Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 1st December 2022 at 12.15pm, held virtually through Microsoft Teams

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DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
Julie Bacon	Interim Chief People Officer, BNSSG ICB	JB
John Cappock	Non-Executive Member – Audit	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Hugh Evans	Executive Director Adults and Communities, Bristol City Council	HE
Julian Fleming	Director of Digital Delivery and Development, Sirona care & health	JFl
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Jon Hayes	Chair of the GP Collaborative Board	JH
Alison Moon	Non-Executive Member – Primary Care	AM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
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
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EY
Apologies		
Maria Kane	Chief Executive Officer, North Bristol Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JSh
Stephen Peacock	Chief Executive Officer, Bristol City Council	SP
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	WW

In attendance		
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
Peter Goyder	Clinical Lead Exceptional Funding Review & Commissioning Policies, BNSSG ICB	PG
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
Chris Moloney	Commissioning Policy Development Manager, BNSSG ICB	CM
Lucy Powell	Corporate Support Officer (Minute Taker), BNSSG ICB	LP
Ruth Taylor	Chief Executive Officer, One Care	RT

	Item	Action
1	**Welcome and Apologies** Jeff Farrar (JF) welcomed everyone to the meeting and noted the apologies outlined above.	
2	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda.	
3	**Minutes of the 6th October 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** – Shane Devlin (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 continued to work with health and care professionals to make sure that their views were considered in the right way. A productive meeting had been held with patient representatives and a proposal for working with people with lived experience would be drafted. The Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance presented a paper on how the VCSE sector could be more involved. The paper contained some considerations on how the ICB can compensate people for their time. SD confirmed that the system would consider all the options for involving the three groups in the system work. Ellen Donovan (ED) welcomed the approach and asked when the arrangements would be in place. SD believed that plans would be developed within the next couple of months. Rosi Shepherd (RS) highlighted that previous work with people with lived experience had provided important challenge in a positive way and welcomed the more cooperative way of working. Dave Perry	

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	(DP) also highlighted the importance of the ICB working with the wider system including public health colleagues. **Action 24** – David Jarrett (DJ) confirmed that the mass vaccination team had been engaged in a range of programmes including COPD. The action was closed.	
5	**Chief Executive Officer's Report** SD highlighted the areas covered in the report which included the decision making Framework, the ICB reorganisation and winter planning. **Decision Making Framework** SD noted that this framework was important as it underpinned how system partners would make decisions and noted that this would be further discussed later in the meeting. **ICB Organisational Structures** The ICB was currently in the process of redesigning the structure in partnership with the staff. It was expected that the ICB would start phase three in January 2023 in line with the projected time frame. One Director role remained vacant, the Chief People Officer, and the ICB was waiting for a response from an individual following an offer. **Winter planning** SD explained that a review of winter plans had been undertaken to ensure that the plans were keeping people safe as intended. SD highlighted that the most important aspect of the plans was supporting flow through hospitals and therefore projects were being refocused to support the flow improvement programme. SD highlighted the 8 priority areas which had been identified to support patient flow; discharge to assess, virtual wards, the new stroke model, falls response, Care Traffic Control, high intensity user support in primary care, ambulance handovers and care sector capacity. SD confirmed that national funding had been made available to support these programmes and the BNSSG system had received a large portion of the funding. Steve West (SW) welcomed the report and agreed that winter pressures should be the system focus. SW noted that an important part of this work was supporting the workforce during what would be difficult period where programmes were expected to be developed at pace. SW reminded the ICB Board that the system needed to work effectively together. SD confirmed that management of sustainable workload was being considered and noted that ensuring patients were in the right place for care would support a productive workplace. Alison Moon (AM) highlighted the 8 priority areas and asked whether there were plans underneath these with quantifiable and measurable actions and	

