NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 2nd February 2023 at 12.30pm, held at The Holder and Frys Rooms, Future Inn, Bond Street South, Bristol BS1 3EN

DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
Jaya Chakrabarti	Non-Executive Member – People	JCh
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
Jon Hayes	Chair of the GP Collaborative Board	JH
Alison Moon	Non-Executive Member – Primary Care	AM
Maria Kane	Chief Executive Officer, North Bristol Trust	MK
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JSh
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	WW
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		
John Cappock	Non-Executive Member – Audit	JCa
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Stephen Peacock	Chief Executive Officer, Bristol City Council	SP
Jo Walker	Chief Executive Officer, North Somerset Council	JW
In attendance		
Jen Bond	Deputy Director of Communications, BNSSG ICB	JB
Katrina Boutin	Chair of the Inner City and East Bristol Locality Partnership	KB

Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Sarah Carr	Corporate Secretary, BNSSG ICB	SC
Jo Hicks	Chief People Officer, BNSSG ICB (Starts Late February 2023)	JH
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
Joe Poole	Integrated Care Partnership Delivery Director – Inner City and East Bristol	JP
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.	
	Address from host Locality Partnership Joe Poole (JP) and Katrin Boutin (KB) attended and provided an update on the work of the Inner City and East Bristol (ICE) Locality Partnership. KB explained that ICE Bristol had a population of 175,000, and 12 GP Practices which were part of 3 Primary Care networks (PCNs). The locality had high levels of deprivation and life expectancy was lower than in other local areas. KB also highlighted that there were higher levels of frailty and ill health at younger ages. KB explained that the population was diverse and English was not the first language for many. The local health care providers had a number of factors to consider when delivering services including interpretation, cultural beliefs and how these related to healthcare. KB confirmed the ICE Locality Partnership was working on addressing health inequalities and ensuring that the ICE population had equitable access, experience and improvement in health outcomes. To address this the ICE Locality Partnership has undertaken a lot of work to coproduce services with local population engagement groups to ensure that service design was driven by local communities. An example of this was the COVID-19 vaccination programme where uptake was maximised through working with local people. This level of engagement has continued into other work programmes such as community mental health. KB noted there was concern about the funding calculations going forward as investment would be required to continue to support the health of the local population.	

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	JP highlighted the strong culture of coproduction and explained that the mental health group was co-chaired by a member of the ICE community with lived experience and there was continued development to ensure that the Locality Partnership Board was reflective of the local population. JP noted that local community members were engaged in decision making processes and the emphasis was on a non-medical approach to care delivery such as community assets and social prescribing to support people to stay happy and healthy. JP highlighted the community inclusion service and noted that recovery navigators had been employed to embed the service into local communities. JP noted that grants had been received for local community projects to support children and young people's mental health, and healthy weight initiatives. The Locality Partnership was focused on the delivery of the Aging Well programme which was a national initiative focusing on loneliness and combating early aging. As part of this the Locality Partnership was also working with Sirona around falls. Shane Devlin (SD) asked what resource the Locality Partnership needed to continue the work as the current funding model was moving from non-recurrent to recurrent funding for the localities. KB noted that providing services was becoming more expensive and additional resource would enable the Locality Partnership to continue engaging with voluntary sectors partners who were working within the communities. KB highlighted programmes such as diabetes education which was important for the community but was expensive to initiate. Sarah Truelove (ST) highlighted that work had taken place in Leicester regarding Locality Partnership funding and the reduction of health inequalities. The local methodology would be reviewed in response to the outcomes of this work. David Jarrett (DJ) noted that the Primary Care Committee would continue to drive through the reduction of health inequalities at primary care level and health inequalities would continue to be a consideration in decision making. It was noted that funding had been received for the Partnership Localities and would be included in the system planning processes. Steve West (SW) welcomed the coproduction element and asked whether any barriers to coproduction had been identified. JP highlighted the community mental health programme work and explained that communication into communities had been the most important aspect. The Locality Partnership had needed support from the voluntary sector to provide the links into the community as well as local knowledge. To support communication further the reference group included members from both the community and frontline services. SW asked about the diversity of the group particularly around age. JP confirmed that age had not been considered as predominantly as other factors as the mental health framework was specific to adult mental health. However	

