Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 2nd March 2023 at 12.30pm, held at The Park Centre, Daventry Road, Knowle, Bristol, BS4 1DQ

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
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	JHa
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
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Hayley Verrico	Director of Adult Social Services, North Somerset Council	HV
Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EY
Apologies		
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Stephen Peacock	Chief Executive Officer, Bristol City Council	SP
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	WW

Steve West	Non-Executive Member – Finance, Estates and Digital	SW
In attendance		
Stephen Beet	Director of Adult Social Care, Bristol City Council	SB
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Sarah Carr	Corporate Secretary, BNSSG ICB	SC
Sue Doheny	Regional Chief Nurse (South West), NHS England	SDo
Deborah El-Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Peter Goyder	Clinical Lead for Policy Development and Exceptional Funding, BNSSG ICB	PG
Simon Hankins	Chief Executive, BS3 Community Development	SH
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Lucy Powell	Corporate Support Officer (Minute Taker), BNSSG ICB	LP
Steve Rea	Delivery Director – South Bristol Locality Partnership	SR
Ruth Taylor	Chief Executive Officer, One Care	RT
Adwoa Webber	Head of Clinical Effectiveness, BNSSG ICB	AW

	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 Steve Rea (SR), Stephen Beet (SB) and Simon Hankins (SH) were welcomed to the meeting. SB explained that the South Bristol Locality was defined by the area of Bristol South of the river Avon. The locality had a population of 170k and encompassed 11 wards of distinct differences including a 6 year life expectancy difference between certain areas. SB noted that 10 of the most deprived neighbourhoods in Bristol were in South Bristol and there were higher rates of domestic abuse, crime and higher levels of child mortality. However, there were high levels of community spirit in South Bristol and this was evidenced by the developments and festivals in the areas. The South Bristol Locality Partnership Board collaborated with local community members and the focus of the Board was the community as an asset and the wider determinants of health therefore SB and SH were the Co-Chairs of the Board rather than a clinician. The South Bristol Locality Partnership priorities were reducing excess weight in childhood, reducing hospital admissions for alcohol use and reducing hospital	

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	admissions from falls. Population Health data had indicated that these were the areas of real challenge. SH explained that the work was focussed on supporting local communities to provide self care. The South Bristol Locality Strategy focused on increasing the wellbeing of the population to reduce demand on the local health and social care systems. SH highlighted the move from clinical support to wellbeing support and exploring different ways to utilise resource. SH noted the importance of mutual benefit across the system and highlighted social prescribing with GP Practices which signposted and supported patients into the wider community. SH explained that 36% of social prescribing referrals were due to isolation and loneliness and there were high levels of low mental health in the South Bristol population. The Locality Partnership worked closely with voluntary sector organisations who offered peer support for those concerned about their mental health. Face to face and online support groups have been set up to provide social support to people who need it, including two groups specifically for members of the LGBTQ+ community and Women of Colour. A Community Development and Innovation Lead has been recruited at a practice in an area of high deprivation. This role provided the link between multiple health and social care agencies. SH described the integrated community clinics which offered the services of GP practices in local community settings. These clinics provided health services as well as social interaction. The recovery rates for health conditions was higher for patients using the community clinics. SH noted that connections within communities was an important part of the work and communities had been self-defining geographic boundaries to support social interactions such as walking groups to bring people together. SR noted that the South Bristol Locality Partnership supported the relationship between GP Practices and Voluntary Sector organisations to increase the 'happiness' of local populations. Local engagement has indicated that peer support and relationships was what kept people happy which in turn supported improved outcomes for physical and mental health. The Locality Partnership wanted to continue to support partners to continue the social initiatives. Jaya Chakrabarti (JCh) welcomed the work and asked who the local partners were and whether there were any gaps. SR noted that the community voice was the most important and therefore the Locality Partnership worked with lots of community groups. The local population was not significantly diverse and therefore the South Bristol Locality Partnership was working with other locality partnerships to support communities to make links across the city. Children was an area which needed additional focus across the localities. SR explained that the Locality Partnership network had expanded to include links with the police.	

