Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 6th October 2022 at 10.30am, held at Engineers House, The Promenade, Clifton, Bristol, BS8 3NB

DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
John Cappock	Non-Executive Member – Audit	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Anne Clarke	Director of Adult Social Services, South Gloucestershire Council	AC
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
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	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JSh
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Mark Smith	Deputy Chief Executive and Chief Operating Officer, University Hospitals Bristol and Weston NHS Foundation Trust	MS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Julie Bacon	Interim Chief People Officer, BNSSG ICB	JB
Jon Hayes	Chair of the GP Collaborative Board	JH
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	WW

Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EY
In attendance		
Dr Kirsty Alexander	GP, Southmead and Henbury Family Practice	KA
Colin Bradbury	Director of Strategy, Partnerships and population BNSSG ICB	CB
Sarah Carr	Corporate Secretary, BNSSG ICB	SC
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Sharron Norman	Delivery Director, North & West Bristol Locality Partnership	SN
Lucy Powell	Corporate Support Officer (Minute Taker), BNSSG ICB	LP
Ruth Taylor	Chief Executive Officer, One Care	RT

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1	**Welcome and Apologies** Jeff Farrar (JF) welcomed everyone to the meeting and noted the apologies outlined above. This would be Mike Jackson's last ICB Board meeting and JF thanked Mike for his contributions to the Board and wished Mike the best of luck for the future.	
2	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda.	
	Address from the host Locality Partnership Dr Kirsty Alexander (KA) thanked the ICB Board for the opportunity to share the experiences of working as part of the North and West Bristol Locality Partnership. KA explained that North and West Bristol contained two distinct areas, an affluent inner area and an outer area with significant deprivation. The population living in the inner area had a life expectancy 10 years higher than those in the outer area. KA noted that those working within the Locality Partnership recognised the differing health outcomes, noting that these were due to the wider determinants of health. KA highlighted that anxiety and other mental health illnesses were prevalent within the more deprived area as was respiratory illness which correlated with the higher levels of smoking and obesity. KA explained that health services could support these people but the Locality Partnership recognised the difficulties for this population to control the wider aspects of their living environments. KA explained that the inequalities across North and West Bristol were unacceptable and provided some examples of challenges facing the population.	

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	Sharron Norman (SN) outlined the work undertaken by the Locality Partnership including the work of the Integrated Personalised Care Team who were working with patients and the voluntary sector to provide social support outside of health. This included the work of Recovery Navigators and Peer Support groups. SN explained that programmes of support had been designed around population needs to consider the outcomes on both physical and mental health needs across the Locality and noted that it was important that the Locality Partnership worked with the community to support prevention plans as well as local health services. KA was grateful for the support of the ICB Board and the recognition that focusing on the wider determinants of life made a difference to the local population outcomes. KA asked for the ICB Board's view on allowing the Locality Partnerships to determine the areas which were priorities and the risk appetite associated with funding programmes of work developed by the Locality Partnerships. Steve West (SW) thanked SN and KA for the presentation which provided a reminder of what the ICB Board was focussed on, keeping people healthier and independent for longer. SW highlighted that the ICB Board would welcome proposals for funding programmes which could be engaged across the system. JF noted the importance that Locality Partnerships could determine the focus for programmes as the local experts. Deborah El-Sayed (DES) noted the importance of using data to understand the challenges mentioned by KA and SN including unplanned care needs. It was important that the drivers of the behaviours were understood so that the proposals were likely to be utilised by the communities. SN highlighted the Community Wellbeing Board which included representatives from the localities plus the voluntary sector and local community leaders. The group discussed how communities could be engaged in different ways and KA highlighted that without the insights into the behaviours, the correct work programmes would not be developed. Shane Devlin (SD) outlined that the challenge for the ICB Board was to ensure that the proposals from the six localities were aligned and supported; not only the local priorities but also the ICB priorities. SD explained that each locality had different challenges but noted that equity of outcomes was very important. The approach needed to be local but the health outcomes needed to be the same. Mike Jackson (MJ) welcomed the change to increased locality working and noted that the localities were better placed to identify the wider determinants of health and suggested that closer working with the Local Authorities would be	

