Gloucestershire Integrated Care Board Meeting

To be held at 2.00pm to 4.30pm on Wednesday 25 January 2023

Boardroom, Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE

(The meeting is also available via MS Teams)

No.	Time		Action	Presenter
1.	2.00 – 2.05pm	**Welcome and Apologies**	Information	Chair
2.	2.05-2.07pm	Declarations of Interests The Register of ICB Board members is publicly available on the ICB website Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk) Register of interests : NHS Gloucestershire ICB (nhsglos.nhs.uk)	Information	Chair
3.	2.07 – 2.09pm	Minutes of the meeting held on 30 November 2022	Approval	Chair
4.	2.09 – 2.11pm	Action Log Matters Arising Primary Care Out of Hours service.	Discussion	Chair
		Business Items		
5.	2.11 - 2.15pm	Questions from members of the public	Discussion	Chair
6.	2.15 – 2.30pm	Patient Story	Discussion	Tracey Cox
7.	2.30-2.40pm	Chief Executive Officer Report	Discussion	Mary Hutton
8.	2.40 – 3.10pm	Integrated Finance, Performance, Quality and Workforce report	Discussion	Cath Leech Mark Walkingshaw Marion Andrews Evans Tracey Cox
9.	3.10-3.25pm	Planning and Joint Forward Plan	Discussion	Ellen Rule
10.	3.25 – 3.40pm	Fit for the Future (FFTF) – Review of Phase 1 Benefits & Costs	Discussion	Ellen Rule / Micky Griffiths

		Items for decision		
11.	3.40 – 4.00pm	Extension of existing Section 75 (joint funding arrangements) between Gloucestershire County Council (GCC) and NHS Gloucestershire.	Approval	Kim Forey
12.	4.00 – 4.05pm	Emergency Preparedness Resilience and Response Assurance	Approval	Marion Andrews Evans
		Information items		
13.	4.05 – 4.20pm	Chair's verbal report on the Primary Care & Direct Commissioning Committee meeting held on 1 December 2022	Information	Colin Greaves
		Chair's verbal report on the Quality Committee meeting held on 14 December 2022	Information	Prof Jane Cummings
		Chair's verbal report on the People Committee meeting held on 12 January 2023	Information	Clive Lewis
		People Committee minutes 6th October	Information	Clive Lewis
		Chair's verbal report on the Resources Committee meeting held on 12 December 2022	Information	Prof. Jo Coast
14.	4.20pm	**Any Other Business**		Chair
		Time and date of the next meeting 2.00pm – 4.30pm 29 March 2023, Boardroom, Sanger House.		

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.

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Gloucestershire Integrated Care Board Meeting

2:00pm – 4:30pm, Wednesday 30th November 2022

Boardroom and Virtually at Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE

Members Present:		
Dame Gill Morgan	GM	ICB Board Chair
Mary Hutton	MH	Chief Executive Officer
Julie Soutter	JS	Non-Executive Director
Colin Greaves	CG	Non-Executive Director
Clive Lewis	CL	Non-Executive Director
Prof. Jane Cummings	JCu	Non-Executive Director
Prof. Jo Coast	JCo	Non-Executive Director
Dr Marion Andrew-Evans	MAE	Chief Nursing Officer
Cath Leech	CL	Chief Finance Officer
Dr Andy Seymour	AS	Chief Medical Officer
Tracey Cox	TC	Interim Director of People, Culture and Engagement
Ellen Rule	ER	Deputy CEO/ Director of Strategy and Transformation
Prof. Sarah Scott	SS	Executive Director of Adult Social Care & Public Health, Gloucestershire County Council (GCC)
Siobhan Farmer	SF	Director of Public Health (GCC)
Deborah Lee	DL	Chief Executive Gloucestershire Hospitals NHS Foundation Trust (GHFT)
Paul Roberts	PR	Chief Executive - Gloucestershire Health & Care NHS Foundation Trust (GHC)

Participants:		
Ingrid Barker	IB	Chair of Gloucestershire Health and Care NHS Foundation Trust (GHC)
Deborah Evans	DE	Chair, Gloucestershire Hospitals NHS Foundation Trust (GHNFT)
Cllr. Carole Allaway-Martin	CAM	Cabinet Member for Adult Social Care Commissioning, Gloucestershire County Council (GCC)
Chris Spencer	CS	Director of Children's Services, Gloucestershire County Council (GCC)
Mark Walkingshaw	MW	Director of Operational Planning & Performance, (GICB)
Kim Forey	KF	Director of Integration (GICB)
Dr Paul Atkinson	PA	Chief Clinical Information Officer (GICB)
Matt Holdaway	MHo	Director of Quality and Chief Nurse, (GHFT)

In Attendance:		
Micky Griffith	MG	Programme Director, Fit for the Future (GICB)
Jill Parker	JP	Engagement and Partnership Lead, Gloucestershire VCS Alliance
Chris Davis	CD	Senior Project Officer, Health Communities, and Individuals, (GICB)
Nikki Richardson	NR	Chair, Healthwatch Gloucestershire
Christina Gradowski	CGi	Associate Director of Corporate Affairs (GICB)

Becky Parish	BP	Associate Director of Patient & Public Experience (GICB)
Lauren Peachey	LP	Corporate Governance Manager (GICB)
Ellie Finch	EF	Guest - Member of the Public
Amber Penton	AP	Guest - Member of the Public
Alex Hodgson	AH	Guest - Member of the Public
Jenny Ragowski	JR	Guest - Member of the Public
Brendan McInerney	BM	Member of the Public

1.	**Welcome and Apologies - Chair**
1.1	Apologies were noted from Mark Cooke, Dr Olesya Atkinson, Dr Jo Bayley, Pete Bungard, and Helen Goodey.
1.2	The Chair confirmed that the Board of the ICB was quorate.
1.3	The Chair informed the meeting that South West Ambulance Service Trust (SWAST) had appointed Stephen Otter as their new Trust Chair, he had previously held the position of Chief Constable of Devon & Cornwall and was a Non-executive director at Taunton NHS Foundation Trust and has a reputation for driving strategic change.
2.	**Declarations of Interest**
2.1	The Chair advised that all members were required to declare relevant interests at every ICB Board meeting. The Chair also advised that it was in line with best practice to consider any potential conflict of interests at each meeting. No interests were declared.
3.	**Minutes of the Previous Meeting**
3.1	There were two amendments to be made to the minutes of the meeting held on Wednesday 28th September 2022 as follows: • Micky Griffths should be recorded in the attendance list on page 2 of the minutes; • The phrase was “linking key strategic risks” on page 14 in the discussion on the BAF. Subject to the changes made the minutes of the meeting were approved as an accurate record of the meeting.

4.	**Action Log and Matters Arising**
4.1	**Action Log:** There were no actions from the meeting on 28th September.
4.2	**Matters Arising: Update on Urgent and Emergency Care**
4.2.1	ER explained that the Winter Plan had been refocussed and provided an overview of the work being undertaken to support Winter and Urgent and Emergency Care (UEC) across the system. The Winter Plan demonstrated the breadth of work being undertaken with a refocus on working with communities on self-care and prevention.
4.2.2	The Winter Plan was underpinned with a communications strategy. Case studies will be used within communications to the public. A successful and well attended Facebook Live event, with interaction from members of the public, was held during November. This will form part of the ongoing forward communications campaign to focus on positive stories about the UEC transformation. Some of the case studies in the Winter Plan will form part of the forward programme of working with the local media.
4.2.3	Significant investments which had been made were starting to materialise; some of the new space in the discharge waiting area had been opened and also the Prescott redevelopment was on track. There was significant capital and estates transformation being made around the UEC pathway to support patient care. There was also significant performance improvement which had been seen at the front door of the Emergency Department, but there was less traction to date on the back door (discharge planning), and although progress was being made, system-wide this was proving to be more challenging.
4.2.4	In terms of the Newton diagnostic, the work was moving into the phase of planning a comprehensive implementation programme to bring about the benefits set out in the Newton diagnostic findings.
4.2.5	In summary the span of work being undertaken in the UEC programme covered a broad range of bases and the new national monies recently announced for Winter Planning would enable system partners to work up a plan, collaboratively.
4.2.6	DE asked how the winter monies received nationally would support the work around discharge planning and help to resolve the issues. ER responded that the this funding should be split between capacity and implementation support.
4.2.7	PR emphasised the important of undertaking the work around the Winter Plan at the scale and pace that needed to be done.
4.2.8	SS stated that the money may have to be spent by 31 March 2023 due to the very robust reporting regime and clear metrics that were required for national reporting.

	An outline plan was almost ready for sign off with the Executives, but it was recognised that there was further work to do to help the system through this winter.
4.2.9	SS reported that Gloucestershire County Council was waiting for details of their allocations which would arrive around 21st of December, after the Council's consultation on their budget. The monies would be used to provide additional support for adult and children's social care.
4.2.10	**RESOLUTION: The ICB Board noted the high quality of work from all staff involved in producing the material for the Winter Planning document**
5.	**Questions from Members of the Public**
5.1	The Chair informed the members that a petition had been received to which the Board needed to respond. As this involved a named individual, the Chair felt it was important to respect confidentiality and stated that it was not appropriate to expand further at this point. A meeting had been held today with key people who had submitted the petition and matters were in hand to effectively respond to that petition.
5.2	Several questions had been received from Mr Burton a member of the public as follows: 1. Will Gloucestershire ICB endeavour to meet all the above objectives of "Our Plan for Patients"? 2. In implementing "The National Endeavour" will all known volunteers (and their support organisations) be retained and expanded? 3. "What is Gloucestershire ICB proposing for services to meet the published "NHS Plan for Patients and National Endeavour" in relation to much needed action following the latest "PHE Prescribed Medicines Review and a Key Recommendation - To Improve the support available from the healthcare system for patients experiencing dependence on, or withdrawal from, prescribed medicines"? "As a family carer, I would stress that such involuntary dependence affects several other persons as well as the sufferer". 4. What progress is being made in Gloucestershire ICB on the STOMP (Stopping the Over-Medication of People with a Learning Disability, Autism, or both) Project? Can Glos ICB obtain statistics on the number eligible for withdrawing, and the number actually receiving appropriate help from Glos Health & Care NHS, GP's, pharmacists, and other prescribers? Dr Andy Seymour and Kim Forey answered the questions at the meeting. The ICB response to the questions would be sent to the member of the public via email. A copy had been posted on the ICB website https://www.nhsglos.nhs.uk/news/nhs-gloucestershire-icb-public-board-meeting-2-00pm-5-00pm-27-july-2022/
6.	**Patient Story: Healthwatch**

6.1	Nikki Richardson shared a case study of a man, Jack (pseudonym), working full-time and not receiving any income benefits. The high cost of living meant that Jack had to cut back and reduce his spending on many essential items, including his car. He recently injured his hand which became infected to the extent that he knew he needed antibiotics, but could not afford the prescription and tried to look after his own wound. Jack ultimately ended up paying twice for his antibiotics as the infection became more severe, once by going to the Out of Hours Service and again by having to visit his GP. He contacted Healthwatch to see if there was any help with prescription fees for him as he thought he would not be the only person in this predicament. Jack was struggling with the cost of food shopping and having to pay for two prescriptions which had an impact on his ability to purchase sufficient food for the week.
6.2	AS commented that this situation had been seen with inhalers where people earning similar income ranges cannot afford prescription charges. IB informed the meeting that GHC had set up a charitable hardship fund which was available to staff colleagues. In the first couple of weeks of this being available, the demand had been considerable and clearly demonstrated it was needed. IB considered that as a system, colleagues could consider what further work could be done on the cost of living crises affecting staff and patients.
6.3	The Chair suggested opening up discussions with NHS charities and Gloucestershire chairities on what more could be done with supporting people during these particularly difficult times. The Board committed to undertaking: • Sharing Jack's story with local MPs; • Working with charities and voluntary groups to assess what further support could be provided to people; • Lobbying around individual conditions, and broadening this subject; • Debating the thresholds for payment around people who are in work but on low incomes.
6.4	The Chair announced that the SW Regional Director had identified around £300k per ICB to be used to help people with poverty, heating and food through the winter. Work will be progressed on agreeing on how that one-off sum of money can be used over this winter.
6.5	JS queried as to whether there was data about the Out of Hours (OOH) GP service to show a breakdown of attendances and if many attendances were similar to Jack's situation. AS responded that it was possible that there was a misunderstanding about being able to obtain free prescriptions from the OOH service in Jack's case, but the full circumstances here were not entirely clear. The Chair commented that the exact details of this case were not known but this area of work would be further explored.

6.6	The Chair thanked NR for attending the meeting and sharing Jack's story. The Chair also acknowledged the valuable contribution from Healthwatch, stating that it enabled the Board to see things through the eyes of the people who receive local health services.
6.7	**<u>RESOLUTION</u>: The ICB Board noted the patient story from Healthwatch**
7.	**ICB Chief Executive Officer Report**
7.1	MH provided a brief overview of her report. MH explained that Active Gloucestershire was at the heart of the charitable organisation We Can Move (WCM). The population as a whole had become more inactive and by 2030, that figure was expected to increase by 30%. The ambition of WCM was to halve that figure and to prompt other organisations to carry out work which aligned with the goals of WCM. Activity had been proven to reduce hip fractures and diabetes in our population.
7.2	MH explained that NHS Gloucestershire ICB was one of the founding partners of WCM and held a contract with Active Gloucestershire for the delivery of WCM. The structure represented a move to a more relational commissioning model whereby the contract funding represented a contribution, as an equal partner, towards the whole movement rather than a traditional commissioner/provider relationship.
7.3	MH spoke about tackling homelessness in Gloucestershire. A Homeless Patient Project in the Emergency Department (ED) at GHFT was the catalyst for change. This project led to an approach being made to the Gloucestershire Strategic Housing Partnership (SHP) which was a partnership made up of the six district councils, the county council and the ICB. By working as a wider partnership with the local authority and voluntary and community sector organisations (VCS), health and care professionals joined forces to make sure homeless patients received the right support following discharge from ED.
7.4	Staff working in ED had experienced a cultural shift after being taught about the tri-morbidity of homelessness which means a homeless person was more likely to suffer from mental ill health, physical ill health, and substance misuse and at the same time more likely to access services. Education about homelessness empowered professionals to swiftly identify the risks to patients who experience tri-morbidity so that support could be put in place sooner.
7.5	MH explained that currently, there was not a homeless person in the top 30 of those who attended the ED the most. This was a striking comparison with 2020, when seven out of the top 10 of those who attended ED were homeless. GHFT was the only acute trust in the South West, which currently had no homeless people who attend the Trust on a frequent basis.
7.6	MH highlighted that there was a new Medical Centre in Stroud. The redevelopment of Number 1 King Street in Stroud was nearing completion and central to this work was the brand new £6.5m medical centre which will become the new premises of

	two of the town's established GP practices, Locking Hill Surgery and Stroud Valleys Family Practice, now merged to become Five Valleys Medical Practice. The building will house the medical practice and a physiotherapy and podiatry suite operated by GHC. These services would be merged into one comprehensive clinic, ensuring the best use of the estate. The new facilities would offer improved accessibility for patients, being in a central part of the town, within a short walk of the train and bus stations, a taxi rank and other amenities, including pharmacies.
7.7	In terms of the workforce, there had been a successful Health & Social Care Recruitment Day during September to give people interested in a caring role in Gloucestershire the chance to embark on a new career in Health and Social Care jobs. Work was continuing in this area to onboard people into their new roles.
7.8	MH explained that the Equality Delivery System (EDS) system helped NHS organisations improve the services they provide, including better working environments, free of discrimination, for those who work in the NHS, whilst meeting the requirements of the Equality Act 2010. A progress report would be brought to a future Board.
7.9	The Chair commended the work carried out on the Diagnostic Centre at Quayside which had had many changing parameters and to which a solution had been found.
7.10	CL referenced Section 2.2 of the Chief Executive report where there was a business case on how physical activity could reduce various health conditions. CL wanted to ensure that the initiative was picked up broadly and with an equal spread around communities, in particular where there are higher levels of deprivation.
7.11	MH responded that We Can Move focused on areas with high need. Some of this work fed into the Frailty strategy and other plans. Health inequality was central to both those pieces of work and health inequalities was being monitored through the Health and Wellbeing Board.
7.12	**RESOLUTION: The ICB Board noted the contents of the ICB Chief Executive report.**
8.	**Maternity & Neonatal Services Update**
8.1	The Chair provided an overview of the importance the independent investigation into East Kent Maternity & Neonatal Services and how the ICB Board needed to assure itself of the quality of service provision in maternity & neonatal services.
8.2	MHo informed the Board that work was underway within Maternity Services at GHFT to transform and improve the service, concentrating on leadership and staffing appointments which will enable a strengthened team to provide good quality services to women and their families.
8.3	It was noted that the East Kent Report highlighted issues at every level within the organisation. It was important that this was borne in mind in our response, which

	would be made collaboratively as ICS and within the Local Maternity and Neonatal Service (NMNS) in a joined-up way.
8.4	In Febuary 2020 NHS England commissioned Dr Bill Kirkup to carry out an investigation into the Maternity & Neonatal Services in East Kent. The primary reason for the report was to set out the facts surrounding a series of complaints and investigations over a number of years about the service at the Trust. The report highlighted systemic failures in the service with a set of key findings and reommendations. The report set out the devastating consequences of failings and the unimaginable loss and harm suffered by families. There were problems at every level - failures to listen and in teamworking, professionalism and compassion. This report reconfirmed the requirement for Boards to remain focused on delivering personalised and safe maternity and neonatal care. It was noted that other maternity & neonatal ervices, including Gloucestershire were reviewing their services against the standards required and to learn from the report.
8.5	The East Kent Report identified four key action areas. 1. Monitoring safe performance – finding signals amongst the noise 2. Standards of clinical behaviour - technical care is not enough 3. Flawed team working - pulling in different directions; 4. Organisational behaviour – looking good while doing badly. Each of the areas had been reviewed and benchmarked and the LMNS was on an improvement journey. The actions outlined by Dr Bill Kirkup fit in with that journey and GHFT was keen to make to ensure good quality services were provided.
8.6	GHFT reviewed the performance of their Maternity Services closely; a review was commissioned in 2020 and colleagues flagged some concerns in July 2020. An Executive-led Maternity Deliver Group was set up to monitor the delivery of the Improvement Plan in Feburary 2021, and this group still continues. The Care Quality Commission (CQC) conducted an inspection in April 2022, resulting in a Secion 29A. Work had been undertaken to address the issues raised and it was hoped that S29A would be closed with CQC Regulators later in December.
8.7	Overall, the service had received an 'Inadequate' rating from regulators. An underlying challenge, along with maternity services throughout te country, was the issue around midwifery staffing. There were national shortages which impacted the ability of staff to deliver care amongst the breadth of services provided in Gloucestershire.
8.8	Leadership was vital to how the service operated. A Band 9 Director of Midwifery post was currently out to advert, which was supported by senior colleagues. A strategy for the service was in development underpinned by broad staff engagement at all levels. There were improvement plans in place, responding to the recommendations of the Ockenden Reports and CQC Action Plans. This Report will be included within that suite of improvements.

8.9	The GHFT CQC rating for 'Caring' remained rated as 'Good'. Staff care about the women and families that they care for, and there were positive Patient Experience comments which reflected well when compated to other Trusts. Culture was identified as an 'Area of Improvement' by the CQC and one which GHFT was working on. A Leadership and Organsiational Development specialist was working specifically in Maternity Services and the implementation of the Action Plan was being led by the Director for People and OD.
8.10	A recent inspection was conducted by the Regional Maternity Team for which formal feedback was largely positive. Compliance against the essential actions outlined in the first Ockenden Report was inspected and in the six monthly intervals, the inspection had improved, around transformation and engagement of staff with changes that had taken place.
8.11	NHSE will work with the Directorate of Health & Social Care (DHSC) to review the recommendations and implications of the East Kent Report. It was noted that with the vast range of improvement plans that there are within Maternity Services, GHFT was looking forward to bringing together all the actions in the various Reports into a single oversight document.
8.12	JC raised a question as to what the impact on staff morale had been and how this might affect recruitment and retention of staff. MHo responded that this had affected morale. Over the last six months, the senior team has spent a great deal of time engaging with staff and involving them with the improvements required. The Chief Midwife of the Region, on her recent visit, felt that staff were more engaged, and whilst morale was challenging, it was improving.
8.13	CS asked if it was possible to target those vulnerable young women who are looked after, or were care leavers, who were pregnant and felt afraid and uncertain about becoming mothers. DL stated that there was additional support available for this group of women and there were named midwives associated with safeguarding and other vulnerable groups, so this is in place, but potentially was an area where more could be done.
8.14	**Action: KF and MHo to provide an update on work being undertaken to support vulnerable pregnant women, including services available to this group of women to be reported to the Board.**
8.15	KF explained that within the LMNS, time had been spent over the past year on focusing on co-production and there had been fantastic feedback from mothers which was fed back to the staff providing that service, which contributed to boosting their morale.
8.16	The Chair stated that at the heart of this, she was hearing that there had been many different views about the maternity process between obstetricians and midwives.

