

## BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 1<sup>st</sup> July 2022 at 9.30am, held virtually via Microsoft Teams

### DRAFT Minutes

<b>Present</b>		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
Julie Bacon	Interim Director of People and Transition, BNSSG ICB	JB
John Cappock	Non-Executive Member – Audit	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Jon Hayes	Chair of the GP Collaborative Board	JH
Mike Jackson	Chief Executive Officer, Bristol City Council	MJ
Maria Kane	Chief Executive Officer, North Bristol Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB (From 1 <sup>st</sup> August 2022)	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	WW
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
<b>Apologies</b>		
Peter Brindle	Interim Chief Medical Officer, BNSSG ICB	PB
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Georgie Bigg	Healthwatch Bristol, North Somerset and South Gloucestershire	GB
Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EY

In attendance		
Lance Allen	Healthwatch Bristol, North Somerset and South Gloucestershire	LA
Colin Bradbury	Area Director for North Somerset, BNSSG ICB	CB
Will Bradbury	Communications Manager, BNSSG ICB	WB
Deborah El-Sayed	Interim Director of Transformation and Digital, BNSSG ICB	DES
David Jarrett	Area Director for Bristol and South Gloucestershire, BNSSG ICB	DJ
Lisa Manson	Director of Commissioning, BNSSG ICB	LM
Lucy Powell	Corporate Support Officer (Minute Taker), BNSSG ICB	LP
Jon Scott	System Chief Operating Officer, BNSSG ICB	JS
Ruth Taylor	One Care	RT
Sarah Weston	Project Management – Integrated Care System Development, BNSSG ICB	SW

	Item	Action
1	<p><b>Welcome and Apologies</b></p> <p>Jeff Farrar (JF) welcomed everyone to the first meeting of the Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB) Board.</p> <p>JF thanked Ellie Wetz, Sarah Carr and Sarah Weston for their work to support the Board meeting and for developing the ICB governance processes. JF confirmed that the paper for item 4.1 had been delayed as a meeting to appoint ICB Board members had taken place immediately before the Board meeting. JF highlighted that the intention was for future Board meetings to rotate across the Locality Partnership areas.</p> <p>JF welcomed members of the public to the meeting.</p> <p>The above apologies were noted. JF explained that Shane Devlin, CEO of the ICB was disappointed to miss the first meeting of the ICB Board but had an important prior engagement, his son's graduation.</p> <p>JF explained that the ICB Board was responsible for delivering the health and social care strategy and the national priorities. The four stated aims of the ICB were; Improving population health, reducing health inequalities, increasing value for money and supporting social and economic development.</p>	
2	<p><b>Declarations of Interest</b></p> <p>JF highlighted the declarations of interest register for the ICB Board and asked whether anyone had any additional interests to declare. Jaya Chakrabarti (JCh) noted that her wide portfolio made listing all her declarations very difficult. JCh suggested that she declare any relevant interests at the start of each meeting.</p>	

	Item	Action
	<p>Steve West (SW) confirmed that he did not have anything to declare pertinent to the agenda but noted that as Chief Executive Officer of the University West of England and Chair of the Academic Health Science Network there may be conflicts of interest to declare in the future.</p>	
3	<p><b>Chief Executive Officers Briefing</b></p> <p>Sarah Truelove (ST) noted that Shane Devlin (SD) had sent his apologies for the meeting but had asked her to convey some key messages for the Board. SD had wanted to stress that there were no organisation was considered a third party on the ICB Board which was tasked with making system decisions to improve outcomes in population health, reduce inequalities, enhance productivity and value for money, and develop the wider social and economic role of the ICB. SD had emphasised the power of partnership and the opportunity to achieve more together, building on the groundwork of previous system working. JF agreed and noted that although the system had worked closely previously, this was an opportunity to develop plans as a system.</p>	
4.1	<p><b>Establishment of the ICB Board Members</b></p> <p>Julie Bacon (JB) confirmed that JF, SD and JB had met before the ICB Board meeting to agree the appointments to the ICB Board. JB confirmed that it was a statutory requirement for the ICB to have a Board to include executive members, non-executive members, partner members and other members. It was confirmed that with these appointments, the ICB Board was quorate to approve the various business today. JB noted that these appointments had been included in the paper.</p> <p><b>The BNSSG ICB Board noted the confirmed appointments of the Bristol, North Somerset and South Gloucestershire Integrated Care Board Board</b></p>	
4.2	<p><b>BNSSG ICB Constitution</b></p> <p>JF thanked everyone who had developed the model constitution. JF confirmed that the template had been provided by NHS England and Improvement (NHSEI) and had been amended for BNSSG ICB. JF confirmed that the regional NHSEI team had signed off the constitution.</p> <p>Jon Hayes (JH) highlighted point 3.5.5 which outlined the 12 month extension of serving officers and asked whether this extension would apply at the end of each 3 year term or at the end of 2 consecutive 3 year terms. JH noted that the pandemic had highlighted that there could be unpredictable circumstances which may require arrangements to continue. JF explained that this point had been discussed as part of the development of the Constitution as a fixed end date would result in all members leaving at one point which was not sensible. The potential extension to tenure provided more flexibility and business continuity. JF noted that there were other factors to consider such as Chief Executives in post for longer than 3 years. JB noted that it could be interpreted as a potential extension to the second term if required and noted the</p>	