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	beneficial. MJ highlighted the importance of crisis prevention and noted that Locality Partnerships and Local Authorities provided a full range of local population support programmes. Maria Kane (MK) noted that the outlined differences in life expectancy were unacceptable and needed to be rectified and highlighted that the ICB Board may need to make decisions to disproportionally invest in areas to provide equity of outcomes. David Jarrett (DJ) noted that the North and West Bristol Locality Partnership engagement with the voluntary sector was exceptional and reflected the core objectives of the Integrated Care System (ICS). Decisions at place level were important and delegation to allow the Locality Partnerships to design programmes to support local populations was integral to support improved health outcomes as Locality Partnerships were able to identify clear priority areas. JF noted that it was important that governance processes were clarified to ensure this work could take place.	
3	**Minutes of the 1st September ICB Board Meeting** The minutes were agreed as a correct record.	
4	**Actions arising from previous meetings and matters arising** The action log was reviewed: **Action 7** – SD noted that the involvement of health and care professionals, the voluntary and community sector and the citizen voice continued to be reviewed. The Chief Nurse Officer and Chief Medical Officer were working with health and care professionals to make sure that the views were considered in the right way. Discussions have been had regarding the voluntary and community sector voice and were near finalisation. The executive team have discussed how people with lived experience could be involved with decision making. SD confirmed that the work continued and was proactively being discussed and the final considerations would be presented to the ICB Board for review. **Action 18** – JF confirmed that the involvement of patients and the public at the ICB Board was being considered as outlined for action 7. Ellen Donovan (ED) noted that the patient voice was a key focus for the Outcomes, Performance and Quality Committee and the Committee supported the rapid decision for an organisational approach. SD confirmed that the overarching framework had been approved but the practical mechanism needed to be developed. It was agreed to close this action and review through action 7. All other due actions were closed.	
5	**Chief Executive Officer's Report** SD highlighted the three areas covered in the report: Strategic Needs Assessment, ICB Organisational Structures and Winter Planning. SD noted that winter planning was included as a substantial agenda item and would be discussed later at the meeting.	

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	Strategic Needs Assessment SD explained that the collective partners of the ICB had produced a joint population needs assessment known as 'Our Future Health'. This significant piece of partnership work had been developed to understand local population needs. SD explained that as highlighted by the North and West Locality Partnership, there were unacceptable life expectancy differences across Bristol, North Somerset and South Gloucestershire and unacceptable health gaps in regards to race and other areas of inequality. SD also noted that some areas had a higher population of older people who had greater health needs. 'Our Future Health' outlined the agenda for the ICB and the future health outcomes the ICB wanted to achieve for the local population. **ICB Organisational Structure** SD reported that all but one director, the Chief People Officer, had been recruited to the ICB Executive Director team. The Directors have begun to map the previous functions into the new structures which had been developed to support the ICB objectives with staff being moved to their new directorate areas from 1st November 2022. SD noted that the reorganisation may take until April 2023 but the aim was to have the majority of staff settled by Christmas. A clear process has been set out and consultation periods built into the timeline. Colin Bradbury (CB) noted that the work undertaken for the joint needs assessment was valuable and provided an important view of the reality that the population was facing. CB highlighted the importance that the ICB had demonstrable outcomes for the population and the importance that staff were involved with the development of the local strategy. SW noted that 'Our Future Health' was important for both staff and the population and highlighted the importance that the plans were developed and mobilised at a local level. SW suggested that it was important that local people understood the strategy. SD agreed and noted that listening to the citizen voice was a priority for the ICB. Alison Moon (AM) welcomed the strategy and noted the links between the experiences outlined in the strategy and those outlined by the North and West Locality Partnership. AM asked whether there was anything else that could be considered to support the system during the winter. SD explained that falls data was being reviewed as falls often resulted in long lengths of stay and plans were being developed to consider short, medium and long term strategies to support the system. Joanne Medhurst (JM) noted that data showed that patients who had fallen often remained in hospital as there was no where for them to be placed safely in the community. The system had the opportunity to review the whole picture. JF noted that this included considering alternative pathways and changing behaviours to better support patients.	