	Both voices were heard and there was not a fundamental difference in the model of good and effective midwifery and obstetric care.
8.17	MHo explained that the management and leadership reviews were based on a quadrumvirate within Maternity, whereby midwives, obstetricians and others, with mothers and LMNS worked together to develop services and hold themselves to account. MHo had been party to conversations where the overlap between obstetrics and midwifery care was discussed very openly, transparently and positively and he would echo the Chair's observations.
8.18	DL commended MHo's leadership, passion and commitment. The Chair thanked MHo for tackling the challenges for all the good work that he and others were doing to improve services.
8.19	**RESOLUTION: The Board noted the steps that GHFT had taken on the initial reflection on the Report by Dr Bill Kirkup to which a more formal response will be made in early 2023.**
9.	**Integrated Finance, Performance, Quality and Workforce Report**
9.1	MW explained that the Integrated Finance, Performance, Quality and Workforce Report continued to develop and this month revealed some of the progress against the Core 20 plus 5 areas within our health inequalities strategy. Early work showed access to elective and cancer services.
9.2	A positive impact has been made with regard to system actions around ambulance handover delays in ED performance during October and early November. The six key metrics reflected in the Winter Plan will be reviewed weekly and these remained a key focus.
9.3	Planned Care performance continued to be strong and additional weekend lists were reducing waiting times for patients. The independent sector partnership that the Trust has developed for haematology services had been positively received by patients.
9.4	Diagnostic capacity funding was confirmed and will be rolled out 2023 offering additional capacity across a number of modalities. The waiting list for echocardiography was still an issue, and this area had received additional capacity with activity now at 20% above 2019/20 levels, enabling inroads to be made into the backlogs.
9.5	In terms of Cancer performance, the 62-day position had deteriorated across the Southwest region. The ICS had a revised trajectory and there was a strong commitment to maintain and deliver the March 2023 target. Pathology had been contributing to some of the cancer delays and good progress has been made to resolve those issues.

9.6	Primary Care performance continued to be strong with appointment volumes above plan with strong performance against the national metrics in relation to access and patient experience.
9.7	Progress has been made in Adult and Children's Mental Health services but ongoing challenges remained in Out of County placements and Eating Disorders services, but the report shows some of the positive actions had been taken.
9.8	Joint work has been undertaken with GHFT, looking in detail at elective waiting lists. Although there were no obvious variation in these or waiting times according to deprivation and ethnicity, there were significant differences in terms of how patients access services; particularly those from more deprived areas and minority groups who tended to struggle to attend outpatient appointments. Further analysis was being undertaken and would brought back to the Board in January.
9.8	It was noted that people who were diagnosed with cancer early on have much better outcomes but deprivation was a well-documented driver of later cancer diagnosis. Further work was being undertaken to fully understand and respond to those differences, which related to access to Primary Care service.
9.9	In terms of the workforce, TC explained that a shortlist of ideas had been drawn up to help staff cope with the cost of living pressures. Work was being undertaken to fund and operationalise those proposals.
9.10	Across the system, partners were making plans for industrial action which would take place on 15th and 20th December. The ICS self-assessment checklist was submitted to NHSE on 28th November and set out the areas for further work. Further clarification on areas of derogation was required. Providers in Gloucestershire will be amongst those impacted by the industrial action.
9.11	The ICS had a number of key workforce priorities including our health and wellbeing offer to staff across the ICS, our approach to international recruitment, and reducing agency costs in the workforce.
9.12	MAE provided an overview of the quality report within the IPR; there were four key domains, assurance, safety, effectiveness and experience. There was a close working relationship between the ICB and GHC and GHFT and ICB staff were fully engaged and welcomed into those organisations, ICB colleagues attend both Trusts' Quality Committees and get good quality information and conversations with regard to the quality of services at both trusts and the challenges they face. Both Trusts have their CQC Inspection Reports and Action Plans on which good progress is being made.
9.13	A face to face conference was held for practice nurses with 70 attending with very positive feedback on the content and organisation of the conference. One general practice had its CQC inspection which resulted in a 'Requires Improvement' notice.

	In response a full support package from the ICB including primary care and quality staff were going into that practice to support the quality of care.
9.14	Serious Incident reporting was decreasing and at the last Quality Committee there was a focus on the new Serious Incidents Response Framework, which would be implemented in 2023. Any incidents which had occurred in Maternity Services were reported to the HCIP for investigation. It was noted that there have been no more Never Events since June 2022.
9.15	DL informed the Board that with regard to theatres there were no Never Events for 328 days, which was really positive. The CQC had been invited in to walk the pathway for Pre-empted patients and Boarded patients. The visit will take place shortly and would provide the Board with some external assurance that patients were safe and safer than those waiting in the community for an ambulance. MAE stated that the CQC was pleased that they had been invited and this demonstrated the openness of the Trust.
9.16	There had been a number of surveys published around Patient Experience, with the Friends and Families data due to come out soon. These surveys will be discussed in more detail at the next Quality Committee.
9.17	The first meeting of the System Effectiveness Group was held which looked at the effectiveness of ICS patient pathways reviewing if patient pathways made best use of information on best practice and achieved the best outcomes for patients.
9.18	CL gave an overview of the financial position. Within the ICS year to date (YTD) the current deficit position was £7.7m. All organisations were forecasting delivery of a break even financial position at year end in line with the plan. The YTD position was driven by GHFT financial position and the overspend against their plan was due to a number of reasons. Workforce was a key one of those in terms of vacancies, retention, sickness and locum and agency costs. Urgent and Emergency Care pressures were causing slippage in savings and inflation was also contributing towards the deficit.
9.19	Across the system a number of programmes had been implemented some were on track as planned others were not and there was financial slippage associated with some of those programmes and individual schemes. Each of the programmes had been risk-assessed; and the slippage and delay with some programmes / schemes meant therefore as a system achieve a break-even financial position was forecast. This position was carefully reviewed on a monthly basis. We cannot as a Board agree the next steps in changing the forecast - there is a protocol which would need to be undertaken as a system in order to do that.
9.20	The system as a whole has started on planning for next year and one of the key areas is to look at the underlying financial position and what the recurrent position will look like. The significant deficit numbers are currently being worked through, some of which will be mitigated non-recurrently next year. We are looking at the key

	areas of transformation which must be progressed, in particular UEC and workforce. There are other transformation areas identified which will help us ensure financial sustainability across the system.
9.21	We are achieving our Better Payment policy code thus paying invoices on time which is important for our suppliers. We are on track to deliver the Mental Health Investment standard for this financial year. The elective recovery target is on track for delivery and the independent sector are ahead of their planned trajectory and are helping us to keep on track.
9.22	SF spoke about the health inequalities aspect of the Report and was very reassured that this area was being examined and thanked MW for the work involved. The Chair had put colleagues in touch with the NHS Race and Health Observatory who were addressing some of the pockets of inequality which was really positive. SF said that regarding the earlier detection of cancer, we could look for support from the NHS Screening and Immunisation team. The Chair said we could also use Public Health data to describe what we are trying to do, and what we aspire to, as a system. AS informed the Board that Rosebank PCN had already done some screening work. It would be a good idea to liaise with Dr Charlie Sharp, Respiratory Consultant at GHFT around bringing this work together and then back to the Board for further discussion.
9.23	JS asked whether there were any themes arising from the recent Staff Health & Wellbeing day. TC said that feedback had been very positive and more formal feedback will be available at a future meeting.
9.24	The Chair summarised the cross-organisational work which demonstrated collective learning, sharing, curiosity and helping each other. Maintaining and sustaining this fresh approach would definitely be a step in the right direction as a Board.
	RESOLUTION: The ICB Board: **1. Noted the key highlights from the Integrated Performance report.** **2. Reviewed the format of the first Integrated Performance report and provided comment and suggestions to support future development.**
10.	**ICB Board Assurance Framework (BAF) and Risk Appetite Statement**
10.1	TC explained that at the last Board Development Session the development of the BAF and ICB's approach to risk appetite were discussed along with a draft of the system wide strategic risks. Since that meeting there had been significant engagement with board sub-committees and executive leads on the strategic risks which comprised the BAF. This feedback was reflected in the report before the Board.

10.2	The BAF was an iterative process and would be refined and improved. It was designed to provide an overview of the controls and assurance mechanisms that were in place to help manage the key strategic risks facing the system and identify any possible gaps in controls and assurances.
10.3	At the last Audit Committee consideration was given to the draft Risk Appetite Statement; which was presented to the committee and feedback was provided by members and the ICB's internal auditors, that feedback has been reflected in this report.
10.4	JS stated that the Audit Committee recognised the work accomplished since the previous committee meeting in September and thanked staff for their input. The BAF still needed further work; in particular the Executive Directors summary should be completed as this would provide an update on the risks. The aim was for specific strategic risks go to specific committees so that they could begin to think about those relevant risks in the context of their future agendas to help inform future discussions. JS spoke about matching the colour coding from the Appetite to the Strategic Risks but this can be worked through as the BAF was used.
10.5	MAE explained that the Quality Committee had just been through their Emergency Preparedness Reslience and Response (EPRR) Assurance process which also reviewed risks within this area. MAE confirmed that an updated report on EPRR would be made available to the Board at its January meeting. The South West Region would be looking for one of the risks to be identified as EPRR in our Risk Management Framework. MAE was working with CGi on a small addition to this framework
10.6	The Chair considered that the management of risk would be vital to agreeing some difficult system wide decisions. The Risk Appetite Statement should be reviewed by the Board on an annual basis.
10.7	JCo thought that the risks on Inequalities and Outcomes were different to that of other risks and should remain separate. The Chair thought this was a fair point and asked the the BAF reflect the separation.
10.8	**<u>RESOLUTION</u>: The ICB Board noted the contents of the ICB Board Assurance Framework and the Risk Appetite Statement.**
11.	**Fit for the Future - Outcome of Engagement Report**
11.1	ER clarified that, subject to the Board's decision, a business case would be developed in the New Year and would be submitted to the Board for decision in March 2023.
11.2	MG informed the meeting that in October, the Health Overview and Scrutiny Committee (HOSC), considered the Output of Engagement Report. The committee noted the breath and depth of engagement on FFTF and commended the high quality of the report. The HOSC did not raise any concerns with the level of public

	involvement activities completed to date and there were no further requests for public involvement on the proposed changes. Subject to the ICB's position, the NHSE SW Regional team, who have been working closely with the FFTF team, were content with the recommendations contained within the report; noting that any decision sat with the ICB Board. Two weeks previously a paper similar to that of today's paper was considered by GHFT's Board and a decision taken not to undertake any further public involvement, and to move to a decision-making Business Case.
11.3	MG asked Board members to consider a number the following points before making a decision as to whether sufficient patient and public engagement had been undertaken: • There has been extensive engagement around FFTF; with two phases of public and staff engagement and one of public and staff consultation. • The public involvement in phase 1 clearly set out our strategy and the principles of Centres of Excellence with the separation of Planned and Emergency Care. • The phase 1 Business Case included reference to a number of the services in phase 2. Positive engagement responses had been collated in phase 2 which were contained in the documentation that had been seen by the Board and assessed in September.
11.4	Another factor was that the ICB had a duty to consider the best use of resources and it was a reasonable assessment for this Board to take into consideration whether the the benefit of undertaking further involvement outweighed the use of additional resources. There were two elements, one would be the money involved in running a consultation and the second would be the staff time required in running a consultation particularly with the current challenges in our system.
11.5	The Board also needed to be confident with regard to how broadly the proposals had been communicated to the public. It was noted that of the five services in phase 2, four were currently in place through temporary service changes, so this would not be news to the public.
11.6	The FFTF Business Case would be submitted to the Board in March 2023 and would include the benefits and costs associated with the changes. Importantly, the decision making Business Case would not come to the Board any earlier than 90 days, if a decision was made today. This would allow sufficient time i.e 90 days plus to defend any legal challenge prior to the Board's decision on the Business Case.
11.7	To summarise, this decision was supported by GHFT, NHSE, and HOSC. The Chair stated that the Board had looked at this on a number of occasions and she herself was convinced about the validity of the phase 2 engagement and believed that all the evidence she had seen had convinced her that we were on very secure ground. The engagement had been very effective and individual and collective assurance

	had been collated. The Chair felt reassured that the engagement and consultation processes were robust.
11.8	**RESOLUTION: The ICB Board took a formal view that there should be no further public involvement in Phase 2 of the FFTF programme. The Board agreed that next steps should be taken to bring a decision-making Business Case to the March 2023 Board meeting.**
12.	**Chair's Report on the Primary Care and Direct Commissioning Committee meeting held on 6 October 2022**
12.1	CG informed members that the Primary Care and Direct Commissioning Committee meeting held on 6th October, received the standard briefings and reports on performance, quality and finance related to primary care. There were two items to highlight: the infrastructure plan, which concentrated on future estates for primary care, which will be the basis of business cases coming forward and the Pharmacy, Optometry and Dental framework which was discussed. It was agreed that this should be a topic at every future committee meeting.
12.2	**RESOLUTION: The ICB Board noted the Chair's verbal update on the Primary Care and Direct Commissioning Committee.**
13.	**Chair's report on the System Quality Committee meeting held on 20th October 2022**
13.1	JC provided a brief overview of the October Quality meeting highlighting the Emergency Planning Response and Resilience Policy and Plan which was reviewed and agreed. The committee also discussed the Annual Safeguarding Report and the update on the new patient safety Incident Response Framework. The discussion in the meeting explored what was meant by system-wide quality and system-wide risks and how risk played into wider discussions. JC as part of a collective of the Chairs of Quality Committees would see what other ICBs were doing.
13.2	**RESOLUTION: The ICB Board noted the Chair's verbal update on the System Quality Committee.**
14.	**Chair's Report on the Audit Committee meeting held on 17th November 2022**
14.1	JS informed the meeting that the Audit Committee meeting was held on 17th November; there were business as usual items and discussions, including an in depth discussion on the development of the Risk Appetite and BAF.
15.	**Chair's report on the System Resources Committee meeting held on 1st November 2022**
15.1	JCo reported that a System Resources Committee meeting was held on 1st November. There was now an approach to overheads across the ICB which has

	been agreed by the Directors of Finance and this will be monitored over the next 6 to 9 months. There was a discussion around the prioritisation of capital funding and how best to approach this. A small group was taking this forward.
15.2	**RESOLUTION: The ICB Board noted the Chair's verbal update on the System Resources Committee.**
16.	**Chair's report to the Board from the People Committee**
16.1	CL reported that the People, Culture & Engagement Committee met on 6th October. There were two main topics to highlight. The meeting came after the joint Recruitment Event which was a success. Providers gave an update on the current levels of vacancies and the meeting talked about some of the challenges being faced around staff retention. The members discussed equality, diversity and inclusion; in particular, disability and race.
16.2	TC and CL have started to discuss holding and facilitating a People Symposium, highlighting Gloucestershire as a great place to work, in the first half of 2023. The ICB would work with partners across the county, both in the public and private sectors to highlight the issues and challenges around the workforce, but also look at it from a very strategic perspective, around infrastructure.
17.	**RESOLUTION: The ICB Board noted the Chair's verbal update on the People Committee.**
17.1	SF spoke about the possible ways in which the ICP could start to work early next year on blood pressure, employment and anchor institutions. The employment theme needed further work and would need to include those who were starting work for the first time and tackling inequalities in work. ICS partners were important anchor institutions, it was therefore important to use our recruitment policies to enable the local population to get into our systems and become leaders. The different themes are all coming together which was very positive.
18.	**Any Other Business**
18.1	The Chair informed the Board of the appointment of the ICB Board Vice Chair which was Jane Cummings who had had agreed to the new role, which was particularly important in covering for the Chair in her absence.
18.2	DL asked for an update on the work being undertaken on the future location of the ICB Headoffice. MH informed the meeting that Sanger House must be vacated or the lease extended by the middle of next year. A Business Case with four options was being finalised and a decision would be taken on the outcome of the Options Appraisal. The leasing arrangements were likely to be around 5 years for any chosen building. DL commented that she would like to be kept informed as there were a lot of site disposals at GHFT and administration also needed to be found a suitable site. The Chair confirmed that capital could be saved by thinking about the needs of

	everybody and there would be a further conversation around this. Some of the NEDs in both GHC and GHFT were interested in an overarching estates strategy for the system. DL stated that knowing the direction of travel would be useful and it would be helpful to take the here and now decisions in the context of the longer term plan.