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	Shane Devlin (SD) asked what support the Locality Partnership needed from the ICB Board. SH confirmed that resource to implement the plans was critical and it was important that the ICB Board advocated and valued the community approach. SB agreed and added that long term commitment was important for locally developed plans as well as a level of autonomy to support locality level decision making. SB also noted that stronger links to the system was important particularly so that the local community could support acute pressures. Maria Kane (MK) noted that it was important to recognise that to sustain the work the resource needed to be in place. MK noted that when the Integrated Care System (ICS) made investment decisions there needed to be investment analysis to evidence that the proposed plans would lead to an improvement in health outcomes. David Jarrett (DJ) noted that the links made between the Primary Care Networks (PCNs) and the community and voluntary sector have been exceptional and this was the model to be rolled out to other localities. An open invitation was extended to the ICB Board members to attend the South Bristol Board meetings to meet the local people and organisations involved with the Locality Partnership.	
3	**Minutes of the 2nd February 2023 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 36** – Rosi Shepherd (RS) confirmed this was in progress and an update would be provided at the next meeting. **Action 53** – RS confirmed that how the industrial action was affecting clinical students had been included within the industrial action plan and would be monitored. The action was closed. **Action 54** – Ellen Donovan (ED) noted that Deborah El-Sayed (DES) had attended the Outcomes, Performance and Quality Committee where the single report had been discussed. ED suggested that DES attend a Non-Executive Director meeting to discuss working with the ICB teams to collate the relevant information. JF noted the importance that the report focussed on the right aspects. ED asked whether the ICB had the resource available to support development of the report. SD confirmed that the report would align with the long-term plan so the ongoing work would be to identify the enablers that needed to be included within the report. **Action 55** – Sarah Truelove (ST) confirmed that the forward plan for the Finance, Estates and Digital Committee had been developed and virtual wards had been included. The action was closed. **Action 56** – JF reminded ICB Board members to communicate any feedback regarding the Board meetings. The action was closed.	

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	All other due actions were closed.	
5	**Chief Executive Officer's Report** SD highlighted the areas covered in the report: ICB organisational structures, winter headlines and the ICS Strategy. **ICB Organisational Structures** SD reminded the ICB Board that the ICB was undergoing a restructure to support the change in organisational responsibilities from CCG to ICB. The staff consultation ended on the 3rd March 2023 and the Executive Team would review the feedback. SD reported that during the consultation period there had been interest from the partner organisations regarding the proposed changes to the Primary and Integrated Care directorate. SD noted that feedback had been received from local authorities, GPs, and voluntary and community sector organisations. SD explained that although the consultation was for staff it was important that the ICB Executive Team understood the partner concerns. SD explained that the funding provided to support locality development had been non-recurrent and was not available for 2023/24. SD explained that the value of the locality model came from the locality communities and local organisations and not the ICB. The Executive Team would be reviewing the feedback from staff and stakeholders and a fit for purpose directorate structure would be developed. **Winter Headlines** Lesley Watt, NHS National Lead for Discharge, visited the system to identify what the ICB was doing well and what opportunities there were to do more. SD explained that the system was heading in the right direction and a considerable improvement in performance was expected within the next 6 weeks. SD highlighted the importance of a sustainable model following winter and noted that sustainability was about home first and not hospitals and that would be the key focus and challenge for 2023/24. **ICS Strategy** SD explained that planning was occurring in parallel with a one year plan developing into a five year plan and the ICS Strategy was being developed alongside this. There was considerable work ongoing to develop the plans and strategy. Dominic Hardisty (DH) noted the stakeholder interest in the restructure and asked whether the ICB was clear what type of consultation was being held. SD confirmed that it was a staff consultation and not a public consultation as staff were at risk and the requirement for a staff consultation was outlined clearly in the employment conditions. JF agreed but noted that it was important that system partners understood the approach of the ICB. DH noted that there was	