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	asked for more information about the key risks. SD confirmed that each of the priorities had underlying plans and the ICB Executive Team was monitoring these on a weekly basis. The system Chief Executives had also agreed to be available to make quick decisions where there were blockages in the system. SD noted that the biggest risk was the behavioural and cultural shift needed to support the work which included development of relationships across the system. Lisa Manson (LM) confirmed that the priority areas had actions not just for winter but also for longer term delivery wider than the immediate winter considerations.	
6.1	**Clinical Commissioning Policies** Chris Moloney (CM) and Dr Peter Goyder (PG) were welcomed to the meeting. CM explained that the Fertility Assessment and Treatment policy had been reviewed in line with the review dates and the reviewed policy was agreed by the then CCG Clinical Executive. Following this the policy underwent 3 months of patient and public engagement which further informed its development. CM noted that two additional factors had been considered during the review. The first was that although the policy reflected NICE guidance and best practice, it was recognised that more was needed around fertility preservation to provide greater equality of opportunity for people to access this treatment who were undergoing NHS care which would have a negative impact on fertility. Secondly, the ICB needed to review the policy's position to only fund assessment and treatment for couples as this stance could be challenged under the Equality Act. It had been recognised that the revised policy should not lead to an increase in the overall fertility spend and therefore any changes which would increase activity should be mitigated through other areas of the policy. CM reported that the engagement exercise had identified that the public supported broadening the scope of fertility preservation and prioritising the length of time someone has tried to conceive. CM noted that an additional policy regarding Fertility Preservation had been developed. PG highlighted that the key aim of the Fertility Assessment and Treatment policy was to enable investigation and treatment for individuals or couples where infertility was likely to be present. PG noted that NICE guidance had not been updated for several years and therefore the proposed changes had been the result of the consultation and to support equality. PG confirmed that access to services continued to be based on not being able to become pregnant despite unprotected intercourse over a two-year period. The previous requirement for at least 10 cycles of self funded cycles has been reduced to six. This change was based on specialist advice and considered more achievable by couples and individuals. PG explained that the current policy allowed early referral in instances where there was no ovulation due to blocked fallopian tubes and where there was zero sperm count. These conditions had been updated to include individuals with severe endometriosis and where sperm count was less than 1 million per ml. PG noted that to remain within the	

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	allocated financial envelope the top age had been reduced from 40 to 39 which was in line with other areas in the country. PG explained that the Fertility Preservation policy was based on NHS England guidance to provide gamete preservation for patients on cancer pathways where fertility may be affected. This was not an equitable position and therefore the policy had been amended to include gamete preservation for individuals whose fertility was likely to be significantly affected by any NHS commissioned treatment. CM highlighted the lowering of age to 39 and noted that there was no change to the range or approach to services that would be delivered although access would be broadened. The key risk associated with the policy was financial and around the inclusion of single individuals. There was no local data to indicate whether this inclusion would significantly increase activity, although previous Exceptional Funding Request data had indicated that it would be unlikely that activity would exceed the levels outlined in the paper. CM also highlighted a risk related to the transition period for the policy and the lowering of the upper age to 39. In order to ensure that women aged 39 were not unfairly disadvantaged by the policy, the ICB would not stop funding for women aged 39 for 9 months to a year after policy implementation. CM explained that this meant that costs connected to fertility preservation would not be fully mitigated within the first year however some of the costs associated with the new policy would be mitigated through other elements covered through the Exceptional Funding Request route. RS confirmed that the policy had been reviewed and recommended by the Commissioning Policy Review Group and by the Clinical Review Group, which was a sub-committee of the Health and Care Professional Executive. AM highlighted the risk section within the paper and was pleased that the proposed changes had been supported with evidence. AM noted the mitigations and asked whether there were likely to be any legal challenge or reputational damage. PG explained that the evidence supported the approach and that the proposals would ensure that policy was legally safe and provided equitable access for the local population. RS confirmed that any women already receiving treatment who was between 39 and 40 would complete their treatment. Jon Hayes (JH) asked how the policy would be communicated to primary care. PG confirmed that following approval primary care and other providers would be informed of the changes through already agreed communications. SW also noted the importance of patient communications which included communications in patient waiting rooms and updating websites. Jaya	