The meeting closed at 4.30pm

Time and date of the next meeting:

2.00pm – 4.00pm Wednesday 25th January 2023, Boardroom, Sanger House and Virtually

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NHS Gloucestershire

Agenda Item 4

Board meeting in public
Action Log
25 January 2023

Minute Ref, & Date	Description	Response	Action owner	Due	Status
Min 8.14 30/11/23	To provide an update on work being undertaken to support vulnerable pregnant women, including services available to this group of women to be reported to the Board		Kim Forey & Matt Holdaway	29th March 2023	Open
Min 11.8 30/11/23	The Fit for the Future Business Case would be submitted to the March Board	On track to include in the March board papers.	Micky Griffiths and Ellen Rule	29th March 2023	Open

Agenda Item 7

Integrated Care Board Meeting

25 January 2023

Report Title	**Chief Executive Report**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
	X					
Route to this meeting	The various reports provided have been discussed at other internal meetings within the ICB.					
Executive Summary	This report summarises key achievements and significant updates by the Chief Executive Officer of NHS Gloucestershire to the Integrated Care Board. This report provides an in-depth focus on This report is provided on a bi-monthly basis to public meetings of the ICB.					
Key Issues to note	This report covers the following topics ○ Urgent and Emergency Care (UEC) update ○ Industrial Action ○ ICS Diagnostic Programme ○ Health Inequalities ○ Primary Care update ○ Integrated Care Partnership Strategy update					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The report includes 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. (4x1) 4 (4x1) 4 (residual meaning accepted risk)					
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	X	**Buildings**	X		
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)	None					

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Impact on Health Inequalities	See section 5 and 6 concentrating on work focusing on inequalities with the Music Works project and targeted work that Integrated Locality Partnerships are undertaking to support people and communities with the Cost of Living crisis particularly in areas of high deprivation .
Impact on Equality and Diversity	See section 5 and 6 which focus on health inequalities through investment in The Music Works and funding allocated to Integrated Locality Partnerships (ILPs).
Impact on Sustainable Development	n/a
Patient and Public Involvement	See the ICP Strategy section 7
Recommendation	The Board is requested to: • Note the Chief Executive Officer report.
Sponsoring Director	Mary Hutton, ICB Chief Executive Officer

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

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NHS Gloucestershire Integrated Care Board (ICB)
Chief Executive Officer Report
25th January 2023

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 will be provided on a bi-monthly basis to public meetings of the ICB.
2.	**Urgent and Emergency Care (UEC) update**
2.1.1	The last month has been particularly challenging for our Urgent & Emergency Care services; perhaps even more so than expected in the winter period. What has been referred to as a 'twindemic' increase in prevalence of Covid and Flu, along with other respiratory illnesses including high national concern about Strep A in children, contributed to unprecedented volumes of patient demand in the run up to the festive period. This has also impacted upon our workforce and their families too. The further uncertainty and inevitable disruption caused by industrial action involving our nursing and ambulance service staff has added further pressure.
2.2	We have made a strong response, as a whole team and system effort. Our comprehensive system Winter Plan (available on the One Gloucestershire website and limited hard copies) continues to be enacted, with health and social care partners working closely together. This clear narrative plan is supported by a detailed monthly Assurance Framework return to NHS England. Winter planning elements have underpinned our specific response plans to each challenge and greatly supported our ability to absorb the additional pressure. The GHC team has made a particularly valuable contribution to ease the workload of other partners including: averting ambulance despatch, providing staff based in GHFT and working with community partners to avoid admissions and enable discharge flow. Our ongoing request to the people of Gloucestershire is to Think NHS111 First and only to call an ambulance or go to our Emergency Departments if seriously ill or injured, or if life is at risk.
3.	**Industrial action**
3.1	The ambulance service was impacted again by industrial action on Wednesday 11th January having previously had a day of industrial action in December. The main union in Gloucestershire is Unison, Unison members took action for 12 hours that day. South West Ambulance Service NHS Foundation Trust (SWAST) worked positively with unions to agree derogations ensuring that there would be ambulance availability for very sick patients.
3.2	One Gloucestershire system partners supported SWAST to mitigate risk and maximise patient safety. GHNHSFT ensured any ambulances arriving in the Emergency Departments were handed over quickly to release crews. Our 111 and Out of Hours services also supported patients by increasing cover. They reported that call demand was less than expected and whilst they saw a number of higher acuity patients throughout the day, these were quickly managed by their clinicians who also were able to

	achieve 100% validation of calls throughout the day. Further strike action is planned by Unison and Unite for Wednesday 23rd January.
3.3	The Royal College of Nursing (RCN) held two days of industrial action in December which involved both local Trusts and ICB nursing staff. Derogations were agreed by both Trusts with the RCN particularly focusing on maintaining urgent care services. Though agreement was reached to staff the minor injury, it was disappointing that two Minor Injury Units, unfortunately had to close due to staff not being available. The planned two days of industrial action by the RCN on 18th and 19th January will not be taking place in Gloucestershire.
3.4	The Chartered Society of Physiotherapists has also called two days industrial action on 26th January and 9th February. Industrial action will take place in both of our local Trusts on 9th February. Local Trusts are making plans for delivering services on that day.
4.	**ICS Diagnostic programme**
4.1	The Community Diagnostic Centre (CDC) programme, as part of the ICS Diagnostic programme, continues to deliver additional activity against trajectory. Between December 2021 and December 2022, over 41,000 additional tests have been delivered, of which just over 27,000 tests are attributed to an imaging modality including X-ray, CT, MRI and US. This has led to an improvement in performance in terms of the time patients are waiting for a test. The additional activity already being delivered will continue once the CDC hub is complete.
4.2	The structure to enable programme delivery has been agreed and established with several workstreams and a CDC programme board that report to Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Director's Operational Assurance Group (DOAG) who will oversee delivery. The current timescales for completion of the CDC hub is December 2023 with the CT and MRI modular units being moved and operational in June 2023.
4.3	Planning for 23/24 is being rapidly agreed ready for submission on the 30th January. The new policy was released on the 22nd December which moves from a business case approach to a cost per test revenue basis. The Directors of Finance will review the submission to ensure the CDC model remains affordable.
4.4	The delivery of the CDC hub in 2023 is one aspect of a growing diagnostic programme that will continue evolve over the coming years. The ICS Diagnostic Programme Board recently engaged and sought input from system colleagues as well as network colleagues on the priorities, actions and measures for the group. This will help inform future strategic plans and will be incorporated into the ICS planning processes.
5.	**Tackling health inequalities in Gloucester City**
5.1	The Music Works is a local charity that is funded by NHS Gloucestershire to provide a Health Inequalities programme that uses music to address some of the health inequalities that exist for young people in Gloucester, engaging those that might not otherwise access support services. There is a strong body of evidence that shows that music helps young people in challenging circumstances to develop a sense of confidence and self-worth, while making music with others can help create social connections.

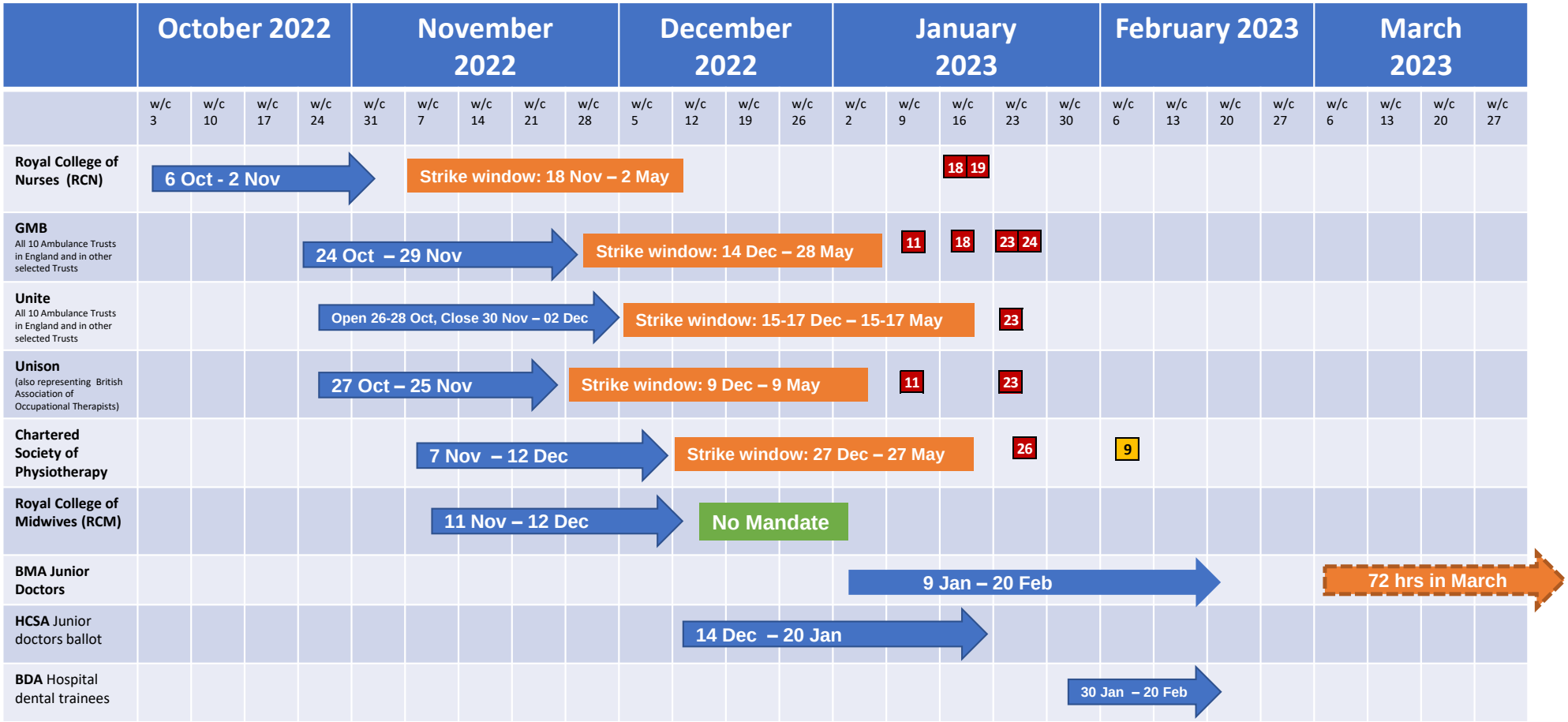
5.2	Young people that have taken part in the programme have been from the following backgrounds. • 24% of the young people living in areas of high derivation; • 44% being from a black or minority ethnic community; • 13% living in care or being a care leaver; • 16% had been excluded from school; • 21% young offenders or at risk of offending. In 22/23 the programme impacted on 505 young people's lives over 1,009 music sessions.
5.3	Using the Short Warwick–Edinburgh Mental Wellbeing Scale (sWEMWBS – a validated outcome measure), participants well-being was measured through their engagement on the programme. There was a 34% increase in young people experiencing a high level of well-being after they attended the music programmes, and a reduction of 15% of young people feeling a low level of well-being. This demonstrates an overall increase of well-being for young people who took part in the music programmes.
6.	**Primary Care update**
6.1	**Community Investment Fund from NHS Southwest**
6.1.1	In late Autumn, Gloucestershire ICB received a non-recurrent fund of £300,000 from NHSE Southwest to provide short-term positive impact over the Winter for the most disadvantaged in our population in acknowledgement of the potential impact cost of living challenges on health. We agreed that the Integrated Locality Partnerships (ILPs) would be the most suitable route for the funding to both meet the requirements of the funding and be impactful for the differing populations across the county.
6.1.2	Members of each ILP suggested schemes to utilise the £50,000 allocated to each ILP with the support of an ICB Non-Executive Director, with suggestions ultimately approved by the ICB Chair. Having our peer elected VCSE representatives of each ILP as part of the conversation was hugely beneficial to maximising this opportunity. Each Locality has determined a number of schemes for example additional warm hubs, support to food banks, and funding for practical items such slow cookers and hot water bottles. Funding will flow to community/VCSE organisations in each Locality. We will be monitoring, learning, adapting, sharing and evaluating between January and March 2023 in order to prepare a high level evaluation, to learn from this approach locally and share the impact this funding has made for people in Gloucestershire most affected by cost of living challenges.
6.2	**Primary Care Nursing Workforce Development**
6.2.1	Various projects are underway to support the nursing workforce in Primary Care. Following the successful launch of a project called 'Nurse on Tour' in The North East of England, where a Primary Care Nurse lead undertook a pilot to encourage Nursing students to experience Primary Care, the training hub has developed a similar project in Gloucestershire, the first in the region.

6.2.2	Whilst Primary Care Nursing is still a popular career destination, nurses can often join practices at a later stage in their career, assuming that secondary care experience is needed. This results in an older nursing workforce in Primary Care with retirements causing concern about future workforce sustainability. The programme was recently launched and implemented in Gloucestershire by our newly appointed Nurse Lead and ICB Strategic GPN Workforce lead. With the initial objective to introduce Nursing students to Primary care as a first-destination career choice, the programme gives student nurses from all disciplines the opportunity to ask questions of Primary Care professionals about their experiences while also delivering meaningful preventative care in the community.
6.2.3	Students were supported to participate in collaborative learning, provide health checks for patients who had been asymptomatic, offer health promotion, diagnose and refer conditions for further treatment. Two tours have currently taken place involving 8 student nurses from year's 1-3 with General Nursing and Mental Health Nursing backgrounds. 98 patients have been seen to date and 44 patients will be followed up in their practices for previously undiagnosed borderline hypertension. Three of these patients needed immediate treatment with antihypertensives; another patient with an irregular pulse needed anticoagulation and one an urgent Face to Face appointment with a GP.
6.2.4	All Nurses have given positive feedback with several now considering Primary Care as their first destination career choice, one asking for a Primary Care placement and another wanting to repeat the Nurses on tour experience. The intention is to continue to grow this programme and offer the opportunity to further practices. For more information about the Nurses on Tour scheme see University nursing students go on tour to deliver NHS primary health care in community - University of Gloucestershire (glos.ac.uk)
6.2.5	The training hub also has in place a preceptorship scheme and dedicated General Practice Nurse (GPN) Fellowship scheme, to support nurses new into Primary Care, which further supports the pipeline of dedicated nursing staff. Gloucestershire Primary Care Networks (PCNs0 have growing numbers of trainee nursing associates, who once qualified as nursing associates can further develop into GPNs. The nursing associate role and associated development pathways are supported by two practice education facilitators within the training hub.
6.3	**Supporting our non-clinical workforce in Primary Care**
6.3.1	With non-clinical roles making up over 50% of our Primary Care workforce, the Primary Care training hub/workforce team are actively developing a number of programmes to support recruitment, retention and development of our colleagues working within Gloucestershire's GP practices. As is the case with clinical roles, those in non-clinical roles such as Practice receptionists and Care Navigators are facing significant challenges. With demand for Primary Care higher than it's ever been and factors including capacity, patient interactions, burnout, pay, complexity of the job versus expectations are resulting in an increased number of non-clinical staff leaving their posts.
6.3.2	The Primary Care workforce team recently launched virtual Primary Care Induction sessions (available for anyone new to Primary Care) which covered a range of topics

	such as contracting, our ICB and PCN structures and digital systems. In addition our training hub GP Clinical Chair is providing a range of bite-sized training offers for reception and administrative staff which are designed to support staff over Winter, including sessions on red flags, pharmacy services and health and wellbeing. Sessions to date have been well attended and further dates are available into February 2023. An 'away day' for administrators is planned for early 2023 with a further training need identified from our PCN workforce conversations which is to support reception staff to identify acutely unwell patients. To support our non-clinical (and clinical) colleagues with development in their roles, we are also providing a number of courses including First steps into leadership, practice accounts and tax, dispute resolution and change management. Further work is being undertaken to identify key factors that would support retention of staff within Primary Care.
6.4	**New Dental Strategy Group**
6.4.1	Gloucestershire ICB takes delegated responsibility from NHSE for the commissioning of dental, pharmacy and optometry services from the start of the new financial year (1st April 2023). In response to delegated commissioning of primary, community and acute dental services the ICB has established a new Dental Strategy Group with membership which includes but is not limited to NHSE, Gloucestershire Health and Care NHS Foundation Trust, Gloucestershire Hospitals NHS foundation Trust, Gloucestershire Local Dental Committee, the South West Dental Network and Gloucestershire County Council Public Health team. Additional members including Healthwatch will be invited.
6.4.2	As a county we face particular challenges. For example the total number of adults seeing an NHS dentist in Gloucestershire in 2020/21 decreased from 36.5% in December 2020 to 28.6% in December 2021. The access rate for the adult population of Gloucestershire (28.6%) is less than the access rate for England as a whole at 36%. Whilst the number of children who saw a dentist in Gloucestershire increased from 30.8% in December 2020 to 43.9% in December 2021 and the access rate is slightly higher than the access rate for children across the whole of England (42.5%), there are oral health challenges for children and young people in areas of the county with the greatest health inequality. Workforce too is a challenge with a shortage of dentists in the county (estimated at 31 whole time equivalent) which affects the ability of high street practices to deliver their contracts.
6.4.3	The new group will utilise NHSE's dental roadmap and as part of building local relationships, will commission services, which address the dental challenges of access, oral health of children in areas of greatest health inequality and workforce shortages.
7	**One Gloucestershire Interim Integrated Care Strategy**
7.1	The interim Integrated Care Partnership Strategy was published in December 2022 as planned https://getinvolved.glos.nhs.uk/ics-gloucestershire This interim document incorporated the feedback received from Board members as well as the feedback received from the wider engagement sessions and has been fully endorsed by all partners.

7.2	As agreed by the Board, the strategy focusses upon three overarching pillars: making Gloucestershire a better place for the future, transforming what we do and improving health and care services today. In addition, this work also identified three key conditions for change: strengthened communities and person centred approaches, evidence led practice, research and innovation and digitally enabled services.
7.3	As previously discussed, attention now moves onto the delivery plan and a further workshop took place earlier this month with the members of the Gloucestershire Health and Wellbeing Partnership in order to begin this work – this included a focus upon the unifying themes. The interim strategy document is also already starting to inform the system Operating Plan and Joint Forward Plans which are being developed during the next couple of months.
8	**Recommendation**
8.1	The Board is asked to note the report.

Industrial Action Ballots and Potential Strike Dates



Agenda Item 9

ICB Board

25th January 2023

Report Title	**Presentation on the proposed approach to the development of the 5-year Joint Forward Plan**						
Purpose (X)	**For Information**		**For Discussion**		**For Decision**		
	X		**X**				
Route to this meeting	Describe the prior engagement pathways this paper has been through, including outcomes/decisions:						
	ICB Internal	**Date**	**System Partner**	**Date**			
	Strategic Executive	19/01/2023	Health & Wellbeing Board	17/01/2023			
Executive Summary	A presentation of the approach to developing the national, legislated Joint Forward Plan (JFP) for Gloucestershire, including proposed structure, relationships to the Integrated Care Strategy and other planning asks, and a high-level timeline for partner engagement and all governance routes.						

Key Issues to note	• JFP guidance (https://www.england.nhs.uk/long-read/guidance-on-developing-the-joint-forward-plan/) was published 23/12/2022.
	• Timescales for development and publication have been adjusted nationally:
	  ○ Draft – 30/03/2023
	  ○ Final publication (and sharing with NHSE) – 30/06/2023
	• The proposed approach to the Gloucestershire JFP is based on 5-year aims and milestones of our transformation programmes, grouped to reflect the 'pillars' of the new Integrated Care Strategy.
	• Engagement has largely been conducted via the Integrated Care Strategy development process to avoid duplication and engagement fatigue. Ongoing engagement with partners and HWB is planned through to June.
	• The JFP will address the ICB's 17 legislative requirements, including Implement joint local health and wellbeing strategies, plus 8 additional recommended content sections (including *PHM* and *supporting wider social and economic development*)
	• The proposed tone and principles of the Gloucestershire JFP will be a clear, accessible document for staff and public consumption, and used across the system for accountability.						

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Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	1. Capacity and availability of subject matter experts and programme leads to provide, review and approve content derived from their transformation plans and other sources. Managed and mitigated through ongoing offers of support and content management by PMO leads. Risk rating: 2x4 = 8 Residual risk: 2x3 = 6			
Management of Conflicts of Interest	No conflicts in the development of the JFP; any indirect conflicts will be in the public domain of any groups and boards engaged with.			
Resource Impact (X)	**Financial**		**Information Management & Technology**	
	Human Resource	X	**Buildings**	
Financial Impact	No direct impact to develop the JFP itself – within existing roles and functions.			
Regulatory and Legal Issues (including NHS Constitution)	The JFP is a legislated requirement of all ICBs, including alignment with, and a statement from, the local Health and Wellbeing Board (HWB)			
Impact on Health Inequalities	Development of the JFP will have no impact directly; content will reflect how the system will address heath inequalities within the scope of the ICS delivery and transformation plans.			
Impact on Equality and Diversity	Development of the JFP will have no impact directly.			
Impact on Sustainable Development	Development of the JFP will have no impact directly; content will reflect how ICS delivery and transformation plans will contribute to sustainable development.			
Patient and Public Involvement	Engagement has been via the Integrated Care Strategy Development; all transformation programmes in the scope of the JFP are being asked to include commentary on how they engage with people and communities (e.g. through reference groups) and will continue to do so through their lifecycles.			
Recommendation	The Board is requested to: • Support the proposed approach to development, structure and tone of the JFP.			
Author	Dan Corfield	**Role Title**	Associate Director of ICS Programmes	
Sponsoring Director (if not author)	Ellen Rule, Deputy CEO and Director of Strategy and Transformation			

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
JFP	Joint Forward Plan
HWB	Health and Wellbeing Board

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Joint Forward Plan Approach

ICB Strategic Executive– January 2023

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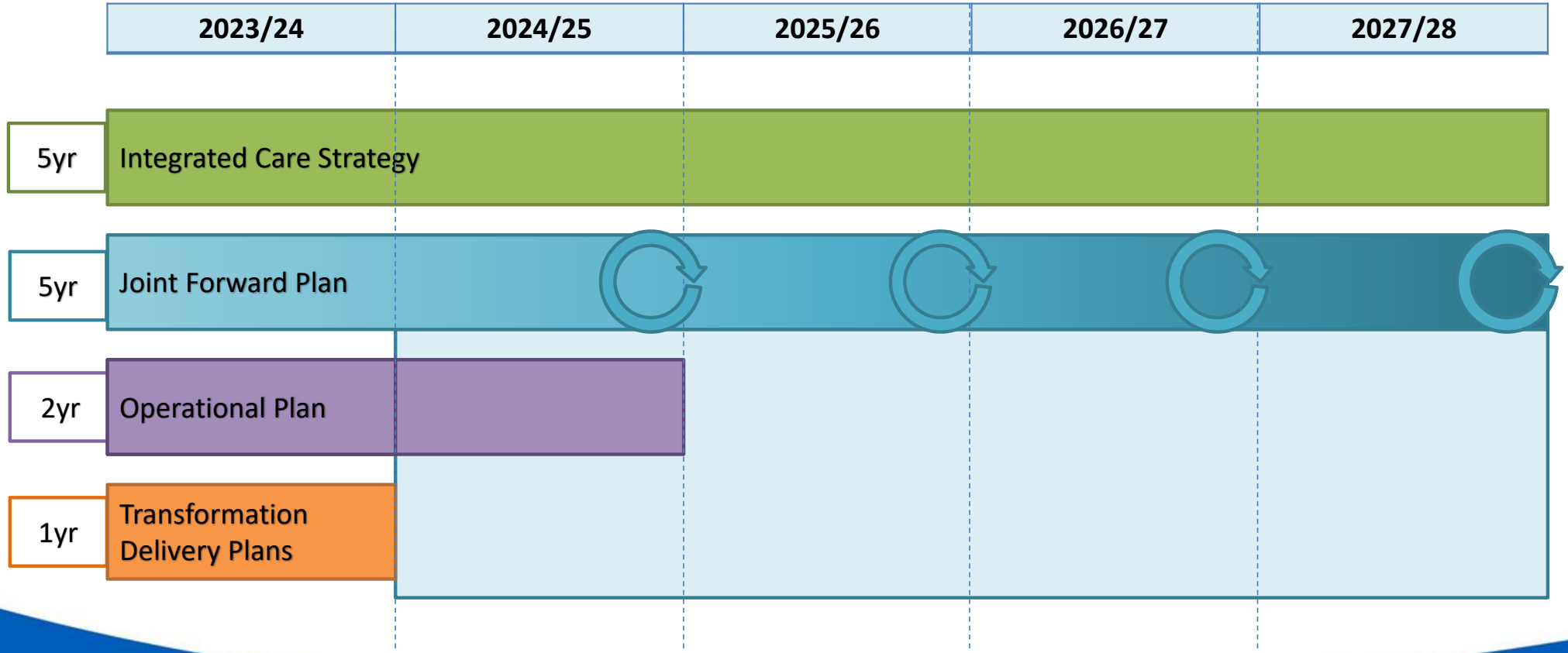
Context – the planning ask to March 2023



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Purpose of the JFP

Describe how the Integrated Care Board (ICB) and provider trusts intend to meet the physical and mental health needs of the population through arranging and/or providing NHS services, supported by local authority and VCSE partners

Delivery of universal NHS commitments:

1. Long Term plan
2. Annual NHS Priorities
3. Operational planning guidance

Address the four core purposes of ICS:

1. Improving **outcomes** in population health and healthcare
2. Tackling **inequalities** in outcomes, experience and access
3. Enhancing **productivity** and value for money
4. Helping the NHS support **broader social and economic** development

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Principles

1. Fully aligned with the ambitions of the wider system partnership to meet the needs of the population as articulated in the integrated care strategy

2. Supports subsidiarity in a summarised, single, cohesive plan by building on existing local strategies and plans as well as reflecting universal NHS commitments, but does not transfer all planning activity to system level.