	Item	Action
	<p>importance that there was flexibility to support the Board. It was confirmed that these issues would be considered as the ICB Board developed.</p> <p>JH also noted that there was a typographical error at point 3.13.3 and it was agreed that this would be amended.</p> <p>JH highlighted point 13.14.1 regarding the role of the Remuneration Committee and noted that the section did not include setting the remuneration of partner members. JH noted that as the nominated representative for primary care, there needed to be a conversation regarding resource in order to attend the ICB Board. JF agreed that there needed to be a governance route for these considerations and it was agreed to include this as part of the Remuneration Committee terms of reference.</p> <p>Ruth Taylor (RT) noted that One Care and Healthwatch were included within the Constitution but had not been included in the appointments paper for item 4.1. JF confirmed that One Care and Healthwatch were participants of the Board but not voting members.</p> <p><b>The ICB Board approved the BNSSG Integrated Care Board Constitution subject to the amendments outlined above</b></p>	<p><b>SW</b></p> <p><b>JB</b></p>
4.3	<p><b>Scheme of Reservation and Delegation and Functions and Decisions Map</b></p> <p>ST confirmed that the Scheme of Reservation and Delegation had been developed in accordance with national legislation and guidance and noted that would continue to be developed as the system reflected on how decisions were made. ST confirmed that NHSEI had received but not provided comments on the Scheme of reservation and Delegation. The Functions and Decisions Map had been developed by the system.</p> <p>Dominic Hardisty (DH) highlighted that there was no reference to the proposed Mental Health Collaborative on the Functions and Decisions Map and asked that it be included as it was a key element to support mental health service delivery. DH noted that the Acute Provider Collaborative had been included in the Functions and Decisions Map and both collaboratives were in the same stage of development and therefore for parity of esteem it was important that both were included. RT noted that there were many projects such as the Out of Hospital Provider Collaborative which were not explicitly mentioned on the Map and noted that it was impossible to include everything. SW agreed that it was important to include the Mental Health Collaborative to the Map as part of the Board's focus was health inequalities. It was agreed to include the Mental Health Collaborative on the Functions and Decisions Map.</p> <p><b>The BNSSG ICB Board approved:</b></p> <ul style="list-style-type: none"> <li><b>The Scheme of Reservation and Delegation</b></li> </ul>	<p><b>ST/SW</b></p>

	Item	Action
	<ul style="list-style-type: none"> <li>• <b>The Functions and Decision Map with the addition of the Mental Health Collaborative</b></li> </ul>	
4.4	<p><b>ICB Committee Terms of Reference</b></p> <p>JF explained that for the ICB Board time to be utilised to best effect, the ICB Board needed to be able to delegate effectively to its sub-committees. JF highlighted that partner member non-executive representation had been requested for the Committees to ensure that there was an external view on the issues discussed, but also to ensure onward discussion into the partner member Boards. JF highlighted the importance that the Committees added value and did not replicate the work of each other. The Chairs of the Committees had been asked to consider the statutory responsibilities of the ICB and how the Committees would support the four aims of the ICB in a strategic way to transform the way health and social care was delivered. The terms of reference for the Committees were presented for approval, however JF noted that these would be developed and amended as the ICB evolved with any significant changes presented again to the ICB Board to be approved.</p> <p><b>Remuneration Committee</b></p> <p>JB confirmed that the Remuneration Committee was a statutory Committee with automatic membership of the Non-Executive Members except for the Audit Committee Chair. Executives could be in attendance if appropriate. There was also a requirement for 4 partner members to be appointed to the Committee in the event that the Non-Executive Members were themselves excluded. This was to ensure quoracy of the Committee. It had been agreed that the 4 partner members on the Remuneration Committee were Dominic Hardisty, Jon Hayes, Mike Jackson and Maria Kane.</p> <p>Ellen Donovan (ED) confirmed that the terms of reference for the Remuneration Committee had been developed from the template supplied by NHSEI and the purpose of the Committee was to agree pay policy, pay frameworks and appointments. The expectation was that the Committee would not meet regularly but once or twice a year. ED noted that there would be additional Remuneration Committee meetings this year due to the development of the ICB executive structure.</p> <p><b>Outcomes, Quality and Performance Committee</b></p> <p>ED explained that the Outcomes, Quality and Performance Committee remit was to scrutinise the robustness of the systems of governance and gain assurance that internal controls were in place. The ambition was that the Committee would take a system wide approach which would incorporate the citizen voice. The Committee would hold the ICB Executives to account in a supportive manner and identify the risks to achievement and suggest mitigations. ED confirmed that the Committee would have a significant number of members and ED was working with the Executives to establish membership.</p>	