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	MK highlighted the importance that digital exclusion and information poverty was included within the plans as how people learn and access information was important to help people live healthy lives and sustain healthy habits. Julie Sharma (JS) noted that review of system strategic structures was important and the system needed to consider the opportunities for shared resource and system wide provision. JS highlighted that in some areas the system was duplicating work and in other areas there was a lack of capacity. JS suggested that reviewing whole system workforce was important to support the system during winter.	
6.1	**Winter Assurance Framework** LM highlighted the key elements outlined within the winter assurance framework which described the national approach to winter planning. LM outlined the six key national metrics which would be measured to demonstrate delivery of the winter plan. Work continued to understand how the plans would be delivered and how the ICB would monitor delivery. LM confirmed that the six key metrics were supported by various work programmes within the system such as actions around discharge to assess, virtual ward expansion, same day emergency care actions, and the mental health ambulance trial. LM reported that the system continued to review these programmes against the impact on bed availability and modelling showed a gap of 490 beds. A plan to reduce the gap has been developed and the system was working through the risks and mitigations to these plans. LM noted that the winter plans would be delivered alongside the immunisation plans, elective care, and children and young people's mental health services. LM reported that there was a separate winter plan for children's urgent care services which aligned with system service delivery. LM highlighted that work to review what worked well in primary care was being considered which included how primary care and Sirona care & health worked together. It was confirmed that the winter plan would evolve as the situation over winter changed and the actions of other health systems were being reviewed and any successful actions would be modelled and reviewed for implementation in the local system. LM highlighted that the key constraint in the system was workforce. Bed capacity, staffing and changes to COVID-19 levels had been modelled for a number of different scenarios and modelling would continue. Daily situation monitoring would also continue and what data could be consolidated and shared across the system daily was being reviewed. LM noted that the ICB Board would be provided with assurance against the framework with reporting against the six metrics through the winter escalation groups. Emergency Preparedness Resilience and Response plans would provide the escalation processes and clear points of escalation to include system Chief Executives had been identified to ensure that system decisions	

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	could be made rapidly. LM highlighted that clinical leadership across the system would be led by JM and this work would include consideration of mutual aid. LM reported that North Bristol Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) were meeting weekly to discuss the challenges regarding system flow and the actions identified by the urgent care and discharge to assess working groups. Prevention, Infection and Control groups were working through processes to support wards and the system had agreed on a nominated clinician of the day to optimise clinical decision making. LM confirmed that the system was reviewing the trajectories and improvement expected through delivery of the metrics. LM outlined the risks in delivering the needed 490 beds. Part of this work included supporting the discharge to assess programme, challenging the actions and unblocking parts of the system as well as supporting community services, Local Authorities and the local care markets and providers. LM highlighted the importance that there were consistent points of contact for escalation across the system and noted that the system had been allocated £14.2m to support the work. ED asked for more information about escalation processes particularly on what would trigger escalation and the expectations of this. LM confirmed that escalation plans had been developed for individual work programmes and the triggers identified. The expectation following escalation was for decisions to be made on how to support that specific area. LM noted that the aim was for the system to move into a proactive space to support the system before escalation was necessary. ED asked how confident the system was that the 490 beds could be delivered and whether further support needed to be provided. LM confirmed that the discharge to assess plans had a comprehensive governance structure but there were challenges to the plans particularly around workforce and it was noted that as part of the work JM would Chair a weekly meeting to check and challenge the system. It was important that workforce could be supported to move around the system to unblock areas under pressure. JS confirmed that the most significant challenge to the system was workforce and noted that although recruiting levels had improved, retention of staff remained low and therefore the emphasis of workforce planning was on the retention of staff. JS noted the importance that the system used shared resource effectively and that staff were undertaking work appropriate to their role. JS reported that the winter plan objectives were a reasonable target to achieve during winter but workforce was the significant challenge. MK noted that when one part of the system was under pressure, the whole system would be impacted by this. MK was assured that the system understood	

