoing support in the community, in addition to follow up from the tobacco free team in the month after they leave hospital. • Our innovative and truly collaborative approach to service delivery has recently been recognised in the National HSJ awards. **Hypertension:** High blood pressure is a leading cause of heart attacks and stroke in England and account for a quarter of premature deaths. CVD is identified within the NHS Long Term Plan (2019) as the biggest area where the NHS can save lives over the next 10 years. Gloucestershire's Integrated Care Strategy identified blood pressure as one of three 'exemplar themes'. The approach for blood pressure within the exemplar themes work is to take a data-informed approach to co-design interventions for our population. When considering hypertension, we talk about: **Diagnosed high blood pressure** - Patients with a confirmed hypertension diagnosis that have a blood pressure reading in the last 12 months that is over the age-appropriate threshold. **Missed opportunity patients** – Patients with no diagnosis of hypertension and with no BP reading in the last 5 years who have had a primary care appointment in the last year. **Missing BP** - Patients with no diagnosis of hypertension and with no BP reading who have not had a primary care appointment in the last year. Our data shows that: • As of June 2024, it was estimated that 159,191 people in Gloucestershire had hypertension. Of this expected number, 106,990 patients in the county had received a confirmed diagnosis (67.2%). This means that to reach the 80%		CVD Clinical Programme Group

diagnosis target, an additional 20,363 patients need to be identified and diagnosed with hypertension by 2029.

- Males aged 45-59 are most likely to be considered missed opportunities.
- Male patients aged 50-69 are more likely to have diagnosed high BPs as well as female patients aged 70-89. For both genders, those aged 50-79 are most likely to have a diagnosed high BP.
- Out of the patients that had received a confirmed diagnosis, 68,645 patients (64.2%) had been treated to target (as per NICE guidelines). This means there are 38,345 patients in Gloucestershire with hypertension who have not yet been treated to target.
    - CVD Prevent data shows that those less likely to be treated to target are more likely to be:
        - under 60;
        - live in the most deprived quintile;
        - black;
        - men.

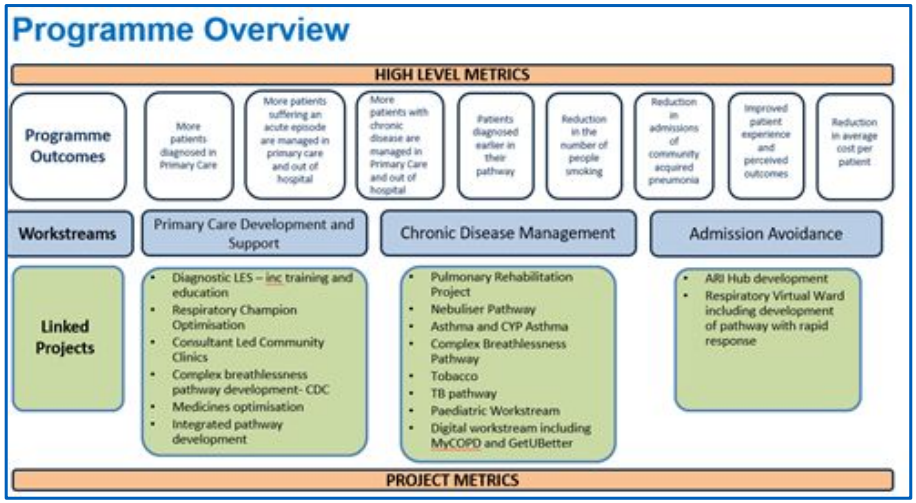


** there is a correlation between age and deprivation, with more deprived deciles tending to have younger patients – this means that the deprivation analysis is not independent from age*

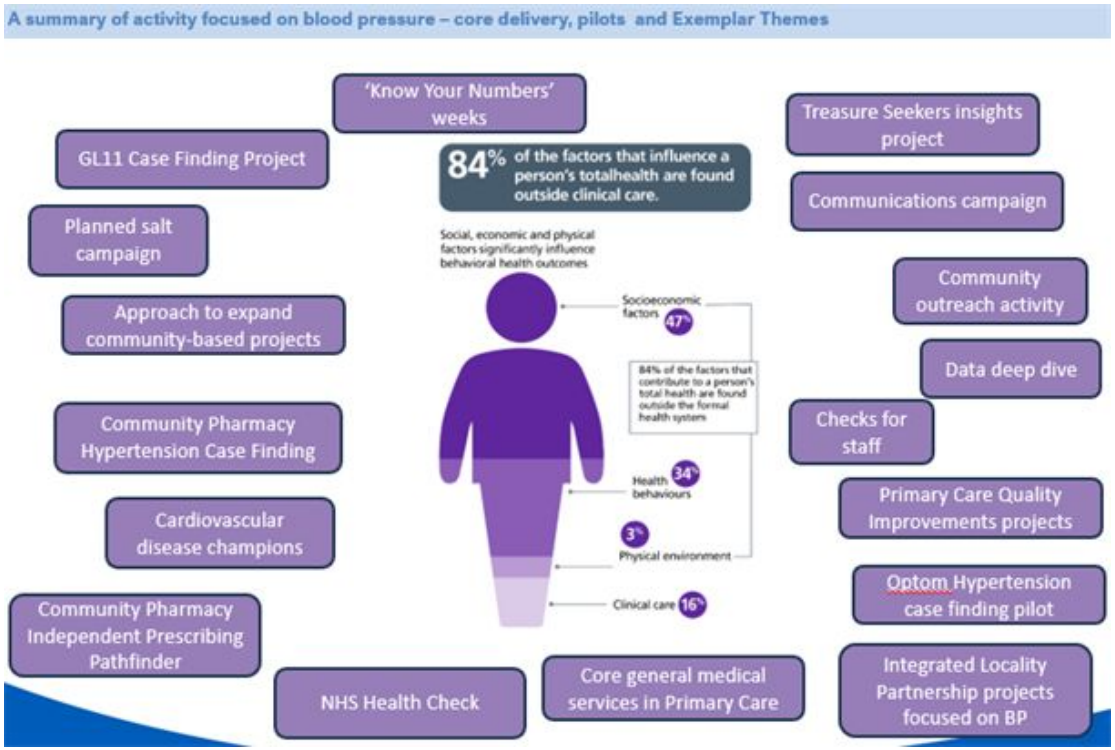
*** there is a large proportion of patients with a 'blank' or 'not stated' ethnicity and an underrepresentation of patients identified as 'white' when compared to 2021 census data – this could be skewing analysis*

		NB. As we increase the number of patients diagnosed, we will increase the number of patients needed to be treated to target. • Cardiovascular Disease (CVD) Champions initiative launched in Primary Care. There are now 10 PCNs signed up to the initiative, which aims to increase both the number of diagnosis and those treated to target. • Through active promotion and community outreach, e.g. Know your Numbers Week, we have seen a steady increase in the number of people diagnosed with high blood pressure. Know your Numbers week typically sees us using the Information Bus across a variety of locations in Gloucestershire (e.g. high streets, community events) as well as joining community group meetings such as: – Fair Shares @ The Friendship Café – Sahara Saheli @ Cheltenham Community Resource Centre – Ebony Carers @ All Nations Community Centre Supported by the Outreach Vaccination & Health Team (OVHT) at Gloucestershire Health & Care (GHC), the 3 KYNs' campaigns (each lasts a week) in 2024 have seen over 750 blood pressure checks completed with over 150 people signposted for additional support. **Childrens' Mental Health support:** Data taken from our countywide Pupil Wellbeing Survey is used to track the prevalence of Low Mental Wellbeing (LMW) in children and young people (CYP) across our education settings. It is clear from recent years that whilst there is no difference in need between CYP whose ethnicity is White British and CYP from minority ethnic communities, the number of CYP from minority ethnic communities accessing services and support (e.g. core Children and Adolescent Mental Health Service, CAMHS) is significantly below that of their White British peers. Consequently, NHS Gloucestershire has formed a collaboration with The Music Works and Gloucester Community Building Collective - GCBC (two VCSE		Children and Young People's Programme Board

		organisations already working with young people and communities in Gloucestershire) to co-design a programme which aims to: • Understand the barriers to accessing mental health support for C&YP from ethnic minority backgrounds; • Engage with C&YP from ethnic minority backgrounds who are traditionally under-represented; • Provide NHS Gloucestershire ICB with an evidence base of user feedback to improve access; • Increase awareness and access to mental health support. The Music Works are already working with young people from global majority communities in Gloucester, taking an open dialogue approach. They will build trust with young people and the communities they live in by engaging in transparent, open dialogue and working within a strengths-based approach across Gloucester City. This in turn will empower them to help inform the redesign of mental health services by exploring the barriers to accessing mental health support for young people and ensuring recommendations are presented to the Children and Young People's Programme Board within the ICB. Following a co-produced recruitment process, the project employed two Community Connectors in May 2024. They each have significant personal stories of overcoming barriers and dealing with mental health issues. They have undertaken a training programme with, and continue to be supported by, experienced community builders from Gloucester Community Building Collective. They are also supported by a colleague from the Friendship Café who is an experienced community builder himself. They have mentorship in place from The Music Works youth development lead who has experience in working with diverse communities, including those living in very challenging circumstances e.g. involved in gang violence.		

	1B: Individual patients (service users) health needs are met	**Respiratory Services:** The CPG team has developed collaborative programme metrics to define progress and success. All projects within the overarching programme feed into the delivery of these metrics. Population health and inequalities data are used to identify areas of need and focus interventions accordingly.  The first 4 programme metrics are underpinned by patients being appropriately diagnosed and managed out of hospital by a highly skilled, confident workforce: • More patients diagnosed in Primary Care; • More patients suffering an acute episode are managed in primary care and out of hospital; • More patients with chronic disease are managed in Primary Care and out of hospital; • Patients diagnosed earlier in their pathway.	Respiratory Clinical Programme Board Primary Care Networks

		Examples of CPG initiated projects that are driving performance against these metrics are: 1. Respiratory rehabilitation, including Pulmonary Rehab, expansion via primary care and voluntary sector exercise providers for patients with a lower breathlessness score (MRC2). Collaboratively, the offers deliver a scaled-down, lower acuity, pulmonary rehab. Patients benefit from earlier access which slows their disease burden and helps them to stay fit and well. Evidence shows patients who undertake regular rehab for their chronic condition also have shorter stays in hospital if, and when, they do suffer an exacerbation. 2. CYP Asthma programme delivering education in schools and wider children's networks; 3. Community Clinics which are secondary care consultant led education and case review sessions to each PCN monthly, prioritised based on PHM data to focus on areas with higher need. Primary Care testimonials on Community Clinics demonstrate "timely access to specialist respiratory support for patients who might not meet the criteria for a Consultant referral" and report "expert support with diagnosis and symptom control". The introduction of the Acute Respiratory Infection (ARI) Hubs has resulted in patients who are acutely unwell being seen, and consequently treated, more quickly. Locating the Hubs in areas of higher deprivation potentially provides improved access to urgent care for the most vulnerable in our communities – there is a correlation between areas of deprivation and people with multiple co-morbidities and also people from ethnic minority communities. The hubs have also demonstrated that they have been able to provide diagnosis of previously unknown long-term conditions, smoking advice and vaccinations resulting in a person-centred, holistic approach to care. Patient experience data shows high levels (over 90%) of satisfaction with the Hubs and evidence of a reduction in attendance/ pressure on General Practice, Emergency Department and NHS 111 services.		

		Hypertension:  The above shows the range of approaches being taken to improve diagnosis and ongoing support of hypertension, which are focussed across Primary Care with further community activity undertaken by the Outreach Vaccination & Health Team (OVHT). We recognise the importance of personalised care and during 2024 initiated two local community projects at GL11 in Dursley and Kingfisher Treasure Seekers in inner city Gloucester, with the additional aim of increasing our understanding of what support people need to better manage their blood pressure.	CVD Clinical Programme Group

Project reports from GL11 demonstrate blood pressure checks have been undertaken across a range of age groups, including those within target groups i.e. ‘missed opportunities’ re diagnosis and those less likely to be ‘treated to target’. Both the GL11 and Kingfisher Treasure Seekers programmes have provided an unidentified benefit of engaging with people with a learning disability or Serious Mental Illness (SMI).

The evaluation of these projects is currently underway and the findings will inform future funded work with the VCSE sector focussing on:

- Detection of hypertension - community-based test and learn approach to delivering blood pressure checks.

		• Identify and work with at risk groups - supporting community research and co-designing solutions. **Childrens Mental Health support:** The programme is youth-led, with active engagement and co-design with young people. The following plan has been designed by the young community connectors: • Collect information from services and young people in communities. • Focus on certain areas in Gloucester with high need (Matson, Barton, Tredworth, Coney Hill, Linden, Tuffley, Podsmead, Kingsholm, Westgate etc.) • Create a survey with questions to engage with young people. • Make the survey interactive and fun and possibly design a social media platform to create interest. • After analysing the data from the surveys/social media, we invite people to a group circle to talk and express themselves, hopefully thereby widening the diversity of people working on this project/create a movement and to help design our next steps. From that initial group, individuals who want to continue to be involved will help create a yearly event which the community would be interested in and spread the message on mental health awareness, continuing to create opportunities for interaction with services to support redesign and closer connections with communities. Although the approach has developed from this initial plan, the community connectors have made some really meaningful connections with young people and are uncovering some themes and issues based on the fact that they are listening and are trusted. They ran a group circle workshop in early December and will be reporting on progress in due course. The expectation is that the group of young people will continue to meet/work together, they will discuss some of the themes that are coming up, build their confidence and think about how they want to share their views and findings with others and influence the system.		Children and Young People's Programme Board

		Using an approach that is led by young people in the community takes time, is based on building trusted relationships and may come up with very different ways of working. Instead of relying on traditional surveys to gather insights about mental health, the Connectors have found that sitting down with young people over food has been far more effective. Sharing a meal creates a relaxed and informal atmosphere, breaking down barriers and allowing for more genuine, heartfelt conversations. Sharing food has long been a universal way to connect. It creates a sense of community and equality, putting everyone on the same level. Young people often feel less intimidated and more willing to open up in these settings. Through these conversations, the Community Connectors have noticed that young people are more willing to share their struggles, hopes, and solutions. The act of eating together humanises the process, making it less about “gathering data” and more about building genuine connections that lead to meaningful insights. What happens next will be dependent on the group, but future work will align with NHS goals, address specific community needs, and leverage evidence-based methods to promote well-being and resilience.  		