	Item	Action
	<p>Maria Kane (MK) welcomed the role of the partner member Non-Executive Directors within the Committees and asked whether this was expected for the Remuneration Committee. JF confirmed he had spoken to the partner member organisation Chairs to ask them to identify Non-Executive Members who may have an interest and the capacity to attend the Committees. JF highlighted that there was flexibility in this role including the possibility of rotational roles. JF confirmed that a partner member Non-Executive Director was not expected for the Remuneration Committee.</p> <p>DH raised that there should be some compensation for the partner member Non-Executive Directors for attending these Committees. JF noted the possibility of an honorarium payment, the arrangements of which would need system discussion and decision.</p> <p><b>People Committee</b></p> <p>JCh confirmed she was the Chair of the People Committee for the Integrated Care System (ICS) and ICB. JCh confirmed that the purpose of the Committee was to support the ICS workforce of around 50,000 people and the ICB workforce of 500 people as well as delivering the improved wellbeing outcomes for the 1,000,000 citizens in Bristol, North Somerset and South Gloucestershire. JCh highlighted the importance that Committee members had the right experience to support people in a strategic way. JCh noted that the Committee was expected to be flexible to evolve as the system developed.</p> <p><b>Finance, Estates and Digital Committee</b></p> <p>SW thanked Sarah Truelove and John Cappock for the good work of the CCG Strategic Finance Committee which had provided the ground work for the ICB Committee. SW was clear that a new Committee needed to be created without losing the current value in the transition. SW highlighted the importance that the advice from NHSEI and the must dos from the Constitution had been captured in the terms of reference. SW noted that there had been discussion about how the Committee would focus on the four aims of the ICB whilst covering the broad strategic focus of the Committee. SW highlighted that initial conversations would be around creating stability in the system before discussing the large strategic pieces around use of resource effectively in the system.</p> <p><b>Primary Care Commissioning Committee</b></p> <p>Alison Moon (AM) explained that the focus of the Primary Care Commissioning Committee was development and implementation of the primary care strategy. AM thanked David Jarrett and Lisa Manson for their support to develop the terms of reference. AM confirmed that the Committee would hold the ICB Executives to account in a supportive way and noted the importance that the Committees did not duplicate work. AM noted that the patient voice element of</p>	

Item	Action
<p>the Committee had not yet been identified and explained that there was a wider piece of work led by the ICB Chief Executive regarding the professional, voluntary and community, and patient voice for Committees.</p> <p>AM outlined the two aspects of primary care for the ICB; delegated commissioning for primary care and the joint commissioning with NHSEI of optometry and pharmacy, with delegation for optometry, pharmacy and dentistry in April 2023.</p> <p>AM highlighted the importance of the voice of primary care at the Committee and noted that there had been discussion around asking the various organisations representing primary care who they considered best placed to attend the Committee.</p> <p>Julie Sharma (JS) asked whether there had been any consideration of attendance by the wider primary care organisations as well as attendance of out of hospital provider representation both in terms of mental and physical health. AM confirmed that as the joint commissioning arrangements developed the expectation was that representatives from the Local Dental Committee, Local Optical Committee and Local Pharmaceutical committee would attend the Committee. AM agreed that integrated models of care were important and would welcome provider interest at the Committee.</p> <p>JH explained that the GP Collaborative Board Terms of Reference included Brisdoc and Local Medical Committee attendance and suggested that the GP Collaborative Board could be utilised to discuss ICB Committee representation.</p> <p>Lisa Manson (LM) noted that one of the key responsibilities was ensuring that the ICB was honouring the commitments within the delegation agreement for primary care medical services but also undertaking the preparatory work for the delegation of the other services from April 2023. It was important that there were representatives from optical, dental and pharmaceutical services at the Committee to ensure that they understood their role on the Committee but also for Committee members to understand the service roles within the primary care landscape.</p> <p><b>Audit Committee</b></p> <p>John Cappock (JCa) highlighted that the Audit Committee was one of two mandated Committees, with the other being the Remuneration Committee. The terms of reference outlined the Committees remit to review governance arrangements, risk management, internal control, internal and external audit, counter fraud and freedom to speak up. JCa explained that the Committee had been built on the work of the CCG Audit, Governance and Risk Committee, and the terms of reference had been developed with the support of the Executives</p>	