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	the problem and the data being collected. MK believed that the plan regarding bed numbers was clear but not yet fully developed however there was confidence that this would happen and contracts would be put in place. MK agreed that enacting the work with the current workforce challenges would be difficult and noted that there were a number of external challenges for the workforce including the increased cost of living and workforce strategies needed to be developed to support staff. Mark Smith (MS) confirmed that there was a high level of confidence that the UHBW beds would be realised as the plans were based on existing plans regarding expansion. Jo Walker (JW) noted the importance that any plans were developed collectively and highlighted the current risk associated with social care. JW highlighted the significant plans for national social care reform but highlighted social care as another part of the system which needed consideration. SD suggested that with workforce being such a significant challenge to the system Chief Executives support their Chief People Officers to review the workforce challenges in a different way to support the system. Jaya Chakrabarti (JCh) noted that similar concerns had been raised at the People Committee. SW noted that in addition to the workforce concerns across the system, there were financial concerns given the high level of agency spending required to fill workforce gaps. SW agreed that the workforce concerns needed to reviewed in a different way as education programmes to support recruitment were a long term solution. DES highlighted a future tech enabled care summit, the outcomes of which would feed into the winter plan. The importance of sharing system data was highlighted particularly data regarding bed availability. DES asked system CEOs to encourage data sharing across the system and noted that the ICB would not request data unless there was a clear system benefit. JCh noted that any barriers to data sharing needed to be understood so that the system could address these. DES highlighted the importance of resource allocation and noted that robust communication and governance structures would support this. MS noted the scenario planning regarding COVID-19, flu and children's services and asked for more information regarding the mitigations and asked whether the ICS escalation framework remained fit for purpose and reflected the current investment. LM agreed to take an action to respond to these queries.	**System CEOs** **System CEOs** **LM** **LM**

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	CB explained that the voluntary and community sector needed to be included in the discussions regarding the system people plan. CB noted that it was important to consider any support that could be provided to the NHS during winter and consideration needed to be given to how communities could also provide additional support. Anne Clarke (AC) highlighted the risks within the care home and domiciliary care sectors and explained that system engagement and relationship development was important particularly in regards to workforce and pathway development. AC provided examples of areas where non clinical staff could undertake tasks to utilise the workforce in the effective way. AC noted that use of technology was a large part of reframing how teams work. John Cappock (JCa) asked whether the winter plan had been developed to improve performance through winter rather than just cope. LM clarified that the plan had been developed to ensure that the system could deliver through winter the expected levels of service for the population. A large part of this work related to risk mitigation. DJ highlighted that Locality Partnerships were considering the local opportunities provided by voluntary and community organisations as well as how pharmacies could further support patients. **The BNSSG ICB Board:** • **Noted the NHS England letter on Winter Resilience** • **Approved the Winter Assurance Framework and the system wide plans to deliver additional capacity and the proposed escalation framework** • **Noted the operational plan performance report and the performance report**	
6.2	**Emergency Planning Resilience and Response Policy and On-Call Policy** LM confirmed that the Emergency Planning Resilience and Response (EPRR) policy had been updated to reflect that the ICB was a category 1 responder in terms of the responsibilities and roles related to EPRR. LM reported that the ICB would be responsible for testing and providing assurance for ICB and system provider processes. **The ICB Board approved the Emergency Planning resilience and Response (EPRR) policy and noted the associated plans within the policy**	
6.3	**Independent Advisory Group on Race Equality to the ICB** JF reported that at the Partnership Board held in March 2022 it was agreed to pilot the establishment of an Independent Advisory Group (IAG) that would initially focus on race equality. The intention was for the IAG to act as a critical friend to the ICB Board, to provide challenge, support, insight and advice on how the organisations approach health and social care inequalities related to	

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	race. It was suggested that to ensure full independence the members of the IAG were not paid employees but the Chair could be offered an honorarium. JF noted that the IAG would be asked to review and advise on ICS processes to support understanding of the impact on local population. JF noted that the IAG would firstly be established for race but if successful could be extended to others areas as required. JCa welcomed the approach and noted that without the understanding as a foundation, the system would not be able to develop processes to support the local populations. JS welcomed the IAG noting that reducing health and social inequalities was an objective of the ICS. JS highlighted the importance that the system worked together to resolve any concerns rather than place blame on individual organisations. SW welcomed the IAG noting that he had seen the positive impact of lived experience as part of staff training. SW believed that the ICS needed to be committed to hearing and listening but the most important part was developing actions to tackle any health and social inequalities. JCh asked for clarification about decision making related to the IAG. JF confirmed that the remit of the group was broad and therefore the actions would be presented to the most appropriate Committee. JF noted that the Chair of the IAG would be invited to attend a number of ICB Board meetings to provide feedback on the findings of the group. MK highlighted that other initiatives had been developed to improve health inequalities and suggested that it would be sensible to check that the work wasn't duplicated elsewhere in the system. MK also asked whether the IAG would also review race inequalities within staff throughout the ICS. JF confirmed that the system could ask the IAG to review any aspect of the system. Rosi Shepherd (RS) noted that workforce culture impacted on health outcomes and would encourage the IAG to talk to the system workforce. Dominic Hardisty (DH) was uncomfortable that the IAG would not be remunerated for their time noting that the IAG would be representing the communities who were affected by health and social inequalities. JF noted that there were some members of the system who were not paid for their services which included Governors at UHBW. JF confirmed that travel expenses would be available. JF noted that if considering payment, recruitment processes for the IAG may need to be considered differently to ensure good representation.	**JF/SC** **JF**