	1C: When patients (service users) use the service, they are free from harm	**Respiratory Services:** Gloucestershire residents are able to access high quality, safe healthcare. The focus of much of our respiratory improvement work is in Primary Care settings, where residents can access good quality GP services, most of which are rated as either 'Good' or 'Outstanding' by the CQC. • ***ICS System Safety Group*** *established to**:*** – *Oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level;* – *Help the system by being proactive;* – *Include digital safety;* – *Inspire safety culture across the ICS;* • Patient safety policies and procedures in place with all providers: additional needs are supported by LD Liaison Nurse Service; Admiral nurse for inpatients with dementia diagnosis; Transgender policy. • Embedded through Professional Registration, Staff mandatory training, Risk Assessments, Information Governance, DATIX reporting, Freedom to Speak Up Guardians, Duty of Candour. **Hypertension:** • ***ICS System Safety Group*** *established to**:*** – *Oversee the implementation of Patient Safety Incident Response Framework (PSIRF) at system level;* – *Help the system by being proactive;* – *Include digital safety;* – *Inspire safety culture across the ICS;* • Policies and procedures are in place to ensure NHS providers are compliant with contractual safety requirements – these are generic for all patients. • DATIX reporting reviewed and actioned.	ICS System Safety Group Respiratory Clinical Programme Group ICS System Safety Group CVD Clinical Programme Group

		• Freedom to Speak Up Guardians, who support staff to speak up on issues relating to patient safety and the quality of care; staff experience and learning/improvement. • One Gloucestershire Quality Framework, Quality Strategy, Whistleblowing Policy support patient safety. • Community programmes have clear, established criteria for onward referrals – monitored through project reporting to ensure safety and compliance. **Childrens Mental Health support:** A range of training sessions formed part of the induction of the Community Connectors, including Mental Health First Aid and Safeguarding. The Community Connectors have lived experience of mental issues and complex lives so they also at times need support. A programme of supervision and mentoring aims to ensure the safety of both the Connectors and those they work with. There are clear strategies in place to ensure this, e.g. work was temporarily suspended during the race-related riots that took place in Summer 2024.		Children and Young People's Programme Board Programme Steering Group
	1D: Patients (service users) report positive experiences of the service	**Respiratory Services:** Working with people and communities Strategy: NHS Gloucestershire's system-wide approach ensures proactive engagement across diverse communities. • Primary Care testimonials note that "patients respond very positively to the Community Clinics including those who have previously been difficult to engage". • Mindsong have been commissioned to provide 'Breathe in, Sing out' groups to improve breathing and emotional wellbeing. The groups meet in easily accessible venues across Gloucestershire - there is also an online group for those who prefer, or are unable, to meet face-to-face. The 12 weekly sessions, with time for a chat afterwards, have been very well received by patients and their carers. Many report significant improvement in their breathing, often seeing 'life-changing' results. Some patients' testimonials are covered in a short film at: https://www.mindsong.org.uk/breathe-in-sing-out/		Respiratory Clinical Programme Group Patient engagement and experience leads

		• Patient experience data shows high levels (over 90%) of satisfaction with the Hubs and evidence of a reduction in attendance/ pressure on General Practice, Emergency Department and NHS 111 services. • Patient experience information gathered through engagement is reported back to service leads and system partners. • Patient Experience data is gathered, monitored and acted upon. • Involvement of people with 'lived experience' ensures Clinical Programme Group remains focussed on patient outcomes – "On behalf of all respiratory patients in the county, being a regular member of this welcoming and respectful clinical group means that lived experience of respiratory patients can be heard. It provides a meaningful space and the opportunity to express any concerns, to improve the patient experience and importantly, to actively contribute to the development of new services for respiratory patients. It is a rich and highly rewarding experience." *Patient Representative, Respiratory CPG* **Hypertension:** • Know your Numbers weeks have been warmly received by local residents, with positive feedback and appreciation of the outreach into familiar community venues and public spaces. • The CPG and Outreach and Vaccination Health Teams have worked closely with ICB Insights Manager to build relationships with local communities and groups and support events. Feedback from those accessing services included positive comments about the location of the checks and convenience of community locations versus having to make a GP appointment. We have received a number of positive comments via our Patient Advice and Liaison Service (PALS) and through the community project monitoring:		CVD Clinical Programme Group Patient engagement and experience leads

		Pseudonymised case studies: Jean, 90+ years old, attended a community event for a blood pressure check. Although she had not had her blood pressure checked in quite some time, she felt fit and well. He BP reading was recorded as 188/88. Our clinical member took over to provide observations and reassurance and we gained permission to send her reading to her GP. She was contacted the same day to book in for an appointment and is now undergoing treatment and on medication for high blood pressure. She is very glad she attended GL11 that day and has also purchased her own machine so she can monitor it at home. Steve, a 37-year-old male, was persuaded to hop onto the One Gloucestershire Information Bus for a BP check. He recalls: "Despite my initial reservations the team were persistent in checking me. They found that my blood pressure was extremely high. Following their advice, I managed to get an urgent appointment with my GP, had blood tests and a 24-hour blood pressure monitor fitted. I hadn't been experiencing any symptoms, so was totally unaware of my underlying health condition. Thanks to the team's persistence, my urgent health condition was identified, and I am now on medication to control it. I am extremely grateful." During KYN week, we have also invited participants to complete a short feedback survey: • When asked about the usefulness of the outreach sessions in terms of increasing knowledge, 82% of respondents said they found the session very useful. • Of the people surveyed, 24% said that this was the first time they had had their blood pressure checked. • Comments included: "Really convenient - this is needed in areas where people are out and about". "This was a useful spur of the moment discussion". "Good job, glad you're in the community."		

		Childrens Mental Health support: Although this project is still in its infancy, it is clear that the voices of young people have been central to the shape and direction of the work. The positive impact of this work is already apparent with powerful contributions from the Community Connectors: *"It would be an honour to be the catalyst of growth in the lives of a young person looking to de-stress and hopefully correct the course of their life to a more fulfilling one by offering my lived experience, skill sharing at workshops and inquiring into their wants and needs then using the wide network of services the NHS has to offer to provide the best support available".* The Community Connectors have already been very active in their communities, making some really meaningful connections with young people and uncovering some themes and issues based on the fact that they are listening and are trusted. These include young men dealing with relationships, use of social media, complex family lives, access to health and fitness to maintain mental health and refugee support and their specific needs. They have attended Kings Jam; a large festival supporting music of black origin and culture, bringing together internationally and nationally renowned artists of various art forms. The event has approximately 2500 attendees each year, and the Connectors used this opportunity to meet with and talk to lots of young people in Gloucester. The Community Connectors had previously planned to use a survey to gain feedback, but upon testing it in their meetings with young people, they found it was getting in the way of listening and the deeper conversations that people wanted to have. Therefore, they decided to work with their own knowledge of young people and their community to come up with better approaches. They have been gathering themes from the young people they meet and have also built up a group of between 5 and 8 young people who are engaged to use their own lived experience of mental health issues to work with others. They are beginning to work with them to build an understanding of the themes impacting their mental health and prepare material/opportunities to share with NHS and/or to think about entirely different approaches that would work for them.		Children and Young People's Programme Board Programme Steering Group

		Excerpts from anonymised case studies collected through engagement with the Community Connectors are included below. They show the depth of connection and the potential for young people with lived experience to influence this work as the programme develops: **X (Jamaican British, age 20)** has shared her experiences of past physical and mental abuse, describing how she felt these issues weren't addressed promptly by the NHS. This left her to navigate much of her healing process independently. Motivated by her journey, X wants to create a supportive space for men and women who have endured similar trauma. Her vision is to offer a platform where individuals can openly share, reason, and develop their own personal solutions. She has expressed a passion for helping others rebuild confidence through habit formation and mental renewal. X believes in empowering people by the development of positive routines and thought patterns. Her aspirations include organizing a series of events and activities aimed at transforming the lives of young people. These initiatives would emphasise reconnecting with nature, encouraging introspection, and guiding individuals toward discovering healthy online role models. I'm excited to explore these powerful ideas further with her. **Y (16-year-old)** currently studying construction at college, dreams of creating his own clothing brand but feels uncertain about navigating online marketing and managing his online image. He shared that he struggles with waking up and immediately scrolling through his phone. While he doesn't fully understand why he does it, this habit leaves him feeling down, anxious, and unsure of himself, affecting his confidence throughout the day. Though our conversation was brief, it was deeply impactful. Y expressed his desire to inspire others, just as he sees me doing, and to help people achieve their dreams. We discussed how reading could be a powerful tool for him not just to gain new ideas and		

		perspectives, but also to develop strategies for staying present and focused when distractions arise. He resonated strongly with the idea of a retreat-style getaway designed to help young people understand their minds, creating self-awareness and flow in their lives. Y felt this approach would be beneficial in learning how to harness his thoughts and energy effectively. **Z (Jamaican British, age 24):** I recently had a meal with Z discussing about pursuing his passion and how it has affected his mental health. He shared how focusing on something bigger than himself his acting career has been a cornerstone for improving his mental health. He described it as "knowing what your purpose is," a sense of direction that keeps him grounded. When I asked, "If there were a service that could support and enhance your development, what would it be?" Z reflected on the importance of introspection. He envisioned a service that could help people release repetitive, unhelpful thoughts and strengthen their focus on the ideas and goals they want to bring into their lives. One challenge he mentioned was a lack of connection to his heritage. He expressed regret that cultural identity wasn't prioritised in his upbringing, whether at home or in school. "Not knowing where you're from," he explained, "can affect knowing where you're going."		
Domain 1: Commissioned or provided services overall rating				**Developing**

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence
omain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	**We have worked hard to improve staff health and wellbeing at work and have made tangible improvements that are illustrated through the increase in staff satisfaction on health and wellbeing.** In the 2024 Staff Survey **77%** of Gloucestershire ICB Staff reported the organisations **takes positive action on health and wellbeing** which was above the Picker ICB average of 61%. **Improved scores from 2023:** **In the last 12-months, have not experienced MSK problems as a result of work activities:** 79.2% up from 78.9% **In the last 12-months, have not felt unwell due to work related stress:** 66.5% up from 62.9% **Not felt pressure from manager to come to work when not feeling well enough:** 86.9% up from 85.4% **In the last 3 months have not come to work when not feeling well enough to perform duties:** 52.9% down from 56.6% **What have we done** to improve staff health and wellbeing; • Policies including Menopause, Drugs and Alcohol, Physical Activity etc • Staff Health-Checks to support identifying diabetes, high blood pressure etc • Blood pressure checks for staff called Know Your Numbers September 2024 • Menopause Awareness sessions to coincide with World Menopause Day; • Cervical Screening sessions • Men's Health Day to raise awareness of men's health conditions • MSK information and guidance in staff handbook and on the intranet • Accredited Mindful Employer and Disability Confident Employer • Accredited Armed Forces Covenant that also covers health and wellbeing • ICB Appraisal process includes section on health and wellbeing etc

		In October topics promoted included Back Care, Bone and Joint Health plus Menopause. November highlighted Ageing Well and December raised awareness of the 16 Days of Action and Keeping Well at Christmas, covering financial, physical and mental wellbeing. **Intranet resources** and blogs cover Women's Health, Alcohol and Drugs, Mental Health including ○ Susan's wellbeing blog: join me for Dry January : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) ○ Women's Health : Intranet – NHS Gloucestershire (nhsglos.nhs.uk) ○ Zero Suicide Alliance (ZSA) ○ Mental health support for staff: Intranet – NHS Gloucestershire (nhsglos.nhs.uk) • Articles and features on mental health, stress and wellbeing in the staff bulletin • Wellbeing Champions (x15 in place) working with directorates to highlight wellbeing initiatives and projects.
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• The ICB has updated its policies on Harassment and Bullying. • The Commissioning Support Unit ED&I specialists delivered Train the Trainer – training in Building a Culture of Conscious Inclusion across the ICS in February and March 2025 so that organisations have sufficiently trained staff to provide in-house ED&I training; two representatives from the ICB have undertaken this training. • ICB has a Freedom to Speak Up Policy that covers Whistleblowing with an induction session on FTSU as well as slots at the Staff Meeting. There are two FTSU Guardians who are trained at the ICB and a lead NED for FTSU. • By-stander training was delivered to ICB staff by the FTSU Guardians in the Autumn 2024 • The ICB introduced a Zero Tolerance of Abuse of NHS Staff Policy in 2023 with reporting forms and a dedicated incidence box. This has continued to be promoted via the Staff Meetings. • ***The ICB offers Restorative supervision*** for clinical staff at the ICB either group or 1:1 available from Professional Nurse Advocate's (PNA).

		• ***The ICB is a signatory to the Sexual Safety in Healthcare Organisational Charter*** Glos ICB is a signatory to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. • A Sexual Misconduct Policy has been produced and is currently being consulted on and will be finalised in March 2025. All these policies, activities are in place and significant work has been undertaken over the past couple of years to ensure that the ICB has good processes in place to listen and act on staff concerns such as FTSU policy, awareness sessions and 2 trained Guardians. However, the data from the Staff Survey for 2024 revealed that there was more to be done around tackling bullying and harassment from patients, colleagues and managers it is evident from the Staff Survey 2024 there is more work to be done around BME staff experiencing discrimination and greater bullying and harassment than white colleagues.
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	The ICB has a range of resources and procedures in place to support staff to manage their stress, and support for staff who have experienced, bullying and harassment as follows: • The ICB provides a range of employee support to help staff manage their health conditions including the Occupational Health Service – working well; the Employee Assistance Programme provided by Care First and the Gloucestershire Wellbeing Line. All three resources listed above are independent and provide advice and support to staff experiencing bullying and harassment, any physical violence and stress be that at work at home or both. Resources are promoted via the Corporate Induction, Health and Wellbeing intranet • Freedom to Speak Up policy and process with two FTSU trained guardians in post; there are briefing sessions at the staff meeting and at corporate induction on FTSU Other support mechanism includes our policies and procedures that help staff cope with stress and achieve a good work life balance including: • Flexible working policy to help staff achieve a work-life balance and reduce stress. • Leave and Other Leave policies including Disability Leave, Compassionate Leave. • Additional Leave procedures and process whereby staff can purchase additional leave with 89 staff taking additional leave in 2024-25 financial year. • Support provided to staff who have lost family / friends via the annual Death Cafes held

		• Survey on Bereavement held in the summer / autumn in 2024, findings and key actions reported to the Staff Partnership Forum • Newsletters and communications around managing stress and encouraging a work-life balance.
	2D: Staff recommend the organisation as a place to work and receive treatment	• **In 2024 57.8% *of Glos ICB staff reported that if a friend or relative needed treatment they would be happy with the standard of care provided by GICB which is above the picker average of 48.45%.*** In 2023 57% of Glos ICB staff reported If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation, this was above the national average 48% but has significantly decreased from 2021 with 71% of ICB staff reporting favourably on this question. • **In 2024 73.4% of staff reported that they would recommend Glos ICB as a place to work, again a dip in scores from 2023 but compares well to the picker ICB average of 54%.** The ICB was top for the second year running in 2023 for recommending the ICB as a place to work compared to other ICBs, however there has been a dip in scores between 2021 and 2022 and a further dip in ***2023 to 75%.***
Domain 2: Workforce health and well-being overall rating		**Developing**

Domain 3: Inclusive leadership

Domain	Outcome	Evidence
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**EDI Objectives for all Board members** • In line with the national EDI improvement plan all ICB Board members have an EDI objective by March 2024. In place across all providers and confirmed as part of South West ED&I Regional Audit in November 2024 and local internal audit for the ICB. Objectives range in scope depending on role. EDI objectives also form part of ICB appraisal process for all staff • ICB Board development session took place in November 2024 with ICB Board members with extended invitation to Executive teams across providers with focus on race discrimination, leadership reflections. **Training & Support for Staff** • One Gloucestershire conference on Health Inequalities took place on 28th June 2024 with over 200 attendees. The event promoted the health inequalities framework, and supporting tools and information contained within the Prevention & Health Inequalities hub as well as promoting local case studies of prevention in action. • Cohort 2 of Reciprocal mentoring continued during 2024/25 • ICB members participated in Regional events Inc. SW event on Too Hot to Handle Report in July 2024 • Restorative & Just Learning Culture Training provided to 27 senior staff across the system • ICB training sessions for staff on bystander training, civility and respect and promotion of cultural awareness events