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	a risk in consulting with partners outside the ICB and explained that the approach needed to be clear. SD confirmed that the stakeholder feedback would not affect the staff consultation but following the reorganisation there would be discussions about the operational actions of the localities as well as wider system discussions about ICB activity. Alison Moon (AM) noted that after the consultation closed it was a good time for the ICB to ask for feedback from staff on how the process felt for them and what can be learned for the future. SD confirmed that informal feedback was being received but staff would have an opportunity to provide feedback about the process. Ruth Taylor (RT) asked whether the structure within the paper was final. SD confirmed that this was the structure staff had been consulted on and noted that it would likely be different following consultation.	
6.1	**ICB Clinical Commissioning Policies – Breast Surgery** Jo Medhurst (JM) provided the background noting that policies presented were for approval. The ICB welcomed Dr Peter Goyder (PG) and Adwoa Webber (AW) to the meeting and it was confirmed that the ICB inherited the duty to review clinical commissioning policies every three years. The attached policies had been reviewed and ICB Board approval was sought as the policies were considered reputationally and financially significant. PG provided the detail behind the changes noting that engagement had taken place with the plastic surgery teams in the acute hospitals as well as their management teams. The commissioning policy team had also reviewed associated complaints and funding requests received as well as NICE guidance and national intervention programmes. All of the information received and reviewed had been used to develop the policies. PG noted that there were significant changes to the breast surgery policies and noted that the current policy prioritised breast reconstruction after cancer. PG explained that this stance had been correct at the time but not now. PG noted that the policies now included all breast reconstruction including patients who self-funded for breast reconstruction following cancer but who were no longer covered by insurance. These patients would have the same access for significant complications. PG confirmed that the most common breast surgeries performed privately were cosmetic and these would always have future complications. PG noted that although most complications were not covered by the NHS policies, there was a rare complication related to the rupture of material and the lymph nodes. PG explained that these patients were often seen as part of the two week wait cancer clinics and noted that if the small number of cases, around a 12 a year,	

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	were included within the policy then this would free up resource within the cancer clinics. PG noted that there would be a slight increase in additional costs at the start. PG explained that one policy had been removed which related to One Step Nuclei Acid Amplification. The technology was no longer used in local health communities and only benefitted a very small number of individuals. The policy was retired following discussions with local breast and oncoplastic surgeons. PG explained that there was evidence to support the financial and activity impact of the policies and these aligned with the approach of local ICBs. The clinical policy review group supported the policies for approval. John Cappock (JCa) supported the amendments and asked whether patients who had been declined for treatment previously would have the right to reconsideration. PG explained that a communications strategy had been developed, which included primary care and the plastic teams, which outlined the changes and the processes to follow. PG confirmed that the exceptional funding team and commissioning teams were aware of the changes and information would be provided to stakeholders including MPs if the policies were approved. **The BNSSG ICB Board approved:** • **Continued use of the current commissioning policies for Breast Surgery Male and MRI Breast Screening** • **The changes to the current commissioning policies for Risk reducing Mastectomy, Breast Surgery Female and Breast Reconstruction post-Cancer** • **The removal of the One Step Nucleic Acid Amplification (OSNA) policy**	
6.2	**Item deferred**	
6.3	**Item deferred**	
6.4	**Joint Working Agreement with NHS England** ST explained that NHS England policy outlined an ambition to delegate commissioning to ICBs for specialised services. As no ICB in the South West would be in a position to take on this delegation from April 2023, a Joint Working Agreement (JWA) with NHS England had been drafted. NHS England would continue to hold the responsibility for specialised commissioning during 2023/24 and the ICB would be well engaged with NHS England to develop a transitional plan for delegation to ICBs from April 2024. DH asked whether the system would need to undertake a similar agreement to include the various other specialised commissioned services such as those for mental health. ST confirmed this was correct and explained that NHS England had already delegated some specialised services to a provider collaborative.	