3. Delivery-focused, including well-defined measurable goals, trajectories and milestones aligned with the operational plans of system partners.

Approach to development

1. **Consultation/Engagement** (building on ICP Strategy development) with primary care providers, local authority and HWB, and people & communities affected by or with significant interest in specific parts of the plan.

2. HWB (and ICP) are a key part of the **legislative framework** informing the JFP development.

3. **Revision** of JFP annually before the start of each new financial year, and/or in-year if necessary.

Does not need 'full formal' public consultation as building on existing plans...

...and on engagement from ICP strategy development Sep-Dec '23

Presented to HWB 17th Jan ✓

JFP to include summary of views expressed and how they're taken into account

Draft March '23

Final June '23

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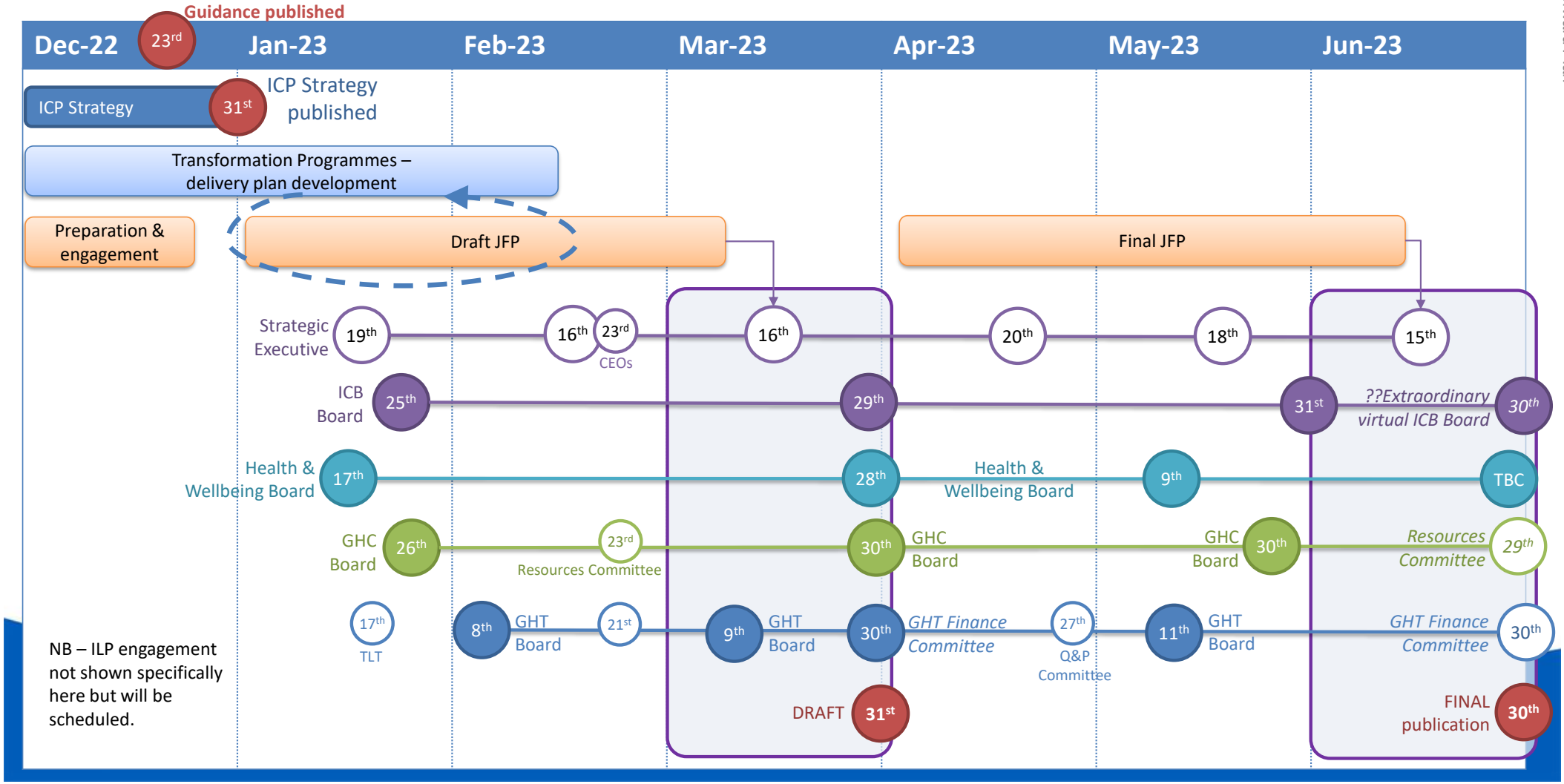
JFP sign-off timeline

Organisational Board

Organisational Committee or senior leadership team meeting

Work in progress and subject to change



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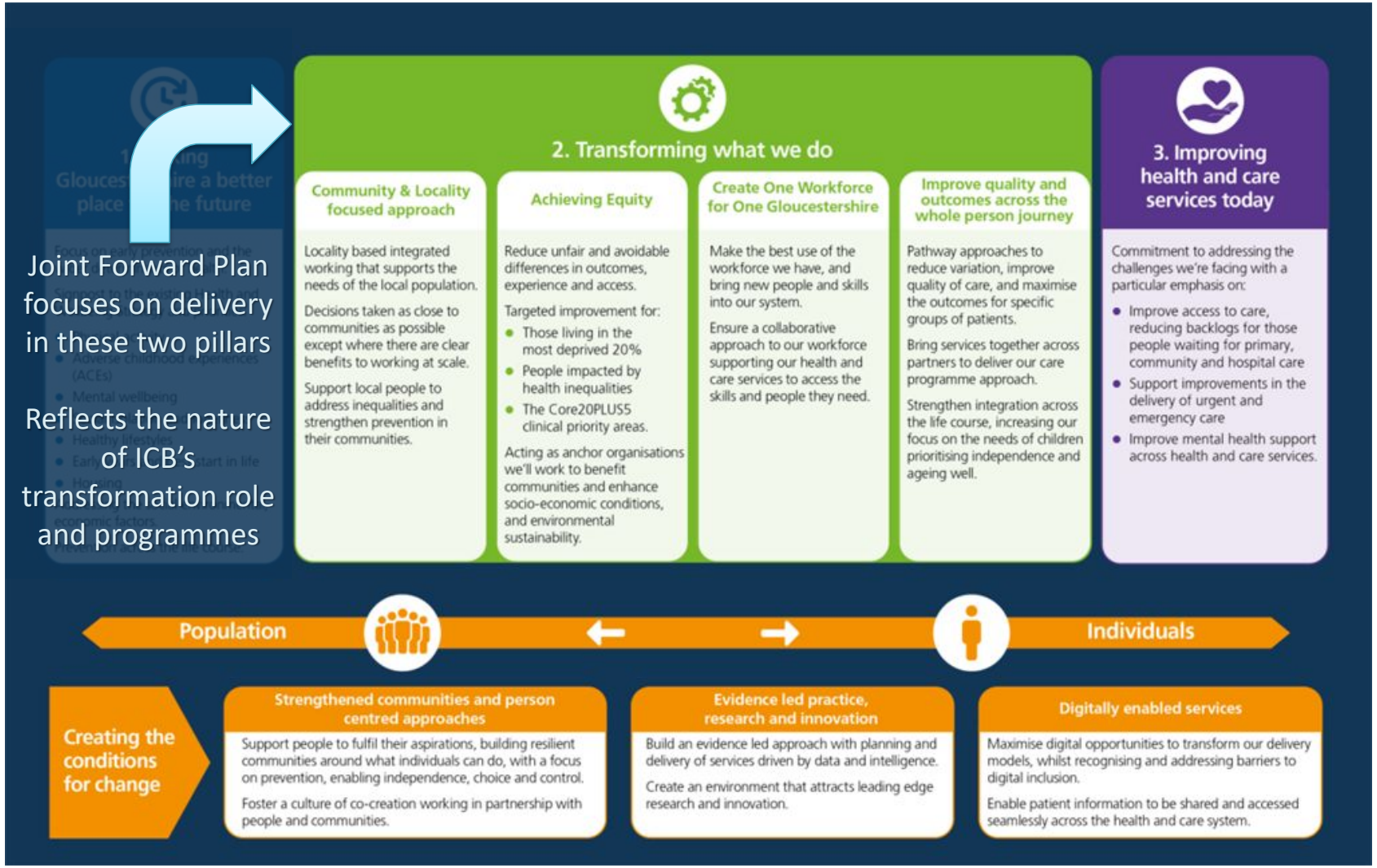
Proposed Structure – reflecting the ICP Strategy

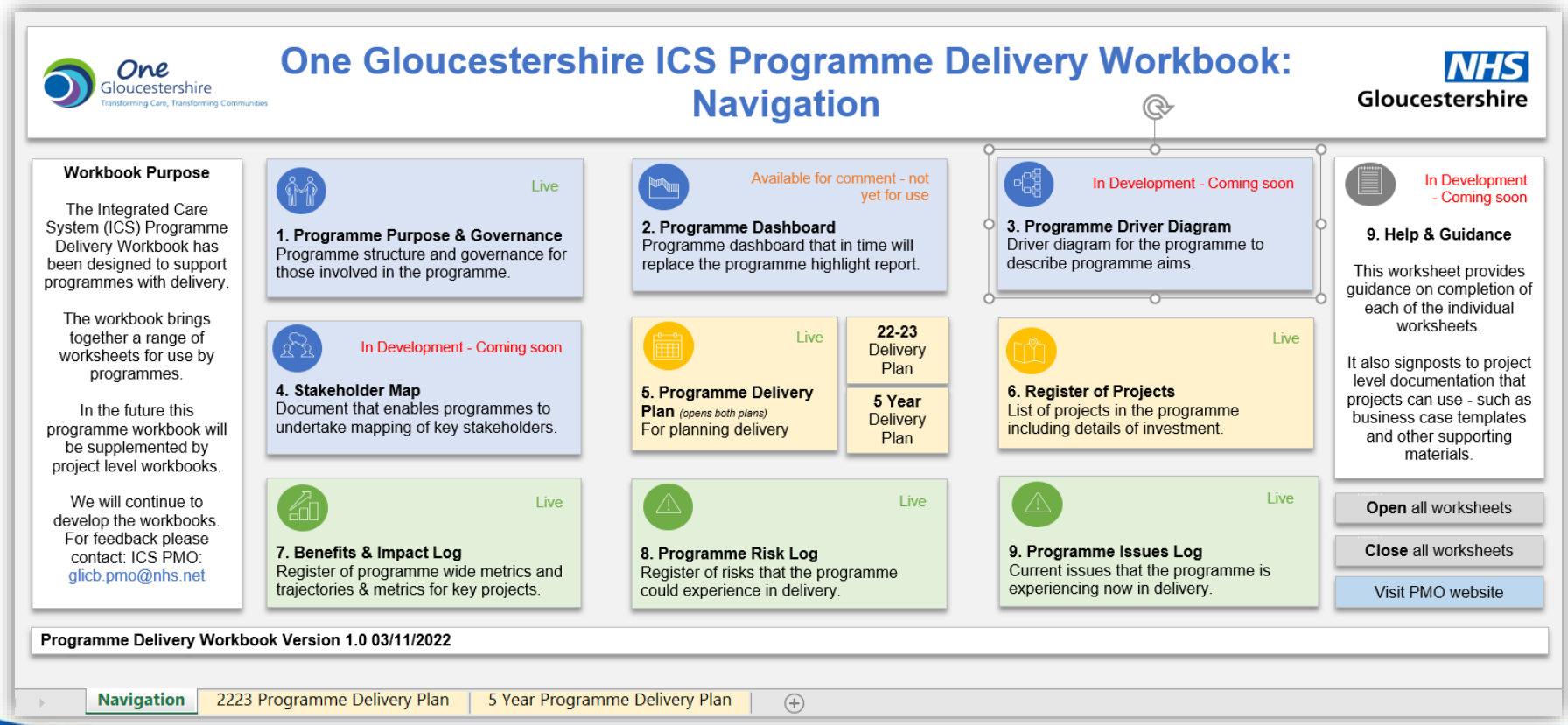
@One_Glos
www.onegloucestershire.net

Three Overarching Pillars

Outline structure- working draft for comment – not for onward forward



Building from the ground up



Proposed structure with *estimated* number of pages

Context 4

- Foreword
- Introduction & Purpose
- H&WB Board JFP statement
- Local Health & Care Context & Interfaces

4

- 5yr Headline & Yr 1 Priorities
- Alignment to System strategies
- Key trajectories
- *Key risks to delivery of the JFP*

Content 36

Better Future

- *EAC-I*

Transforming

- FFTF
- Clin. Progs – Med.
- Clin. Progs – Cancer
- Meds Opt.
- Diagnostics
- LDA
- CYP
- Mat. & Neo-Natal
- Primary Care
- Ageing Well & Frailty

Improving Today

- UEC & Flow
- Planned Care/ERP
- MH - Adults
- MH - CYP

Enablers

- Workforce
- Estates
- Digital & IT
- PHM
- Personalised Care

10

- ICS Development, QI, Innovation, Research, Evaluation & ongoing engagement — 6

c.60 pages + Appendices (incl. statutory duties matrix)

Each section to contain…

1. Purpose, SRO & Governance of programme
2. 5yr programme aims and key outcomes
3. Contribution to ICB statutory functions
4. Yr 1 & 2 programme milestones and trajectories
5. Yr 3-5 programme milestones and measures
6. How will the programme engage with people & communities?

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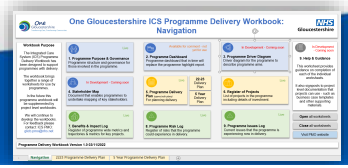


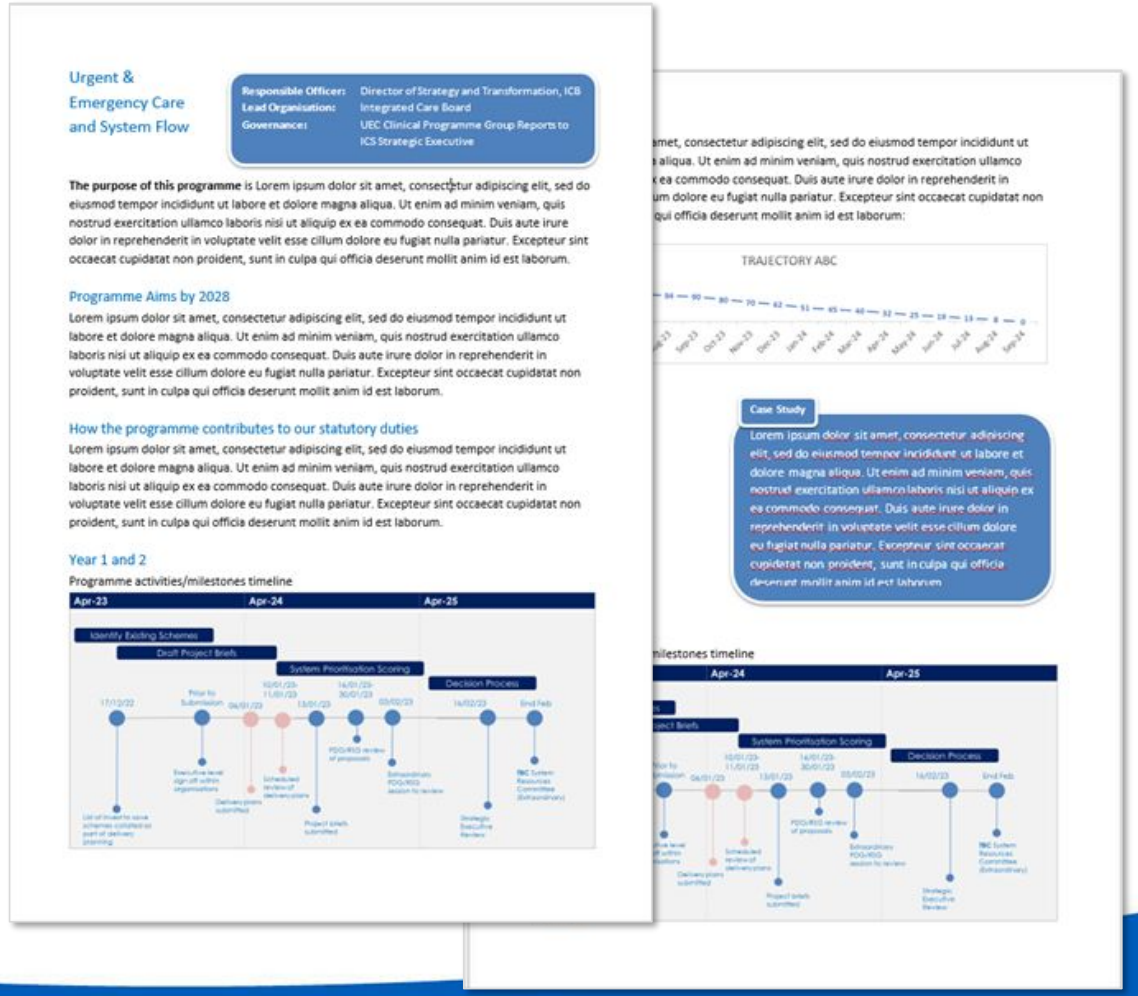
Basic mock-up example (without design or graphics)

Propose a similar approach to 2022/23 Winter Plan (though a little more detail)

Very plain language, publicly accessible

Mix of information formats – text, graphics, charts, timelines, etc.