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	Chakrabarti (JCh) highlighted the importance that the upper age limit for treatment was emphasised in communications to support people to plan. Vicky Marriott (VM) agreed and noted that people were making the decision to have babies later and therefore it was important that people were aware of the limits of the policy. **The BNSSG ICB Board approved the changes to the current commissioning policy for Fertility Assessment and Treatment and approved the proposed new policy for fertility Preservation**	
6.2	**NHS England and Improvement Operating Framework, ICB Memorandum of Understanding and NHSE Enforcement Guidance** LM explained that NHS England had published a consultation on the enforcement guidance for providers of NHS service that hold a provider licence and ICBs. LM explained that the proposed response to NHS England reflected that the ICB did not understand how the regulatory framework would distinguish between the issues that the provider could address independently, without support from system partners and therefore it may be more effective for the whole ICB to be in receipt of regulatory action. LM highlighted that the ICB was a collection of partnerships and therefore it was also proposed that the response to NHS England recognised this. LM noted that the ICB needed clarity on how enforcement worked for direct commissioning arrangements such as Continuing Healthcare. It was noted that there needed to be a consistent approach and it was difficult to see how one part of the system could be under enforcement action without significant impact to the rest of the system. LM explained that the Memorandum of Understanding (MoU) outlined how NHS England would work with the ICB on the implementation of the Oversight Framework. LM confirmed that this was based on the ICBs governance arrangements and would be updated to reflect the decision making framework if approved. It was recommended that the ICB review the MoU in February 2023 to include the outcome of the enforcement guidance consultation and the work of the Chairs and CEOs of the seven South West ICBs to review the NHS England contract working arrangements. SD highlighted the importance of the BNSSG system and therefore individual enforcement regulations on a single provider did not make sense and welcomed the response which emphasised this. John Cappock (JCa) agreed with the response and noted the effort that had been invested in partnership working and building relationships across the system.	

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	RS highlighted that the papers contained the national guidance on quality, risk response and escalation and noted the system had developed a local system framework for to mitigate risk and work together which supported joint system working. ED highlighted that the MoU referenced the Outcomes, Performance and Quality (OPQ) Committee as a key element of governance assurance and asked that clarity was provided on what that meant for the Committee and what needed to be the priorities. LM agreed that the Terms of Reference would be reviewed and noted that the Committee may need sub-Committees to deliver the required functions. AM agreed that clarity on the roles of the ICB Board Sub-Committees would be useful and asked for live examples or case studies to understand the value the MoU added to the ICB. LM noted that this would be included in the discussions around how the ICB and NHS England worked together. LM noted that the ICB also needed assurance the MoU would evolve over time as the Oversight Framework was expected to change. SW agreed that case studies would help to understand the MoU and noted that how NHS England and the ICB engaged was vitally important. SW agreed with the response to the enforcement guidance and highlighted the importance that the system supported each other. The importance of considering the MoU a working document was important to ensure that people remained engaged. RS confirmed that the Health and Care Professional Leadership group had an action to test the risk and decision making framework and the proposal was to test this alongside delivery colleagues which would provide a case study of working through the MoU. It was noted that this work was due to take place in the Spring 2023. **The ICB Board approved the Memorandum of Understanding and the response to the enforcement consultation.**	**LM/RS** **LM/RS**
6.3	**Draft BNSSG Decision Making Framework** Sarah Truelove (ST) presented the framework explaining that this was an important document for making decisions within the ICB and provided clarity to the system and reflected the changes in statutory duties across the system. ST noted that the framework focused on NHS decisions, but the aim was to make decisions as a partnership and to involve the Local Authorities in the decision making. The aim of the framework was to ensure that that functions and decisions of the ICB were made in a timely, responsive and proportionate manner. ST confirmed that the framework was aligned with the ICB Scheme of Reservation and Delegation and Standing Financial Instructions.	