	Item	Action
	<p>and the internal auditors. JCa thanked Sarah Carr for her support in developing the terms of reference, as well as the associated work plan which reflected the governance and assurance needs of the ICB in the first year, as well as the unusual challenge of developing two sets of year end annual accounts, for the last 3 months of the CCG and the 9 months of the ICB. JCa wanted the work plan to be responsive to the long term plan and avoid duplication across the Committees.</p> <p>JCa explained that the Committee would have four members which included Steve West and hopefully a partner member Non-Executive Director. JCa explained that for the fourth member, he would welcome a Local Authority representative and asked if the Local Authority Chief Executives could identify a representative. JCa noted it was important that the representative was available for the annual cycle to support sign off of year end processes. JCa noted that there would be 4 to 5 meetings a year. The Council Chief Executives agreed to discuss this and welcomed the opportunity to engage with the Committee.</p> <p><b>The ICB Board approved the Terms of Reference for the following Committees, recognising that these would evolve as the ICB was established:</b></p> <ul style="list-style-type: none"> <li>• <b>Audit Committee</b></li> <li>• <b>Remuneration Committee</b></li> <li>• <b>Finance, Estates and Digital Committee</b></li> <li>• <b>Outcomes, Quality and Performance Committee</b></li> <li>• <b>Primary Care Commissioning Committee</b></li> <li>• <b>People Committee</b></li> </ul>	<b>MJ/DP/ JW</b>
4.5	<p><b>Standing Financial Instructions</b></p> <p>ST noted that the Standing Financial Instructions formed part of the governance handbook and ensured that the ICB fulfilled its statutory duties and carried out functions effectively, efficiently and economically. ST confirmed the Standing Financial Instructions had been developed in line with national guidance and discussed with NHSEI as part of the Readiness to Operate Statement.</p> <p>JS noted that the contract value limitations had been set at £1m for ICB Board approval and asked whether that was too low. ST confirmed that decision making would be discussed by the system Directors of Finance and although the Standing Financial Instructions were based on current guidance these may need to change as the system develops.</p> <p>DH explained that he read the Standing Financial Instructions as approving overarching agreements rather than all the subcontracting within contracts and also that he understood that the Standing Financial Instructions were for ICB contract agreements. ST confirmed this was the case and clarified that the decision making discussions were around how ICB Board decisions were made</p>	