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	ST explained that work to understand the implications of all the delegated commissioning across the system would continue. MK asked whether there was any learning from the delegation to the provider collaboratives which could be circulated to the system to support future delegation. ST and DH agreed to bring back some of the work around issues identified and opportunities. RS highlighted that there had been some differences between the provider collaborative and ICBs regarding quality management and so there was collaborative work ongoing across providers and ICBs to develop a joint process for quality management. Eugine Yafele (EY) asked whether it was possible that there would be a roll back on the mental health provider collaboratives. ST explained that the local ICBs would be setting up a joint committee for specialised services to make the decisions for their populations and ST noted that this could also be an option to support the mental health provider collaboratives. **The BNSSG ICB Board approved BNSSG ICB entering into the Joint Working Agreement with NHS England across the South West region**	**ST/DH**
7.1	**Outcomes, Performance and Quality Committee** ED noted that there were significant challenges facing the system, however a robust operational plan had been developed and the focus was on measuring the performance indicators. The Terms of Reference for the Outcomes, Performance and Quality (OPQ) Committee had been reviewed. Some minor amendments had been made to include a Director of Public Health as a member. There would be further discussion regarding voluntary and community sector attendance. JF noted the importance of including local authority colleagues on Committee membership as it was important part of integrated care and asked whether there was the right level of engagement with Directors of Public Health. Dave Perry (DP) explained that Directors of Public health played an intrinsic role in the strategic work of the system. Hayley Verrico (HV) noted their significant role in the Integrated Care Partnership (ICP). SD highlighted that the ICB had Chief Nursing Officer and Chief Medical Officer roles but no equivalent for Social Services. SD noted that this would be explored. Sue Doheny (SDo) confirmed that this had been raised at a national level. RS noted that public health representation at the OPQ Committee was appropriate to provide information on the public health actions which aligned with the discussions. RS confirmed that the Chief Nursing Officer role was	

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	accountable for nursing and allied health professionals and RS attended the Allied Health Professionals council. Julie Sharma (JS) noted that the Strategy supported moving the rehabilitation model into community and therapy and noted that some colleagues within that group were not as well represented. JM confirmed that this had been considered through the Leadership Group which had identified the need for an overarching strategy which would focus on inequity in the system and this would be fed through to the Committees. JCa confirmed that a Director of Public Health attended the Finance, Estates and Digital Committee and added value as they provided the Committee with a view on areas outside health. AM also confirmed that a Director of Public Health attended the Primary Care Committee and connected the work of the Committee to the work of the local authority. RT asked that when membership to Committees was discussed that it was considered whether GP membership was also appropriate. ED confirmed that the Committee had discussed the Board assurance framework and the risk management framework and how the Committee could utilise those documents. There had also been discussion about whether the OPQ reports were sufficiently detailed, and this would be reviewed. It was reported that NHS performance was challenged however there were some positive improvements which included the breast cancer two week wait pathway where 90% of patients have been seen in the timeframe. MK noted the importance that this was sustained and explained that the system needed to change the way it worked to support the significant workforce challenge. MK noted that the performance improvement had been achieved through a wider team effort which included both clinical and admin roles. ED noted that for the key performance indictors there were more green rated areas for January and February 2023 which included improvements in ambulance Category 2 and urgent community response times. RS highlighted the industrial action and noted that the Quality Surveillance Group and the Health and Care Executive Group were reviewing the risk appetite work in advance of the action. It was confirmed that each organisation had mitigations in place, and these were shared across the system. An impact assessment had been developed from the risk matrix and a meeting was scheduled to further discuss this. MK asked how the system could support the work and RS noted that activity reduction in other areas was part of the system considerations. **The ICB Board received the update from the Outcomes, Performance and Quality Committee and approved the revised Terms of Reference**	
7.2	**People Committee**	