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	ST explained that the framework outlined the different levels of decision making. ST explained that the Integrated Care Partnership (ICP) was concerned with setting strategy which the ICB would then take decisions on for investments over £1 million, and for agreeing the joint forward plan, the operational plans and medium term financial plans. The ICB Board Sub-Committees would be responsible for the oversight and assurance of all elements of work with the System Executive Group being available to progress actions between ICB Board meetings and for decisions relating to investment between £0.5m and £1m. These decisions would be reported to the ICB Board, and the Sub-Committees could be provided with detail for assurance if required. ST reported that four Health and Care Improvement Groups had been proposed which provided an opportunity for partners to come together to make practical work programme decisions. ST noted section 5 of the framework which highlighted the limitations and included the management of potential conflicts of interest and that the framework was being developed during a time of limited resource. There needed to be a rigorous review of decisions as these would be around moving resource around the system. JF noted that Chief Executives needed to be empowered to run their organisations but significant challenges needed to be raised at ICB Board level rather than decided at the Chief Executive group. SD explained that this had been discussed and the role of the Chief Executive group was to implement the actions discussed at the ICB Board. SD also noted that the Chief Executive group was the place for continuous improvement to be discussed between Board meetings. SD noted that the relationship between the ICB Board and Chief Executive group would evolve to ensure that the right items were discussed at Board level. ED agreed that it was important that there was a mechanism for rapid decision making. ED asked whether the system had the resources to support the decision making framework and ensure there was no overlap in decision making. ST confirmed that ensuring the appropriate resource was available was part of the process of designing the structures and removing the duplication was part of this. It was acknowledged that more clarity was needed regarding decision making. ED also noted that an example had been provided within the papers of the OPQ Committee sponsoring an initiative with no input and asked how this was possible. ST agreed to answer this point as an action.	**ST**

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	JCh commented that it would be useful to have clarity on headroom funding and welcomed the decision making structure which supported quick decision making. JCa welcomed the framework but noted the importance of building in a review. DP noted that although this was primarily a decision making framework for NHS funding it was important that other ICS organisations were involved in the decisions and delivery of plans. Decisions needed to be joint across all the organisations and asked whether a non NHS Senior Information Responsible Officer (SIRO) could be included. Eugine Yafele (EY) explained that decisions of less than £0.5m could have repercussions for other organisations and noted that the framework needed to support challenging decisions to ensure that all implications were considered. ST recognised the need to review the framework in the future and this would also include review of the thresholds. VM asked the ICB to consider Healthwatch involvement in the Health and Care Improvement Groups. SD highlighted the importance of spirit and tone of decision making and explained that the system needed to consider all decisions in terms of the impact across the system. The ICB recognised that leadership across the system included the NHS, Local Authorities, and the Voluntary and Community sector organisations. The decision making framework related to NHS money but the investments made were about system improvement and therefore not only partners but people with lived experience needed to be involved in decision making. SD noted that the framework would be reviewed every 6 months and after each significant decision. Deborah El-Sayed (DES) noted that digital decisions spanned the four Health and Care Improvement groups, and digital solutions were important enablers for the system. ST explained that digital enablers were expected to have links to the four groups and the work programmes would support the improvement with the decisions made though the various enabler groups. DP asked that there was greater flexibility in the Terms of Reference and asked that a partner organisation SIRO was included on the improvement groups. ST agreed to update the Terms of Reference to include this and further consideration would be given to how other system organisations could be involved. **The BNSSG ICB Board agreed:**	**ST** **ST**