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	there was a system group for children and young people's mental health which was led by Barnardos and attended by young people. KB confirmed that the voluntary sector had a vital role in these programmes and continued funding for them to continue to attend and participate was important. JP noted that a policy was being locally developed to support national guidance around voluntary sector organisation funding. SW noted that funding was likely by project and therefore specific funding for these organisations would be welcome. Maria Kane (MK) welcomed the analysis and approach and highlighted that providing health education programmes in schools was important. MK asked whether there was a funding formula which considered both physical and mental health and therefore the complexities of a population. KB noted that there was no Locality Partnership specific project for children, but ICE Locality Partnership has started to review this as funding was expected to support this. ST confirmed that there was a programme of mental health support in schools across the three Local Authorities which was driven at a wider level that the Locality Partnerships. Jaya Chakrabarti (JCh) asked whether the Locality Partnership had identified all the organisations within the local area who could support the work programmes. KB confirmed that the Inner City was very good at this partnership working and although the East was less experienced in this area, the Aging Well programme was beginning to expand the partnership links. Alison Moon (AM) supported work at community level and asked whether the Locality Partnership had identified what success would look like for the population. KB explained the plans discussed were very long term and sustainable reductions in health inequalities were expected in five to ten years and this was why continued investment and engagement with the population was vital. JP highlighted that the ICE Bristol population had higher levels of A&E attendance and therefore plans and communications to support individuals to utilise more appropriate services were in place. It was hoped that these plans would provide an impact in the short term. KB highlighted the use of apps to support the population to take up screening services as another way to support health outcomes in the short term. Jon Hayes (JH) asked whether the ICE GP Practices had specific estates constraints which affected the ability of the Locality Partnership to undertake programmes of work. KB confirmed that there were issues with estates across all the PCNs within ICE and this affected access. KB noted that there were also concerns regarding access to dentistry services. JH asked whether estates had been considered as part of the Locality Partnership approach and JP confirmed that ICE had participated in the ICB estates prioritisation process. KB noted that there were also concerns regarding IT resources.	

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	Ellen Donovan (ED) asked whether there was anything further the ICB could do to support the Locality Partnerships. JP asked for clarity around what programme elements could be tailored specifically for local populations. DJ highlighted that there needed to be equitable access and consistency of service across the Locality Partnerships but added that the ICB would be clearer on what elements could be locally developed. DJ noted that the delegation of dentistry, optometry, and pharmacy services to the ICB would support the ability to enact changes at a more local level.	
3	**Minutes of the 1st December 2022 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 confirmed that the action had been updated. The action was closed. **Actions 30 and 31** – Lisa Manson (LM) confirmed that an update on winter planning had been included on the agenda. The actions were closed. **Action 36** – Rosi Shepherd (RS) agreed to review the action. **Action 37** – It was confirmed that the People Committee minutes had been presented to the ICB Board. The action was closed. **Action 38** – JF confirmed that monthly meetings have been arranged between the Committee Chairs to review the Committee agendas and discuss the overlaps. The action was closed. **Actions 46,47 and 48** – The Health and Care Improvement Groups have been considered and more detail was provided in the Chief Executive Update. The actions were closed. **Action 49** – The national template has been developed and submitted in line with national timelines. A single page report would be developed in line with these submissions. The action was closed. **Action 51** – The Health and Care Improvement Groups have been developed to connect with the ICB Board Sub-Committees with the decisions that need Committee oversight to be presented. The action was closed. All other due actions were closed.	
5	**Chief Executive Officer's Report** SD highlighted the areas covered in the report: Decision Making Framework – Improvement Groups, ICB organisational structures, winter headlines and the approach to planning. **Decision Making Framework – Improvement Groups** SD explained that the update provided more detail on the Health and Care Improvement Groups which would consider the big improvements the system needed to make. The Terms of Reference had been agreed. The groups would be driven through a partnership approach, and Chaired by an ICB Executive Lead, with members including ICS partners, and clinicians from health or social	