Pop-outs e.g. Case Studies, patient/staff quotes, etc.



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Legislative requirements

Describe health services the ICB proposes to arrange to meet needs	Duty to improve quality of services	Duty to reduce inequalities	Duty to promote involvement of each patient	Workforce
Duty to enable patient choice	Duty to obtain appropriate advice	Duty to promote innovation	Duty to facilitate and promote research and use its evidence	Performance
Duty to promote education and training	Duty to promote integration	Duty to have regard to wider effect of decisions	Duty as to regard to climate change and adaptation to impacts	Digital/data
ICB involve the public in decisions about services	Addressing particular needs of children and young people	Addressing particular needs of victims of abuse	Implement joint local health and wellbeing strategy	Estates
Financial duties				Procurement/supply
				PHM
				System Dev.
				Support wider social & economic development

Additional recommended content

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Summary

1. JFP in development in harmony with Delivery and Operational Plans, and we can therefore ‘show our working’ from published document back to specific programme delivery plans.

2. Intended as an accessible staff- and public-facing document.

3. Health and Wellbeing Board have been engaged with and are supportive.

4. Handover into PMO annual refresh ownership will start from April 2023.

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Agenda Item 10

ICB Board (Public)

Date: 25/01/23

Report Title	**Fit for the Future (FFTF) – Review of Phase 1 Benefits & Costs**					
Purpose (X)	**For Information**		**For Discussion**		**For Decision**	
			X			
Route to this meeting	FFTF Phase 1 Decision-making Business Case was approved by CCG in Mar 2021.					
	ICB Internal	**Date**	**System Partner**	**Date**		
	ICB Board	18/03/21	ICS Resources Steering Group	16/12/22		
Executive Summary	The purpose of this paper is to: • Provide an update on implementation of FFTF Phase 1 with particular focus on benefits and costs • To provide context for FFTF Phase 2 Decision-making business case due for review/ approval by ICB in March 2023.					
Key Issues to note	Four of the seven FFTF1 services have been implemented; the remaining three are due for implementation in 2023.					
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	A detailed risk log is maintained as part of the programme management approach used to manage the FFTF programme. The specific risk in relation to this item is the delivery of benefits and the cost of investments.					
Management of Conflicts of Interest	The programme has been conducted in line with the relevant conflicts of interest policies.					
Resource Impact (X)	**Financial**	X	**Information Management & Technology**			
	Human Resource		**Buildings**			
Financial Impact	FFTF Phase 1 Business Case included a £1.2M cost pressure with an intention for the programme to be cost-neutral (CRB & NCRB) once changes had been implemented. Risks to this assumption have been identified and shared with Resources Steering Group (RSG) with mitigation work in progress. The full Phase 1 & Phase 2 financial and economic case will be included in the FFTF2 Decision-making business case.					
Regulatory and Legal Issues (including NHS Constitution)	FFTF Phase 1 Decision-making business case (DMBC) passed through all regulatory steps and the period for legal challenge has elapsed.					
Impact on Health Inequalities	The FFTF1 Integrated Impact Assessment considered the impact of the service change proposals on people with protected characteristics who live in our health and care community. Full details can be found in the appendices to the DMBC					

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Impact on Equality and Diversity	As above, full details can be found in the appendices to the DMBC		
Impact on Sustainable Development	There is no direct impact or detriment on sustainable development identified for the FFTF programme		
Patient and Public Involvement	Details of the FFTF1 public, patient and staff consultation are detailed in the Decision-making business case (DMBC)		
Recommendation	The Committee/Board is requested to note the following: • Successful delivery of a number of FFTF1 benefits; • On-going work to deliver remaining benefits, and; • On-going work to reduce cost pressure in-line with Phase 1 DMBC commitments		
Author	Micky Griffith	**Role Title**	FFTF Programme Director
Sponsoring Director (if not author)	Ellen Rule, FFTF Programme Executive Lead and Deputy CEO/Director of Strategy & Transformation, NHS Gloucestershire		

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
FFTF1	Fit for the Future – Phase 1
FFTF2	Fit for the Future – Phase 2
DMBC	Decision-making Business Case
RSG	ICS Resources Steering Group
CRB	Cash Releasing Benefits
NCRB	Non-Cash Releasing Benefits
NHSE	NHS England

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NHS

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Phase 1

Information to support discussion regarding Benefits and Costs

Version 3.1

January 2023

Fit for the Future

Developing specialist hospital services in Gloucestershire

Contents

Document Control

Author:	Micky Griffith, Programme Director, Fit for the Future
Location:	\\glos.nhs.uk\GCCG\Hub\Strat and Planning\Sustainability & Transformation Plan\10. One Place Programme\12. Fit for the Future\Phase 2
Status:	v 3.1

Version	Date	Author/Reviewer	Comments
1.0	09/12/22	Micky Griffith	Draft for FFTF SROs (Senior Responsible Officers)
2.0	15/12/22	Micky Griffith	Updated for ICS Resources Steering Group
3.0	16/01/23	Micky Griffith	Updated for ICB Board
3.1	18/01/23	Simon Lanceley & Ellen Rule	SRO review & updated for ICB Board

Document Distribution:

Forum/Audience	Date	v#	Comments
ICS Resources Steering Group	16/12/22	2.0	
ICB Board	25/01/23	3.1	

1 Strategy

1.1 One Gloucestershire Integrated Delivery Plan

Our Integrated Delivery Plan sets out our priority programmes and the activities that we will be seeking to deliver as partners across the health and social care system in Gloucestershire in 2022/23. The plan has been formed from delivery plans that have been developed for each of our Integrated Care System transformation programmes, setting out objectives for 2022/23. These plans have been worked up with partner organisations and reflect a shared commitment to delivery for the year ahead.

Our headline priorities for Gloucestershire

This Integrated Delivery Plan sets out our priority programmes and the activities that we will deliver as partners across Gloucestershire in 2022/23. These priorities reflect what we need to do today to improve services for our patients and service users whilst continuing to work on what we will do for residents and citizens of Gloucestershire in the longer-term.

Improving health and care for our service users and patients today:

- Support improvements in **urgent and emergency care** – ensuring a range of options are available to those who need it.
- Improve access to care, recovering from the last two years. This includes **work to recover elective care**, reducing long waits whilst ensuring that those waiting are given advice and support to manage their conditions.
- Expand and improve **mental health support for people of all ages** as well as for **people with learning disabilities and autism** so they have the support needed.
- Work together to **address the financial challenge** we have across the system to narrow the financial gap and deliver efficiencies.

Making Gloucestershire a better place for residents in the future:

- **Across all priorities tackle health inequalities** across our populations drawing on data and population health approaches.
- **Improve population health through locality based working**, placing a greater focus on personal responsibility, wellbeing and prevention.
- Continue changes in **out of hospital services that enable care to be delivered closer to home**. Our Clinical Programme Approach and the work within Primary Care Networks are key to making this happen.
- **Improve integrated care across the life course** – increasing our focus on the needs of Children and Families and supporting people to age well

Transforming what we do to deliver this longer-term change:

- Bring together specialist resource across the county to deliver new models of care through **Fit for the Future**
- Ensure that we have in place the enablers to deliver on the above priorities. This includes delivering our **workforce programme** to attract new people into Gloucestershire to work across health and social care whilst supporting those existing staff as well as ensuring that we seize the opportunities presented by **data and digital technologies**.
- Successfully **transition to an Integrated Care System,** develop our five year strategy and embed new ways of working across the Gloucestershire (ICS) enabling further collaborative working across all partners and with local people and communities.

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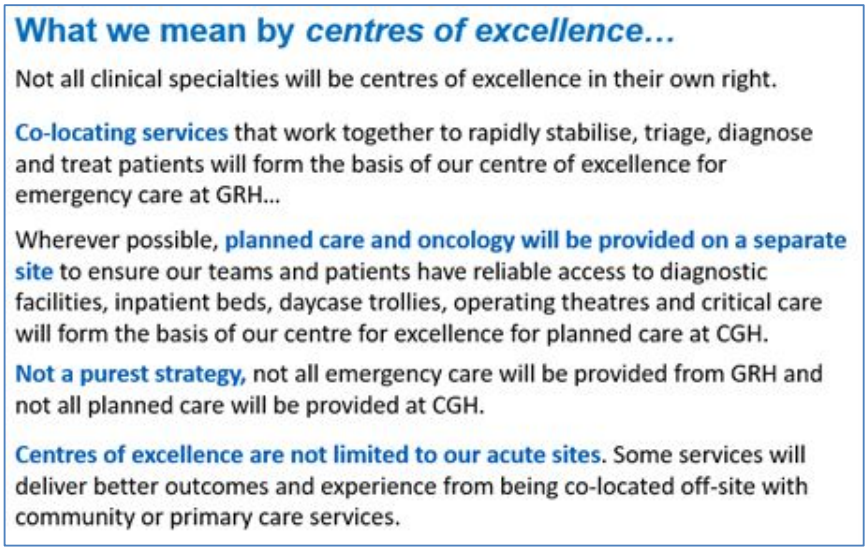
1.2 Fit for the Future Programme

As part of our response to the NHS Long Term Plan and commitment to the public in Gloucestershire, when patients require specialist care, we believe they should receive treatment in centres with the right specialist staff, skills and equipment by delivering care that is fit for the future.

Our FFTF Programme includes looking at how we can develop outstanding specialist hospital care at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) across Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospitals. Our "*Centres of Excellence*" vision for the future configuration of specialist hospital services is for GRH to focus more (but not exclusively), on emergency care, paediatrics and obstetrics and CGH to focus more (but not exclusively), on planned care and oncology. Across the UK and the world, it is recognised that an element of separation between planned and emergency care services can improve access, outcomes and experience for patients and colleagues.



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1.3 Fit for the Future: Phase 1

FFTF Phase 1 completed its Stage 2 review in September 2020 and the Decision-Making Business Case (DMBC) was approved in March 2021[1]. The reconfigurations agreed in Phase 1 are presented below, including their implementation status which is linked to GHNHSFTs Strategic Site Development (SSD) programme. These two programmes are linked as it is the SSD programme that provides the estate, equipment and supporting infrastructure required to implement the service reconfigurations.

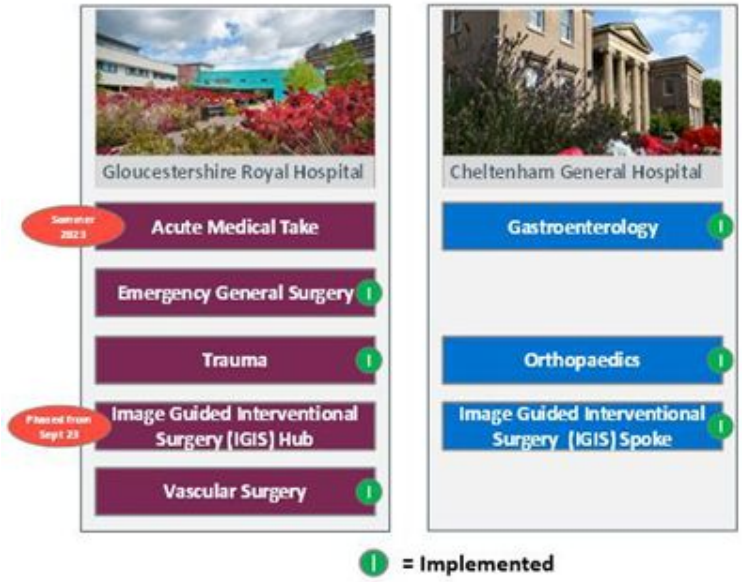
The SSD programme provides two additional operating theatres and a Day Surgery Unit at CGH; these new facilities will improve patient access, reducing waiting times and lists, result in fewer operations being cancelled and through new facilities, improve patient and colleague experience. At GRH, the SSD programme provides an expanded Emergency

[1] The DMBC is available at Fit for the Future | Get Involved In Gloucestershire (glos.nhs.uk)

Department and Acute Medical Unit (AMU), designed to improve diagnosis, assessment and treatment times, alongside a redesigned [trauma] fracture clinic co-located within ED. The programme has already delivered a purpose-built Same Day Emergency Care (SDEC) unit and a new 24-bedded inpatient ward. The timescales for completion of the SSD developments are:

- GRH Gallery wing ward – opened to patients in July 2022
- GRH Expanded Emergency Department and Acute Medical Unit – delivered in phases (first phase opened to patients in December 2022), final phase in June 2023
- CGH Day case unit – open to patients in March 2023
- GRH Catheter Labs (part of IGIS model) – open to patients in September 2023
- CGH Theatres – open to patients in September 2023.
- GRH Hybrid Vascular theatre – open to patients in Q3 2023/24
- GRH Interventional Radiology Labs (part of IGIS model) – May 2024

1.3.1 FFTF Phase 1 Service re-configurations



1.3.2 FFTF Benefits and Aims

The benefits to services included in Phase 1 were designed to:

- Make sure patients are always assessed by the right hospital specialist (e.g., doctor) with timely decisions about their treatment and care
- Ensure there are always safe staffing levels, including senior doctors available 24/7 and teams have the best equipment and facilities
- Reduce waiting times and limit the number of operations that are cancelled
- Support joint working between services to reduce the number of hospital visits people have to make
- Improve health outcomes for patients
- Create flagship centres for research, training and learning - attracting and keeping the best staff in Gloucestershire

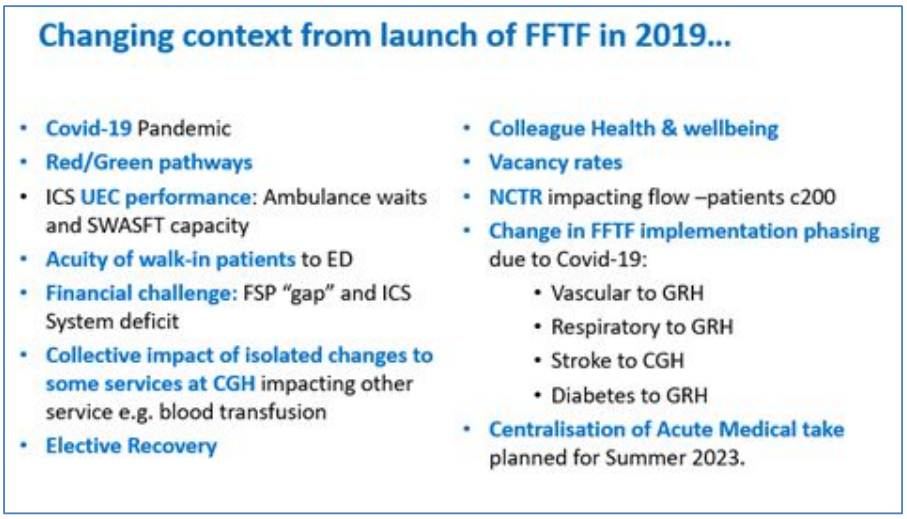
- Deliver more specialist services in Gloucestershire to enable people to receive care locally rather than travelling to Bristol, Birmingham and Oxford as they do now.

1.3.3 Planned General Surgery

The only FFTF Phase 1 service not covered above is Planned General Surgery. Prior to the DMBC approval, GHNHSFT Trust Leadership Team (TLT) explored in detail the configuration options for Lower GI (colorectal) surgery, taking in to account feedback received during the FFTF Phase 1 public consultation, and it was evident that there was an potential alternative option, that includes the best elements from the two options presented during consultation, that could deliver even more planned elective surgery at Cheltenham Hospital, an objective of the centres of excellence strategy.

The planned General Surgery reconfiguration was therefore not included in the FFTF Phase 1 DMBC and the GHNHSFT Surgical Division were charged with working up this alternative option in more detail. This option was supported by GHNHSFT TLT in November 2022 and a separate DMBC is now being produced that will go through necessary governance process in April 2023.

2 Implementation Context



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3 FFTF1 Service Summaries

The sections below summarise the original case for change and describe the benefits delivered as at December 2022.

3.1 Emergency General Surgery (EGS)

Service	**Emergency General Surgery (EGS)**		
FFTF Phase:	#1	**Proposal:**	Centralised to GRH
Implemented:	Yes	**Implementation Date**	01/04/2020
Case for Change:	1) Requirement to reduce extreme Clinical Risks (scored >15) in relation to: • Staffing • Trainee environment • Senior surgical review • Access to sub specialty treatment • Access to emergency theatre		2) Rate of emergency admission is higher than peer group 3) Greater separation of planned and emergency (elective and non-elective) services 4) Creation of separate emergency rotas for Upper GI & Lower GI
DMBC Investment	2 FTE x Urology Registrars (£137,200)		Previously EGS supported Out-of-hours urology rota at CGH
DMBC Benefits	NCRB £314,382 CRB = £0		Detail see below
Benefits Realisation (2022 update)	Extreme Clinical Risks - reduce Staffing and Trainee environment		Risk (GHNHSFT Ref: S2275) Score: Moderate Risk - #6 (Previously Extreme #16)
	Senior surgical review		Risk (S2930) Score: Low Risk - #4 (Previously Extreme #15)
	Access to sub specialty treatment		Risk (S3036) Score: Low Risk - #4 (Previously Extreme #15)
	Access to emergency theatre		Risk (S2930) Score: Low Risk - #4 (Previously Extreme #15)
	Rate of emergency admission is higher than peer group: reduce the admission rate by 20% (NCRB £314,382)		 NCRB = £379,797
	Greater separation of planned and emergency (elective and non-elective) services		Delivered through implementation
	Creation of separate Upper GI & Lower GI emergency rotas		Delivered – patients now see right specialist team, first time

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	The provision of a protected dedicated Surgical Assessment Unit (SAU)	This will be implemented in June 2023 as it is linked to a number of ward moves dependent on delivery of SSD Programme milestones
	Achieve compliance with Regulatory Bodies	This has now been achieved and Theatres provision at GRH is fully compliant with NCEPOD recommendations
	Rota resilience	Yes
	Reduction in Inpatient beds (#8 across all Gen. Surgery, enabled through centralisation)	NCRB as beds have not been closed, but assumed savings incorporated into Division baseline. Notional value (@£381/d = £1.1m)
Remaining		
-Actions		
-Issues		
- Risks	Funding for recruitment of Urology STs	One ST (£68,750) to be funded in 2023/24

3.2 Planned General Surgery

Service	**Planned General Surgery** including upper and lower (colorectal) GI surgery, elective and day case. (a.k.a. "Option C")		
FFTF Phase:	#1	**Proposal:**	Day case and Elective short-stay to CGH Elective longer stay to GRH
Implemented:	No	**Implementation Date**	Planned Summer 2023
Case for Change:	1) Greater separation of planned and emergency (elective and non-elective) services 2) Demand for healthcare is increasing due to population growth		2) Trustwide over 400 operations cancelled on the day for non-clinical reasons e.g. emergency activity requiring bed & theatre capacity
DMBC Investment	2 FTE x ANPs (£112,514)		**Implementation planned for Summer 2023** Required to implement model Not in baseline
DMBC Benefits	NCRB £216,731 CRB = £0		Detail see below
Benefits Realisation (2022 update)	• Greater capacity to cope with higher levels of demand		NCRB £210,000 (Sept 2023)
	• To support sustainable implementation of ERAS (enhanced recovery after surgery) programme		NCRB GSSD (Sept 2023)
	• Reduction in cancellations due to bed pressures		NCRB GSSD (Sept 2023)
	• Reduction in length of stay.		NCRB £5,870 (Sept 2023)
	• Standardisation of pathways		(Sept 2023)
	• Workforce benefits		(Sept 2023)
Remaining			
-Actions	Implementation 2023		
-Issues			
- Risks	FFTF1 investments not in baseline		Option C ANP requirement > 2 FTE