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	• **Adoption and implementation of the Decision Making Framework by the ICB and all partner organisations** • **To cascade the Decision Making Framework within the ICB and all partner organisations**	
6.4	**Delegation of Decision Making for Winter Expenditure** LM explained that the ICB had received an additional winter allocation to improve flow through the system particularly hospital discharge. The allocation was based on fair shares but also reflected the scale of the challenge within the system. Each of the Local Authorities had received an allocation and the ICB had received £8.3 million which would be allocated as part of a pooled budget alongside the Better Care Fund. LM asked for the ICB Board to approve delegated authority for the £8.3 million spending plan to be agreed by the Chief Executives on the 15th December 2022. LM confirmed that a virtual joint Health and Wellbeing Board Chairs meeting would be convened to approve the Better Care Fund element of the funding and to ensure that the NHS decision making was considered alongside Local Authority needs. LM noted that the allocation would be received in portions and the spending plan needed to be submitted by the 16th December 2022. Activity monitoring against the plan would be submitted on a fortnightly basis. SW supported the delegation as sensible and noted the importance that the system was able to demonstrate that the investment was improving flow. ED noted that the allocation was a great opportunity and highlighted that the later investment would be based on the systems ability to make measurable improvements. ED asked what was the role of the Committees and the ICB Board in this programme of work and noting that workforce remained the significant challenge. LM explained that activity would be submitted to NHS England fortnightly and formal updates would be provided to the OPQ Committee and also the Chief Executives Group. LM noted that all partners would have oversight of this programme of work as scrutiny of the system was important. ED requested that the data showing performance for the Committees was a simple one page document to ensure that this important piece of work received the oversight it needed. SD agreed and noted that the central measure was no criteria to reside and therefore the reporting should be very simple. SD noted that the local system had received the largest allocation due the scale of the challenge around no criteria to reside. DP highlighted the importance that short term solutions were built upon to develop medium and long term sustainability within the system. **The ICB Board approved the delegation of the agreement of the spending plans to the BNSSG ICB Chief Executive Meeting on the 15th December 2022. The fortnightly monitoring of the activity plans would be undertaken**	**LM**

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	at the BNSSG ICB Chief Executive meetings. The spending plans would be considered via the three Health and Wellbeing Boards.	
7.1	**Outcomes, Performance and Quality Committee** ED noted the challenge facing the system regarding patients with no criteria to reside and noted that the Committee had raised concerns given the significant numbers of patients across both secondary and community care particularly as the current plans for winter had not improved the position. Julie Sharma was leading a focussed piece of work on Home First on behalf of the ICB. LM noted that LM, DES and DJ were delivering the core elements of the winter plans. LM offered to circulate to the ICB Board the project initiation document to provide more information. LM explained that progress was being made against 104, 78 and 52 week waiters and noted that although patient numbers remained high progress was being made against trajectory and expected to meet the 31st March 2023 target. Progress was being made in terms of cancer two week waits particularly by North Bristol Trust (NBT). Mega Clinics and consistent validation of the waiting list led to improvements in the two week wait performance for breast surgery. RS noted the increase in Clostridium difficile (C Diff) infections nationally. BNSSG remained under the national average but infection rates would be monitored through the OPQ Committee. If needed, work would take place with the Medicines Optimisation regarding any changes in practice required. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	**LM**
7.2	**People Committee** JCh noted that the ICB People Committee had discussed the comprehensive People Plan in place. There was a risk related to having the available resource in place to deliver the actions and a key mitigation of this was recruitment of the Chief People Officer. JCh highlighted that the key message from the ICS People Committee was staff wellbeing and support for staff during this difficult winter. Julie Bacon (JB) noted that financial investment to support staff wellbeing continued to be considered by NHS England. JCh noted the workforce report which reported on staff vacancies and explained that JB had undertaken a piece of work to review the financial costs of people leaving which JCh hoped would be considered during headroom funding discussions. JCh highlighted that a cost of living report had been included on the agenda as a standing item to ensure that the ICS People Committee could support staff to be able to afford to work and deliver the best productivity. The People	