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**Board, Strategy & Committee meetings:** We can evidence health inequalities are regularly discussed at ICB Board meetings – a recent review of agendas and meeting papers for 2024/25 showed that there are frequent discussions on health inequalities. • *2 specific topic items and many separate references to EDI/Inequalities as part of the non-standard Board items across Public and Confidential sessions* • *Patient Stories (every meeting apart from extraordinary Board) – covering issues such as Pharmacy access, Bowel cancer, Asthma and Parkinson's disease.* • *Health Inequalities & ED&I clearly form part of the Board Assurance Framework* • We published our first annual report and statement on Health Inequalities. This report covers progress om metrics on deprivation and ethnicity and covers areas such as Elective waiting lists, urgent and emergency care, respiratory, mental health, cancer, cardiovascular disease, diabetes, smoking cessation and oral health. The report also includes recommendations for the future. A copy of the report is available here
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**Tools to Support Staff across the system:** During 2024 GCC colleagues launched the Prevention & health Inequalities hub. The hub is an online compendium of information, resources, and practical tools to help people to better understand and take action to improve health equity in their areas of work. It includes tools such as :- • Health Equality Assessment Tool (HEAT) • Health Equity Audit (HEA) • Health Impact Assessment (HIA) • The Hub can be found here: www.gloucestershire.gov.uk/PHI-Hub

		The ICB Board adopted an Inequalities Framework in the Summer of 2024 and a progress report was provided to the ICB Board at the end of January 2025. All ICB staff have access to key demographic and deprivation information through the ICB's Power BI tool. We continue to work with our Programme Management office to collate best practice including case studies and equality impact assessments.	
Domain 3: Inclusive leadership overall rating			**Developing**

Agenda Item 14

NHS Gloucestershire ICB Public Board

Wednesday 26th March 2025

Report Title	**2025/26 Capital Plan**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
					X
Route to this meeting	**ICB, ICS & Partners**		**Date**		
	Capital plan prioritisation via Trust Committees CEO & DoF review		Various through January – March 2025		
Executive Summary	This paper covers the proposed 2025/26 Capital Plan The ICS receives a system capital allocation each year, in addition, other capital funding sources are available such as disposals and national allocations. Each organisation has developed a prioritised capital plan taking into account organisational priorities and risks. The overall plan was then reviewed and tested looking across the whole system, taking into account risks and priorities, to finalise the plan. There are three capital bids to the national programme currently in progress, these are included in the paper for completeness, however, it should be noted that that system and NHSE are reviewing these. The System has developed a balanced capital plan for 2025/26.				
Key Issues to note	The Gloucestershire NHS System has worked jointly to develop a capital plan focusing on the key System priorities and risks within this. It is acknowledged that prioritisation has been challenging due to the level of backlog maintenance and other estates risks across the system in order to ensure a safe environment for services.				

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

Original Risk (CxL)
Residual Risk (CxL)</td><td>The System plan includes:
Schemes to address some backlog and essential maintenance, however, backlog maintenance is still significant across the system and there is a risk that urgent remedial work may arise in year
The assumption that inflation will not increase further
The proposed capital programme is larger than in previous years and there is a risk that the system will not be able to progress all schemes
Bids for national programme funding may lead to increased revenue costs
Mitigations include:
strong programme management within organisations to deliver capital programmes within plans without delay to ensure inflation can be managed
bids for national capital are being reviewed by the system to ensure that revenue consequences are affordable and that the anticipated benefits are fully realised
4 * 4 = 16
4 * 3 = 12</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>There are no conflicts of interests involved in producing this report.</td></tr>
<tr><td>Resource Impact (X)</td><td><table>
<tr><td>Financial</td><td>X</td><td>Information Management & Technology</td><td>X</td></tr>
<tr><td>Human Resource</td><td></td><td>Buildings</td><td>X</td></tr>
</table></td></tr>
<tr><td>Financial Impact</td><td>The ICS is proposing a breakeven capital plan</td></tr>
<tr><td>Regulatory and Legal Issues (including NHS Constitution)</td><td>ICBs and their partner NHS trusts and NHS foundation trusts should exercise their functions with a view to ensuring that local capital resource use does not exceed income in each financial year.

NHS England has set the objective that each ICB, and the partner trusts that have their resource use apportioned to it, in accordance with the financial direction set out below, should seek to deliver a financially balanced system, which may be referred to as a ‘breakeven duty</td></tr>
<tr><td>Impact on Health Inequalities</td><td>Various programmes within the budget may impact on health inequalities and the impact will be assessed by the specific programmes</td></tr>
<tr><td>Impact on Equality and Diversity</td><td>Various programmes within the budget may impact on inequalities and diversity and the impact will be assessed by the specific programmes</td></tr>
<tr><td>Impact on Sustainable Development</td><td>Various programmes within the budget will impact on sustainable development and the impact will be assessed by the specific programmes</td></tr>
<tr><td>Patient and Public Involvement</td><td>There is no public and patient involvement on the overall capital plan but the plan is in line with the ICP strategy which had public and patient involvement</td></tr>
</table>

Recommendation	The Board is requested to: • Approve the proposed 2025/26 capital plan noting that GHFT are currently finalising some parts of the proposed plan and the significant risks that the organisations within the ICS are holding and managing on an ongoing basis • Note the bids for national programme funding that are currently in draft and undergoing review by both the system and NHSE
Sponsoring Director (if not author)	Cath Leech, Chief Finance Officer

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

1.0 Introduction

This paper outlines the proposed 2025/26 capital plan for the ICS.

The Gloucestershire NHS System has worked jointly to develop a capital plan focusing on delivery of the System priorities and risks. Each organisation has undertaken a detailed process to develop a prioritised plan based on replacement programmes, backlog maintenance, high risk areas and strategic priorities. The proposals were then combined and underwent a detailed review and testing by Chief Executives, Directors of Finance and relevant Directors to arrive at an agreed programme for the System.

2.0 Resources

System Capital Limit

The System has been issued with a system capital allocation of £43.6 plus £1.25m for primary care capital; this allocation includes the IFRS16 allocation and the system will need to manage its core capital and the implications of leases within this budget. In addition, there is an allocation of £8.244m due to be received as the system financial forecast is breakeven for 2024/25.

	£'000
Notified capital resource limit	43,619
Estimated impact of ICS breakeven	8,244
Primary care capital allocation	1,254
Total Potential System CDEL	**53,117**

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

	GHFT £'000	GHC £'000	Primary Care £'000	Total £'000
Disposals		3,265		3,265
IFRIC12-GHFT	533			533
Donations Via Charitable Funds	1,274			1,274
Sub total	**1,807**	**3,265**	**0**	**5.072**
National prog bid: Constitutional standards	4,500			4,500
National prog bid: Critical Infrastructure Risk	7,797			7,797
National prog bid: PC utilisation & modernisation			1,048	1,048
National programme bid total	**12,297**	**0**	**1,048**	**13,345**
Total potential other sources	**14,104**	**3,265**	**1,048**	**18,417**

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

Total anticipated capital resources for the system are £71.5m.

3.0	**Capital Plans** Each organisation has developed a draft five year capital plan, this is still being refined, and the 2025/26 plan is set in the context of this longer term planning with a number of schemes across several years to both manage risk and ensure that we can remain within the system capital allocation. The capital programme is set out in Appendix one and the majority, c£37m, of the planned schemes are on estates programmes; this is an acknowledgement of the risk around the current estate. The balance of the programme is then on digital (£14m) and medical equipment (£9.6m). GHFT are currently finalising some elements of their programme, c£6m and the updated programme will be reviewed by Strategic Executives. In developing plans and prioritising by the System a number of factors have been taken into account: - Backlog maintenance: the system has a significant level of backlog maintenance, plans in 2025/26 address some of the significant backlog maintenance risks - Estates risks (other than back log maintenance) – as identified on Trust risk registers - Equipment replacement programmes (digital and medical equipment) – to ensure equipment is replaced in a timely manner. The level of backlog maintenance across the system is significant, with the majority on the GHFT estate, in addition, there are a number of other estates risks within GHFT in particular. The 2025/26 programme will address some of these, however, it should be noted that significant risk remains and continues to grow. Future year's programmes will continue these programmes and will need to include theatre refurbishments as a number of theatres will reach that point in their lifecycle. Bids have been submitted to the national programme by GHFT for: - Critical infrastructure risk £7.7m - Constitutional standards £4.5m And by the ICB for primary care: - Utilisation & modernisation funds £1.048m These bids are currently under review by the system to test for value for money and revenue affordability. The bids have been submitted in draft to NHS England.
4.0	**Risk Management** The 2025/26 capital plan is balanced and includes a small contingency. Risks in year relate to: - Inflation increases above budget plans - Equipment breakdown requiring urgent replacement

	- Estates issues requiring urgent capital work to replace/repair - Delays in capital disposals leading to reduced capital resources in year - IFRS16 expenditure differing to planned values In year management of the capital programme is undertaken both within and between the System organisations to ensure that the capital allocation use is maximised and the position is managed jointly. This process is overseen by Directors of Finance. Risk management measures include: - Tight project management of schemes to ensure that delays do not lead to inflation increases - Slipping or ceasing schemes into a future year to manage unexpected capital expenditure in year - Review of disposals to bring forward if possible - Bids for national capital to release system capital, where appropriate, address urgent capital expenditure needs
9.0	**Recommendation** The Board is asked to: • Approve the proposed 2025/26 capital plan noting that GHFT are currently finalising some parts of the proposed plan and the significant risks that the organisations within the ICS are holding and managing on an ongoing basis • Note the bids for national programme funding that are currently in draft and undergoing review by both the system and NHSE
	Appendices • Appendix 1 – Proposed 2025/26 capital plan

Appendix 1

Gloucestershire ICS Capital Plan 2025/26

Programme Area	25/26 Capital Plan				
	GHFT £000's	GHC £'000	Primary Care £'000	ICB £'000	Total £'000
Digital	9,721	3,380	1,104	0	14,205
Medical Equipment	7,876	1,780	0	0	9,656
Building / Medical equipment	2,868	1,496	0	0	4,364
Backlog / Lifecycle maintenance	533	0	0	0	533
Vehicles	0	250	0	0	250
Net Zero	0	2,643	0	0	2,643
Estates	31,159	5,900	1,198	0	38,257
Other	0	0	0	1,626	1,626
Total Expenditure Plans	**52,157**	**15,449**	**2,302**	**1,626**	**71,534**

Funding Sources	Disposals	0	3,265	0	0	3,265
Funding Sources	National Prog	12,297	0	1,048	0	13,345
Funding Sources	IFRIC12-GHFT - PFI Lifecycle	533	0	0	0	533
Funding Sources	Donation Charitable	1,274	0	0	0	1,274
Funding Sources	Grant	0	0	0	0	0
Funding Sources	National Funding for new IFRS 16 lease	0	0	0	0	0
Total Other Funding Sources		**14,104**	**3,265**	**1,048**	**0**	**18,417**

Call against System CDEL	**38,053**	**12,184**	**1,254**	**1,626**	**53,117**

System CDEL	Notified - 25/26	**43,619**
	Primary care capital allocation	**1,254**
	24/25 Revenue Fair Shares Allocation	**8,244**
	Potential System CDEL	**53,117**

Net Position against System CDEL under/(over) commitment	**0**

System Capital Allocations - National Program Funding	Return to Constitutional Standards	**4,500**
	2025/26 Estates Safety	**7,797**
	Primary Care Utilisation Fund	**1,048**
	Indicative Total Capital	**13,345**

AUDIT COMMITTEE 6th March 2025

ASSURANCE REPORT

Part I

Area	Assurance	Notes
External Audit	**Green**	24/25 Audit Plan on track with cross SW work on POD planned April. Risks, materiality and audit approach discussed. Year-end timetable noted as being one week earlier than last year.
Internal Audit	**Green**	Progress report and sector update noted. Lessons learned on transformation programme work being shared with System Improvement Group. Recommendation on Personal Health Budget progressing but not yet completed. Cyber Security Strategy due for publication will complete key recommendation. EDI reporting recommendation implemented. Key Financial Systems audit - achieved significant assurance on design and effectiveness Conflict of Interest audit - achieved significant assurance on design and effectiveness. MHA Report – information only. Referred to System Quality Committee for further consideration of how assurance is maintained across key areas. Draft Plan 25/26 approved. Indicative Head of Internal Audit opinion – moderate
Risk Management	**Amber**	BAF – noted outstanding update required on BAF 5. Other matters discussed included Primary Care risks and their reflection in relative terms in BAF10 on estates and infrastructure. Noted that BAF 6 to be updated to reflect BMA recently standing down collective action. Further work progressing on improving BAF reporting. CRR – Noted proposed improvement to register with revised layout to June meeting. Old risks to be reviewed as part of the work. Agreed closure of risks presented to committee. Full review of Counter Fraud risks to be done with team. Transformation and UC Directorate – main risks reviewed and assurance process discussed. Noted impact of risks in primary care and health and social care sector and need to reflect these in risk management of U&EC. Assurance remains at amber to reflect work on improvement and sustainability
Conflicts of interest	**Green**	Update received. Noted IA report above
IT Policies	**Green**	Approved updates on Acceptable use, Forensic readiness, Portable equipment and media, Action cards
Counter Fraud	**Green**	Progress report and draft work plan 25/26. Single tender benchmarking report considered for information and potential reflection in annual procurement report.

Procurement	**Green**	No decisions to report. Register of waivers noted.
Financial Management	**Green**	Aged Debtor and write off report noted. No Losses/Special Payments. Annual accounts timetable noted.

NHS Gloucestershire ICB Audit Committee Part 1 Meeting

Held at 09.30am on Thursday 5th December 2024
as
Hybrid Meeting via MS Teams and in Wilson Room, Shire Hall, Gloucester

Members Present:		
Julie Soutter	JS	Non-Executive Director, ICB (Chair)
Karen Clements	KC	Non-Executive Director, ICB (Deputy Chair)
Dr Jo Bayley	JB	Chief Executive Officer, GDOC
Participants:		
Andrew Davies	AD	Engagement Manager, Grant Thornton LLP
Adam Spires	AS	Partner, BDO LLP
Cath Leech	CL	Chief Finance Officer, ICB
Justine Turner	JT	Audit Manager, BDO LLP
Lee Sheridan	PK	Head of Local Counter Fraud Service
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB (taking minutes)
Ryan Brunsdon	RB	Board Secretary, ICB
Kelly Matthews *(Agenda Item 5)*	KM	Programme Delivery Director, ICB
Robert Mauler *(Agenda Item 5)*	RM	Assistant Director of Quality & Safety, ICB
Paul Atkinson *(Agenda Item 11)*	PA	Chief Clinical Information Officer, ICB
David Porter *(Agenda Items 13 & 14)*	DP	Associate Director Procurement, ICB
Dawn Collinson	DC	Corporate Governance Administrator, ICB
Remi Pacifico *(Agenda Item 11)*	RP	Senior Solutions Architect, ICB

1. Introduction and Welcome

1.1 JS welcomed members and attendees.

2. Apologies for Absence

2.1 Apologies were received from Bilal Lala, Dr Marie-Annick Gournet and Christina Gradowski.

2.2 JS confirmed that the Audit Committee meeting was quorate.

3. Declarations of Interests

3.1 JB declared that she was now the Clinical Director of the West Forest Primary Care Network (PCN) to which the work of the Gloucestershire Integrated Care Board extended. 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 5th September 2024

4.1 Minutes of the meeting held on 5th September 2024 were approved as an accurate record of the meeting.

The Chair directed that for practical purpose, meeting items would not necessarily follow the order set in the agenda.