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	JCh noted that the ICB People Committee had met and discussed the statutory and mandatory training of ICB staff which was not at the levels expected. JCh noted the importance that staff were provided with ringfenced time to undertake training. ICB staff wellbeing temperature checks continued and the feedback from these were being considered by the Executive Team. JCh noted that Jo Hicks (JHi) had started as the ICB Chief People Officer and Jen Bond (JB), Deputy Director of Communications and Engagement, would attend the People Committee to speak to the standing agenda item regarding system communications. JCh noted that the People Programme Board would be refocused now that the targets to achieve had been developed and the Board would be discussing actions needed to further support staff and address the workforce challenge. JHi noted the commitment of the system to address the workforce challenge and explained that this was a system endeavour. JHi highlighted that there was work to do around communication with staff to improve health outcomes for the system and the system was committed to this engagement work. EY explained that the People Programme Board had developed plans to make a difference to the nursing profession in terms of recruitment and retention. These plans would be tested, reviewed and modified, and where successful, rolled out to other professions. MK asked for more information regarding the staff wellbeing checks. JCh confirmed that these were internal ICB questions to review how staff were feeling. The ICB People Committee reviewed the questions to ascertain whether they led to measurable outcomes or whether there were better questions to ask. SD noted that the questions asked were relevant to the whole system and the approach could be system wide if appropriate. JF noted that understanding the background to staff wellbeing supported the right improvement actions. DP noted that wellbeing work of the wider system could also support ICB staff. ED asked what were the three actions which would make significant improvements to the workforce challenge. SD explained that the focus was currently, “why do nurses not choose to join us and why do they leave”. Once that was understood then actions could be taken to improve. ED noted the importance that any issues were addressed early to support winter pressures. JF noted that it was important to consider the leadership and culture of the system as the same posts were being filled nationally. SD noted that there were other reasons which were outside of the system’s ability to fix such as house prices. AM suggested a third question “why do they stay?” and highlighted that retention was as important as recruitment. AM suggested that other organisations would have already undertaken this work so important to make	

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	those links across the local systems. SDo agreed and noted that the BNSSG system had the opportunity to discuss this with students at the start of their career journeys. EY confirmed that the system Chief People Officers and Chief Nursing Officers were working on this engagement and determining where the system could make the greatest impact. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** JCa explained that the Finance, Estates and Digital (FED) Committee had discussed estates and capital planning particularly how the ICB could better utilise existing estate. The ICB was exploring the estate available to the system and the FED Committee had discussed the challenges relating to the existing estate and the extent to which it could be modelled. ST noted that the system was forecasting achievement of the financial plan. The key challenge was the level of savings being delivered and this would be reviewed next year. ST confirmed that a savings plan would be in place at the start of 2023/24. ST noted that the operational plan targets regarding agency staff would be a challenge to achieve and explained that the system was reviewing escalation capacity. JCh asked about the opportunities within the existing estate. JF noted that there were significant opportunities within NHS owned estate but also noted the opportunities for the system to utilise other public sector owned estate. JM noted that it was important that that estates strategy supported putting money back into the community. JCa confirmed that the estates strategy supported this in terms of planning and community developments. ST noted that the ICB was working with NHS England to develop the tools to provide the visualisation of the estate. DP highlighted that the local authorities had undertaken an exercise to map estate across the public sector and this could be provided to support a whole system review of public estate. DP suggested that any consideration of system estate should also include community, the localities, voluntary sector organisations and potentially education. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
7.4	**Primary Care Committee** AM explained that the Primary Care Committee (PCC) received assurance that the ICB primary care team was working with partners across the system to develop the operational plan which included measurable targets such as increased access. AM noted that the key challenge related to workforce and those interdependencies within the system. PCC had received good assurance that the operational plan aligned with local plans.	