	Item	Action
	<p>as a system and these discussions would include consideration on what contracts and agreements needed to be considered by the ICB Board.</p> <p><b>The ICB Board approved the Standing Financial Instructions</b></p>	
4.6	<p><b>Core Policies</b></p> <p>JB highlighted the suite of policies outlined in the paper and explained that these were the policies which existed within the CCG and needed to be formally transferred to the ICB for use. JB highlighted that two policies, the Supervision Policy and the CHC Operational Policy had not been included in the paper but also needed to be approved for transfer to the ICB.</p> <p>JB highlighted that the Managing Conflicts of Interest Policy and Gifts and Hospitality Policy had been updated to reflect ICB arrangements and needed to be approved to meet the ICB Standards of Business Conduct obligations. The Risk Management Framework had also been updated to reflect ICB arrangements to ensure that the ICB had an agreed process for managing risk. JB reminded the Board that these policies and frameworks would likely evolve as the ICB was established. JB highlighted that the paper also suggested continued use of the current policy approval framework.</p> <p>AM highlighted that the CCG Clinical Executive Committee had been referenced in the Risk Framework and would need to be removed. AM also highlighted that some of the policies to be transferred had overdue review dates and asked whether there was any risk to the ICB in transferring these policies. JB replied that despite having not been reviewed, these policies still applied as they transferred with staff who TUPE transferred on the same terms and conditions which included the policies. ST noted that the policies would be reviewed and amended as appropriate as the ICB was established.</p> <p><b>The ICB Board agreed:</b></p> <ul style="list-style-type: none"> <li>• <b>The ICB Conflicts of Interest Policy</b></li> <li>• <b>The ICB Gifts and Hospitality Policy</b></li> <li>• <b>The Risk Management Framework with the above amendment made</b></li> <li>• <b>The adoption of CCG Policies, noting that changes would be made in line with review arrangements to include ICB branding</b></li> </ul>	JB
4.7	<p><b>Hand over from CCG – Due Diligence Assurance</b></p> <p>JF thanked everyone working at the CCG particularly Jon Hayes and Julia Ross for their leadership at the CCG and their work to bring together local services. JB highlighted the transition working group which had been set up to work through the due diligence checklist and Readiness to Operate Statement (ROS). An internal audit of the checklist had been undertaken and no significant concerns raised. The final due diligence checklist and ROS had been reviewed in detail by the Strategic Finance Committee on the 27<sup>th</sup> May 2022 and approved by the Chief Finance Officer of the CCG and the CCG</p>	

	Item	Action
	<p>Accountable Officer. On the 17<sup>th</sup> June 2022, NHSEI had confirmed that there were no areas of concern and no amber or red items outstanding. JB explained that there had been 3 green items outstanding, those that were on track to be completed, and related to actions which needed to be completed at the end of June. Formal confirmation has since been received of a positive review for assurance and legal requirements have been established and the required documents have been included on the ICB website. The outstanding items for the CCG included the production of the final 3 months audited accounts and annual report and these activities were in train.</p> <p>JCa confirmed that the transition team had reported monthly to the CCG Strategic Finance Committee and Governing Body and at the May Strategic Finance Committee the members had reviewed the ROS line by line. JCa thanked those involved for the excellent work and recommended the ICB Board receive the information for assurance.</p> <p>JH thanked JF and highlighted that the CCG had provided a good legacy for the ICB despite the challenging circumstance.</p> <p><b>The ICB Board received the paper and noted the content</b></p>	
5.1	<p><b>Operational Plan and Budget 2022/23</b></p> <p>ST highlighted that the final Operational Plan had been submitted on the 20<sup>th</sup> June 2022 following delegated sign off, the Operational Plan and approved budget would transfer from the CCG to the ICB. ST explained that this had been the first full year population based budget considered for two years as the system moved out of the extraordinary financial regime which had been in place to respond to COVID-19. ST noted that the planning guidance issued in December 2021 had expected very low levels of COVID-19 which had not materialised. ST also noted the unanticipated significant inflationary challenges caused by global factors. ST confirmed that additional allocations had been received to reflect the challenges.</p> <p>ST highlighted the revised Operational Plan and noted that there were areas where the system had not performed as expected, these were outlined as out of area mental health placements, perinatal mental health, children's and young adults mental health services, elective recovery and waiting list times, and also activity to a percentage of 2019/20 levels. ST noted that there was a level of financial risk associated with elective service recovery funding. ST noted that there were also particular challenges around 62 day cancer performance.</p> <p>A balanced budget had been developed for 2022/23 but ST emphasised that this had only been achievable through the use of non recurrent reserves and there remained a £76m system deficit. A medium term plan has been</p>	