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	JCh highlighted that the IAG was being convened to represent people whose health and social outcomes were disadvantaged and so remuneration was appropriate. JCh also asked that consideration be given to ensure that the time given by the IAG did not impact their work/life balance. RS noted the importance that the group provided the opportunity for women with children to be represented and asked that consideration was given to childcare responsibilities. AM asked about the impact of the IAG. JF confirmed that the IAG would take time to establish and mature and it was expected that the actions recommended from the IAG would improve health outcomes and may result in investment across the system. JF acknowledged the need to recognise the contribution of the IAG and DES highlighted that the ICB would have a policy in place to support these conversations and Sarah Carr (SC) confirmed this was the case. JF agreed to review the possible options for remuneration of the IAG members. **The BNSSG ICB Board agreed:** • **The implementation of a pilot proof of concept Independent Advisory Group (IAG)** • **The IAG Terms of Reference** • **The process for the appointment of the IAG Chair** • **In principle an honorarium for the IAG Chair with the amount being agreed by the ICB Remuneration Committee** • **Consideration needed to be given to remuneration options for the IAG members**	**JF** **SC/JF**
6.4	**Sexual Health Services (Unity) Procurement** LM explained that the ICB was an associate commissioner of the Unity Sexual Health contract which was due to expire on 31st March 2024. LM explained that due to the publication later in 2022 of the national sexual health strategy and national sexual health specification, commissioners have been asked to support an additional year of current arrangements to 31st March 2025. This recommendation has been supported by the Bristol City Council cabinet. Legal advice recommended that if approved, commissioners across the system action the additional year by issuing a Contract Award Notice via two legislative routes in accordance with the Public Contracts Regulations 2015, Regulation 32 and Regulation 72. JCa asked whether there was opportunity for localities to contribute to the specification of the contract given the focus on health inequalities. LM agreed that it was important that the specification was developed locally whilst including all the national requirements.	

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	The ICB Board formally approved the recommendation of adding the additional year to the current Unity Sexual Health contract arrangements, to now end on 31st March 2025.	
7.1	**Outcomes, Performance and Quality Committee** ED noted that performance had been included as part of the discussions relating to winter planning and added that both emergency and elective care performance was challenged. Plans to improve patient flow had been developed and were key to improving performance. ED highlighted that JM had been asked to support the discharge to assess plans. JM explained that she had worked with JS to separate out the wider out of hospital flow around the system and include the ageing well and virtual wards programmes. JM confirmed that weekly operational meetings had been arranged and would feed into the winter assurance plans. The group was made up of senior leaders in the system who would be able to make decisions to unblock areas of the system under pressure. JM highlighted that key to this decision making was consideration of whether the decisions made would impact other system organisations and asked the ICB Board to consider how groups could be given the delegation to act on behalf of the system. JM highlighted workforce as the key concern and the focus was on supporting people to move around the system as needed. JS noted the importance that local authority colleagues were involved in the conversations as Home First was an important aspect to this work. RS confirmed that an end to end risk review of the discharge to assess plans would be undertaken by the Quality Surveillance Group which would include how risk would move across the system. JM noted that other considerations included how GPs could support the plans. Ruth Taylor (RT) agreed and asked that clarity be provided on how decisions would be made and communicated. ED reported that the Committee membership continued to be developed and highlighted the letter from Claire Murdoch, National Director of Mental Health which had been sent to all ICBs regarding the content of the Panorama programme regarding care homes. RS confirmed that discussions had taken place with system Chief Nursing Officers and the letter would be responded to. **The ICB Board received the update from the Committee**	**JM**
7.2	**People Committee** JCh explained that no Committee minutes had been included as these would be approved at the next meeting. The People Committee minutes would be sent to the ICB Board members once approved. JCh reported that the People Strategy had been agreed and outlined the plans to be actioned between now and March 2024. JCh noted the Strategy would evolve to support staff as appropriate. The People Strategy included work from across the ICB directorates to review challenges and retention of staff. Local	**JCh/SC**