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	care. The groups would drive design, development and implementation of improvement plans. SD highlighted that the Improvement Groups would provide clarity to the improvement agenda and the ICB staff reorganisation would support this. **ICB Organisational Structures** SD outlined the four-phase approach to the reorganisation of the ICB staff structures. The first phase has been completed and the next step was consultation with affected staff. SD confirmed that there would be a reduction in fixed term posts at the ICB and noted that the ICB had not considered a voluntary redundancy process. **Winter Headlines** SD noted that there would be a detailed update as part of item 6.1 but the system had worked incredibly hard during a challenging winter period with increased demand and infection within the system. This has been managed alongside the industrial action. SD reflected that December had been an extraordinary month in terms of patients needing support within the system and although demand remained high, the short term solutions put in place through the winter meant that January felt less challenging. **Approach to Planning** One year and five year forward plans had been developed with engagement from the system. AM thanked everyone across the system for their hard work over the winter period and noted support for the Improvement Groups. AM asked how sustainable the transformation was and asked whether the ICB had the capacity to undertake the planned work and asked what risks there were. SD highlighted the transformation directorate within the ICB as resource and noted that there was an expectation that partner organisations would be part of the Improvement Groups and support delivery. The Service Delivery Units (SDUs) would also support performance improvement. SD noted the importance that this was not considered performance management and all system partners would support performance improvement together. SD highlighted that there was a cultural element to the partnership working and the system needed to create an environment of system working. LM explained that the system would be improving performance through the system operational plan and the system would need to collectively mitigate any barriers and ensure this was undertaken without creating challenges elsewhere in the system.	

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	JCh noted the importance that the Improvement Groups considered workforce data but didn't create pressures elsewhere in the system. SD explained that work continued to review what decisions would be made at the Improvement Groups. SD noted that the Executive Group also played a role in the decision making framework. Dave Perry (DP) thanked everyone across the system for their hard work over the winter period and stated that the situation had not been sustainable. DP highlighted the importance of the localities in improving the lives of local communities. DJ agreed and noted that this connected through the Locality Partnership projects.	
6.1	**Winter Planning 2022/23 Update and Early Lessons** LM provided an update on the situation throughout December and provided examples of the significant challenges facing the system. North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW) had utilised escalation beds to cope with the increased capacity and the system had responded to the challenge in line with the delivery plan. Three tranches of funding had been received to support patient flow and the delivery of additional beds. The funding had been used in different ways including starting the work to increase the bed base by 500. There were plans in place to open beds in NBT and to utilise bed flow in a different way. LM confirmed that virtual ward capacity had increased although there remained challenges in discharging patients, and this would need to be optimised to support the system. LM highlighted that many of the plans would result in the need for a cultural change in the ways the system worked. LM noted that some of the funding would be recurrently available to the system as part of the improvement work but the challenge was around capacity and resource to support the plans. The system was working with care sector providers to support discharge and teams were working in hospitals to support discharge working to the ethic that every bed matters. Additional care home beds were commissioned over the New Year bank holiday to discharge patients into care settings to free up beds in hospitals. To support discharge, social workers had been present in hospitals and were an integral part of the ward teams. LM highlighted the waiting list initiative noting that there were a number of patients with no criteria to reside who were in beds and unable to be discharged. The system was working through solutions and had purchased additional beds, agency social workers and intensive care coordination therapists. The additional capacity supported the significant numbers of patients requiring discharge. The NHS system partners were supporting nursing homes through additional capacity and building on the virtual ward	

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	work. LM confirmed that the system was having daily capacity calls at the level of individual bed capacity being considered. The system was managing and supporting the market to ensure care was available. LM explained that the Local Authorities pay a rate to nursing homes and the Continuing Healthcare (CHC) team was ensuring that health was paying a rate which was reflective of the costs associated with the staff required and length of stay for each patient. Domiciliary care providers had been commissioned outside block arrangements to support the waiting list initiative. LM highlighted that improving flow would support the whole system to run effectively and efficiently. At the end of the April 2023, £100m of extra funding was expected to develop plans for 2023/24. ED asked how the scale of partnership working would be maintained and asked whether the improvements made in early January 2023 had continued. ED also asked about any challenges which needed mitigation. LM confirmed that for certain parts of the system it felt more manageable, but every part of the system needed to feel less pressured every day. LM noted that OPEL 4 remained in place across the system. MK highlighted the huge amounts of work over the winter and noted that the current concerns were long term problems which required multiple solutions. MK noted that there was risk tolerance variation across the system around pathways and explained that there was more work to do on transparency of data across the system, however this was much improved. Eugine Yafele (EY) agreed that the situation currently felt better than December 2022 but sustaining these changes was important and something the system struggled with. There was challenge in balancing system demand and relationships, but this had improved. DP supported the comments and noted that short term bedded capacity wasn't sustainable and that there were systemic issues which would take time to improve sustainably. DP noted that social care was the end step of the acute system pressures but was the best way to support long term recovery for patients. DP noted that the pressures within social care needed to be addressed to support the system. Julie Sharma (JS) agreed and noted the importance that long term measures were put in place and suggested that the system focus was on system capacity. Dominic Hardisty (DH) explained that the demand patterns for mental health services were very different from those in other care settings although the operational resilience issues were similar.	