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3.3 Vascular Surgery

Service	**Vascular Surgery -** 24/7 Image-Guided Interventional Surgery hub at GRH including the Vascular arterial centre		
FFTF Phase:	#1	**Proposal:**	Relocated to GRH
Implemented:	Yes	**Implementation Date**	09/06/2020
Case for Change:	1) Undifferentiated emergency admissions will have access to vascular care without the need to transfer to CGH 2) Reduction in inter-site transfers resulting from same site location of vascular and dialysis services		3) Right care, first time enabled through colocation of vascular team, emergency general surgery, 24/7 IGIS hub, trauma and diabetes at the centre of excellence for emergency care
DMBC Investment	£0		
DMBC Benefits	NCRB £0 CRB = £0		NCRB Reduced transfers £44,640 Detail see below
Benefits Realisation (2022 update)	• Undifferentiated emergency admissions will have access to vascular care without the need to transfer to CGH • Reduction in inter-site transfers for vascular inpatients admitted via the other site		Thereby improving the patient experience and reducing time to intervention  NCRB = £36,000
	• Reduction in inter-site transfers resulting from same site location of vascular and dialysis services		 NCRB = £8,640
	• Benefits from colocation of vascular team at centre of excellence for emergency care		• Contributor to length of stay reduction of 0.9days evidenced in diabetes (part of FFTF Phase 2) • 24/7 IGIS hub due in Sept 2023 • Vascular hybrid theatre due in Q3 2023/24
Remaining			
-Actions	Ward location at GRH		Implementation brought forward as part of ICS response to Covid in 2020. Provision of dedicated Vascular ward at GRH will be implemented in June 2023 as it is linked to a number of ward moves dependent on delivery of SSD Programme milestones
-Issues			

- Risks	Completion of all IGIS infrastructure and implementation	• IGIS hub due in Sept 2023 • Hybrid vascular theatre due in Q3 2023/24

3.4 Image-guided interventional surgery (IGIS)

<table>
<tr><td>Service</td><td colspan="3">Image-guided interventional surgery (IGIS) 24/7 ‘hub’ established at GRH (x2 cath-labs, x2 Interventional Radiology (IR) rooms, recovery and day-case areas co-located with vascular hybrid theatre); IGIS spoke (IR room) at CGH</td></tr>
<tr><td>FFTF Phase:</td><td>#1</td><td>Proposal:</td><td>Hub to GRH
Spoke to CGH</td></tr>
<tr><td>Implemented:</td><td>No</td><td>Implementation Date</td><td>Sept 2023 to May 2024</td></tr>
<tr><td>Case for Change:</td><td colspan="3">1) Existing dispersed configuration of facilities for image-guided surgery reduces our capacity to offer minimally invasive techniques
2) Image-guided surgery is currently offered in three separate sites in GHNHSFT, driving up the cost of equipment and storage
3) The Trust’s imaging equipment is recorded on the risk register as being out of date
4) Shortage of radiologists - are not compliant with The Royal College of Radiologists’ recommendation
5) 600 patients travel outside of Gloucestershire for image-guided surgical procedures</td></tr>
<tr><td>DMBC Investment</td><td colspan="2">IGIS Staffing
2 FTE x Band 5 Nurses (£202,000)
0.5 FTE x consultant (£65,000)
Theatre Staffing incl. day case recovery
4.42 FTE (£292,135)
TOTAL = £559,135</td><td>IGIS & theatre investment required from Q4 2023/24
IGIS staff modelling under review. Any cost increase to be included in FFTF Phase 2 DMBC</td></tr>
<tr><td>DMBC Benefits</td><td colspan="2">NCRB = £142,147
CRB = £27,000
Repatriation Income = £463,589
TOTAL = £632,736</td><td>Detail see below</td></tr>
<tr><td rowspan="4">Benefits Realisation
(2022 update)</td><td colspan="2">• Reduction in expired IR inventory (CRB £27,000)</td><td></td></tr>
<tr><td colspan="2">• LoS reduction resulting from new IR procedures replacing open surgery</td><td rowspan="3">NCRB £142,000 (IGIS IR labs due in May 2024)

In addition, shift to IR creates theatre capacity (5 list/week) which could be used for elective recovery activity but would require funding.</td></tr>
<tr><td colspan="2">• Improved access to interventional radiology for patients on an emergency pathway</td></tr>
<tr><td colspan="2">• Improved access to adjacent specialty advice for second opinion / clinical advice</td></tr>
<tr><td colspan="2">• Improved recruitment and retention</td><td>IGIS model and investment in required estate, equipment and infrastructure has improved recruitment in Interventional Cardiology and Radiology with candidates attracted to Gloucestershire by the IGIS model and centres of excellence strategy</td></tr>
</table>

	• Repatriation Income (CRB £463,589)	Repatriation trajectory agreed with service. *See income note below*
Remaining		
-Actions	IGIS implementation	
-Issues		
- Risks	Achieving repatriation income Theatre staffing increase	FFTF1 investments not in baseline Full implementation of the IGIS model may require additional workforce and investment

IGIS Income

- Due to the significant patient benefits that can be delivered through IR procedures, prior to the IGIS estate and equipment coming on line from September 2023, GHNHSFT have increased the number of patients treated using IR procedures.
- Most of this is replacement activity that was previously delivered using more invasive surgical techniques. The productivity and efficiency gains for patients, the ICS and local economy are therefore starting to be delivered as IR procedures result in quicker patient recovery and reduced LoS, enabling patients to resume their lives sooner. Each procedure conducted by the IR team also frees up theatre capacity for other surgical activity, contributing to emergency flow and elective recovery.
- Due to protracted contractual discussions, GHNHSFT is not yet receiving any additional income for these IR procedures.
- Once the full IGIS implementation is complete GHNHSFT will be able to deliver additional IGIS activity as detailed in FFTF Phase 1 DMBC. This requires finalisation of contractual arrangements with NHSE Specialised Commissioning and sub-contract arrangements with other acute hospitals. Activity trajectories have been agreed with IGIS service

3.5 Acute Medical Take

Service	**Acute Medical Take**		
FFTF Phase:	#1	**Proposal:**	Centralised to GRH
Implemented:	No	**Implementation Date**	Planned Sept/Oct 2023
Case for Change:	1) **Clinical** • Healthcare experiences disproportionate increases in demand associated with age, multi-morbidity and socio-economic factors • Demand for healthcare is increasing due to population growth		2) **Workforce** • The Trust had a 43% vacancy rate for acute medical physicians 3) **Performance** • National standards recommend all acute medicine patients to undergo consultant review within 14 hours of arrival. (67%)
DMBC Investment	SDEC Expansion (FTE 1.6/ £72,456) Acute Take staff efficiency (FTE -5.9/ -£187,607) Acute Take income reduction (-£250,000) ACRT business case cost pressure (£397,000) Inter-site Transfers (£277,470)		• SDEC expansion implemented at GRH • Centralised Acute Medical Take planned for Sept 2023 • ACRT investment being phased in
DMBC Benefits	NCRB £144,143 CRB = £187,607		Detail see below
Benefits Realisation (2022 update)	• Increased number of ED attendances managed by SDEC		Baseline: GRH = 32%; CGH = 23%. Sept-Nov 2022: GRH = 56%; CGH = 51% NCRB £144,143.
	• Acute Take staff efficiency		Implemented from September 2023
	• Provision of consultant review within 14 hours of arrival – impact of SDEC and LoS		Increased SDEC (see above) removes <24hr cohort; therefore LoS (excl. SDEC cohort) will increase not decrease. Baseline 1.2d Vs revised target 2-3d.
	• Earlier access to 'in reach' advice from other specialties		Implemented from September 2023
	• Enhanced staff training and support		Implemented from September 2023
	• Improved recruitment and retention		Implemented from September 2023
	• Improved patient pathway and patient experience		Implemented from September 2023
	• Reduction in Acute Take income		No indication that activity has shifted to GWH (see Appendix 3)
	• Reduction in Non-elective admissions associated with reduced SWASFT conveyances		No indication that activity has shifted to GWH (see Appendix 3)
	• Increased SWASFT costs due to centralisation		SWAST have been mostly concerned with handover delays

	• Inter-site Transfers	When combined with FFTF2 changes estimate revised to £400,177 but efficiency opportunities anticipated – work in progress.
Remaining		
-Actions		
-Issues		
- Risks	• 'Go' criteria for centralisation not met • Ability to realised ACRT business case FTE savings to limit cost pressure to £397k • Risk that FFTF Phase 2 DMBC is not approved, including investment in Respiratory High Care Service required to mitigate pressure on GRH DCC	• Acute Take Go/No Go task & finish group set up by GHNHSFT, Chaired by Medical Director. All 'Go' criteria to be met by September 2023 or implementation re-scheduled • ACRT staff model being reviewed by GHNHSFT

3.6 Formalise 'Pilot' Configuration Gastroenterology

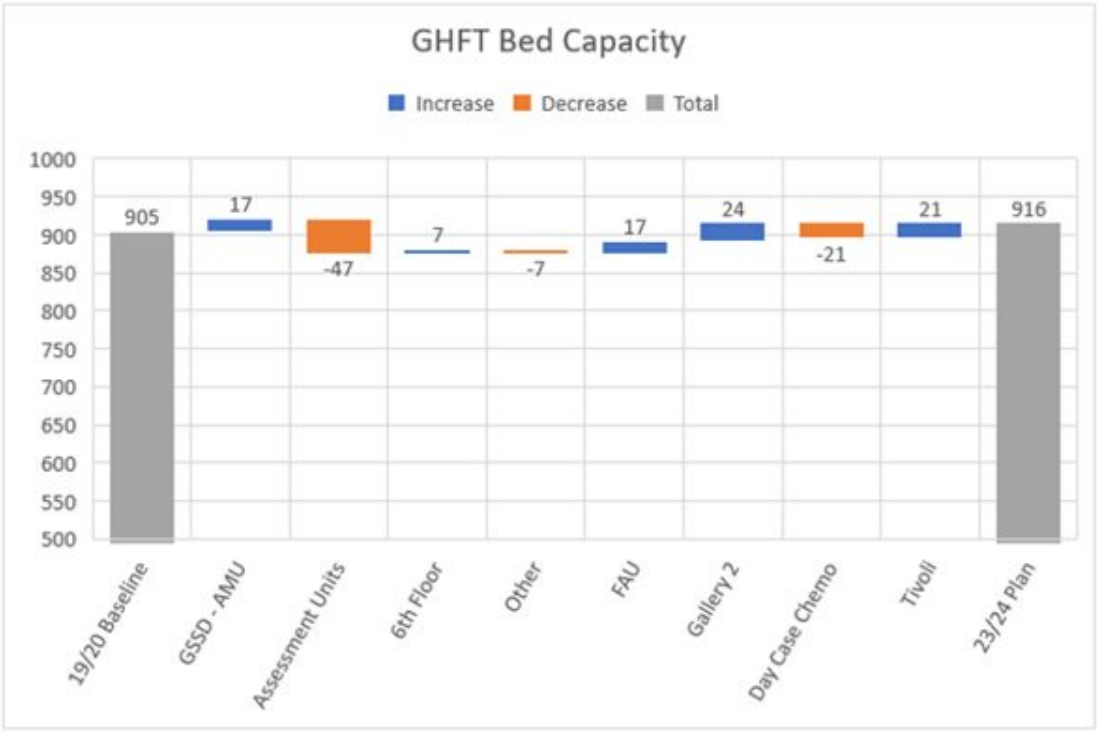
Service	**Formalise 'Pilot' Configuration Gastroenterology**		
FFTF Phase:	#1	**Proposal:**	Centralised to CGH
Implemented:	Yes	**Implementation Date**	November 2018
Benefits	Benefits part of Business As Usual.		

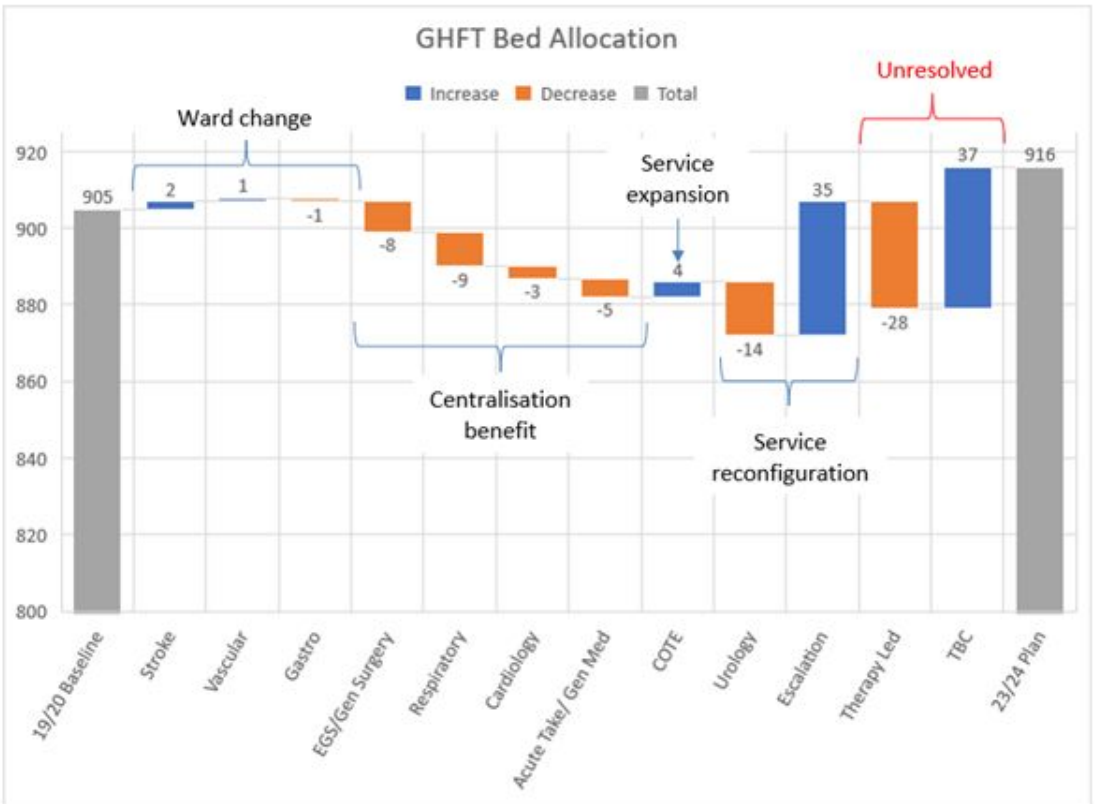
3.7 Formalise 'Pilot' Configuration Trauma and Orthopaedics

Service	**Formalise 'Pilot' Configuration Trauma and Orthopaedics**		
FFTF Phase:	#1	**Proposal:**	Trauma to GRH Orthopaedics to CGH
Implemented:	Yes	**Implementation Date**	October 2017
Benefits	Benefits part of Business As Usual		

4 Appendices

4.1 Appendix 1: Proposed Bed Modelling Capacity and Allocation





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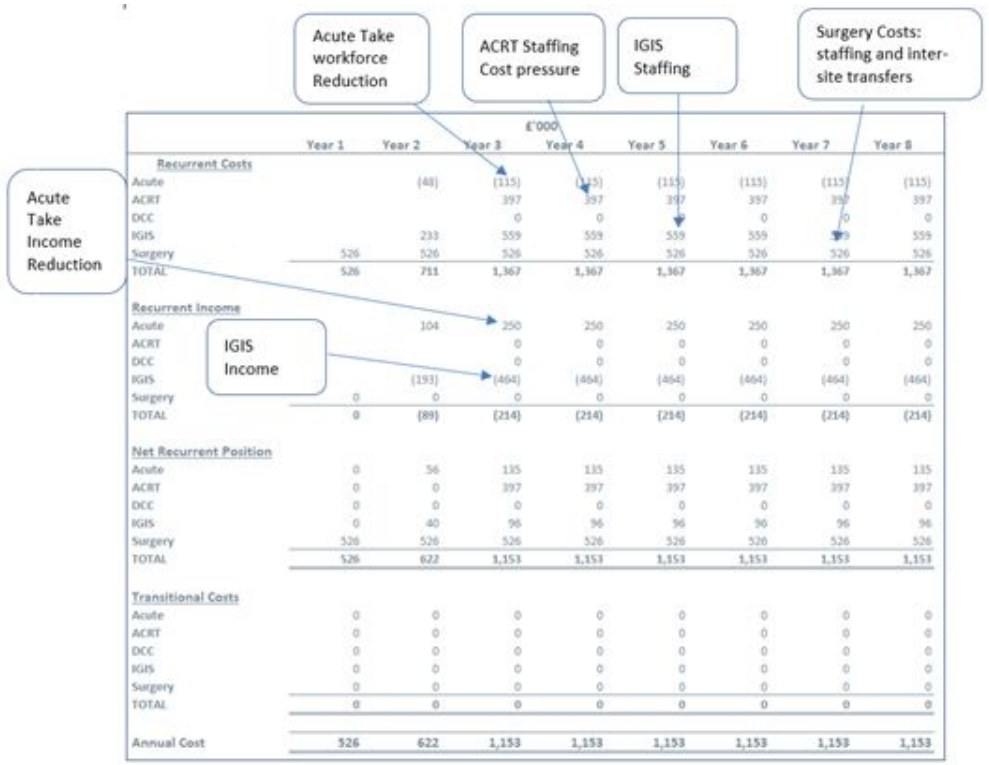
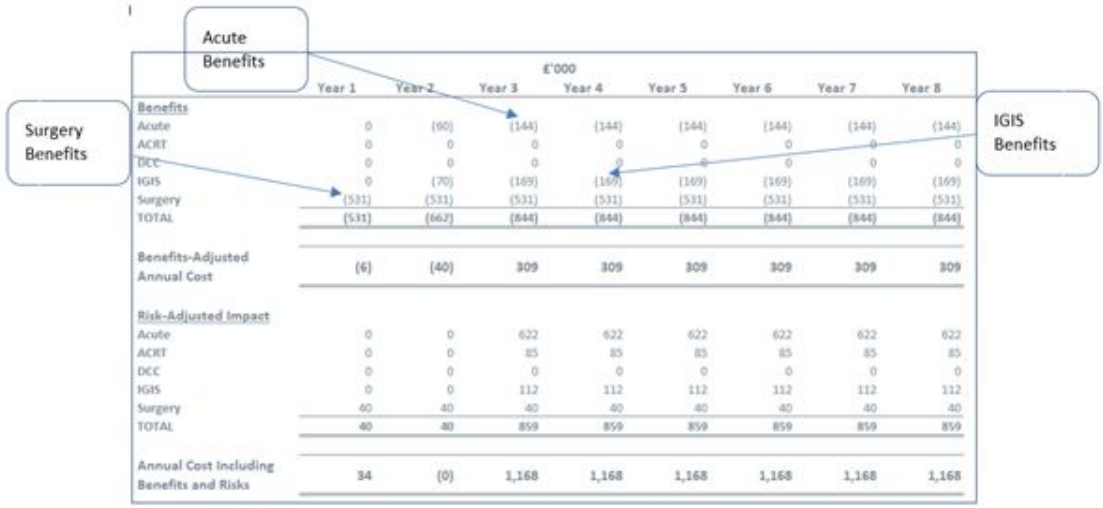
4.2 Appendix 2: FFTF1 DMBC Approved Financial Case





			Of which already within GSSD		New / Unclaimed benefits	
	Cash-Releasing Benefit	Non-Cash-Releasing Benefits	Cash-Releasing Benefit	Non-Cash-Releasing Benefits	Cash-Releasing Benefit	Non-Cash-Releasing Benefits
Emergency and Acute Medicine	793,886	3,134,353	793,886	2,990,210	0	144,143
Emergency General Surgery	0	314,382	0	0	0	314,382
Elective Colorectal Inpatient Surgery	0	93,054	0	49,800	0	43,254
General Surgery Day Cases	150,000	173,477	150,000	0	0	173,477
IGIS	27,000	142,147	0	0	27,000	142,147
	970,886	**3,857,414**	**943,886**	**3,040,010**	**27,000**	**817,404**