	Item	Action
	<p>developed to address the deficit and this had been approved by the Healthier Together Executive Team and Partnership Board.</p> <p>ST highlighted the risks to the plan including the inflationary issues which could increase above what has been anticipated, and the discharge to assess programme. ST noted that there was a potential risk reserve for the programme set up through a Section 256 agreement. ST highlighted that there was also a financial risk relating to ambulance handover delays, where unachieved performance trajectories would result in additional costs for the ambulance service. It was highlighted that the risk of withdrawal of the elective recovery funding due to the system not delivering the levels of activity expected had been included as an unmitigated risk.</p> <p>ST confirmed that the Operational Plan and budget had both been developed as a system across NHS organisations. JF noted that the expectation was that the Chief Executive of the ICB would be accountable for system performance and therefore the ICB Board would be challenged to gain assurance on these issues.</p> <p>Will Warrender (WW) highlighted the significant financial and operational risks regarding ambulance delays which impacted both the BNSSG system and the other local services the ambulance service served. WW explained that the current trajectories would be difficult to achieve within 2022/23 and current modelling indicated that trajectories would not be reached for 3 years. JF noted that the risk around ambulance handovers was discussed daily and this was a whole system issue and not the fault of the ambulance service. ST highlighted that the system ambition was to resolve the issues more quickly. The most significant concern for the system was patient flow and it was hoped that the whole system agreement regarding the discharge to assess programme would also support improvement of ambulance handover delays. WW noted the importance that the ambulance service could identify how the actions proposed would affect the trajectories. JF noted that hearing the patient voice at the ICB Board would highlight that the performance issues discussed affected people and their families. JF agreed to consider how the patient voice could be heard at Board meetings.</p> <p>SW suggested the system needed to be creative, focused and work effectively together to identify available resource to improve performance and noted that focus on quality and finance would support reduction of the deficit. SW highlighted the importance of prevention and early engagement with the population.</p> <p>MK agreed that ambulance handover delays needed a system response and would test whether the system could work effectively together. A review of the</p>	<p><b>JF</b></p>

Item	Action
<p>whole pathway was needed to ensure that resources were in the right place. MK noted that she would be concerned if these delays continued for a further 3 years.</p> <p>ED noted that ambulance handovers would be reviewed as part of the Outcomes, Quality and Performance Committee and highlighted the importance that there was time to stop and consider what plans need to be put in place to reduce these delays. MK confirmed that there was robust data available from the providers but less data from pathways into domiciliary care and other residential placements. Work needed to be undertaken to review that the right services were being commissioned and in the right quantities.</p> <p>Deborah El-Sayed (DES) highlighted the Care Traffic Control programme noting that this programme built on the flows between organisations. DES confirmed that this would be discussed further at the digital Non-Executive Director meeting and had been presented to the system Chief Operating Officers. DES explained that the programme was about behavioural change, data sharing and how data was utilised. The Local Authorities had helped develop the programme by identifying gaps in data. DES noted that there was a big programme of work around digital data systems which all linked. It was important that the priorities of the ICB were correct and the programme was a great opportunity to support the system.</p> <p>DH highlighted that AWP had reflected on the current challenges and had proposed running a perfect month in mental health which aligned with the average length of stay. The outcomes of this would be reviewed and learning considered. DH highlighted that another piece of work involved ward attendance of voluntary sector workers who specialised in housing. They have been working with patients regarding their living situation and it had been identified that around 50% of patients admitted did not have a safe place to return. With the additional support of the voluntary sector workers and planning for discharge from admission around 93% of patients had a safe place to go to at discharge. DH suggested bringing the outcomes of the above work to the ICB Board.</p> <p>JB highlighted that workforce was key to delivery of the Operational Plan and noted that there were some significant gaps to fill. Consideration needed to be given to onboarding requirements which had an impact on current staff and it was important that any resource gaps were visible for the planning teams.</p> <p>JW highlighted that the cost of living crisis would affect resource across the system particularly for those on the lower ends of pay scales such as care workers and noted that the scale of national challenge was an opportunity to request additional funding to support systems. JW noted that this linked to the</p>	<p><b>DH</b></p>

	Item	Action
	<p>life course view, if people weren't living well they won't age well. There needed to a culture shift as well as a data shift to recognise that there was different risk across the system and the system needed to work together to improve outcomes for individuals. JF noted that the risks cut across all the Committees and agreed to discuss with the Non-Executive Members about coordinating effort.</p> <p><b>The ICB Board:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the operational plan position submitted on 20 June., which was signed off through delegated approval by CEOs, CFOs and Finance Non-Executive Directors</b></li> <li>• <b>Noted the key assumptions, principles, risks and mitigations underpinning the ICB-led aspects of the financial plan</b></li> <li>• <b>Noted the impact on direct ICB Savings requirements</b></li> <li>• <b>Noted the underlying system financial deficit of £76.2m and requirement for further management action to mitigate this for 23/24 and the medium term</b></li> <li>• <b>Approved the financial governance principles for managing the budget during 2022/23</b></li> <li>• <b>Approved the final budgets for 2022/23</b></li> </ul>	<b>JF</b>
6.1	<p><b>Single Oversight Framework and Scorecard</b></p> <p>JF explained that the NHS had a single oversight framework and scorecard and noted that Chairs from ICB's including JF had challenged NHSEI on lack of inclusion of social care oversight.</p> <p>ED confirmed that the Outcomes, Quality and Performance Committee was considering the metrics that needed to be used to monitor performance and whilst these were determined the ICB would continue using the CCG metrics. The Committee meetings in July and August would be used to work through the metrics as well as the membership of the Committee. ED noted that the oversight framework considerations were wider than the Committee and ultimate review of performance and quality was for the ICB Board.</p> <p>ED highlighted two sections of information that would focus the role of the Committee; page 23 of the oversight framework which outlined the legal duty of NHSEI to annually assess the performance of each ICB and publish a summary of findings and page 13 which outlined the segmentation rate which was a rating of 1 to 4 for ICB's and Trusts which reflected performance and support requirements. ED explained that a rating of 1 reflected consistent good performance. Initially NHSEI would rate all systems as 2 and during the first 6 months, an appropriate rating would be applied. ED confirmed that as Chair of the Committee, she would be seeking assurance from the Executives that there were firm and robust actions in place to deliver the operational plan.</p>	