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	programme report was presented and although early in development, 1, 3 and 5 year plans had been drafted and the ICS People Committee was reviewing which metrics could be measured to support greater retention and recruitment. JCh highlighted the importance that the system considered the ICS rather than individual organisations particularly in terms of staff benefits and system wide values. The value and resources provided by third sector organisations was also being reviewed and an action had been taken to explore the opportunities in more detail. JB highlighted that the Terms of Reference for the ICS People Committee had been amended to include the ICB Chief Finance Officer and Deputy Chief Executive as there had been several conversations around funding. JB noted that a second Non-Executive Member had been included on the Terms of Reference for the ICB People Committee to ensure that quoracy could be met. The ICB Board was being asked to approve these amendments. JB explained that the ICS People Committee received the Operational Plan. This was monitored and a standing item on the agenda. JB also noted that an update on the industrial action had been provided at the meeting. JF asked the Committee Chairs whether partner Non Executive Director attendance at the Committees had added value. All the Committee Chairs agreed that their presence added value and supported system thinking. **The ICB Board received the update from the People Committee and approved the revised Terms of Reference**	
7.3	**Finance, Estates and Digital Committee** SW reported that the members had good understanding of the remit of the Committee and how finance, estates and digital supported delivery for the population and quality of services. SW noted that finance was a key enabler and noted the importance that Committees share information as solutions may be within other Committee remits. SW explained that the Committee had a good mix of reporting across finance, estates and digital work programmes at system level. SW reported that there were a number of key themes including the importance for teams to continue to focus on savings delivery. SW noted that the Committee had also discussed undertaking work in a different way given the challenges relating to workforce and noted that a significant amount of financial resource was being spent on agency staff. SW noted the importance that future schemes needed to consider the implications for workforce and challenge whether workforce could be deployed differently. ST highlighted that the perspective from South Gloucestershire Council at the last Committee meeting had been valuable.	

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	SD asked how the Committee would drive the digital and estates work programmes forward as these were also important enablers for the system. SW explained that the Committee needed the oversight and understanding of the programmes and needed to work closely with the system to understand system needs but SW felt that there needed to be a subgroup with the right people around the table to develop the work programmes. DES highlighted the Digital Delivery Board which undertook the system level work and reported to the Finance, Estates and Digital Committee. DES highlighted that it was difficult to have the breadth of discussion needed about digital work programmes at the Committee and although the Committee was working through balancing the 3 different aspects, there may need to be review into how the current governance structure works to support the system. Julian Fleming (JFl) highlighted that digital solutions were important across the system and noted that although the Committee held the assurance and oversight, all areas of the ICB needed to be discussing digital. JF noted that this was similar for workforce which also cut across all areas of the ICB. JCa noted that digital had been discussed in detail at the Committee and through lenses other than finance. Jo Medhurst had attended the Committee and provided a clinical view of the digital and estates work programmes and these conversations were expected to evolve with the Committee. LM suggested that the Executive Team review the ICB Board Sub Committee governance substructure to further support joint delivery. JCh highlighted the importance of considering the Committee elements in terms of assets and functions and how the functions could support the assets across the various workstreams. ST reminded the Board of the approved Decision Making Framework and highlighted that the Service Improvement Groups would be the place to have those discussions and there would be representatives from all the work programmes including digital on those groups. These discussions would be fed back into the Committees as well as the current groups such as the Digital Delivery Board. SW agreed and highlighted that the Committees needed to consider items strategically whilst the ICB Executives worked across the system to ensure the Committees were reviewing the right things. SD confirmed that the role of the Committees was check and challenge and oversight and assurance of the relevant functions to support the system. **The ICB Board received the update from the Finance, Estates and Digital Committee**	**ICB Execs**
7.4	**Primary Care Committee**	