5. Matters Arising & Action Log

5.2 Ambulance Partnership Board (APB) ToR & Delegation Agreement

5.2.1 KM presented and reiterated that the seven South West ICBs had collectively agreed the Ambulance Partnership Board's Terms of Reference (TOR) and the Delegation Agreement which would go before the respective Boards for approval. KM reiterated that the TOR and the Delegation Agreement were first brought before members for on 5th September 2024.

5.2.2 KM highlighted that Gloucestershire ICB which was charged with the responsibility for performance and quality of delivery. CL added that the Chief Finance Officers of regional partner organisations worked together to provide a financial perspective.

5.3 Patient Safety Incident Response Framework (PSIRF)

5.3.1 RM presented and explained that the report was discussed at the System Quality Committee meeting held on 4th December 2024, and the report would be circulated to members of the Audit Committee. RM stated that the PSIRF was primarily developed for provider trusts, and the quality committee would be looking at how they used this as part of oversight and assurance.

5.3.2 RM explained that GHFT and GHC had agreed to bring their BDO LLP audit results before the ICB System Quality Committee and share opinion on approach to PSIRF implementation. JB commended the change in approach but cited evidence of breaches impacting delivery of quality service. The breaches related to some patients developing deep thrombosis due to poor adherence to NICE guidance.

5.3.3 Members discussed the breaches cited by JB. JS directed that such matter be taken to the System Quality Committee before further consideration by members. RM highlighted that a full year may be needed to assess the effectiveness of PSIRF. Members issued the project an Amber Assurance rating.

RESOLUTION: The Audit Committee noted the:

1. **Patient Safety Incident Response Framework (PSIRF) report.**
2. **Ambulance Partnership Board (APB) ToR & Delegation Agreement.**

5.1.1 **Action No.28, 07.03.2024, Item 14.1** Waivers. JS suggested that trends and administration of waivers be included in the Annual Report. Members agreed that this matter required consideration. Report submitted on 5th December 2024 for reconsideration. **Item closed.**

5.1.2 **Action No.31, 24.06.2024, Item 10.2.2** Risk Scoring. JS and CGi stated that they were working with partner organisations to explore ways of standardising system risk scoring. Work reported to be progressing well. **Item closed.**

5.1.3 **Action No.32, 24.06.2024, Item 10.2.2** POD Recommendations. Monitoring and reviewing of POD transition by the Chairs of the Audit Committee and the PC & DC Committee continue. Chair of Audit Committee reviewed. Chair of PD & DC still reviewing and producing a summary report. **Item remains open.**

5.1.4 **Action No.33, 24.06.2024, Item 11.3.2** Social Media Policy. Members requested that social media policy be updated and be brought before the Board through its committees. Tracy Cox (TC) and CGi drafted the policy, and the policy was sent to the Communications department for further input. **Item remained open.**

5.1.5 **Action No.37, 07.03.2024, Item 15.2** Counter Fraud. Members highlighted a need to review Counter Fraud risk scoring. PK and RB reviewed the risk metrics. **Item closed.**

5.1.6 **Action No.38, 05.09.2024, Item 3.2** Declarations of Interest. GN required to create accounts for BL and MAG on the Civica platform and to add the new members' names to the Audit Committee Register and to the ICB Register of decision makers. This was actioned. **Item closed.**

5.1.7 **Action No.39, 24.09.2024, Item 6.6.2** Patient Safety Incident Reporting Framework (PSIRF) Report. Waiting for EPRR manager to supply intranet pages where specific training will be uploaded and provided to those required to do so. Those on-call and in specialist roles will be required to complete training as advised. **Item remains open.**

5.1.8 **Action No.40, 24.09.2024, Item 8.1.2** Risk Management. There was a risk appetite / risk tolerance session included in the Board Development session in October but need more dedicated time in 2025 (suggested March Audit Com) to review system partner approach to appetite and tolerance. Quarterly mtgs with Governance Leads across the system have been set up also. **Item remains open.**

5.1.9 **Action No.41, 24.09.2024, Item 8.4.3** A Report from the Integrated Commissioning Directorate Team on Risk and Assurance. Integration Commissioning directorate requested to provide greater detail regarding its risk controls. Update to be provided in March 2025. **Item remains open.**

5.1.10 **Action No.42, 24.09.2024, Item 8.4.4** A Report from the Integrated Commissioning Directorate Team on Risk and Assurance. JS drew attention to the ICB's concern that the Collective Commissioning Hub (CCH) would not have the capacity to support local POD

initiatives. CL proposed to follow up with others and update the Committee. Update provided by the Primary team. **Item closed.**

5.1.11 **Action No.43, 24.09.2024, Item 9.4** CG agreed to discuss with JB offline to the Audit Committee.

5.1.12 **Action No.44, 24.09.2024, Item 11.2** Terms of Reference (TOR) Review. TOR reference to be updated as per feedback during the Audit Committee. **Item closed.**

5.1.13 **Action No.45, 24.09.2024, Item 15.1** Register of Waivers of Standing Orders. Members requested justification for the provision of a £126,000 waiver for British Sign Language Translation and Interpretation Services. It was clarified that Interpretation and Translation services are not 'healthcare' services and are therefore excluded from the Provider Selection Regime. **Item closed.**

6. Internal Audit

6.1 Internal Audit Progress Report and Sector Update

6.1.1 JT presented a sector update and stated that whilst the BDO LLP looked at short term challenges and common Board resource capacity problems, it largely focused on equipping Boards for future success. JT emphasised a need for Boards across sectors to move from conventional assurance duties to a more proactive and foresighted role capable of withstanding long term economic changes and increasing regulatory demands.

6.2 Population Health and Inequality Review

6.2.1 JT presented and commended the inclusion of Clinical Programme Groups, Integrated Locality Partnerships, and the Voluntary Sector in looking at health inequalities. JT stated that the auditors were of the view that there was good governance in place but there were some areas which needed strengthening. JT explained that BDO LLP issued a Moderate rating for both Design Opinion and Design Effectiveness.

6.3 Primary Care Commissioning Report

6.3.1 JT presented the report and explained that the delivery plan for recovering access to Primary Care guided ICBs to develop system-level access improvement plans. JT highlighted the progress made within Gloucestershire in recovering access to Primary Care despite the prevailing resource constraints. JT also stated that NHS England's Primary Medical Services Policy and Guidance Manual (PGM) was updated in July 2024 to reflect current developments and changes in the commissioning.

6.4 New Data Security and Protection Toolkit (DSPT) and Audit Approach

6.4.1 AS presented and described the new Data Security and Protection Toolkit (DSPT) and Audit Approach and its connection to the Cyber Assessment Framework (CAF). CAF provided a

systematic and comprehensive approach to assessing how cyber risk to essential functions are managed. Members requested feedback on implementation and effectiveness of the new DPST. **Action: RB and GN to add to confidential Meeting Planner and arrange for the ICB team to bring an update before members on 6th March 2025 in P2 of the meeting.** **RB& GN**

6.5 Internal Audit Follow Up Report

6.5.1 AS highlighted the overdue recommendation relating to the cyber security strategy. The auditors acknowledged that the ICS Cyber Strategy had been drafted and was going through governance process. Members issued an overall Green rating for Assurance but stated that more work needed to be done.

RESOLUTION: The Audit Committee:

- **Noted the Progress report and Sector Update report.**
- **Noted the Population Health Inequalities report.**
- **Noted the Primary Care Commissioning report.**
- **Noted the New Data Security and Protection Toolkit (DSPT) and Audit Approach**
- **Noted the Internal Audit Follow-Up report.**

7. External Audit

7.1 AD presented and stated that Grant Thornton LLP and the ICB finance team had carried out a review of the previous audit identifying areas to improve. AD highlighted POD as one of the areas found demanding in the previous audit because this was a new area for the ICB. AD explained that Grant Thornton LLP was planning an early start on the auditing of contracting work and processes. AD stated that detailed planning for the audit would start at the beginning of 2025; this included planning the Value for Money (VFM) exercise. AD explained that the Audit Plan would present on 6th March.

7.2 AD explained that the Accounts timetable had been published and the deadline for submission was 09:00am, 23rd June 2025. Members noted that the audit committee for June would need to be rearranged to meet the deadline. **Action: RB and GN to facilitate the change of meeting date.** AD invited NEDs to join a webinar session to be held on 6th December 2024. JS accepted the invitation. Members issued an overall Green rating for Assurance. **RB & GN**

RESOLUTION: The Audit Committee noted the External Audit update report.

8. Risk Management Report

8.1 Board Assurance Framework (BAF)

8.1.1 RB presented and explained that a Board Development Session took place in October 2024 and focused on risk appetite and the alignment of strategic risk management tools within the system. An agreement in principle was reached that implementation of strategic risk management tools would come into effect once Gloucestershire Hospitals Foundation Trust (GHFT) had concluded its strategy review. RB reiterated that conclusion of the GHFT strategy

review would enable partners to appreciate the broader risk appetite environment required to inform system level risk management strategies.

8.1.2 RB stated that Governance Leads planned to meet on quarterly basis to discuss system risks. RB described arrangements in place to promote deep-diving and the probing of system level risks. JS expressed that taking the BAF before the Board was not limited to providing conventional assurance, but also had the benefit of supporting concise reporting.

8.2 Corporate Risk Register (CRR)

8.2.1 RB presented the 137 risks on the CRR of which 34 were rated Red. RB stated that of the 34 Red risks, 10 emanated from commissioning activity. RB added that the Audit Committee had 9 risks assigned to it. RB highlighted that there were risks on the CCR spanning periods of over three financial years. RB added that the Governance team were compiling a report on such risks and such risks would be brought before members on 6th March 2025**.**

8.2.1 RB reiterated that the Governance team provided support to Risk Leads to maintain effective risk management and reporting. Members requested a review of Integration Risk37 which referred to risk of reputational damage to the ICB. The risk emanated from transferring long term complex packages of care to a new provider. **Action: RB to support reviewing of Risk37.** **RB**

8.3 Risk Closure Report

8.3.1 RB presented 16 risks for closure. These were namely:

- Integration 2: Risk of waiting list for Wheelchair Service provision in the recovery phase;
- Integration 3: Risk of financial sustainability of hospice at home providers;
- Integration 6: Risk that children and young adults would not receive the specialised care they would receive in a Tier 4 Eating Disorder bed;
- Integration 12: Risk of market instability as a result of price rising;
- Integration 21: Risk that there are a large number of people in Nursing Homes waiting for assessments;
- Integration 25: Risk of deviation from NICE NG87 and QS39; Attention Deficit Hyperactivity Disorder (ADHD);
- PC&P2: Risk that the ICB's requirement of providing Primary Medical Services for Practices that are facing resilience challenges could not be met;
- PC&P3: Risk for Practices in the Forest of Dean that are facing resilience challenges;
- PC&P4: Risk to specifically challenged Practices.
- PC&P5: Risk to the delivery of the delegation of Pharmacy, Optometry and Dental (POD) services;
- PC&P8: Risk of the delivery of the delegation of Dental services;
- PC&P15: National Funding for GP & GPN Fellowships ceased end of March 2024 - resulting the fellowship offer being unavailable from April 2024, impacting newly qualified GPs and nurses;

- PC&P17: Risk to Drybrook APMS Contract - Contractors should not provide services unless they are CQC registered. Currently awaiting approval of CQC application. High risk score due to length of time CQC are taking with regard to progressing this application;
- U&EC5: Risk that the ongoing pressure within UEC and recovery from Covid impacts service delivery quality;
- PC&P20: Risk relating to provision of services at Beachley Barracks for entitled persons (Eps);
- PC&P21: Risk that the contract term is not extended as anticipated when the initial 3-year term expires on 31st March 2025.

8.3.2 Members reviewed the risks and agreed that although Integration Risk12 could be closed, a new risk should be opened to support mitigation of risk elements associated with the closed risk. Overall risk Assurance rating from members was Amber.

RESOLUTION: The Audit Committee:

1. **Noted the Board Assurance Framework (BAF).**
2. **Noted the Corporate Risk Register (CCR).**
3. **Approved closure of risks cited in paragraph 8.3.1.**

9. Managing Conflicts of Interest

9.1 GN presented and outlined compliance levels measured against the 95% standard as follows:

- members were 100% compliant;
- members and senior staff were collectively 99% compliant;
- junior staff were 99% compliant;
- overall compliance rate was 99%.

9.2 GN presented the Registers and explained that staff in Bands 8a and above constituted the senior staff, and all staff below Band 8a were junior staff. GN clarified that NHS England required all decision makers under its auspices to declare interests, but the requirement did not extend to junior staff. GN reiterated that the ICB as good practice, extended the requirement to junior staff. GN stated that the Governance team trained and provided refresher sessions on managing conflict of interest. The Conflict-of-Interest Guardian provided support as well.

9.3 GN presented the 5 declarations in the Hospitality & Gifts Register and highlighted a culture of low appetite for accepting gifts and less inclination to accept offers of hospitality. RB and GN presented the new guidance on managing conflict of interest, and RB explained that the guidance intended to protect public funds, patients, members and staff. RB added that the guidance replaced the NHS guidance issued in 2017, and it took account of changes introduced by the Health & Care Act 2022. GN stated that the new guidance, although more succinct, did not introduce significant change to process.

9.4 GN explained that one notable change was the suggestion in the guidance that decision making level started from Band 8D. GN highlighted that the guidance clearly advised that decision-making level should not be treated rigidly. NHS England considered that organisational situations and structures varied, and this informed decision-making structures and levels for separate organisations. GN stated that decision making in the ICB started from Band 8A going up. Members discussed the report and issued a Green Assurance rating.

RESOLUTION: The Audit Committee noted the report on Managing Conflicts of Interest.

10. Terms of Reference (TOR) Review

10.1 RB stated that there was requirement to periodically review the TOR, and if deemed necessary, to update such terms. RB presented an updated draft TOR and highlighted the changes made. RB stated that paragraph 4.3.1 of the TOR had been amended to reflect that the ICB engaged two sets of auditors: one for external audit work and the other for internal audit work. RB added that introduced changes included procurement terms and extra detail relating to Committee Chair.

10.2 Members commended the draft but suggested a need for more detail in provisions relating to corporate governance. Members also pointed out that paragraph 7.1 incorrectly suggested that the Audit Committee sat six times in a year. Members clarified that the Committee formally met once every quarter, but also informally met ahead of the quarter 4 meeting convened to approve the final Accounts. Members also suggested that paragraph 9.11 covering procurement procedure required more detail and clarity. **Action: RB to amend accordingly.** **RB**

RESOLUTION: The Audit Committee approved the Terms of Reference subject to amendment.