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	Ruth Taylor (RT) explained that primary care was very also under significant pressure. RT suggested that the system reviewed admission avoidance and developed system wide solutions. RT noted that there was an opportunity for local work at community level to support this. RT confirmed that primary care was strongly engaged in the daily system communications. JH noted the increased communication between pharmacies and in and out of hours primary care. This level of communication had been instigated due to the level of demand and to meet the increase in expectation. JH noted that primary care workforce had been affected by the current winter infections as much as patients and therefore different ways of working had been developed to sustain the current levels of access. LM highlighted that plans to improve workforce growth had been included in the recovery plans for emergency, elective and community care but noted that this also included consideration that staff wouldn't be taken from other areas to the detriment of services. LM noted the industrial action during December 2022 and January 2023. The system had planned for this and detailed plans at critical incident level had been developed. The system had provided clarity regarding how individual organisations would be impacted by the action and following the industrial action the system had met to debrief and consider the collective understanding and learning. Processes which were helpful or unhelpful had been identified and further plans developed for the next day of action. LM confirmed that the learning was being built into business as usual and operationally the days had been well managed. RS highlighted the significant system response and the 'on the day' management had worked well. The longer term impact was being considered as some processes had been changed to support system working. RS noted that to manage the day, some services would have been suspended and some planned work delayed. RS explained that this would have an impact on the waiting lists and consideration was being given to how this could be observed and monitored longer term to ensure that harm was minimised. MK asked the ICB Board to be mindful that wider industrial action also had an impact on patients and noted that with the industrial action from train staff and teachers, patients were cancelling appointments due to transport and childcare concerns. MK also noted that patient behaviour changed on a day of the strikes and there were less attendances and therefore there were surges following. JF asked whether scenario planning was taking all this into account. RS confirmed that everything was being modelled and the Acute Trusts were working through	

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	rescheduling appointments and monitoring patient behaviours alongside public health colleagues. SW noted that the University West of England was also monitoring aspects of the industrial action as it could delay clinical students undertaking elements of their courses to satisfy graduation requirements. RS agreed to review how clinical students were being impacted. DH explained that staff had not decided on taking industrial action lightly and noted those who were working on the wards to support the system supported the action. DH highlighted that staff were angry but never forgot that they were looking after people. **The BNSSG ICB Board noted the progress and challenges in delivering the Winter Plan.**	**RS**
7.1	**Outcomes, Performance and Quality Committee** ED explained that the Outcomes, Performance and Quality (OPQ) Committee had asked for clarity on "critical incident" particularly what factors would mean the system was in a critical incident, and how it would be managed and deescalated. The information would be provided to the next OPQ Committee. ED highlighted the virtual words noting the ambition to increase these as well as add an additional 450 beds into the system. The OPQ Committee had asked for more information to understand what the milestones were to get to this position. The Health and Care Professional Executive group has been established and local partners have a strong voice within this group and were passionate about getting the virtual wards up and running. ED explained that the OPQ Committee had discussed what was needed to be effective. It was important that the operational plan was in place by the 1st April 2023 and that the plans were stretching but achievable. The OPQ Committee also asked for a clear and concise set of performance reporting which was consistent across all the Committees. The Board discussed having one report with information relevant for all Committees to ensure that the Committees were reviewing the same information. It was agreed to review whether this was possible. LM reported on the positive progress made around elective waiting times between November and December 2022 with the total waiting list reducing from 87,481 to 80,920. 52 week waiting patients reduced from 5,386 to 4,761, 78 week waiting patients reduced from 799 to 552, and 104 week waiting patients reduced from 99 to 16. LM explained that this was because of the hard work from across the system but noted that there had been less progress from December due to the urgent care pressures and the industrial action.	**ICB Execs**