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	The delegation of Pharmaceutical, Optical and Dental (POD) services was discussed at the Committee, with the safe delegation checklist presented. AM confirmed that there was a significant amount of work to do to prepare for delegation and assurance had been provided that the outstanding actions would completed. AM highlighted that following the South West Primary Care Committee Chairs meeting it was clear that most ICBs were in a similar position and the Chairs had discussed the importance of collating data at a regional level which could be filtered for each ICB. AM noted that the key risk to delegation was workforce. AM explained that dental services were under significant pressure and noted that delegation of dental services provided an opportunity for the ICB to provide support. PCC had asked how much flexibility the ICB would have to make local decisions for the delegated services particularly dental. AM also noted that the Committee had received a presentation from the Access, Resilience and Quality (ARQ) team who had provided an explanation of the work they undertook to support practices. Information had been provided on the data measured and reviewed as part of the ARQ dashboards. PCC had asked whether this work would be scalable to the POD services. DJ noted that the full checklist of risk assurance continued to be reviewed by both PCC and the FED Committee. A summary position would be provided to the ICB alongside the amended Scheme of Reservation and Delegation at the next ICB Board meeting. DJ explained that dental activity was a key focus for PCC and the ICB would be inheriting a dental reform roadmap and reform plan to continue. RT welcomed the collaborative approach to planning and noted that practices appreciated the support of the ARQ team which provided bespoke resilience plans for practices which needed support. RT noted the importance that the POD providers were included within the system work and noted that delegation would provide good opportunities to support the local population. RT noted that GP Practices had similar challenges with these services and collaborative working was important. Jon Hayes (JHa) noted the opportunity to undertake redesign work on care pathways for primary care which included working with the community. JHa highlighted that the benefit of this could be evidenced with the work between GP Practices and pharmacy which had already happened. SD noted that there were still some areas of clarity needed around the delegation of POD services such as where the accountability and responsibility was in some areas. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Audit and Risk Committee**	

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	JCa highlighted that the focus of the Audit and Risk Committee was currently year end preparation but noted that there had been a deep dive into safeguarding training at the Committee. The Committee had been assured that there was good progress on training and there was a clear plan to address any concerns. JCa explained that ST and JCa had suggested a system Audit Chair and Director of Finance meeting to undertake a financial health check to review and gain assurance from the work of the system. JCa noted that the group would be utilised to understand emerging system risks and ensure that the system was sighted on the key system risks. **The ICB Board received the update from the Audit and Risk Committee**	
8	**BNSSG Integrated Care Partnership Updates** JF explained that the ICP worked inclusively and engaged with the local authorities, and voluntary and community sector organisations. The Chairs of the Health and Wellbeing Board rotated Chairing the ICP Board. The ICP Board continued to review the ICS Strategy and the four key aims of the ICB. The ICS Strategy had been developed through several system engagement days and both national and local priorities had been included. SD noted that there had been good system engagement and highlighted that the strategy was an ICS strategy and not ICB focused. SD confirmed that public health had been involved with the development of the strategy. **The ICB Board received the update**	
9	**Questions from Members of the Public** A member of the public highlighted that the changes being made from the CCG to the ICB were significant and noted that it appeared that decision making took a long time within the NHS and involved a significant number of people. JF explained that public services were very complex and that as services were publicly funded, decision making needed to be robust and thorough to ensure value for money. JM noted that the pandemic had highlighted inequality within services and explained that the levels of decision making were there to ensure that there was balance and diversity when reviewing plans.	
10	**Any Other Business** HV explained that the North Somerset Council had met with the Home Office regarding the needs of asylum seekers. HV asked whether there needed to be a system approach and whether the system understood the needs of this population. SD agreed with a system approach and noted that the locality partnerships were well placed to develop and deliver services as local populations changed. DJ agreed to take an action to support a review of the	**DJ**

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	impact across the system. JS supported closer system working in this area and noted that it was appropriate that any inequalities were addressed.	
11	**Date of Next Meeting** 6th April 2023, Winter Gardens, Weston-super-Mare	

Lucy Powell, Corporate Support Officer, March 2023