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	surveys for staff wellbeing would continue and JCh noted that a concern for staff included the number of posts filled by fixed term contracts and these would be reviewed as part of the organisation realignment work and would be addressed by December 2022. JCh reported that the People Programme Board terms of reference had been reviewed and the feedback incorporated ready for approval. The feedback included consideration on how the Locality Partnerships and Community voice would be heard. JCh highlighted that possible funding to action system concerns had been discussed and options would be presented at the next ICS People Committee. This would include consideration of the cost of attrition and retention of staff and would be reviewed for the whole range of workforce. RS noted that there were high attrition rates for student nurses related to unacceptable culture and behaviours. RS highlighted the importance that the experience of staff was understood to address these concerns. JCh confirmed this would be built into the engagement with staff and included in the work of the Independent Advisory Group outlined earlier. JCh reported that the People Committee had discussed the possibility of a learning academy to support retention and training of staff as well as the need for all organisations to encourage system working. It was noted that a communications officer had attended the meeting to discuss system wide communications. JF welcomed the conversations and agreed that the communications element was very important. JF noted that the system finance teams were working as a single unit but in some areas such as HR system working was not as mature. JCa and SW agreed with this assessment and SW noted that workforce issues were considerably different between teams and asked how the system could invest to improve this. Sarah Truelove (ST) confirmed that system Finance Directors have met with system Chief People Officers to further understand the challenges. ST noted the importance that the system worked jointly to address these issues. **The ICB Board received the update from the Committee and approved the ICB People Strategy and Plan**	
8.1	**Finance, Estates and Digital Committee** SW reported that the Committee had discussed the delivery of the savings plans noting that the biggest challenge was agency spend which was the result of the current workforce challenges. The Committee asked the system to focus on the savings and getting a grip on agency spend. SW noted that the Committee needed to connect with the Outcomes, Performance and Quality	

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	Committee and People Committee to ensure that any money was invested in the right areas. SW noted the Committee had discussed primary care and access for patients as well as the challenges facing the Acute Trusts. JF highlighted the importance of Committee Chair co-ordination and this would be reviewed. ST highlighted the finance report noting that the key indicators measured were part of the fiscal outcomes framework which the ICB would be monitored on as well as the system financial position. ST noted that the Committee had discussed the delivery of the savings plan and a series of deep dives into key areas would be presented to the Committee. RT noted the importance that primary care was included in the discussions and asked that a primary care representative be considered for the Committee. JCh confirmed that through the People Committee, groups would be set up to review collaborative working. DES highlighted a future system wider cyber panel which had been arranged to review system resource and noted the conversations with primary care medical services regarding the end of the EMIS contract in March 2024. The procurement plan for which would be discussed at the next Committee meeting. **The ICB Board received the update from the Committee**	**JF/ NEDs** **SW/ST**
8.2	**Primary Care Committee** AM explained that the Primary Care Committee had recommended the ICB Board support proceeding with the delegation of pharmaceutical, ophthalmic and dental (POD) services. The Primary Care Committee had reviewed the risk based assessment of the delegation and agreed that delegation would benefit the local population and the Committee was assured that the risks would be actively managed. AM highlighted that the pharmaceutical representative at the Committee had expressed an interest in pharmacy services playing a bigger part in supporting the system. AM reported that dental services were highly challenged and it was noted that NHS England had developed major transformational reform programmes for both pharmaceutical and dental services. The ICB would be held to account for the action plans associated with the reform programmes. Delegation of services would commence April 2023 and the POD representatives were already attending the Committee to ensure that there was good understanding of the challenges and opportunities. AM reported that the Committee had discussed the non-recurrent funding for primary care of £791k which would support primary care medical services recovery. AM highlighted that the Committee had requested that any investments consider health inequalities. AM noted that the GP patient's survey results had been discussed at the meeting and further detail would be provided	