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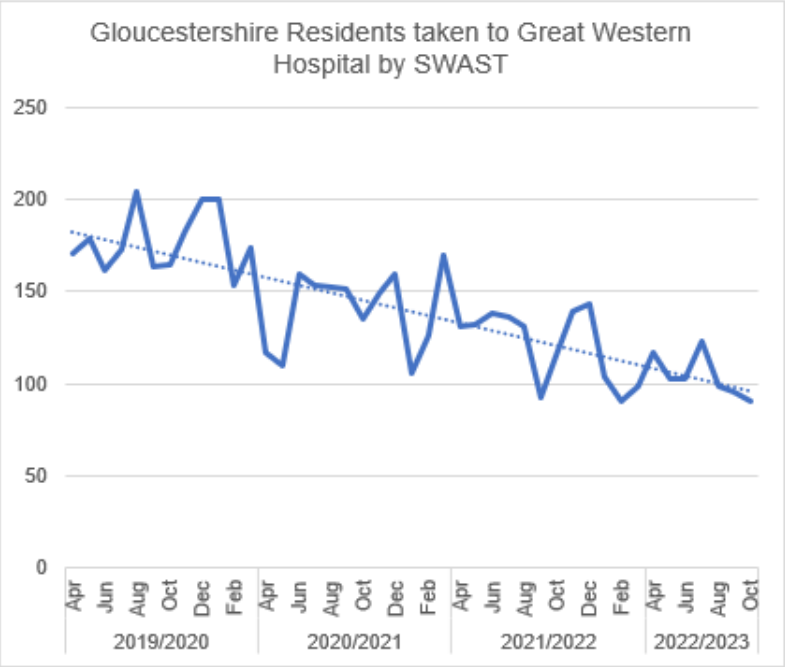
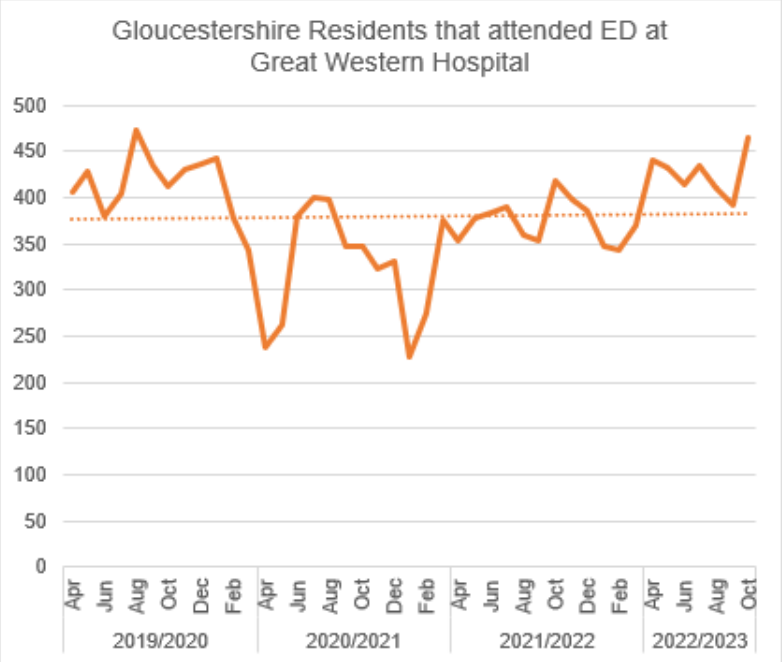
4.3 Appendix 3: GWH ED Activity





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Agenda Item 11

NHS Gloucestershire ICB Board

25th January 2023

Report Title	**Extension of existing Section 75 (joint funding arrangements) between Gloucestershire County Council (GCC) and NHS Gloucestershire to 31 March 2025.**		
Purpose (X)	**For Information**	**For Discussion**	**For Decision**
			X
Route to this meeting	Prior engagement pathways this paper has been through, including outcomes: Cabinet Decision (pending 25/01/2023) – as outlined below. As a Section 75 Agreement is a mandated requirement an extensive engagement process has been undertaken during 2022, and the approach to extend the existing agreement, as well as further work to explore options, has been agreed by the below. ICB Development Session (21/12/2022) ICS Strategic Executive (15/12/2022) ICS Operational Executive (25/10/2022) Joint Commissioning Partnership Executive (19/10/2022) Previous decisions for background. Officer Decision (22/03/2021): Section 75 Agreement with Gloucestershire Clinical Commissioning Group Cabinet Decision (11/03/2020): Section 75 Agreement with the Gloucestershire Clinical Commissioning Group for the commissioning of health and social care services		
Executive Summary	To seek authority to exercise a 2-year extension option under the council's Framework Partnership Agreement with NHS Gloucestershire Integrated Care Board (NHS GICB), (the successor body to NHS Gloucestershire Clinical Commissioning Group (GCCG) with whom the agreement was entered into originally) relating to the commissioning of health and social care services.		

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Key Issues to note	The extension to the existing s75 agreement is to give a further 2 years to explore the opportunities to consolidate contracted health and care services. Whilst the s75 agreement is a mandated requirement, the Gloucestershire system has additional annual agreements within Section 76's and Section 256's (as outlined in the financial impact section) that potentially could transfer to the overarching s75 agreement for greater transparency of all for joint funding arrangements purchased for community health and care services. This funding agreement is outside of Acute and Primary Care arrangements.			
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The main risk is to not have a current Section 75 in place for 1 April 2023 which would have significant consequences to services funded by this money. The original and residual risks are low. 5 x 2 5 x 1			
Management of Conflicts of Interest	No conflicts of interest have arisen.			
Resource Impact (X)	**Financial**	X	**Information Management & Technology**	
	Human Resource		**Buildings**	

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Financial Impact	The Section 75 Agreement in Financial Year 2022/23 (subject to year-end variations) totals £188m as reported to the Joint Commissioning Partnership Executive on the 24 November 2022 i.e., £149m NHS GICB and £39m GCC. This includes Continuing Health Care and Funded Nursing Care which is solely NHS at a value of £46m. It also includes Adult and Children's Mental Health services at £79m of which £61m relates to Adult Mental Health within NHS Gloucestershire. It covers the Better Care Fund (BCF) at a value of £54m including Carers. The remainder is Integrated Community Equipment Services, Occupational Therapy, and Integrated Brokerage staffing. The financial schedule within the Section 75 Agreement is reviewed annually to reflect any funding changes, such as demographic growth, inflation, agenda for change and savings. The council and NHS Gloucestershire Integrated Care Board are mandated to have a Section 75 Agreement in place for the Better Care Fund. The use of a Section 75 Agreement is also required under new government funding re: the DHSC: Adult Social Care Discharge Fund funding announced on the 18 November 2022 to be included in the BCF. This new funding will be in addition to the existing £54m in the BCF. The other mainstream services that are already commissioned under the Section 76 and Section 256 transfer agreements are outside the scope of this decision. Their future inclusion within the Section 75 Agreement will be subject to further consideration and any such expansion will be subject to a separate decision. As of 19/12/22, the following Section 76s and Section 256 Agreements are in place: The council has 40 Section 76 Funding Transfer Agreements with NHS GICB under which the forecast out-turn in the period 2022/2023 is c£14.2m, of which £11.6m relates to Public Health services. Other examples include Community Wellbeing, Dementia and Extra Care. NHS GICB has 28 Section 256 Funding Transfer Agreements with the Council under which the forecast out-turn in the period 2022/23 is c£14.2m, of which over £10.4m will be used to fund placements for complex children and adults with a learning disability. This is in addition to the forecast ICB spend £15.8m (£12.1m placements).
Regulatory and Legal Issues (including NHS Constitution)	Regulatory and legal issues for both the NHS and GCC constitutions are covered within overarching Section 75 Partnership Arrangement.

Impact on Health Inequalities	The s75 Agreement is a mechanism for transferring funding to support contracts such as Gloucestershire Health and Care and for services purchased on behalf of NHS via GCC mechanisms such as Funded Nursing Care and Continuing Health Care. These are covered by the contracts (service specifications) which are funded via s75 agreement.		
Impact on Equality and Diversity	. No EIA was required. These are covered by the contracts (service specifications) which are funded via s75 agreement.		
Impact on Sustainable Development	No Impact on Sustainability was required. These are covered by the contracts (service specifications) which are funded via s75 agreement.		
Patient and Public Involvement	No Patient and Public Involvement was required. These are covered by the contracts (service specifications) which are funded via s75 agreement.		
Recommendation	The Board is requested to: • Approve the exercise of a 2-year extension option under a Framework Partnership Agreement between the council and NHS GICB relating to the commissioning of health, public health, children's and adult social care services (in exercise of powers under Section 75 of the National Health Service Act 2006) that was entered into pursuant to a Cabinet decision on 11 March 2020 (the "Section 75 Agreement").		
Author	Donna Miles	**Role Title**	Head of Integrated Commissioning – Community Care
Sponsoring Director (if not author)	Kim Forey, Director of Integration		

Glossary of Terms	Explanation or clarification of abbreviations used in the paper
ICS	Integrated Care System
ICB	Integrated Care Board
GHC	Gloucestershire Health & Care Foundation Trust
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GCC	Gloucestershire County Council
VCSE	Voluntary, Community and Social Enterprise
Add more as required	
S75	Section 75 Agreement
S76	Section 76 Agreement (Council to NHS)
S256	Section 256 Agreement (NHS to Council)

Agenda Item 12

ICB Board
25th January 2023

Report Title	**Emergency Preparedness Resilience and Response (EPRR) Annual Assurance paper 2021/22**				
Purpose (X)	**For Information**		**For Discussion**		**For Decision**
	x				
Route to this meeting	The pathway undertaken for this paper was the NHS EPRR assurance process, submission of evidence and assurance rating from confirm and challenge meetings and feedback from NHSE held between October and November 2022.				
Executive Summary	As part of the EPRR annual assurance process we are bound by NHSE to summit the feedback to the ICB Board, on the level of assurance that has been rated from the evidence that was submitted and the confirm and challenge meetings that were held for Gloucestershire health and Care NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, and the Integrated Care Board.				
Key Issues to note	**<u>Common challenges/issues</u>:** A common theme across all organisations was more emphasis needed on Business Continuity training and especially needing Business Impact Assessments (BIAs) in place for all key services. EPRR attendance for training and exercise needs further improvement /support. This was a key identifier in the Manchester Arena report ('too busy'). To support this the ICB took on an EPRR training lead in September and training is being offered collaboratively across our health / LRF partners where able and applicable. This role also includes the health training lead with our LRF. E.g., Loggist training and joint exercises.				
Key Risks: **Original Risk (CxL)** **Residual Risk (CxL)**	The ICB not being prepared well enough to respond to Incidents by either not having unto date departmental Business Continuity plans and or On call staff not meeting EPRR training requirements. Both areas are the focus of EPRR work over the next few months.				
Management of Conflicts of Interest	**N/A**				
Resource Impact (X)	**Financial**		**Information Management & Technology**		
	Human Resource	x	**Buildings**		
Financial Impact	What financial impact will there be to the ICB and/or wider system? If small, include 'small financial impact' and try to outline. If significant, this should be further discussed within the detail of the report. **N/A**				

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Regulatory and Legal Issues (including NHS Constitution)	Consider statutory requirements and laws. How does the issue / project relate to the NHS constitution and the ICB constitution? Are there any potential legal issues that could arise that the Board/Committee need to be aware of? **N/A**		
Impact on Health Inequalities	This is about patients. How will this impact on health inequalities for people? **N/A**		
Impact on Equality and Diversity	An EIA should be completed for large scale projects and initiatives and the outcomes should be included here. **N/A**		
Impact on Sustainable Development	Will there be any impact on sustainability of programmes, places or people. How does the proposal meet the ICB/ICS objectives for sustainable developments? **N/A**		
Patient and Public Involvement	Will the decision impact on patients, carers, families or the public? If so, how have they been involved in the process? Will the report be published anywhere? **N/A**		
Recommendation	The Board is requested to: Note the content of this report and record it in the minutes of the meeting.		
Author	Rachel Minett	**Role Title**	ICB Emergency Planning Manager
Sponsoring Director (if not author)	Executive Lead, if not the author. Dr. Marion Andrews-Evans.		

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
EPRR	Emergency Planning Resilience and Response

Agenda Item XX

Board of the ICB

25th January 2023

1. Introduction

1.1. The EPRR assurance process is an annual NHS mandated process for ensuring that NHS organisations meet statutory EPRR standards as set out in EPRR framework. https://www.england.nhs.uk/ourwork/eprr/gf/ .The process is by submission of evidence to meet the standards and confirm and challenge meetings with partner organisations and NHS regional team.

2. Purpose and Executive Summary

2.1. **EPRR Core Standard 2021/22 summary.**

2.2. This assurance summary has been completed by NHS Gloucestershire ICB in fulfilment of the NHSEI National EPRR Core Standards assurance process. The diagram below shows the snapshot in time as it was on Monday 30th November 2022, when the ICB was assessed in a virtual meeting by EPRR colleagues from NHSEI EPRR.

2.3. NB. During the Covid years 2020 and 2021 the assurance process was a lighter touch. In 2022 the process went back to being more in-depth and with a different expectation and preparedness level for CCG changing from a Cat two to a Cat one responder as an ICB. This year's assurance levels now reflect the more in-depth approach and growing NHS challenges.

2.4. NHS Feedback: ICB outcome from the 2022 EPRR Core Standards review

2.5. This year following a tri-annual review of the National Core Standards a full assurance process took place. The table below summarises the outcome of the assurance review and provides the overall compliance rating:

Organisation	2020	2021	2022
NHS Gloucestershire ICB	Substantial CCG	Full CCG	Substantial ICB

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Provider Assurance levels:

Organisation	2020	2021	2022
E-Zec Patient Transport Services (PTS)	Fully Compliant	Fully Compliant	Fully Compliant
Practice Plus Group (PPG) formerly Care UK	Unknown	Fully Compliant	Substantial
Gloucester Hospitals NHS Foundation Trust	Substantial	Substantial	Substantial
Gloucestershire Health and Care NHS Foundation Trust	Substantial	Substantial	Substantial
NHS Gloucestershire CCG/ICB	Substantial	Fully Compliant	Substantial

2.6. Considering the pressures that have been ongoing throughout this assurance period, the organisations should be congratulated on their performance. EPRR assurance is a deep searching evidence based process that requires a considerable amount of preparation that could barely be spared during this past twelve months.

2.7. We have seen great improvement across all of our providers and as a commissioning body are satisfied with the standards achieved, which are based on self-assessment and then through confirm and challenge meetings during September and October 2022.

2.8. All organisations have recognised the increase in EPRR workload in the last two years and this is on a continuing trajectory. A lot has been learned through Covid, the Manchester Arena report, and the Business Continuity challenges and risks that we are facing. Further endorsing the need for well supported EPRR teams and to imbed EPRR in our cultures and departmental work plans.

2.9. Key identified ICB areas needing improvement are:

- Core Standard 7: Risk Assessment
- Core Standard 21: Trained on-call staff

- Core Standard 22: EPRR Training
- Core Standard 23: EPRR Exercising and Testing Programme
- Core Standard 24: Responder Training
- Core Standard 46: Business Impact Analysis/Assessment

These are being addressed through the ICB EPRR work plan over the next 12 months.

2.10. **Areas of notable EPRR good practice:**

- GHFT: noted the systematic nature in which Gloucestershire Hospitals has approached its EPRR over the last two years, which has enabled it to continually reflect and improve their planning and response capabilities.
- Gloucestershire Health and Care: noted the novel way in which the organisation was approaching its training by deploying a range of packages to suit different requirements.
- The adaptability to have virtual Incident Coordination Centres (ICC)
- Good collaborative EPRR work.

2.11. **Common challenges/issues:**

- A common theme across all organisations was more emphasis needed on Business Continuity training and especially needing Business Impact Assessments (BIAs) in place for all key services. EPRR attendance for training and exercise needs further improvement /support. This was a key identifier in the Manchester Arena report ('too busy'). To support this the ICB took on an EPRR training lead in September and training is being offered collaboratively across our health / LRF partners where able and applicable. This role also includes the health training lead with our LRF. E.g., Loggist training and joint exercises.

- Due to the age (old) of a considerable amount of GHC and GHT estates, challenges for Shelter / Evacuation, Lockdown and environmental temperature control esp. in hot weather remain. However, there is a lot more emphasis to address this in planning and work is ongoing to minimise the risk and mitigate any impacts.

3. Considerations for EPRR improvement/ development activity:

3.1. During the time of the Covid-19 Pandemic, all organisations have struggled to maintain response plans that are completely up to date and can bear scrutiny. There is still a considerable amount of catching up to be done alongside continuing the transition to an Integrated Care Board and step up to a Cat one responder responsibilities.

3.2. Throughout very difficult times during the past twelve months, both the CCG now ICB and their Providers have at least maintained their level of assurance measured against National Core standards for EPRR. This is a remarkable achievement, and all parties should be congratulated.

4. Recommendations

The Board is asked to:

4.1. Note the content of this report and record it in the minutes of the meeting.

People Committee
Minutes from 6th October 2022
9:00 am – 12:00

Members present		
Clive Lewis	CL	Non-Executive Director, Committee Chair, ICB
Jane Cummings	JC	Non-Executive Director, Committee Vice-Chair, ICB
Tracey Cox	TC	Interim Executive Director of People, Culture and Engagement, ICB
Mary Hutton *(from 9:15)*	MH	Chief Executive Officer, ICB
Marion Andrews-Evans *(from 9:30)*	MAE	Chief Nursing Officer, ICB
Andy Seymour	AS	Chief Medical Director, ICB
Sarah Scott	SS	Director of Adult Social Care,
In Attendance		
Lauren Peachey	LP	Governance Manager, ICB (minutes)
Neil Savage	NS	Director of HR & OD, GHC
Deb Evans	DE	Chair and Non-Executive Director, GHFT
Ruth Thomas	RT	Associate Director: OD, Learning and Development, GHC
Sophie Atkins	AS	ICS People Programme Manager, GHC
Claire Hines	CH	ICS - Workforce and OD Project Lead, GHC
Claire Radley *(from 9:11)*	CR	Director for People, GFHT
Ali Koeltgen	AK	Deputy Director of HR and OD

Christina Gradowski	CGi	Associate Director of Corporate Affairs,ICB

1.	**Apologies and Introduction**
1.1	No apologies were received.
1.2	CL welcomed the members and attendees to the second People Committee of the Integrated Care Board (ICB). It was confirmed the meeting was quorate.
2.	**Declarations of Interest**
2.1	The Chair asked if any members or attendees in the meeting held any interest in any items on the agenda. No interests were declared.
3.	**Minutes of the meeting held on the 14th of July 2022**
3.1	**Resolution: The minutes of the meeting held on 14th July were agreed as an accurate record of the meeting.**
4.	**Actions Log**
4.1	There were no open actions to discuss.
5.	**ICS People Function Summary Report**
5.1	TC summarised the key issues from the Integrated Care System (ICS) People Function Summary Report. TC said that a key potential workforce challenge was the threat of industrial action by doctors and nurses. TC explained that the Royal College of Nurses opened their ballots for strike action on the 6th of October 2022 with a closing date of the 2nd of November. The Junior Doctors Committee of the BMA were expected to open a ballot in January 2023. TC explained the potential for significant strike action would likely occur during the peak of Winter which would result in substantial challenges in the system.
5.2	NS explained that Unison's Head of Health had written to provider organisations explaining the formal dispute with provider organisations and that formal ballot notices were to follow in due course. NS said that provider organisations' Emergency Planning and Business Continuity Leads were refining their Business Continuity Plans.
5.3	AS said the BMA had recently published high standard rates for consultant overtime. DE added that the situation was complex; staff had expressed concern about the quality of care they are able to provide given the current day-to-day working challenges which may be contributing to the unrest. CL asked

	how the committee would remain informed about this risk. TC responded that keeping the dialogue open with the Social Partnership Forum would be critical.
5.4	TC said there was an issue relating to the impact of the 2022/23 pay award and the effect this had on take-home pay due to the increased pension contribution.
5.5	TC said the national position around vacancies had deteriorated over the last 6 months.
5.6	TC highlighted the Health and Care Support Worker Recruitment Event had been successful with 270 job offers made on the day; distributed across the system. The next step would be onboarding.
5.7	TC said the ICS had been successful in receiving non-recurrent funding for several bids including the Leadership Academy Bid and the Nursing and Allied Health Professions Community Upskilling Funding for 2022-23.
5.8	In terms of Equality, Diversity and Inclusion, TC said the ICB had made a successful application to be part of the Diversity in Health and Care Partners programme being hosted by NHS Employers. October was Black History Month and local events were being promoted within organisations. The ICB had a successful Black, Asian and Minority Ethnic Away Day which included hearing about the experiences of the networks in other systems.
5.9	In terms of the Health and Care Support Worker Recruitment Event, CL asked when successful candidates were likely to commence in post and how these offers were split across providers. TC responded that the highest number of these were going to Gloucestershire Hospitals NHS Foundation Trust (GHFT). TC said the onboarding process was going to be monitored to work towards reducing the attrition rate, which had been 30% in other parts of the county for similar events. CR said the start dates were expected to be two to three months from the time the offer was made; this was in part governed by mandatory processes such as lengthy employment checks.
5.10	AS asked if it were possible to commence some aspects of the induction during the onboarding process. NS responded that some aspects could be offered however there would be no obligation for people to engage in this prior to formal employment.
5.11	CR explained the challenges for band 2 and band 3 pay as a national issue in terms of the cost of living. NS explained that although all staff were earning above the national minimum wage, there were staff who were earning less than the real living wage which had recently increased to the top of band 2. CL highlighted that this was a risk that needed to be escalated at a national level. NS responded that there were regional and national forums where this can be raised at