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	AM welcomed the improvement in breast waiting times and thanked NBT for all their hard work in this area. **The ICB Board received the update from the Outcomes, Performance and Quality Committee which included the quality and performance reports**	
7.2	**People Committee** JCh welcomed Jo Hicks to the meeting who would be starting as the Chief People Officer later in February 2023. JCh explained that the ICB People Committee had discussed the processes around the ICB reorganisation. JCh reported that the ICS People Committee had discussed the action of the People Programme Board which had prepared for the industrial action. EY explained that different workstreams had been put in place during the industrial action. EY explained that the People Programme Board also focused on retention and attraction of staff and was currently reviewing the profession of nursing as there was a significant need to reduce the number of agency nurses. EY noted that this was learning exercise, the outcomes of which would be used for other professions. JCh highlighted the importance of system communication and noted that she would be meeting with the new Deputy Director of Communications soon to discuss how information could be effectively communicated across the system. JCh highlighted that the Committee had also discussed the importance of engaging with the voluntary sector, community sector and locality partnerships. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** SW noted that Finance, Estates and Digital (FED) Committee had updated the Terms of Reference, and these were requested to be approved. SW confirmed that the FED Committee received good engagement from Partner Non-Executive Directors and this resulted in robust system working to ensure finances were right for the system. The FED Committee was optimistic about the required in year savings although the effects of inflation would be a challenge. SW confirmed that system wide planning was underway with the focus on health inequalities. SW explained that having money available supported the system to develop innovative plans. SW commented that having a single report for all Committee would support the work at the FED Committee as workforce was critical across the system and the enablers of physical and digital estates were key to support work programmes. SW explained that a deep dive into digital was planned as the system needed to use data effectively to develop plans. SW noted that the FED Committee was also reviewing the best way to utilise estates across the system	

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	and investment would be required to meet the needs of the system. JF highlighted the importance that a prioritisation assessment was undertaken for all estates decisions. ED noted that during the virtual ward discussions at OPQ Committee it had been raised that there were challenges in the IT not being joined up. SW agreed to add virtual wards to a future FED Committee agenda and noted that this was part of a wider piece of work which needed engagement from across the Committees. JS confirmed that Sirona and NBT Clinical Leads were leading the work and developing a single programme approach with shared responsibility. **The ICB Board received the update from the Finance, Estates and Digital Committee and approved the revised Terms of Reference**	**SW/ST**
7.4	**Primary Care Committee** AM confirmed that the delegation of pharmacy, optometry and dental (POD) services continued with significant work ongoing to receive the assurance required with a further checklist to be submitted in February 2023. AM highlighted that there were both risks and opportunities associated with delegation with mitigations being identified for the risks. AM confirmed that the Primary Care Committee (PCC) would evolve as delegation proceeded and information regarding POD services was already being received at the Committee. AM explained that there had been good Local Committee engagement from the POD services. Dentistry in particular was significantly challenged and a transformation programme was in place which the ICB would eventually lead on. The Primary Care Strategy which had been developed in 2019 was coming to the end of its five year plans and a new strategy would be developed which would support the GP Collaborative Board (GPCB) Strategy and Fuller Report recommendations. The Committee had discussed how the strategy deliverables needed to be visually represented to the Committee to support the identification of areas of good performance and areas which needed improvement. The Strategy would contain plans for primary medical services and the delegated POD services. DJ highlighted that GP Practices were currently under significant pressure due to unprecedented demand and work force changes and the ICB was working with the Local Medical Committee and the GPCB to prioritise workload without loss of income for practices. System working was key to this. DJ highlighted that following allocation for acute respiratory hubs all the PCNs had developed and implemented hubs which were working well.	