	Item	Action
	<p>LM explained that the Single Oversight Framework was the mechanism for NHSEI to consistently monitor everyone and formed part of the accountability agreement with NHSEI and provider licences. A consultation had been undertaken during 2021/22 and system feedback had been provided. The framework contained a collective set of system metrics and the segmentation framework had been designed to emphasise that systems succeeded or failed together. LM outlined the five national themes within the framework; quality of care, access and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources, and leadership and capability. LM highlighted that a sixth theme had also be included; local strategic priorities which would be locally defined by the system. LM confirmed a Memorandum of Understanding had been developed between the ICB and NHSEI so that reporting was undertaken through the existing governance structure to reduce the level of duplication in assurance processes. It was important that the Committees worked together to support joint oversight.</p> <p>LM reported that segmentation was a challenge and the discussions with NHSEI had been around acknowledging the performance challenges but also demonstrating that there were robust actions and governance in place. LM highlighted that the key principle was around delivering improved outcomes for the population and this needed to be evidenced and assurance provided to NHSEI.</p> <p>LM confirmed that the metrics reflected the 2022/23 Operational Plan and the terms of reference of the Outcomes, Quality and Performance Committee. It was noted that the metrics brought in some of the wider metrics such as the Quality Outcomes Framework (QOF) from primary care as well as some of the wider metrics not routinely measured and noted that as the wider primary care delegation was established then the further metrics would be included.</p> <p>Rosi Shepherd (RS) noted that the metrics were light in some areas particularly children, quality, and patient experience and highlighted the opportunity for the ICB Board to consider the local strategic priorities as the sixth domain. RS encouraged the system to consider how performance and quality was explicitly linked as well as how the patient voice linked to performance and how performance gaps created a quality risk for the local population. RS highlighted the importance that the system was a learning system and asked the ICB Board to consider how learning was shared across the whole system and how this would influence the local strategic priorities.</p> <p>MJ reminded the ICB Board about the Integrated Care System Partnership Board and the system Outcomes Framework which the oversight framework needed to align with. MJ asked that the local strategic priorities were developed in line with the Health and Care Strategy which had not been finalised yet. JF</p>	

	Item	Action
	<p>highlighted the importance that the governance arrangements for the ICB Board and sub-committees were worked through correctly and linked to the Partnership Board. JF confirmed that regular meetings would be arranged between himself and Mike Bell, Chair of the Partnership Board. JF outlined the importance of social care within the system and as part of the ICB and MJ noted that the Outcomes Framework was a requirement of Local Authorities to operate and therefore needed to be considered. LM suggested reporting to NHSEI that the work of the Partnership Board on the Outcomes Framework, the Health and Care Strategy, and the engagement work currently ongoing would define the local strategic priorities. JF agreed to take an action to communicate this to NHSEI. RS highlighted that the System Quality Group and the Health and Care Professional Executive were both multi-disciplinary groups which were expected to input into the local strategic priorities.</p> <p>AM noted the importance of ambition and flexibility around the local strategic priorities and agreed that this was wider than the health system.</p> <p>JS noted that the System Oversight Framework did not apply to Sirona and provided assurance that Sirona was an equal partner within the system and continued to support the system. JS suggested that NHSEI be reminded that Sirona was part of the system. RS agreed and noted the importance that organisations not within the Framework were considered for funding streams and that the workforce considerations within the system also included the community providers.</p> <p>ED noted the importance of linking the ICB Board and the Partnership Board as well as the importance of ICB Board consideration of what topics the ICB Committees should be focused on.</p> <p><b>The ICB Board noted and commented on the NHS System Oversight Framework</b></p>	<p><b>JF/SD</b></p>
7.1	<p><b>Action Log</b></p> <p>The ICB Board reviewed the action log noting that these actions were from the June CCG Governing Body meeting and the Shadow ICB Board meeting held in June:</p> <p><b>Action 1:</b> DES confirmed that representatives from public health had been invited to be involved with the draft digital strategy. The action was closed.</p> <p><b>Action 2:</b> RS confirmed that language support for people living at asylum hotels had been discussed with the Local Authorities and support would be provided but not necessarily through the Bath Language School due to geographical challenges. The action was closed.</p> <p><b>Action 3:</b> JF clarified that this was an action from the CCG Governing Body regarding circulating a letter from Trust Chairs to NHSEI. JF confirmed that it was expected that Acute Hospital performance would be managed through the</p>	