	ACTION: To record a risk around staff earning lower than the real living wage.
5.12	**Resolution: The committee noted the contents of the ICS People Function Summary Report**
5.16	**Workforce Report September 2022**
6.	CH explained that the current key workforce issues in the system were high vacancies and the potential impact arising from the cost-of-living crisis. CH added that there had been an increase in the 12-month leaver rate for both the NHS and Adult Social Care. Data on sickness rates until July 2022 had also increased in the NHS however they had decreased in Adult Social Care. CH explained that there was an ambition to include Children's Social Care in these data sets going forward.
6.1	CH said that there had been a small reduction in nursing vacancies and for the Integrated Care System (ICS) there had been an overall increase in registered nursing staff employed.
6.2	In terms of Primary Care, CH said the latest data was from August 2022. GP Whole Time Equivalent (WTE) per 10k weighted population had increased which was expected to be partly due to the increase in GP trainees. Direct Patient Care was very slightly reduced in terms of WTE per 10k.
6.3	CH explained that there was a key risk in terms of data quality; the definitions of many of the metrics used were different between individual organisations and across the region. CH was writing a list of queries for NHSE regarding the development of consistent definitions.
6.4	CL asked if the reason for the increase in staff sickness was known and if this could be due to Long Covid. CH responded that the data available didn't show a single clear reason. CH added that it was usual to have seasonal variations for sickness absence. CGi explained that Long Covid was not identified as a unique reason for reporting staff sickness, therefore staff who were off due to Long Covid would be recorded within existing sickness reporting reasons.
6.5	AS suggested for primary care data excluding Registrars from the headline data as it takes time for them to be effective in the workforce. AS suggested that the headline data did not identify parts of the county which were experiencing the most difficulties. CH responded that the local metric could be amended to reflect these requests however the Strategic Oversight Framework had strict requirements and could not be amended.
6.6	SS highlighted the benefit of including children's social care data. SS highlighted that there would be 11 social workers starting in September; a further 14 were

	expected to start in September 2023. SS added that this recruitment would support issues around UEC.
6.7	**Resolution: The committee noted the contents of the Workforce Report September 2022**
6.8	**ICS WRES and WDES performance and action plans**
7.	TC explained that there were nine Workforce Race Equality Standards (WRES) that the NHS was required to adhere to report on an annual basis. This formed part of the standard NHS contract for providers.
7.1	TC detailed the WRES and WDES position for Gloucestershire, showing the comparison between GHFT, Gloucestershire Health and Care (GHC), the ICB, and the South-West. TC showed how Gloucestershire compared against the national position. TC explained that, except for GHFT, the ICS employed a lower-than-expected number of people from a Black and Minority Ethnic background in relation to the local population. TC explained that, in terms of underrepresentation occurring across pay bands, the position was variable.
7.2	TC defined the Race Disparity Ratio as a measure of the progression of Black and Minority Ethnic staff from low to higher levels in the workforce. By comparing Black and Minority Ethnic representation amongst the lower set of pay bands with Black and Minority Ethnic representation at a higher set of pay bands; a value of 1 indicated equity and representation at higher and lower levels, a value greater than 1 indicated that staff were underrepresented, at the higher pay bands, a value below 1 indicated staff were overrepresented.
7.3	TC explained the differences in the experience of staff in relation to entering formal disciplinary process. In all instances, the experience of Black and Minority Ethnic staff was worse compared to staff from a white background.
7.4	RT detailed the GHC WRES key actions. RT highlighted that, overall, raising awareness of the key issues had supported a fundamental shift in approach. Raising awareness had contributed to an improved level of the completion of Equality Impact Assessments and employee information being shared with the organisation and recorded on ESR. NS added that it was too early in the action programs to understand their long-term outcomes. NS added that the staff networks established within GHC have been significant in developing and supporting campaigns within the organisation, such as the Race Equality Network, Disability Network, and Women's Network. NS said there was a film about the Black and Minority Ethnic staff experience through the pandemic. **ACTION: NS to Share the link to the film.**

7.5	NS explained that GHC had taken positive action in recent board appointments, which made a difference to the diversity on the board, in addition to taking positive action with several senior management positions.
7.6	CL asked if the data captured progress. RT responded that the data had been captured every year since 2015. RT explained that with a small sample size, just one person could impact the percentage of figures significantly.
7.7	CR explained that, in addition to the WRES and WDES data, there was also data collected from the annual NHS staff survey which provided detail about staff experiences such as bullying, harassment and a sense of equal opportunities. CR added that GHFT had put in place a quarterly survey which provided an opportunity to frequently monitor whether the interventions that are being put in place were making a difference.
7.8	CR summarised the WRES and WDES key actions taking place in GHFT. CR said there had historically been an organisational culture of tolerance for poor behaviour. There was work underway to support underrepresented groups through recruitment processes. CR said there was work to be done on capturing and explaining stories and narrative to support empathy and create a better sense of understanding. Black history month provided a good opportunity to showcase stories of staff who were willing to share.
7.9	CR expressed concern about the disproportionate number of ethnic minority staff who go through disciplinary processes, often they were no more likely to have a sanction at the end of the process. CR explained that the implementation of the Restorative Just Culture programme would be key to addressing this issue. Twenty places for the Restorative Just Culture program have been secured across the system and HR leads were prioritised for access to the programme. NS added that the Restorative Just Culture combined with the Civility Saves Lives campaign could have a significant impact. CGi observed that Black and Minority Ethnic employees were disproportionately overrepresented in the lower-graded staffing groups.
7.10	SS explained that Social Care were not included in the NHS indicators discussed however, similar issues were being experienced in Social Care. SS asked how the data and experiences of Social Care could be included in the discussions. SS explained that Social Care were finalising an audit against the LGA equalities framework to identify good practice and gaps. The outcome of this audit will inform the Equality, Diversity and Inclusion action plan for the organisation.
7.11	TC highlighted there were opportunities to join up programmes and experiences across the NHS and Social Care. TC highlighted the Flourish programmes were offered to both Social Care and NHS employees.

7.12	JC explained that the trend analysis and level of improvement over the last seven years since WRES and DES were established was a key factor to consider. JC advised that a zero-tolerance culture of poor staff behaviour has been seen to support staff in speaking up about issues and making a push for positive action. JC added that it was often more impactful to focus on just a few initiatives at a time to avoid overwhelm.
7.13	TC said the Southwest Equality and Diversity workshop held in 2021 had some excellent resources provided as part of it. **ACTION: TC to circulate the resources from the Southwest Equality and Diversity workshop**.
7.14	CGi detailed the Equality and Diversity programmes in which the ICB had participated in, such as the Flourish Programme, Chairs training and the establishment of the Black and Minority Ethnic Group including support from a Equality, Diversity and Inclusion specialist. CGi added that the Clinical Commissioning Group, prior to becoming an ICB, had employed two Lay Members in developmental roles from a Black and Minority Ethnic background. CGi said the CCG had commissioned a compliance and culture review with specialist Equality, Diversity and Inclusion support which identified a number of recommendations for the CCG/ICB to implement.
7.15	MH highlighted that the CCG Graduate Scheme had been successful in the past and suggested that an ICS Graduate Scheme, focused on providing more opportunities for people with protected characteristics, might also prove to be successful. CGi added that a corporate scheme which had seen success in other organisations was the Handshake Scheme.
7.16	CL asked if there was an Allyship Programme in Gloucestershire. RT responded that the ICS ran an Allyship Programme this year, 2022/23, which had an uptake of around 100 people. A formal evaluation of the programme was underway.
7.17	TC summarised the future system developments and opportunities. RT emphasised that there was likely to be a significant additional amount of work to do with regard to the Equality Delivery System following guidance that was issued in August 2022.
7.18	In terms of the WDES, TC summarised that the percentage of the workforce with a disability compared to the national average was slightly under or below across all organizations. With the exception of GHC, staff with a disability were less likely to be appointed than staff without a disability. Staff with a disability were more likely to experience bullying and harassment. With the exception of the ICB, staff with a disability believe their organisation provides equal opportunities for career progression.

7.19	TC summarised the future system opportunities which specifically related to WDES. TC said the ICS had been successful in a bid to do some mapping around line management training and quality of management training. There was further potential to develop positive action targets in some areas.
7.20	RT observed that capturing WDES data was often challenging as staff were less likely to disclose information regarding disabilities.
7.21	**Resolution: The committee noted the contents of the ICS WRES and WDES performance and action plans**
7.22	**Recruitment and Retention Update**
8.	NS explained that risk around recruitment and retention had become increasingly significant and was reported at the Board level in GHC. NS added that the level of tolerance for this risk had also increased. A new Recruitment and Retention Strategic Framework had been approved that outlined the GHC workforce priorities and provided a long-term focus. There was a further deep dive at the Great Place to Work Committee planned for October 2022.
8.1	NS said GHC had a vacancy rate of approximately 12% which was the highest on record for GHC, however, it was lower than the model hospital peer benchmark. Many of the GHC vacancies were for the Admin and Clerical staff group and Health Care Assistants. NS said the vacancy rate began to improve and the number of new starters was now higher than the leavers each month. NS said there were also challenges in recruiting and retaining registered nurses in the community positions.
8.2	In terms of staff turnover, NS said that there was room for improvement, however, the local position compared favourably to the benchmark organisations. The trend data showed that staff turnover had doubled since 2021. NS explained that a key factor in this turnover rate was due to pension changes at the end of March 2022.
8.3	NS summarised the five delivery pillars of the Recruitment and Retention Strategic Framework. AK said the work was underpinned by workforce retention and taking a sustainable approach. AK added that recruitment into hospitals in urban areas required a very different approach to recruitment in rural areas.
8.4	In terms of international recruitment, NS said there had been work underway to achieve the recruitment target of 38 Community Nurses, 35 Mental Health Nurses and ten Community ICTs by the end of the year 2022/23. NS explained that the recruitment process was lengthy. AK said the work on developing pastoral care for international staff had been recognised and appreciated by the workforce. AK highlighted support for international recruits went beyond their first six months in post, to help them settle, particularly in rural areas. NS said

	finding appropriate accommodation was key to supporting international recruits. CGi added that accommodation was very expensive in Gloucestershire and the UK. MAE added that other parts of the UK had raised the issue around the cost of accommodation. MAE said a challenge in recruiting into community positions was that people may not have a UK driving license. NS highlighted the expense of keeping a car and the payment mechanism for mileage was not always enough to cover expenses.
8.6	TC said that NHSEI had carried out a staff accommodation survey and there was a sample size of around 2500 across the Southwest region. Despite the geographical differences, there were noticeable trends seen in the general feedback from staff in terms of rent prices and the type of accommodation that they needed. TC added that a discussion with Reef Housing on key worker accommodation in central Gloucester which was being broadened out to a whole system conversation. There are initiatives such as Home-share and Home Stay that could be further expanded. The Southwest NHSEI team were looking to produce information packs around navigating the housing processes and local area guides for each system.
8.7	MH said there was a very good and active strategic housing partnership in Gloucestershire, looking to identify options which could be further developed to support staff which were being looked into.
8.8	CR explained that the GHFT vacancy levels were fairly high with approximately 850 vacancies, a significant portion of this was nursing vacancies. In terms of turnover, CR added that the biggest turnover rates were within the estates and ancillary areas.
8.9	CR said there was a workforce risk on the Board Assurance Framework which was recently scored at a 20. CR said, in conversations at GHFT, recruitment was being split out from culture and retention, as they needed to be treated differently.
8.10	CR said there were significant plans in place, particularly around the band 5 vacancies and the healthcare support worker vacancies.
8.11	CR expressed concern that every month, there were more leavers than new starters at GHFT, particularly across nursing and midwifery. CR explained there was a Recruitment Transformation Programme underway and the issues were now better understood. CR explained the importance of the Recruitment Transformation Programme to speed up recruitment which would support the recruitment of nurses and midwives. CR explained the retention programme was essential to supporting staff to remain in post.
8.12	CR said the establishment increased significantly in December which accounted for a sudden increase in vacancies at that time.

8.13	CL asked if there were common themes in the exit data. CR responded that there was limited exit data and the exit interview process would benefit from a review. CR explained that the most common reason for leaving was indicated as 'work-life balance' however this did not provide a good level of detail as to why people were leaving. CR explained that the NHS was a difficult environment to work in given the current challenges. CR described that there was also a 'Stay' process which focused on staff retention.
8.14	CR explained that the vacancy rate for medical and dental was low compared to the other staff groups.
8.15	JC explained there had been discussions at a senior level and with the University of Gloucestershire and the Chief Nurses on how to promote Gloucestershire as a good place to live and work in health and care. JC highlighted that Gloucestershire was less expensive to live in than some of the neighbouring areas. MAE added that discussions were looking at how to show Gloucestershire as a great place to develop a career, particularly considering the options to develop a portfolio career across NHS and care organisations across the county.
8.16	MAE said that for some staff, particularly up to the band 5 grades, there was a barrier to working which concerned childcare, due to the cost of childcare being so high. NS added that the government had discontinued childcare vouchers. NS said that there were two NHS nurseries in Gloucestershire however there were limited spaces available, and they were only available in Cheltenham and Gloucester. In terms of childcare, MH said there it may be worth looking into providing support for the cost of childcare. CR added that discussions about supporting staff with the cost of childcare had been discussed at GHFT however there was a lot to work out particularly the tension between financial balance and supporting staff.
8.17	AS added that as a CCG, there was a successful campaign to promote Gloucestershire as a great place to live and work for GPs which led Gloucestershire to become a net importer GPs despite a challenging national position. MH highlighted the broader benefits of this campaign on local morale in Primary Care. **ACTION: Share the link to Be a GP in Gloucestershire campaign** **ACTION: Explore the potential for a Gloucestershire-wide recruitment campaign highlighting how the county is a great place to live and work.**
8.18	CL highlighted that Gloucestershire had a major investment program to become the leading centre for cyber over the next few years. CL advised there was an opportunity to highlight opportunities for families as well.

8.19	RT highlighted the work on retention was essential. RT highlighted the importance of having skilled line managers. The organisational culture was an important factor for retention and line managers were key to whether staff stayed or left.
8.20	AS summarised what was being done to attract and retain GPs and other primary care staff into the county amidst national headlines that GP recruitment was poor. There were supporting programs at each career stage of GPs.
8.21	CL asked if the recruitment of GPs into areas of deprivation in Gloucestershire was a current issue. AS responded that it was a current issue, particularly in the Core 20 areas. This was primarily down to workload and the funding formula for Primary Care. AS explained that locums were keen to work in inner-city Gloucester and the next step would be to identify what could be done to provide an incentive and support them to take work in inner-city Gloucestershire.
8.22	SA explained that the Reservist Programme was a mandated program that began at the end of the financial year 2021/22. There was a Project Officer now in place to support the programme and it was now moving forwards. SA explained that there was only pump-priming funding available for the current financial year and therefore there needed plans in place to enable the programme to continue from April 2023. The Gloucestershire Reservist Programme was being hosted by GHC. A national campaign to recruit into the Reservist Programme was due to start, however, SA explained that local, targeted campaigns may be required to support recruitment into specific staff groups which were needed in Gloucestershire.
8.23	SA explained that one of the next key jobs for the Reservists was to support the onboarding process for those offered positions at the recent Healthcare Support Worker Event. The majority of people in the programme held employment elsewhere and were able to offer 1-2 days a week.
8.24	SS explained that Adult Social Care were facing a huge amount of national reform, preparing for a CQC assurance process in addition to changes brought about by the Care Act and the huge increase in the number of people who will be eligible for local authority-funded Adult social care. SS said the modelling suggested there may be 3000 - 6000 social care assessments a year and the Finance and Assessment Benefits Teams would see a significant increase in their workload.
8.25	SS said there had not yet been a dedicated recruitment and retention programme for Adult Social Care. However, over the last year there was a specific focus on the needs of the staff and Adult Social Care service. SS explained there had been a focused piece of work to investigate vacancies and identified a £5 million underspend across a range of services on the staffing

	budget. There was a new recruitment and retention strategy which encompassed a lot of the learning over the last year.
8.26	SS said there were many vacancies and high levels of sickness, which was affecting performance. However, Adult Social Care had the best staff survey results of the five directorates in terms of receiving positive responses and the highest response rate.
8.27	SS explained that an Evergreen offer had been established for a number of pre-approved posts however the onboarding process was lengthy. The adult social care recruitment focus was beginning to show some positive outcomes.
8.28	CL asked what the adult social care sickness absence rate was. SS responded that it was around 8% which was higher than the Gloucestershire County Council average.
8.29	TC summarised the next steps and future system opportunities. TC highlighted there was an opportunity to appoint a dedicated recruitment and retention lead for the system, funded through NHSE.
8.30	**Resolution: The committee noted the contents of the Recruitment and Retention Update**
8.31	**People Risk Report – focus on Winter Risks**
9.	TC explained that coming into Winter, a shared focus particularly urgent care would be critical. TC highlighted the importance of taking a practical approach over winter and focusing on the initiatives that could be staffed. TC explained that some areas of focus such as home discharge and reablement services were critical throughout winter.
9.1	TC highlighted that there had been some improvement in some areas of urgent care recently which lifted staff morale, TC added that it would be beneficial for staff to understand when there was positive news to share to support staff morale through organisational communications. AS agreed that these good news stories would lift morale.
9.2	NS explained there were key things that needed to be prioritised such as Covid and Influenza vaccinations, to try to minimize sickness absence. NS added that the option of providing mutual aid and redeploying staff may be critical.
9.3	DE emphasised how hard staff were working on the urgent and emergency care pressures. DE explained that there had been a lot of work to understand what the ideal hospital would look like for winter and review the plan, based on feedback from colleagues. DE said that in response to the CQC's criticism of GHFT, they had reviewed and updated the governance around escalation areas

	and the use of theatre recovery. DE highlighted that GHFT had done a significant amount of work to prepare for the winter pressures.
9.4	**ICB HR Policies for Approval**
10.	CGi explained that within the ICB Governance Structure, each committee had delegated authority to approve ICB policies relevant to their area of expertise. Therefore, the People Committee was responsible for approving Human Resource (HR) Policies.
10.1	CGi explained that many of the up-to-date CCG policies were carried over to the ICB, however, there were a number of policies that were due a review and formal approval from the People Committee. These were: Bullying and harassment; Other leave; Guidance on Investigating Complaints; Professional Registration; Travel and Expenses; Sickness Absence; Secondary Employment; Maternity, Paternity and Shared Parental Leave; Disciplinary Policy. The recommendation to the committee was for formal approval of these policies.
10.2	CGi said HR colleagues from the NHS South, Central and West had reviewed the policies and updated them in line with current HR standards. In the Other Leave Policy, the number of days available for Carer's leave had increased to five days per year. The Disciplinary Policy was updated to be written in line with Just Culture principles.
10.3	**<u>Resolution</u>: The committee approved the ICB HR policies: Bullying and harassment; Other leave; Guidance on Investigating Complaints; Professional Registration; Travel and Expenses; Sickness Absence; Secondary Employment; Maternity, Paternity and Shared Parental Leave; Disciplinary Policy**
10.4	There was no other business raised.
	Next meeting: **12th January 2023, Prout Room, Sanger House**

13.1