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	DJ also highlighted the work to review the supplementary services across BNSSG. The ICB was working with practices to ensure that the significant investment for these services was being utilised in the most appropriate way and targeting health inequalities. JCh asked about the resource capacity for the ICB to manage the delegation of the POD services. DJ explained that commissioning support would be provided by NHS England through a Commissioning Hub which was up and running and sending through data for the ICB to monitor and review. AM asked whether the ICB Board felt sighted enough on primary care medical services data. JS suggested that the ICB Board needed more information on where the pressures were in primary care such as where access was a challenge or where there were high levels of vacancies. ED agreed and noted that there needed to be more information about the plans of the locality partnerships. RT noted that the information from locality partnerships would be different from information relating to GP practices. RT noted that GP Practices provided situation reports which could be fed into the appropriate Committee if required. DH commented that the Health and Care Improvement Groups would support these conversations and JF highlighted that the level of detail at Board level needed to be appropriate. JS noted the importance that the system understood the pressures within primary care so that other organisations can support the areas of highest need. DJ noted that primary care was an important part of the system and that a Health and Care Improvement Group would have oversight of the priorities of the localities. AM highlighted the importance that the Board received the data to assure themselves that the challenges associated with POD services delegation were mitigated and explained that although PCC would review primary care in detail, the ICB needed to see the system as a whole. SW suggested that there needed to be an appropriate way to review system data to include both health and social care data as both were important to reduce health inequalities and would support investment into the right areas to make the most difference in terms of health outcomes to local populations. **The ICB Board received the update from the Primary Care Committee.**	
7.5	**Audit and Risk Committee** The December Audit and Risk Committee minutes would be presented at the March ICB Board meeting.	
8	**BNSSG Integrated Care Partnership (ICP) Updates**	

	Item	Action
	JF highlighted the development of the Integrated Care System (ICS) Strategy which was being led by Colin Bradbury. The draft ICS Strategy had been presented at the December BNSSG ICP meeting. The Strategy would continue to be presented at the meeting as it developed. JF explained that the BNSSG ICP members included voluntary and community sector partners and was Chaired in rotation by elected members from the Local Authorities. **The ICB Board received the update**	
9	**Questions from Members of the Public** A written question was received from a member of the public asking: "How confident can we be that when this health centre [built on the former rugby ground in Weston super Mare] opens it will be as dementia friendly a building/health service as we can make it?" It was agreed that as the member of the public was not present a written response would be provided. **Response added after the meeting** We shared your question with estates colleagues who were able to inform the ICB Board that the new building will be a modern, purpose built health centre. It will comply with the most up to date guidance and regulations for this type of building. There is significant overlap between these regulations and the Dementia Friendly guidelines. Beyond the design and construction of the building itself, the practice's Patient Participation Group will be engaged in the process of designing the internal colour schemes, signage and furnishings and members of the public are welcome to be a part of that process. A member of the public asked: "What should the government do in order to improve procedure waiting times, ambulance handovers and staff shortages?" JF explained that that the establishment of ICBs was an opportunity to join up healthcare across systems. The ability to plan, use resources and infrastructure together as a system would help resolve the significant challenges mentioned. LM highlighted the recovery documents published by NHS England which had included associated financial resource. These documents shared examples of improvement plans implemented across the NHS which had resulted in tangible improvement. Further plans were expected from NHS England focused on workforce and on primary care. LM confirmed that workforce remained the fundamental challenge to the NHS and Social Care in terms of recruitment and retention, particularly with the current cost of accommodation across Bristol, North Somerset and South Gloucestershire.	
10	**Any Other Business**	

	Item	Action
	JF had discussed with other system Chairs the value of partner Non-Executive Directors (NEDs) attending the ICB Committees as it supported system working and awareness of system wide challenges. JF highlighted the possibility of a one page system briefing for NEDs and explained that a learning session for NEDs would be arranged soon. JF asked that system partners encourage their NEDs to attend Committees particularly the People Committee as this represented an area of huge challenge within the system and the Committee had both an internal ICB focus and an external system focus. JF also asked for feedback on the ICB Board meetings, particularly on how and when the Board met and whether there was added value in meeting in person. JF also provided feedback on presentations at meetings and highlighted that the focus should be ensuring that ICB Board members had time to comment on the papers. JF also asked ICB Board members to consider whether there were any areas raised under the Committee updates which needed additional consideration.	**All**
11	**Date of Next Meeting** 2nd March 2023, The Park Community Centre, Daventry Road, Bristol, BS4 1DQ	

Lucy Powell, Corporate Support Officer, February 2023