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	at the next meeting. There were concerns regarding the number of patients deliberately not contacting their GP for an appointment due to concerns regarding access. The Committee agreed that this could negatively affect the system if not addressed. DJ noted that the Primary Care Committee had reviewed the risks and opportunities to POD delegation and the recommendation to proceed had been made following significant scrutiny. DJ noted the key benefit was the opportunity for the ICB to develop responsive services at local level and to enhance partnership working across primary care and the system. DJ explained that the risks outlined in the paper were national risks and noted that although there were some outstanding issues within the delegation checklist, these would be worked through with NHS England. Directors of Finance were working to secure a single allocation for the three services and this was currently around £81m but not finalised or confirmed. There also remained a risk relating to the capacity of the NHS England Commissioning Hub to provide support and discussions were continuing regarding the realignment of resources needed. DJ noted that the Primary Care Committee and the Finance, Digital and Estates Committee had recommended delegation to proceed. MS asked about the membership of the Primary Care Committee and asked whether it would be beneficial to have a member representing secondary care on the Committee. It was agreed to consider this. Vicky Marriott (VM) highlighted the GP patient survey and noted that Healthwatch undertook a lot of engagement with patients regarding access to services. AM confirmed a member of Healthwatch attended the Primary Care Committee and was an active participant. VM asked whether there was more that the ICB could do to work with Healthwatch and AM agreed that this would be explored. **The ICB Board received the update from the Committee and supported the recommendation to proceed with delegation and delegated authority to the Primary Care Committee to seek assurance against the risks included within the paper**	**AM/DJ** **AM/DJ/ VM**
8.3	**Audit and Risk Committee** JCa reported that the first meeting of the Audit and Risk Committee had taken place. The meeting had been candid with good contribution from members. The four objectives of the ICB were considered alongside the items discussed. JCa noted that close down of the CCG had been discussed as a necessary part of year end processes. The Head of Internal Audit Opinion had been received and was mostly satisfactory. JCa reported that useful benchmarking data would be received from the internal auditors and the Committee would review this. The	

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	internal audit plan had been approved by the Committee and the ICB was in the process of finalising the appointment of the external auditors. **The ICB Board received the update from the Committee**	
9	**BNSSG Integrated Care Partnership Updates** JF reported that the BNSSG Integrated Care Partnership had discussed the development of the Integrated Care Strategy. JF highlighted the significant work undertaken on the Strategy and encouraged ICB Board members to attend the Partnership day on the 18th October where the system would discuss and develop the Strategy further. JF noted that he was Deputy Chair of the BNSSG Integrated Care Partnership and met bi-weekly with the Chair to discuss issues important for the ICS and ICB. **The ICB Board received the update**	
10	**Questions from Members of the Public** JF thanked two members of the public for their questions and confirmed that these would be responded to formally outside of the meeting and the questions and the responses included in the minutes as a post meeting note. **Questions and responses added after the meeting** **Questions received from Mrs Harris:** *Does the ICB intend to carry out an audit of healthcare provision in Bristol, North Somerset and South Gloucestershire, treating each area as a separate entity when showing the results?* We are currently developing our five year system plan which is underpinned by demand and capacity requirements reviewed at a system wide level across BNSSG and at the respective local authority level through the JSNA's produced. There is no current plan for a separate audit of healthcare provision across BNSSG. *How many NHS beds have been lost since the year 2000 in South Gloucestershire? I am anxious that any audit will show that during a reconfiguration of services begun in 2005, the result will show a reduction in bed numbers from 1120 in Frenchay and Southmead hospitals down to 800 in the new PFI Brunel building.* *In 2010, a plan for a community hospital of 68 intermediate care beds with outpatients and diagnostics, after two years of work, was formally approved. The incoming Conservative Government immediately scrapped the plan. Does the ICB consider the recent proposal of 40-45 rehabilitation beds, a reduction of 23 beds, will be sufficient for the future when South Gloucestershire's population has increased by 40,000 since 2005 and is likely to be much higher*	**SC**