The Chair directed the meeting to proceed to agenda item 12.

12. Counter Fraud Report

12.1 LS presented the progress report and outlined the new Economic Crime and Corporate Transparency Act (2023) which would come into effect in 2025. LS described the Economic Crime and Corporate Transparency Act (2023) as a tool to fight fraud offences; and it would sit along with the Bribery Act (2010) and strengthen the fight against corporate fraud. LS stated that the position created by the new Act was that the ICB could be vicariously liable for a fraudulent activity committed by an employee to advance organisational interests.

12.2 LS suggested that there could be a need by the ICB to revisit the Counter Fraud policy and a need to review employment contracts to strengthen fraud prevention measures in an evolving environment. **Action: CGi to consider and advise on the matter.** LS outlined three live investigations. LS stated that one of the cases involved an employee signing several parallel contracts of employment whilst still in the employment of the ICB. The employee concealed such interests. LS emphasised that Local Counter Fraud Service were of the view that this was a criminal offence. Members issued an overall Green rating for Assurance. **CL & CGi**

RESOLUTION: The Audit Committee:

- **Noted the Progress report.**
- **Noted the summary of Counter Fraud investigations.**

The Chair re-directed the meeting to agenda item 11.

11. Generative Artificial Intelligence Usage Policy

11.1 PA and RP presented, and PA highlighted that generative Artificial Intelligence (AI) has emerged as a transformative tool in HealthCare and has the potential to revolutionise clinical decision-making and improve health outcomes. PA stated that AI comes with risks, and he expressed a need to be mindful of such risks. RP concurred and added that there was a need to create a strong platform for mitigation, and this included using strictly approved and controlled software.

11.2 RP suggested that there may be a need to develop tools and skills to aid insight into the handling of AI by contracted third parties as part of mitigating risks. JB commended the potential value of AI but expressed a concern that there appeared on how AI impacted and informed the equality/inequality in the health sector. PA agreed that there was a need to explore how best to use AI to ensure no bias. Members discussed the report on AI policy and issued an Amber Assurance rating.

RESOLUTION: The Audit Committee approved the Generative Artificial Intelligence Usage policy.

13. Procurement Activity

13.1 Annual Procurement Report

13.1.1 DP presented the first Annual Report on procurement regime. DP stated that the report highlighted the work of the ICB's procurement staff and the relevant legislative development. PD reassured that members of the procurement team were fully qualified and were committed to continuous professional development. DP outlined legislative changes in the procurement environment and stated that the ICB was developing a comprehensive procurement policy document which would reshape its current interim procurement strategy.

13.1.2 The report described the collaboration between the ICB procurement team and the procurement teams in partner organisations. Members shared the view that the risk impacting Provider Selection Regime appeared to be less than that given in the CCR. Members therefore requested the procurement team to review the risk. **Action: DP to review the risk downwards.** Members suggested that the report should not follow the calendar year but should align with the financial year end of the ICB which is 31st of March of each year. **DP**

13.2 Summaries of Procurement Decisions

13.2.1 DP presented the report which related to the decision to award a 5-year contract with a value of £52,799,594 to GHC's Integrated Urgent Care Services (IUC) Services (OOH/111/CAS).

DP stated that there was an option to extend the contract for a further 2 years. DP reassured members that the contract was being monitored on monthly basis. Members discussed the report and issued a Green Assurance rating.

RESOLUTION: The Audit Committee:

- **Noted the Annual Procurement Report.**
- **Noted the Summaries of Procurement Decisions.**

14. Register of Waiver of Standing Orders

14.1 DP presented 18 waivers of Standing Orders approved by the ICB Executive. Members examined the waivers and discussed their impact. DP stated that an audit was conducted on how the ICB employed waivers and the audit outcome showed that the ICB made prudent use of waivers. Members discussed the report and issued a Green Assurance rating.

RESOLUTION: The Audit Committee noted the Waiver of Standing Orders.

15. Losses and Special Payments Register

15.1 Nothing was reported under this item.

16. Debts Write-offs

16.1 Nothing was reported under this item.

17 Aged Debtor Report

17.1 CL presented the outstanding debt report as at 21st November 2024; this showed total debt of £225,408 of which £45,855 was NHS and £179,553 was non-NHS. 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 issued a Green Assurance rating.

18. Forward Planner

18.1 JS presented the meeting Forward Planner. Members reviewed the Planner and suggested that meetings already covered should be removed from the Planner. It was also agreed that a risk deep dive by the Integration directorate should be moved back to 6th March 2025. Members also directed that the 23rdJune 2025 meeting scheduled to discuss final Accounts be brought forward to meet the new deadline.

19. Any Other Business

19.1 CL explained that the ICB was currently going through due diligence for specialist commissioning; and it was expected that specialist commissioning would take effect starting

from April 2025. CL added that the ICB was getting support from NHS England to rollout the programme. BDO LLP committed to supporting process. CL stated that she looked forward to updating members on progress, on 6th March 2025. **Action: CL to provide an update.** CL also stated that the commissioning of the new Oracle Ledger had been postponed until further notice. **CL**

The meeting ended at 11:45am.

Date and Time of Next Meeting: 6th March 2025 at 09:30am.

Minutes Approved by the Audit Committee: Signed (Chair): Julie Soutter Date: Thursday 6th March 2025

NHS Gloucestershire System Quality Committee Meeting

Wednesday 4th December 2024, 2.00–5.00pm
Boardroom & Virtually from Shire Hall, Westgate Street, Gloucester GL1 2TG

Members Present:		
Prof Jane Cummings (Chair)	JCu	Chair, Non-Executive Director, GICB
Dr Ananthakrishnan Raghurum	AR	Chief Medical Officer, GICB
Hannah Williams	HW	Deputy Director of Nursing, Therapy and Quality, GHC
Jan Marriott	JM	Non-Executive Director, GHC
Julie Soutter	JSo	Non-Executive Director, Audit Committee Chair, GICB
Marie Crofts	MC	Executive Nurse & Director for Quality, GICB
Matt Holdaway	MHo	Director of Quality and Chief Nurse, GHFT
Nicola Hazle (part meeting)	NH	Director of Nursing, Therapies and Quality, GHC
Sarah Scott (part meeting)	SS	Executive Director of Adult Social Care, Wellbeing and Communities, GCC
Suzie Cro	SC	Deputy Director of Quality Programme, Director Nursing and Midwifery Excellence, GHFT
Participants Present:		
Annalie Hamlen	AH	Senior Nurse, Quality & Integrated Commissioning, GICB
Becky Parish	BP	Associate Director Engagement and Experience, GICB
Mel Munday	MM	Associate Director Integrated Safeguarding, GICB
Ryan Brunsdon	RB	Board Secretary, NHS Gloucestershire GICB
Dawn Collinson	DC	Corporate Governance Administrator, GICB
Rob Mauler	RM	Assistant Director, Quality Development & Patient Safety, GICB
Sarah Morton	SM	Chief Allied Health Professional, GICB
Trudi Pigott	TP	Deputy Director of Clinical Quality, GICB
In Attendance:		
Andrew Bruce (part meeting)	AB	Head of EPRR, GICB
Emma Sidebotham (Agenda Item 8)	ES	Public Health, GCC
Katie Hopgood (Agenda Item 8)	KH	Consultant in Public Health, GCC
Althia Lyn (Agenda Item 9)	AL	Commissioning Officer, GCC
Harriet Roberts (Agenda Item 9)	HR	Inclusion Gloucestershire
Paul Tyrrell (Agenda Item 9)	PT	Inclusion Gloucestershire
Nicholas Baker (Agenda Item 9)		Expert By Experience, Inclusion Gloucestershire
Craig Bradley (Agenda Item 10)	CB	Deputy Chief Nurse & Director of Infection Prevention & Control, GHC
Richard Thorn (Agenda Item 11)	RT	Senior Commissioning Programme Manager, GICB
Eve Olivant (Agenda Item 13)	EO	Director of System Flow, GICB

1. Introduction and Welcome

1.1 The Chair welcomed members to the meeting. Andrew Bruce was welcomed as the new Head of Emergency Preparedness, Resilience and Response (EPRR) for the ICB.

2. Apologies for Absence

2.1 Apologies were received from Siobhan Farmer, Julie Symonds and Christina Gradowski.

2.2 NH and SS needed to leave the meeting at 16.00. The meeting would remain quorate.

3. Declarations of Interest

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

There were no new Declarations of Interest to note for this meeting.

4. Minutes of the last meeting held 2nd October 2024

4.1 The minutes from the last meeting held on 2nd October 2024 were approved as an accurate record. The Chair remined members that any confidential parts of the meeting should be clearly stated and redacted from this public meeting.

5. Matters Arising & Action Log

5.1.1 **Action 56 - Health Inequalities. December Update:** Action to be carried forward to February meeting. **Action to remain Open.**

5.1.2 **Action 64 - ED&I Future Plans. December Update:** To be moved to the People Committee. **Action to be Closed.**

5.1.3 **Action 68 – IPC.** Action included on today's Agenda. **Item to be Closed.**

5.1.4 **Action 78 – Care Home Data. December Update:** An update is to be provided around the approach being taken from S Scott and B Leigh at Feb meeting. **Action to remain Open.**

5.1.5 **Action 79 – PSIRF. December Update:** Updated at Committee today. **Reopen if needed in 2025. Action Closed.**

5.1.6 **Action 83 – Pharmacy Manufacturing Unit December update:** Re-inspection was due, with a full report to follow later in December. **Action to remain Open.**

5.1.7 **Action 84 - Maternity deep dive. December update:** LMNS updates would be brought to these meetings along with any additional deep dives conducted at GHFT being fed through to this Committee, as necessary. **Action to be Closed.**

5.1.8 **Action 85 - Berkeley House. December Update:** Updates are provided under the Quality Improvement Group update within the Agenda. **Action Closed.**

5.1.9 **Action 88 - Out of County Children's placements. December Update:** Matter unresolved. Jill Crook to be advised around the number of placements coming into Gloucestershire and the implications for health and social care. **Action to remain Open.**

5.1.10 **Action 89 - Special Allocations Service (SAS) December Update:** MCr had met with colleagues at GHC in order that a plan might be arranged which would cover the next six months, which would cover what could be provided for those patients. MCr and NH were working closely together on this. **Action to remain Open.**

5.1.11 **Action 90 – BAF 4 Risk. December Update:** BAF 4 has been re-assessed and is reported as Red. **Action Closed.**

5.1.12 **Action 91 – SHMI Risks.** There is now an established QIG for SHMI which is led by the ICN CMO multiple workstreams have been identified and work is progressing. This can be picked up in the QIG escalation part of the agenda going forward. **Action to be Closed.**

5.1.13 **Action 92 - ADHD and Autism Risk.** To be forward planned for Feb/April. **Action Open.**

5.1.14 **Action 93 – System Falls Training.** Discussed at 7.1.2 in Dec minutes. In Julie's absence it was decided: Action: MCr, NH and Jane Haros to liaise over system falls prevention work. **Action Open.**

5.1.15 **Action 94 – PCREF Progress.** Initial work drove PCREF through a standalone working group without any clear reporting structures which has now evolved into a steering group structure with working groups and short-term T&F groups falling out of this. **Action Open.**

5.1.16 **Action 95 – Migrant Health.** Update to be provided in Feb 2025 due to JS apologies at Dec 24 meeting. **Action Open.**

5.1.17 **Action 96 – QAF for Older People's Services.** To be picked up in April 2025. **TBC Action Open.**

5.1.18 **Action 97 - CQC Adult Social Care Inspection.** Report not yet available. **Action Open.**

5.1.19 **Action 98 – Breast Screening Services.** Due for Feb 2025. **Action Open.**

5.1.20 **Action 99 - Section 140 Policy.** KG and NH met on 13/11/2024 and KG was due to meet this week with Sarah Branton, Chief Operating Officer who started on 04/11/2024. From that KG, SB and NH would meet to agree the best mechanism/group for undertaking the refresh and review of the policy and would ensure it went through the relevant assurance groups before returning back to SQG. **Action to remain Open.**

6. Risk Report and Board Assurance Framework (BAF) Update

6.1 RB updated members that all five of the BAF strategic risks presented to the Committee today had been taken to the ICB Board on 27th November 2024 for review. BAF 4 had been re-appraised to a score of 16 since the last System Quality Committee meeting. There would be a deep dive session at the Primary Care and Direct Commissioning Committee meeting on 5th December of BAF 6 included in the papers and could be brought back for discussion should this be warranted.

6.2 Updates had been received for the Emergency Preparedness, Resilience, and Response (EPRR) BAF risk which would be presented at the next committee meeting to be held in February 2025.

6.3 RB updated on the Corporate Risk Register stating that there were two new risks since October which related to the purchasing of equipment, risk rated at 20 and reputational damage from the Children's Continuing Care Team of transferring long term packages of care, which was risk rated at 16. There were two risks within the report with a high consequence score for the ICB of 5. One was around antenatal screening, and the other was around reputational damage.

6.4 There had been no movement in the scores around the other risks since October with scores remaining the same. It was noted that there were 4 risks that have been listed for at least three years and it was agreed these risks would need to be reappraised.

6.5 JS commented that there appeared to be a number of risks held on the CRR that had not reduced in their risk scores despite mitigations being in place. JS suggested that Directors may wish to review how the risks were articulated to ensure that they were still contemporary and review the mitigations in place as well as the risk score. It was noted that both the BAF and CRR were discussed at each Audit Committee meeting, the next meeting would be held on 5th December.

6.6 The risk around market instability due to price rises had been requested to be closed as it stated that hyper-inflation was no longer present. JS felt that there were many aspects to hyper-inflation such as energy, staffing, repairs and maintenance and felt that this was still a risk both to the provision and costings.

6.7 It was noted that the risk of reputational damage to the ICB and the Children's Continuing Care Team by changes to the packages of care provided to vulnerable children was a very high-rated risk. JS requested that the way the risk was articulated should be reviewed as while reputational damage was a consideration, it was not the primary risk in this case.

6.8 NH commented that GHC was currently reviewing those risks that continued to be held on risk registers and the Corporate Risk Register for considerable lengths of time and there was a consideration about how these risks would connect with risks held by other ICS partners. Reputational risk also needed to be revisited to ensure that the wording around this risk was correctly applied.

6.9 AB spoke about various EPRR risks not having been incorporated into the current version of the BAF; the visibility of which needed to be increased for awareness and oversight, as well as giving assurance that the EPRR team had considered and worked on every possible mitigation, should any serious incidents arise. JS responded that EPRR risks would also be covered in the Audit Committee meeting discussions on 5th December.

6.10 MCr suggested that risk leads review the risks on the CRR and that scores should be checked and possibly changed, particularly any risks that referenced reputational damage. JCu asked about the equipment buying risk, which did seem inordinately high compared to others which were more clinically risky but were rated lower. **SS**
Action: SS to examine the risk for purchase of equipment score and report back to the Committee at a future meeting.

Resolution: The Committee noted the Risk Report and BAF updates.

7. System Partner Highlight Assurance Reports

7.1 *GHFT Exception Reporting including Maternity*

7.1.1 MH updated:

- There had been no new Trust inspections since the last update.
- Care Quality Commission (CQC) visited Diaverium (sub-contracted renal services) and there will now be an inspection of the service.
- There were two outstanding inspection reports (Emergency Department (GRH site) December 2023, and Medicine & Oncology July 2024 (CGH site).
- The Maternity Service had now received their draft inspection report (GRH site) for the March 2024 inspection.