	Item	Action
	<p>ICB to ensure that there was a system response to any NHSEI queries. The action was closed.</p> <p><b>Action 6:</b> Internal and external communications regarding the ICB had been developed and sent staff and a number of stakeholders. The action was closed.</p> <p><b>Action 7, 9, 10, 11 and 12:</b> It was reported that these actions were ongoing and an update would be provided at the next meeting.</p> <p>All other due actions were closed.</p> <p>The actions from the meeting were summarised to include:</p> <ul style="list-style-type: none"> <li>• DH to report back on the AWP work programmes</li> <li>• Local Authority Chief Executive Officers would consider ICB Committee Memberships</li> <li>• The Mental Health Collaborative would be included on the Decisions and Functions map</li> <li>• Further consideration would be undertaken of the citizens voice at the ICB Board</li> <li>• JF would meet with the Non-Executive Members to discuss how the Committees could best work together</li> <li>• JF would discuss with NHSEI the links with the Partnership Board and how the local strategic priorities would be developed using the Partnership Board Outcomes Framework, Health and Care Strategy and engagement with the population as well as input from other system groups.</li> </ul>	
7.2	<p><b>Standing Items for Future Meetings</b></p> <p>The ICB Board reviewed the suggested standing items for the ICB Board agendas.</p> <p>JF requested that Committee Chair reports was added as an item and suggested the agenda reflected equality, diversity and inclusion as a central theme. JCh agreed and suggested that once the appropriate metrics had been agreed the agenda could be reviewed to reflect these.</p> <p>Joanne Medhurst (JM) suggested that a Chief Medical Officer and Chief Nursing Officer update was included on the agenda to provide information regarding clinical matters such as pandemic updates. MJ noted the importance that clinical care was seen within the wider picture of prevention, independence and communities which were at the centre of the system. JF suggested that the relevant clinical matters be included as part of the Chief Executives update and JM agreed to discuss this with Shane Devlin.</p> <p>JS highlighted the importance that the agenda reflected the high level strategic objectives and included the key decisions to support what the system wanted to achieve. JF agreed and encouraged the members of the Board to communicate if the items on the agenda were not considered the focus of the system.</p>	JM



	Item	Action
	<p>JB suggested it may be valuable to discuss the effectiveness of the Board at the end of the meeting to identify whether the right items had been discussed and whether the right actions had been agreed.</p> <p>SW agreed with the comments regarding prevention and community engagement being key and noted that as the ICB had been established to reduce inequalities, then there needed to be regular reporting on whether the ICB was achieving this.</p> <p>The Board discussed whether it would be valuable to undertake deep dives into big strategic items at ICB Board level. JF noted that that ICB Board was made up of the most senior people in the system and the aim was to have shorter meetings and therefore regular deep dives may not be the best use of time but noted that where concerns needed a deep dive approach this could be delegated to the Committees.</p> <p>JW suggested that as part of the joint working with the Partnership Board, it would be sensible to include an item to consider messages to or from the Partnership Board. JF agreed that this needed to be included.</p> <p>JF noted that the agenda for the ICB Board would evolve as the ICB matured and all comments were welcome.</p>	<b>JF</b>
8	<p><b>Questions from Members of the Public</b> There were no questions from the public</p>	
9	<p><b>Any Other Business</b> There was none</p>	
10	<p><b>Date of Next Meeting</b> 1<sup>st</sup> September 2022 at 9.30am</p>	

**Lucy Powell, Corporate Support Officer, July 2022**