	Item	Action
	AM noted that minor changes to the Primary Care Committee Terms of Reference had been presented to the ICB Board for approval. AM reported that at the October Committee meeting the Committee had received assurance on the primary care winter planning approach and discussed how the allocated funding could be utilised to further support the system. At the November Committee meeting, the Committee had discussed the significant workforce challenge facing primary care and reviewed the progress against the Primary Care Strategy. The four key elements of which were models of care, workforce, quality and resilience, and infrastructure. AM noted that the Primary Care Strategy overlapped with a number of other Committee workstreams such as workforce and digital infrastructure. AM highlighted the significant amount of information provided for assurance and noted that at the meeting it had been requested that the key metrics be presented as a brief visual representation. AM highlighted the whole system impact of current performance noting that patients waiting for secondary care treatment would contact their GP more often which impacted on primary care capacity. It was noted that a key part of the Primary Care Strategy was reducing unwarranted variation and the Committee was working through what this meant for the local population. AM noted the Additional Roles in primary care and explained the importance that the recruitment to the roles did not affect workforce capacity in other areas of the system. Work continued in terms of improving access with over 50% of appointments in primary face now face to face. The Committee was working through what was needed for the local population and whether over 50% was the right proportion of face to face appointments. AM highlighted the ongoing work regarding delegation and noted that the Committee had been sighted on the opportunities of delegation as part of locality working. AM reported that the Committee had a seminar regarding dentistry which outlined the significant challenges facing services. A major dental reform programme had been developed which NHS England were currently managing but the ICB would be taking on the responsibility from 1st April 2023. DJ added that the Primary Care Strategy was now in the fourth of five years of plans. The ICB was working with One Care and the GP Collaborative Board to further develop the Strategy and intertwine this with wider Strategies in place. DJ confirmed that the ICB was working with the commissioning hub on the Safe	

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	Delegation Checklist and this would be presented to the Primary Care Committee in February 2022 and then to the ICB Board for approval. **The ICB Board received the update from the Primary Care Committee and approved the revised Terms of Reference**	
7.5	**Audit and Risk Committee** JCa highlighted that there had been minor revisions to the Terms of Reference to reflect that all the independent Non Executive Members were members of the Committee. The ICB Board were asked to approve these. The Committee continued to develop the partnership approach with provider and local authority members. JCa noted that the Counter Fraud Policy had been recommended for approval by the Committee and this was attached for ICB Board approval. JCa reported that all ICBs had been asked by NHS England to provide a self assessment of their management of conflict of interest processes. A joint response would be sent from the ICB Chief Executive and the Audit and Risk Committee Chair. JCa was assured that good, robust processes were in place and reminded ICB Board members to review their declarations regularly and inform the ICB Corporate Governance team of any changes. JCa reminded the ICB Board members that the January seminar session would focus on the assurance framework which was an important piece of work which supported governance arrangements. The session would be facilitated by the Internal Audit lead and would be engaging and focused on the practical applications of the framework. **The ICB Board received the update from the Audit and Risk Committee and approved the revised Terms of Reference and ICB Counter Fraud Policy**	
8	**BNSSG Integrated Care Partnership Updates** JF confirmed that the ICB Board had received the first draft of the Integrated Care Partnership Strategy which developed the partnerships between health and social care and this would be developed further through consultation with the public and patients. Colin Bradbury (CB) noted that the Strategy development was iterative and would be refreshed and reviewed regularly. CB confirmed that all partners showed a commitment to the partnership working. It was acknowledged that this was a time of significant pressure for the health and care system so those involved in the development of the Strategy needed to consider prioritisation and be pragmatic on the actions that could be taken. CB confirmed that the Strategy would be presented at the Integrated Care Partnership meeting on the	

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	16th December 2022 and this meeting was open for members of the public to attend. **The ICB Board received the update**	
9	**Questions from Members of the Public** Sarah Carr (SC) confirmed that a statement had been received from a member of the public regarding ICB engagement with voluntary sector organisations. It was confirmed that a written response would be provided explaining that the ICB was exploring ways of working with the voluntary sector. <u>Response added after meeting</u> The ICB has not yet made a decision on the future of the contract that it holds with the Bristol and District Tranquiliser Project. The importance of such services and the role of the community is both recognised and welcomed by the ICB. I understand that colleagues are engaging with the Project and working with people who use the services to better understand the local need for support. Brian Blestowe, a member of the public, noted that he had raised the idea of convening a small group of engineers to support the ICB with their Green Plans. It was confirmed that Green Plan had been developed and published and ST explained that the lead worked for NBT and ST agreed to put Brian in touch with the Green Plan lead.	
10	**Any Other Business** There was none	
11	**Date of Next Meeting** 2nd February 2022, Location to be confirmed	

Lucy Powell, Corporate Support Officer, December 2022