- Improvement actions were ongoing with safeguarding training and fire training compliance being a focus for services
- On 9 May 2024, the Trust received a CQC Section 31 enforcement notice for Maternity. Good progress had been in all the workstreams
- Of note was that the PPH >1.5L target metric which was met by the Trust and the national average was 32 per 1000 deliveries. The national data was three months behind the Trust data and since then, there had been a rise. The rolling six-month Trust rate was 37.7 per 1000 deliveries, which was much improved on the initial rate.
- There was a priority Quality Summit for Falls Prevention on 26 November, the output would be reported to the Quality Delivery Group. This had been well attended with positive processes resulting for the review of current data, enabling local improvements metrics to be driven forward.
- Focused improvement work was ongoing in relation to increasing the number of patients receiving a venous thrombosis risk assessment within 14 hours of admission, which Mark Pietroni was leading on. The improvement work was focused on short stay admissions in surgery and in maternity.
- No Criteria to Reside (NCTR) had continued to fluctuate, with current figures of 120 NCTR across the two hospitals. The system goal remained at 87. There had been improvements within the median average wait to be discharged when waiting for a pathway 1-3, with the median wait across all pathways having reduced to 5 days as at the end of September, reducing down from 7, in May 2024.

7.1.2 MCr referred to the falls work and wondered whether any further improvements could be made across the system. MH had noticed an action previously for Craig Bradley and Julie Symonds to liaise over this type of work. In Julie's absence it was decided MCr, NH and Jane Haros to liaise over system falls prevention work.

7.1.3 MCr referred to Delay Related Harm and informed the meeting that Christian Hamilton had recently delivered an overview of Elective Waits and Follow-Ups to the ICB Board. MCr had requested information regarding the level of risk, so that this could be monitored by GHFT. AR commented that follow ups were not measured but the analysis of what that harm meant was examined, to see how this was being addressed. Urgent and Routine appointments had revealed that there had not been a great deal of disparity in the waiting times.

7.1.4 JCu also posed a question about people in their own homes being able to access social or nursing care to prevent delay related harm. This was a system risk, and it was noted that this would be a substantial piece of work and would necessitate all partners being brought together to really understand this going forward.

7.1.5 HW stated that community metrics around delay related harm were starting to mature at GHC in community mental health, learning disabilities and in physical health. HW would be happy to liaise with colleagues in a co-production workshop, to start to build the basis of what a system dashboard on delay related harm across the community might look like, should the Committee wish to take this approach.

7.1.6 MHo confirmed that a Report had been written on delay related harm and there had also been a Quality Summit on the same topic. It was noted that it would take senior leadership to address this. **Action: MHo to present Delay Related Harm Report to next Committee meeting in February 2025.** **MHo**

7.1.7 There were points raised around pressure ulcers:

- JM observed that there was delay related harm around pressure ulcers and more frequently these were being picked up in the community due to people waiting in A&E or in ambulances.
- MH commented that numbers were monitored monthly Work had been undertaken last year to make pressure relieving equipment available for patients as soon as they arrived.
- JM thought that feedback could be given from the community to the Trust about numbers for this.

HW/TP

Action: HW and TP to discuss pressure ulcers in a future systemwide Wound Care conversation and report back to the Committee.

7.1.8 JS referred to falls stating that the Lead Nurse in Tewkesbury had reported that the Falls Prevention Assessment process had highlighted the need to work across the whole pathway to tackle those people at risk from falling rather than those who had already sustained a fall. JCu thought that the Frailty Team was addressing mild frailty, much of which involved activities around strength and core balance with the aim of reducing the risk of falls.

7.1.9 AR suggested that a deep dive was required around delay related harm, considering the different subsets of people to be involved and which would need a far wider approach. The issue needed to be further explored in order to understand the root causes.

7.2 *Adult Social Care Exception Reporting*

7.2.1 SS informed the meeting that the draft Report mirrored the self-assessment that had been sent to the Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) for them to check for factual accuracy. Due to some statutory functions being delegated to GHC, they had been mentioned in the Report around the ongoing improvement work.

7.2.2 JCu referenced the slide referring to "lack of framework or timeframe for further development of Quality Assurance of Older Peoples Services. The risk was being managed and an Adult Transformation Programme (ATP) project commenced." SS explained that under the Market Management portfolio led by Benedict Leigh, there was work being undertaken regarding quality with the aim to have a quality framework with standards and processes that would go with it. The risk was still significant, and this was currently being addressed.

7.2.3 The CQC ratings around domiciliary care and supported living graph had shown very little movement but the community beds had shown a downward trend. JCu asked whether any further support was required. SS explained that care was bought on behalf of the ICB so the risk around the lack of quality assurance was also shared by the ICB.

7.3 *GHC Exception Reporting*

7.3.1 NH updated:

- A deep dive was carried out around restrictive practice and gave good assurance on work having been done around low and no harm incidents. A broader summary around training compliance and considerations of psychological and physical harm in restrictive practice had been carried out.
- There had been an update around the Integrated Urgent Care Service, the clinical governance structure and work around clinical safety and risk management in preparation for go live.

- The Gloucestershire Suicide Prevention Strategy had been well received with an Action Plan to be developed.
- The Quality Dashboard Report had been circulated and the Adult Safeguarding Annual Audit had been done with an improvement in compliance seen since last year. This would be forming part of the Improvement Plan.
- Positive developments had arisen from work around the Self-Harm pathway, particularly at Wotton Lawn and the falls work which was continuing at Charlton Lane.
- Pressure ulcers continue to be closely monitored being a quality priority and there will be a Community and District Nursing deep dive coming to the January Quality Committee to deliver more detail.
- Rapid Tranquilisation numbers had dropped but Clinical Holds had increased. These had been supportively linked to seasonal vaccination and the Covid booster programme.
- GHC were working with operational colleagues around Datix incidents to ensure that these were completed and closed to aid good governance and assurance.
- Continued strong performance was being seen around Friends and Family with compliance being met around the 3-day requirement for complaints.
- There had been good assurance around the work being done by operational colleagues around long waiting lists and how those patients and their families were being supported due to the impact and potential harm of long waiting.

7.3.2 JS referred to Violence and Aggression shown on the chart in the report and asked why there was a dip in this, which then went back up. HW was able to explain that this was due to a patient having been discharged, and then subsequently re-admitted.

7.4 *ICB Quality (Primary Care) Exception Reporting*

7.4.1 MCr noted that Julie Symonds would be bringing an update on Migrant Health and Beachley Barracks to the February meeting.

Resolution: The Committee noted the content of the System Partner Highlight Assurance Reports.

8. Gloucestershire System Infection, Prevention & Management (IPM) Action Plan

8.1 TP introduced Emma Sidebotham (ES) who had supported the system in contributing a huge amount of work towards the IPM Action Plan for Gloucestershire. ES presented slides on this topic and explained the aim of the Action Plan and the advantages that this would bring.

8.2 The purpose of the Action Plan was:

- To develop a whole system infection prevention and management action plan for Gloucestershire with an aim of reducing harm from infection across the local population.
- To better understand and act on inequalities in the risk, incidence and outcomes of infection across the local population.
- To embed the learning and collaboration seen during the COVID-19 pandemic into usual practice.
- To make the best use of finite resource in the system, including collective uses of enabling support services such as business intelligence, communications, and engagement.

8.3 Development of an Action Plan for HCAI/AMR had been decided due to various reviews and health recommendations. There had been recognition of a tendency to siloed working across the ICS around IPM with opportunities for more effective working and sharing of resources. There was a desire to move towards a proactive, preventative approach and embed lessons learnt from the COVID-19 pandemic, with a system that was ready to acknowledge and respond to changes in demographics and patterns of infection.

8.4 TP spoke about how objectives had been developed with all objectives having been reviewed by a golden threads expert group which were to be further developed as required.

8.5 Governance and reporting arrangements were explained:

- Operational groups would provide regular updates to the IPM groups and escalate risks.
- Responsibility for monitoring delivery of the Action Plan would be enshrined within the IPM group Terms of Reference.
- IPM group to then report annually into System Quality Group for overall assurance of plan and escalate any risks or issues in relation to implementation.
- The IPM group (and programme leads in Health Care Associated Infections/AMS and Vaccination) would provide regular updates to the Health Protection Assurance Board to develop its bi-annual statement to Gloucestershire's Health and Wellbeing Board and provide assurance on the delivery of health protection functions by NHS services.

8.6 Next Steps:

- A Stakeholder workshop had taken place on 2nd December 2024.
- Objectives would be rated with time for discussion and consideration of resources for implementation of "must do's".
- Prioritised objectives would make up the IPM workplan and delegated to the appropriate subgroups and organisations.
- The Action Plan would be a live document, where objectives would be re-visited and re-prioritised by the IPM group when activities were completed, and capacity allowed, or where new priorities emerged.

8.7 MCr thanked ES, KH and TP for their work on the Action Plan. MCr suggested the priorities be aligned to health inequalities (Core20Plus5).

8.8 JS noted that the Influenza Pandemic Plan was out of date and queried whether there could be a requirement for this to be submitted and whether there was an external deadline. KH said that this was in the process of being reviewed nationally and regionally to agree the best way forward. There was a very comprehensive Communicable Disease Plan which would cover most scenarios along with a Seasonal Plan which would cover ordinary influenza.

8.9 JCu observed that numbers of people with Influenza this year had risen substantially, and this looked to be on the same trajectory as the pandemic a couple of years ago. This was a huge risk to the system and having vaccinations available and being responsive was vital in the event of local figures escalating further.

8.10 JCu said that clarity would be needed around resources and intended delivery of the Plan. JCu referenced Terms of Reference and membership, noting that Adult Social Care of GCC were optional dependent upon discussions. It was critical that representation from residential care/nursing homes and other domiciliary care providers

be included as well as those from Public Health. **Action: KH to find out more about representation at future IPC meetings from Adult Social Care and report this back to the Committee.** **KH**

8.11 SM referred to resources and said that there was no extra workforce or money. TP said that the prioritisation exercise had been undertaken to examine areas of duplication. Much of the content such as vaccination had already been delivered and so further mapping would be examined to see where priorities were, and where they needed to be delivered. . It was to be noted that this was a five-year Plan, which would involve taking time to address some of the desired delivery aspirations.

***Resolution*: The Committee members gave approval to:**

- ***The continuation of the IPM group;***
- ***Responsibility of the IPM group delivering the Action Plan, once prioritisation was complete;***
- ***The IPM group continuing to report into the System Quality Committee on an annual basis, or by exception. The ICB would be accountable for the overall assurance of the Action Plan.***

9. Learning from Lives and Deaths of people with a Learning Disability and Autistic People (LeDeR) Annual Report 2023-2024

9.1 AL introduced her colleagues who were present at the meeting today and highlighted key areas of the Report:

- The Gloucestershire LeDeR Programme (as of 31st March 2024) had completed 54% of reviews of notified reviews. Gloucestershire has completed 81% of all reviews notified to the programme since 2017.
- Of the 22 reviews outstanding for the reporting period April 2023-March 2024, 11 had been completed and were presented to the Quality Assurance Panel during April to July 2024.
- Of the reviews completed during the reporting period, 94% were graded as receiving excellent or good care a 32% increase on the previous year (72%).
- In Gloucestershire, the leading cause of death in the learning disabilities population in 2023-24 was respiratory causes (n813 deaths). This is a 38% decrease on the previous year and could be attributed to reduction of Covid-19 infections.

9.2 Nationally 42% of deaths of people with a learning disability or autistic people were deemed avoidable, this compared to 24% for Gloucestershire and 22% in the general population. Of these unexpected deaths, 50% were due to respiratory causes, and 50% were gastrointestinal related.

9.3 The median age of death in Gloucestershire was 61.9 down from 63 years in 2022/23; this compared to 62.9 nationally in 2023/24 and 62 years in 2022/23. Five deaths under the age of 40 years of people with profound and multiple disabilities were reported to Gloucestershire LeDeR, impacting median age. In the absence of these five deaths the median age of death for Gloucestershire was 66.9 years. This, combined with the 30% increase in quality of care, indicated a positive impact of the LeDeR programme.

9.4 AL described the work done around Annual Health Checks (AHCs). The team were now fully staffed and would be able to assist at GP surgeries with the AHCs. It was intended to launch a mobile clinic into the community and a clinical toolkit had also been developed for professionals.

9.5 There was a short talk and presentation from Experts by Experience on a case study about the benefits of statutory advocacy access for family carers, particularly for those who might be an older family carer (who may have capacity issues themselves) looking after a loved one with a learning disability, autism or with major health challenges, who may not be able to decide on the right course of action to take for their particular needs.

9.6 HR said that actions from the learning had been identified:

- Talk to the person in charge of advocacy services, to highlight that there needed to be a way that family carers could obtain help from an advocate;
- Make sure the Council's advocacy videos showed the needs of family carers around advocacy;
- Include advocacy videos in future LeDeR newsletters.
- Learning was shared in the annual report, Gloucestershire LeDeR newsletters, easy read resources and presentations (including the Carers Partnership Board, Health Action Group, Autism Partnership Board and care providers and to the people who bought services for the Council and the NHS.

There was also shared learning across various forums demonstrated in the annual report.

9.7 JS noted that referring a death to LeDeR was not mandatory (so there would not be data on all the people who had died) but reference was made that as from July 2024, all people would have opted out from sharing their information prior to their death. AL explained that all those who had opted out would have been sifted at the national stage and would not have come to their local ICB, but this had changed so that every single death would be notified to the LeDeR programme, regardless of whether they had opted out. AL said that she would adjust this slide to reflect the correct wording.

9.8 MCr brought up extra work being required to address the median age of death and to also address those facing issues in minority communities. MCr offered to support the team in bringing about some changes. AL explained that the programme was trying to ensure that where organisations had responsibilities for health inequalities, that every attempt was made to reduce them. It was about matching the cohorts of people into the health inequalities programme and was part of everyone's business to do that work around health inequalities.

9.9 AL agreed with AR's comment about the importance of preventative work, saying said that the LeDeR team wanted to carry out this work in the first place in order to help prevent more drastic health issues arising further along, with all the toolkits at their disposal and to try to embed this as a whole system-wide approach. Thanks were extended to the LeDeR colleagues for bringing their Annual Report to the System Quality Committee meeting.

<u>Resolution</u>: The Committee members approved the Gloucestershire LeDeR Annual Report for 2023-2024.

10. <u>GHFT Water Safety Programme Update</u>

10.1 CB delivered an update to the Committee. Following a serious incident a comprehensive review of the Water Safety Programme had been undertaken. This had resulted in a number of actions having been flagged.

10.2 CB informed that there was just one action to be completed and then evidence would be presented to incorporate this into Business As Usual (BAU). CB had been pleased around significant progress having been made.

10.3 Pseudomonas and Legionella risk assessments were now in place and a wider review of all the water safety risk assessments by an external provider was ongoing. There were some areas in the Trust where the quality of the water was not as good as was desired. CB assured that a great deal had gone into the Water Safety programme and as a result of this, Gloucester Royal Hospital (GRH) had the lowest number of water borne pseudomonas aeruginosa bacteraemia.