	Item	Action
	in future? There are between 130 - 170 bed blockers in Brunel hospital every day? The number of patients experiencing a delayed discharge across our system is a real concern. We know that delays in discharging patients can have a detrimental impact on their wellbeing and has a significant impact on the whole health and care system. Our Discharge to Assess and 'Home First' programmes are focused on home-based rehabilitation and reablement. We understand however that there are times when it is better to care for people in a more formal care setting. We currently commission 50 designated pathway 2 (rehabilitation) beds in Grace Ward, Thornbury and Skylark Ward, Yate and an additional 37 'block beds' in nursing homes in South Gloucestershire. We also commission a range of services through our community provider (Sirona care & health) to enable discharge from hospital to a home setting where this is a better option for patients. **Questions received from Mr Burton:** *Will BNSSG ICB endeavour to meet all the above objectives of the "Our Plan for Patients"?* Much of our existing work is already focusing on achieving results in these areas and we are currently considering how this impacts and shapes our plans for winter and our ICB system strategy that will be published early in 2023. *In implementing "The National Endeavour" will all known volunteers (and their support organisations) be retained and expanded?* We are working closely with the VCSE through our locality partnerships to ensure that we optimise the contribution of volunteers and the great work that they do. It would be helpful to understand if you have particular thoughts or concerns in relation to retaining and expanding the number of the volunteers and support organisations so that we can provide a more detailed response to your question. *What consideration will be given to patients wishing to withdraw for over-prescribed medicines to have the necessary information for making an informed choice and with access to specialist services?* There is work through the medicine optimisation team and colleagues across the system that supports the polypharmacy and over-prescribing agenda, with work already in progress. It includes education, production of relevant tools and guidance for clinicians and patients to discuss their options, along with structured medication reviews (SMRs) in targeted areas.	

	Item	Action
	What progress is being made in BNSSG on the STOMP (Stopping the Over-Medication of People with a Learning Disability, Autism, or both) Project? The ICB has an Integrated NHS Pharmacy and Medicines Optimisation (IPMO) plan. This plan sets out our medicine's optimisation vision and priorities across the ICS from a Pharmacy perspective. Within the IPMO plan we highlight below: <u>STOMP and STAMP</u> Stopping The Over Medication of People with learning disabilities and/or autism and Supporting Treatment and Appropriate Medication in Paediatrics are national projects to help ensure that these individuals are not prescribed psychotropic medicines if they do not need them. People with a learning disability, autism or both are more likely to be given these medicines than other people. While they are appropriate for some people and can help them to stay safe and well, sometimes they are prescribed for people in whom they are not indicated, and they can have side effects that affect their quality of life. BNSSG Integrated Care System (ICS) believes the best approach to fully implementing STOMP and STAMP is via a system wide approach. Consideration is being given to scoping the role/s of specialist learning disability prescriber pharmacists working across the system to fully implement these national medicines safety priorities. In addition to this Structured Medication Reviews (SMR) are utilised, in partnership with the patient, to reduce unnecessary polypharmacy, medication related harms and hospital admissions. This includes a focus on STOMP and STAMP. As well as this BNSSG ICB has devised a medication safety dashboard which is used across our GP practices as part of a prescribing quality scheme project. An indicator on this dashboard is "Learning disability or autism on an antipsychotic medication as a current medication". This indicator helps practices identify patients on antipsychotic medication with an aim where appropriate, to improve their quality of life by reducing the potential harm of inappropriate psychotropic drugs, for example by planning a supervised dose reduction or using other treatment options where appropriate. As an ICB we monitor this data on a quarterly basis. It is envisaged that practices will use this as a tool to support their ongoing safety work. The medicines optimisation team monitors prescribing data through open prescribing and EPACT2, this is in relation to anti-dementia and antipsychotics medicines. Although these are not specifically linked to STOMP/STAMP this does provide insight into prescribing and trends monitoring.	

	Item	Action
	In addition to this we are part of the working group to support the development of Oliver McGowan Mandatory Training in Learning Disability and Autism Roll Out Programme in 2022/23. We believe the key areas highlighted above will support the programme of STOMP/STAMP. Going forward we continue to monitor this and are considering a bespoke project for 2023/24 in this subject area. We are exploring additional alerts for prescribers in relation to this and as part of future polypharmacy training sessions incorporating STOMP/STAMP to provide further education.	
11	**Any Other Business** JF noted that the next meeting of the ICB Board was a seminar session.	
12	**Date of Next Meeting** 1st December 2022, to be held virtually via Microsoft Teams	

Lucy Powell, Corporate Support Officer, October 2022