10.4 It would be recommended to the next Risk Management Group within the Trust that the risk around water safety be downgraded, with reasons able to be demonstrated for that. The Chair and members were assured regarding the oversight and governance around the Acute Trust's Water Safety programme.

Resolution*: *The Committee members noted the update on the GHFT Water Safety Programme.

11. Proposed changes to the ICB Commissioning Policy on Anal Skin Tags and Risk Reducing Surgery Policy

11.1 *Anal Skin Tags Policy*

11.1.2 It was proposed that the existing policy on surgical treatment of anal skin tags that only funded treatment in exceptional circumstances, following a successful IFR application, be removed and replaced with a new policy that funded removal of skin tags in limited circumstances, based on agreed access criteria. These changes were expected to result in a small increase in the number of patients qualifying for surgical treatment.

Resolution*: *The Committee members approved the changes to the Policy on Anal Skin Tags.

11.2 *Risk Reducing Surgery Policy*

11.2.1 It was proposed that the existing policy on Risk Reducing Surgery be removed from the Effective Clinical Commissioning Policies list, as the policy simply described established clinical practice, as set out in NICE guidance, and was therefore no longer required.

Resolution*: *The Committee members approved the removal of the Risk Reducing Surgery Policy.

12. Patient Safety Incident Response Framework (PSIRF) update including internal audit response

12.1 Key Risks included:

- Failure of the ICS to establish and maintain structures to support a coordinated approach towards PSIRF would set the ICB at odds with its statutory responsibility to improve Quality.
- Failure of providers to implement PSIRF would set them in breach of their contract
  and would be detrimental to improvements in patient safety.

12.2 RM spoke about the governance and assurances required around PSIRF.

- BDO was currently auditing GHFT's PSIRF implementation. Early feedback had suggested that the audit was a tabletop exercise based on assurance documentation.
- In a recent NHSE Southwest Patient Safety Specialist meeting, ASW Assurance (an alternative internal audit provider) gave a presentation on their approach.

Rather than looking at the implementation of PSIRF as a piece of standard assurance work, they were looking at a maturity matrix model.

12.3 RM said that a system review needed to be considered and JCu queried resources. RM said it would be down to what BDO could offer as the ICB's auditors and whether this would be part of their existing audit plan.

12.4 JS said she thought that March 2025 could potentially be too soon to undertake a system review and thought it might be better done after 18 months; secondly the audit plan would need to be examined – this was a three-year rolling programme with certain things that had to be done via internal audit and any additional items would be added to their total number of days. A discussion at the Audit Committee could address the content of the internal audit plan and also whether there would be enough days in order to accomplish the work required.

12.5 RM felt also that March 2025 would be too soon to undertake a system review and that enough time needed to be given to demonstrate a new way of working. SM also had concerns that this could be too soon. PSIRF needed to demonstrate that it was being used effectively. Impact and outcomes were key, along with transparency, trust and culture and these were not criteria which could be audited. **Action: RM to circulate the BDO Audit Report to Committee members.** **RM**

12.6 HW said that BDO had been identified at internal auditors for GHC with a focus on PSIRF. They would begin to look at the impact of how far PSIRF had gone into embedded learning. It would be looked at alongside the huge cultural programme that was being worked up and rolled out where it was hoped some of the changes would be seen.

12.7 RM suggested that once GHFT and GHC's internal audit reports had been finalised then these could come back to this Committee to decide on next steps. JM said that this would have to be taken to GHC's Audit Committee for an agreed approach. JS said that the Audit Committee should have oversight of the assurance being given from providers and should look at the risk and assurances coming through those routes rather than duplicating anything.

12.8 JCu was of the opinion that PSIRF should sit on the System Quality Committee and was feedback that needed to be made. JCu felt that everyone across the system should have quality objectives, and this should not just be around PSIRF. JCu wanted to sight the reviews from the two providers which could then promote a discussion around where the system stood and whether or not it was having an impact.

Resolution*: *The Committee members noted the verbal update on the PSIRF.

13. Operational Pressures Escalation Levels (OPEL) Policy and Maintaining Quality in Pressurised Services

13.1 The policy had been circulated prior to the meeting and EO said the key update for the Committee was to advise that the OPEL policy had now been approved through the strategic executives. The policy explained the different levels and the actions required to reduce those operational pressure levels, with a key focus on patient safety.

13.2
- The national framework had been built into the policy, but the ICB had also worked with Adult Social Care and Brokerage colleagues, to agree local actions.
- The new framework had been designed to put in lower thresholds around escalation, meaning the system would be in OPEL 4 more frequently. Region

were fully aware of this, with many of the indicators in the new framework already having been incorporated into much of the system work.

- The step change would be seen simultaneously by colleagues across the system, so Region had been quite specific about a “go-live” date for the Acute framework. EO was yet to receive confirmation from Region.
- GHC was only appearing in the action cards at the point at which they were at OPEL 4 but when the national framework went live, it would then include community, mental health and NHS 111.
- A demand and capacity tracker was in place over the winter with the ability to give a good prediction of OPEL 4 surges, based on known issues within the system.
- Proactive working across the system needed to continue effectively at OPEL levels 2 and 3 to avoid going into OPEL 4.
- The OPEL framework needed to operate equitably, and issues needed to be understood from everyone’s perspectives, but the system was probably not yet quite at this stage. Changes for Brokerage had enabled this team to reach a sense of stabilisation through some recent difficult times.
- Good relationships between partners existed enabling collaborative teamwork and keeping patient safety as the priority.

Resolution: The Committee members noted the verbal update on the OPEL Escalation Policy.

14. Cenobamate Proposal

14.1 The Quality Committee was being asked to agree that Cenobamate be initiated by the GHFT epilepsy team, following local Multi-Disciplinary Team (MDT) agreement. This proposal had been approved by the ICB and GHFT Medical Directors. Additionally, the National Clinical Lead was strongly supportive. . AR confirmed that there were no differences around side effects or costs and that he and Mark Pietroni had been unanimous that this was the right decision for patients in Gloucestershire in which the National team had also confirmed in writing that they had agreed.

Resolution: The Committee members approved initiation of Cenobamate by the GHFT epilepsy team following local MDT agreement.

15. Quality Improvement Groups

15.1 Maternity

MCr said that Maternity were still on Enhanced surveillance and the Quality Improvement Group continued to meet fortnightly. A lot of progress had been made around the S31 notice and antenatal scanning and screening had been added to the list where good progress had been made. MH informed that scanning capacity for reduced foetal movement had been addressed with extra mitigation in place, in the form of access to cardiotocography (CTG) scanning to be able to assess the wellbeing of the babies.

15.2 MH said that some of the workstreams associated with the Section 31, were to return to Business As Usual. GHFT would be sharing with the Quality Improvement Group (process of check and challenge and the resulting actions coming from that.

15.3 Summary Hospital-level Mortality Indicator (SHMI)

The SHMI rate was still showing a rise outside of indicator levels.

A subset discussion was needed, and the quality of coding was perhaps not as good in Cheltenham as it was in Gloucester.

AR said the fundamental issue which needed to be explored was whether there was a coding issue or a quality of care issue, or both. Significant improvements had been seen in both areas so although progress had been made, the Quality Improvement Group (QIG) contiued to meet. It was added that Region would be conducting a Mortality Insight visit in the spring.

Resolution: The Committee members noted the verbal updates on the Quality Improvement Groups.

16. Escalation from Local Maternity and Neonatal System (LMNS) – Maternity Incentive Scheme

16.1 The purpose of the paper was to provide assurance to the Local Maternity and Neonatal System (LMNS) and to the ICB System Quality Committee that there was a plan in place to fund the Maternity and Neonatal Voices Partnership (MNVP) at the expected level, with an action plan to implement. The funding was in place, and there was a plan to utilise this; however, there would be a gap in MNVP leadership overall, as the Strategic Lead was leaving, Region needed to know that there was a plan in place in order that GHFT could proceed.

16.2 MCr noted that the plan still needed some work, but the funding was there, and figures were that £64k was being used from an £82k budget. JCu asked whether any more hours for workforce were needed or could the service deliver with the hours it already had and was this the right amount. MCr said the regional MNVP lead had been exceptionally good and had been advising Helen Ford and there was an expectation that all the money available should be used on this. TP said that there had been recognition that there were pockets of work that needed focus, but resources, until now, had not been available.

Resolution: The Committee members noted that there was funding to meet the requirements of the MNVP guidance and a plan in place to utilise the funding.

17. Meeting Review, Items for Escalation to the Risk Register and Any Other Business

17.1 There were no items of any other business
The meeting concluded at 17.07pm

Time and date of the next meeting:

Wednesday 5th February 2025 – 2.00-5.00pm
Shire Hall, Westgate Street, Gloucester GL1 2TG

NHS Gloucestershire ICB System Resources Committee

Meeting Held at 2:00- 3.30pm on Thursday 9th January 2025 as Hybrid Meeting via MS Teams and in ICB Board Room, Shire Hall Gloucester

Members Present		
Ayesha Janjua *(Chair)*	AJ	Non-Executive Director, ICB
Cath Leech	CL	Chief Finance Officer, ICB
Mark Walkingshaw	MW	Director of Operational Planning & Performance, ICB
Julie Soutter	JS	Non-Executive Director, ICB
Participants Present:		
Jaki Meekings-Davis	JMD	Non-Executive Director, GHFT
Sandra Betney	SB	Deputy Chief Executive Officer & Director of Finance, GHC
Jason Makepeace	JMa	Non-Executive Director, GHC
Paul Atkinson	PA	Chief Clinical Information Officer, ICB
Haydn Jones	HJ	Associate Director of Business Intelligence, ICB
Dan Offord	DO	Head of Digital Transformation and Portfolios, ICB
Kat Doherty	KD	Senior Performance Management Lead, ICB
In Attendance:		
Gerald Nyamhondoro	GN	Corporate Governance Officer, ICB
Dawn Collinson	DC	Corporate Governance Administrator, ICB
Dan Corfield	DCo	Associate Director ICS Programmes, ICB

1. Introduction and Welcome

1.1 The Chair welcomed members and others present.

2. Apologies for Absence

2.1 Apologies were received from Jo Coast, Mary Hutton, Will Cleary-Gray, Rosanna James, Ellen Rule, Graham Russell and Steve Brittan.

2.2 The Chair confirmed that the System Resources Committee meeting was quorate.

3. Declarations of Interest

3.1 DCo declared a new Interest as was standing in for Mark Golledge for today's meeting. DCo said he was a Trustee of Home Start Stroud & Gloucester, a charity that received ICB funding. This Declaration was noted on the Committee Declarations Log.

3.2 JS declared that her husband was no longer on the Board at the University of Gloucestershire so she would be updating her Conflict of Interest. This would not affect the meeting to be held today.

3.3 The Chair stated that she had registered her Conflict of Interest on the Register as there was a BDO (Internal Auditors) item on the agenda today and the Chair worked for them during her day job. As there were no decisions on that item, this would not be a problem.

3.4 Gill Morgan had asked for this article to be shared with the System Resources Committee members, and had provided the link attached.

The mythbuster: Buying 'innovative' drugs is not the best use of NHS funds | Daily Insight | Health Service Journal

4. Minutes of the System Resources Committee from 7th November 2024

4.1 The minutes of the meeting held on 7th November 2024 were approved as an accurate record of the meeting.

RESOLUTION: The System Resource Committee approved the minutes of the meeting held on 7th November 2024.

5. Action Log & Matters Arising

5.1. **16/01/2024, Action 30 - Investments & Benefits Review. January 2025:** On Agenda today. DCo to take feedback Evaluation of Key Projects away and report back to a future System Resources meeting. **Action to remain Open.**

5.2 **04/07/2024, Action 38 - Sharing and Learning from Productivity**. **January 2025:** Recommended to be postponed; however, JM said this could not be viewed in isolation (BAF 7 mentioned sharing and learning of productivity as being high risk). CL said that packs were still being worked on nationally and there was no timescale on these. When timescales were clearer, it could be decided to wait for these and/or do some benchmarking in between times. **Action to be Closed.**

5.3 **05/09/2024, Action 41 - ICS Finance Report including Savings Plan System Financial Risk Share. January 2025:** Information delays re dashboard. Now close to getting a dashboard which will support the risk share which will be circulated within the next couple of weeks. **Action to remain Open.**

5.4 **07/11/2024, Action 42 – Health Inequalities. January 2025:** On agenda for today. Commitment to sharing learning across organisations with a paper to go to the January ICB Board with a process of working through all the submissions against the Health Inequalities Framework which had now gone out to each partner organisation with opportunities to share that learning during discussions. **Action to be Closed.**

5.6 **07/11/2024, Action 43 – System Resources Workshop feedback. January 2025:** To be set in context of 5 year Operational Plan currently in train. Update to be brought to next meeting. **Action to remain Open.**

6. Evaluation of Key Projects Paper

6.1 The key change was to build on the success of the current Evaluation Advisory Group (EAG), with a refreshed approach to the Evaluation Review Panel (ERP) who were there to take a robust approach to the analysis and review of pieces of work in transformation portfolios and programmes.

6.2 The EAG were there to advise, guide and steer programmes. They would also frontload proposals and business cases with how they would be evaluated. The ERP would be looking at programmes which would have a significant impact, require assurance , or review concerns around performance or progress against plan. DCo suggested looking at membership so that more defined recommendations and endorsements could be made.

6.3 **Discussion/Q&A/Feedback**

- **SB - Q.** Gateway process and clarity around definitive programmes rather than other things defined as such. **A.** Definitions would need to be given for this approach.
- **Q.** Reviews should be conducted prior to implementation of a programme and also when in flight. **A.** Consistent methodology would be applied on programme backlog, meanwhile the EAP would be doing a similar job before a programme went into delivery mode and would provide that consistency whilst a programme were in flight.
- **Q.** Why not a series of gateways rather than different processes which could become complicated. **A.** DCo said he would look at this again to examine perceptions of what was meant by the gateway description and felt this was a valid query.
- **JS – Q.** Could use up valuable time if other consistent mechanisms in transformation programmes and Working as One were already in place.
- **JM – Q.** How could processes be simplified. Examples of work in flight could be good to see and share to give assurance and confidence that this would not be an onerous process and would be intuitive to follow.

Action: DCo to take feedback Evaluation of Key Projects away and report back to a future System Resources meeting. **DCo**

<u>RESOLUTION</u>: The System Resource Committee noted the paper.

7. Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Updates

7.1 The Chair said that any updates could be discussed prior to taking a revised version of the BAF to the ICB Board at the end of January 2025. The Chair asked for any comments on the BAF.

7.2 The Committee reviewed and discussed BAF 5. There was an agreement that this felt outdated and that a review of actions and mitigations was required prior being presented at the next Audit and Resource Committee's. It was felt the score of 12 did not reflect the current pressures within the System.
Action: The Committee recommended that the BAF 5 score be reviewed with a view to better reflect the increased risk due to mitigating actions having not delivered the required results to date, to allow the risk to remain at a score of 12. **MG**

7.3 JM said that this risk did not reflect where the system was at present. JM asked whether BAF examined the year as a whole or was a reflection to the situation today and queried whether there was an annual target for the whole year in the round for these risks as it was not something that would be changed weekly or even monthly. JM did not know what national guidance was around this.

7.4 JS thought this should be a rolling forward risk management system, reviewed every three months by individual Committees and by the Audit Committee from an assurance perspective.

7.5 The Chair asked JM whether due to the lack of integrated data and community performance around delivery of some of the transformational improvements, she was sufficiently assured. JM said that national guidance would better inform the ICB's timetable around delivery of some of these mitigating actions.

7.6 The Chair suggested the Lead Directors, when updating their risks on the BAF, could also indicate the impact of what waiting for some of that data could be on the current risks.

7.7 DCo informed members that there were three risks with a score of 12 or above on the Coprorate Risk Register assigned to the Committee.:

- One was around realisation of benefits in transformation programmes; the evaluation item discussed was part of the approach to ongoing management and mitigation of those risks.
- There was a risk around core UEC performance rated at 4x4 giving a score of 16 (which would be expected to be seen on the BAF at the next Board)
- There was one risk that had been changed which related to the delivery of transformation programmes whilst the system was under extreme operational pressure and had been changed to a likelihood of 5, consequence of 3 which would be a red risk of 15. This should be a relatively short term change.

RESOLUTION: The System Resource Committee noted the Risk Management Reports. NB: The updated CRR was circulated post this meeting, by GN.

8. Health Inequalities Internal Audit Report

8.1 Colleagues had received the report circulated prior to the meeting and it had been encouraging to see that the audit had identified some areas of strength as set out on page 3 of the report. However the audit did identify three areas of concern which were;

- It had been acknowledged that governance arrangements could be clearer, with work having been undertaken to strengthen these;
- In terms of addressing the recommendations within the information review, the ICB were establishing a System Outcomes Framework and focus areas for Health Inequalities analysis aligned to system strategic priorities;
- An overview of the Health Inequalities Framework would be brought to the ICB Board at the end of January which would include a summary of the responses received from each of the partners, together with some proposals on how it was planned to develop this.

8.2 The Chair commended the positive strength of the work highlighted in the report. A recommendation was made by the Chair that Health Inequalities should be a standing item on the agenda for the System Resources Committee.

8.3 JS referenced the diagram regarding delegation to the Board but noted that there was no upward reporting from the Health Inequalities programme. MW said that this would be added prior to the next meeting.

8.4 SB said that resources may need to be considered around any decisions being made and queried if the Committee was to be seeking assurance about what was happening elsewhere or whether this Committee were to be part of changing the landscape on Health Inequalities with any decisions being made around investments.

8.5 The Chair said it was her understanding that as a sub-committee to the Board, decisions around investments or changes to investments would not be made here; these would be recommended to the Board who would make final decisions on delivery of strategic objectives and resources for the system.

8.6 JM said that disinvesting or transferring of investments for certain services also needed thought and should be included within Health Inequalities discussions with reviews around proposals to disinvest and whether this was also part of this Committee's remit.

8.7 The Chair summarised that the role of this Committee was to examine Health Inequalities but also to ensure best use of resources; either investment, or disinvestment, in order to deliver systemwide priorities and objectives around Health Inequalities.

RECOMMENDATION: The System Resource Committee noted the information regarding the Health Inequalities Internal Audit Report. A recommendation was also made to have Health Inequalities as a standing item on the agendas for this Committee.

9. ICS Data Strategy

9.1 HJ explained, there had been a need and proposal for implementation of a systemwide ICS Information and Data Sharing Strategy and the Health Economics Unit from the Midlands had assisted with a draft. The aim was for the ICB Board to approve the ICS Data Strategy at the end of January 2025. Following this, a roadmap would be developed in order to deliver key components of the Strategy.

9.2 HJ emphasised the importance of citizens and carers being at the heart of the Strategy, with as much as possible being aligned to the ICS objectives. The Strategy also linked into Health Inequalities. HJ explained the structure of the Strategy which listed Operational and Commissioning advantages that this would bring.

9.3 DO said that there had been numerous amounts of feedback from system partners and had enabled the Strategy to focus on the Gloucestershire environment with a huge focus on citizens across the county along with the safe and secure retention of their data which of course would be ethically managed and supported.

9.4 Areas to work on were alignment, often due to capacity as well as more work around Operational Development and relational investment moving forward, alongside the delivery of enterprise architecture, really understanding what was impeding the ambition to bring all this to fruition, whilst bringing the whole system together to work as one.

9.5 From a resource perspective, it needed to be recognised that investment planning was also a priority of this and that a roadmap could be developed that would be delivered going forward.

9.6 Finance and planning assumptions had been built into the design of the Strategy and critical activity and joint controllership agreement would need to be fast-tracked, allowing acceleration of the information governance agreements and to confirm the used cases where data could be shared. Enterprise architecture would also need further examination prior to taking this forward.

9.7 JMd noted this had not been through the Finance and Resources Committee at GHFT, and it was important that this could go through their governance processes regarding decision making and ownership as quickly as possible. DO said that digital advice had been offered by colleagues in the Acute Trust. The Chair suggested this might be done virtually as the processes thus far had been robust.

Action: HJ and DO to take the ICS Data Strategy to the Finance and Resources Committee at GHFT. **HJ/DO**

JMa said this had come to the GHC Resources Committee and endorsed visibility across GHFT as soon as possible. JMa also mentioned the Digital Workforce Programme which was concluding at the end of 2026, so could give rise to options around cash savings etc.

9.8 DO said digital workforce was fully integrated into the Strategy incorporating the confidence of people using digital and data, as well as planning interventions driven towards increasing efficiencies and reducing clinical administrative time, which would be the two key areas of keeping workforce at the heart of the ambition.

9.9 Committee members were invited to send any other thoughts/questions they may have, to HJ and DO following this Committee meeting.

RESOLUTION: The Committee members endorsed and approved the ICS Data Strategy to be presented to the ICB Board, ready for their formal approval in January 2025.

10. Specialised Commissioning – Due Diligence

10.1 MW said that colleagues would be aware of the journey to delegation from the Board Report at the end of November where it had been formally agreed to support the Principal Commissioner model, working together with the other systems in the South West to commission Specialised Services from 2025/2026 (building upon the current shadow arrangements).

10.2 The paper described the due diligence process that the ICB was undertaking to support this process. Under the governance arrangements this Committee had responsibility for overseeing Specialised Commissioning delegation.

10.3 The due diligence work involved members of the Operational Planning and Performance team working with BI and finance colleagues in CL's team which has concluded that further due diligence work needed to take place and nothing had been identified to date which would prevent the ICB from moving forward with this process.

10.4 The paper also demonstrated an update (in section 4) on the finance arrangements and the implications as well as the ICB's position against the allocation for physical health services. It also highlighted the specific challenge around the mental health and learning disability allocations.

10.5 CL said the understanding of the physical health budget was greater than that of the mental health budget and whilst there was risk, it was understood with the variable elements of physical health contracts. .

10.6 The Chief Finance Officers (CFOs) had been more concerned about mental health specialist commissioning which had come along in September/October 2024, post the August briefing to the Board. Most of the funding had passed through to the Provider Collaborative, but due to little funding information provided, was work in progress for the Specialist Commissioning teams. There was a possibility of the ICB taking delegation without that understanding of funding due to a lack of national formula for Mental Health services, and it would probably be 2025/2026 before this work was completed. This would probably be quite complex and would require further refinement.

10.7 Risk across organisations was unknown and a concern had been flagged. SB said there had been little clarity around budgets and what was to be spent and where had been unknown.

10.8 CL said the other nuance around Provider Collaboratives was that the ICB was guided within the South West for the adult mental health services, and within the Thames Valley for the children's mental health services.

RESOLUTION: The System Resources Committee noted the update on Specialised Commissioning.

11. ICS & ICB Performance Report

11.1

- The many challenges being faced by colleagues around urgent and emergency care (UEC) performance had led to a declaration of a system critical incident. Emergency services across the country were under pressure particularly due to an early flu season which had resulted in significant numbers of flu related hospital admissions. infection control had also significantly impacted upon bed capacity and caused pressure to build in Accident and Emergency (A&E). This has meant long delays for some patients in the Emergency Department (ED) due to significant ambulance handover delays.
- There had been an overall improvement in diagnostic performance, albeit echocardiography remained a concern, despite the percentage of patients now waiting over 6 weeks had significantly reduced.
- It was highlighted there was the successful launch of the IUCS in November which had already made a significant contribution to coping with the current pressures.
- the launch this week of the Reforming Elective Care for Patients policy document which set out an ambitious programme for the redesign and improvement in performance of elective services. The full implications of that document were being worked through for the system
- Endoscopy waits was another positive area to highlight, with additional evening and weekend lists in place to reduce those waits. A Business Case was to be developed by the Acute Trust, aiming to put in place a more sustainable solution.

11.2 KD also summarised as follows:

- The latest cancer position had come out since the report had been written and unfortunately there had been deteriorations in the 28 day and 62 day

performances. Most of this had been due to capacity in the skin specialty and pathology turnaround times

- It was hoped to see an improvement in the next couple of months, of the 62 day performance as urology performance had seen a rise of around 20% in the 28 day diagnosis target. It was hoped this would also feed through into the later treatment time targets in the coming months.
- The diagnostic performance position had been very positive in October, but deterioration had been seen in November with a growing waiting list, despite stable activity. There was likely to be more urgent care demand on the diagnostic services as well as a potential increase in referrals which was being considered as the ICB entered the 2025/2026 planning round, particularly in the CT and MRI modalities where the system was at capacity.

11.3 The Chair referred to diagnostics, saying that things might be picked up during this process that otherwise may not have been, and wondered whether this would come through in increased activity further down the pathway. KD said this was hard to determine. Referral To Treatment (RTT) waiting lists were being examined and it had been noticed that a lot of this growth was not being driven by referral, rather by intra-hospital referral such as a patient being referred to a different specialty by another consultant, or by a lack of pathway stops. People were on RTT waiting lists for longer which potentially implied that things were more complex. A deep dive was to be conducted on this. **Action: Result of deep dive on RTT waiting lists to be brought back to a future Committee meeting.** **KD/MW**

11.4 JS referenced the General Practice section whereby 183,747 appointments had been delivered in October, which had been the highest appointment activity volume on record. JS wondered what types of appointments these were
D confirmed that the figure would have included those around the Additional Roles Reimbursement Scheme (ARRS) roles for primary care. There was not an ideal way of splitting those out as all that was available were the national statistics in that activity space currently. **Action: KD to liaise with Primary Care on local appointment activity data breakdown.** **KD**

11.5 The Chair observed that a lot more appointments were delivered in Gloucestershire compared to those in other areas and sometimes people were happy to wait for continuity to see the GP of choice and so were prepared to wait for an extra two weeks. The Chair felt that some of the data obscured the fact that patients locally were very happy with primary care and could get appointments.

11.6 DCo observed that the breakdown would be particularly useful and would provide intelligence on this for the Committee as GP colleagues were going through collective action, The Chair said that Gloucestershire was not taking as much collective action as was being seen in other areas and the ARRS roles had taken on what would have gone to GPs which had definitely helped with appointments being well managed during collective action.

RESOLUTION: The System Resources Committee noted the content of the ICS and ICB Performance report.

12. ICS & ICB Finance Report (Month 8)

12.1 CL said the year-to-date income and expenditure position was a surplus of £0.3m with a positive variance to plan of £5.0m. This was attributable to non-recurrent benefits within GHFT,

12.2 Month 8 was forecast break-even . There were risks within this around savings delivery in all the organisations with a theme of current plans not delivering being a common denominator. Working as One and P2 beds had not delivered in the ICB. In GHFT there were a number of schemes that had not delivered recurrently

12.3 The run rate for GHFT had reduced with good work around agency costs for both GHFT and GHC, which remained below the 3.2% national cap. Non-payment pressures had emerged in a number of areas around volume and pricing which were driven by demand as well as price. These were likely to remain for next year.

12.4 The ICB pressures continued around Continuing Health Care (CHC) and high cost placements out of county placements. There was an ongoing increased demand for packages of care, impacting the recurrent performance position. Non-recurrent measures were being identified to offset pressures, allowing the system to continue to forecast breakeven.

12.5 Cash was keeping on track and Capital Departmental Expenditure Limit (CDEL) continued to forecast break-even against the capital programme but there was significant slippage year to date which had not improved through Month 9. There was significant work to ensure break-even with the capital programme allocation having been maximised.

12.6 The Elective Recovery Fund (ERF) was below the delivery target, although the ICB was above the target which was 107%, it had set a local target of 118% but were below that target in terms of valuated activity.

12.7 The 118% would be contributed through a number of factors both from GHFT and it had been anticipated that the out of county providers would be over-delivering, based on their plans for the year.

12.8 Work had been taking place and continued around coding with examination to see whether this had been completed, and whether an impact of a coding review had been over-estimated within the plan. This work was currently still underway.

12.9 The Chair queried cashflow and CL said that more than £15m would be spent in the next couple of months. The £15m variance was the year to date position. The ICB would then have to spend what had been planned in Months 9-12 as well, which was a significant challenge for colleagues to deliver in both organisations as slippage had been greater than anticipated.

12.10 JS queried the cash management (provider cash holdings) part of the pack, realising that the ICB were now in Month 10, as this stated that the GHFT cash balance forecast at year end was for only 22 days cash cover.

12.11 CL said, no specific requirements around this but good practice would probably indicate a minimum of a month, which was why this was being pulled out in the reporting, and was being examined in more detail to understand it further. GHC's cash position was fairly positive and reasonably robust. GHFT had been working on pulling in some of their debtors to manage their cash position.

12.12 JM had found the month on month position very variable and wondered what was normal for others across the region.a SB said she could not give an acute trust comparator but said that GHC tried to ensure there was enough cash to manage the next five years of capital programme which was what their cash balance represented. The test was whether backlog maintenance could be kept pace with, and given the size of this for GHFT, the cash available would not cover this.

12.13 SB said NHSE had largely not bothered about cash in the last few years and there was no cash to cover backlog maintenance or for the new hospitals programme. Funding from the national pot (should it be allocated) would have to be utilised for any capital work required. The real strategic risk was not being able to keep pace with capital expenditure.

12.14 JS said that year end positions as a system would be scrutinised, and this was worth flagging that this was something that should be discussed at each System Resources meeting so that the position would not come as a surprise at the end of March. CL said the reporting would be looked at in order to bring that for a discussion at some point in the new financial year.

12.15 JS said if the system were going to be using more independent sector providers over the next few months to reduce waiting lists, she would assume their payment terms would be quite quick and wondered if this would be a pressure on the year end cash position.
CL said this would not be an area of increased pressure for the ICB and had been factored in. Looking into 2025/2026, there was no planning guidance which was yet to be issued but looking at reconciling the financial position and the elective planning guidance issued earlier this week. **Action: CL to bring back a report on financial reconciliation to the next meeting.** **CL**

RESOLUTION: The System Resources Committee noted the content of the ICS and ICB Finance Report

13. Any Other Business or Items of Escalation

13.1 There were no items of Any Other Business raised for discussion.

The meeting concluded at 3.40pm.

Date and Time of Next Meeting: Thursday 6th March 2025 – 9.30-11.45am

Minutes Approved by: System Resource Committee Signed (Chair): Prof Jo Coast Date: Thursday 6th March 2025