NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 6th April 2023 at 12.00pm, held at The Winter Gardens, Royal Parade, Weston Super Mare, North Somerset

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DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
John Cappock	Non-Executive Member – Audit	JCa
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
Alison Moon	Non-Executive Member – Primary Care	AM
Stephen Peacock	Chief Executive Officer, Bristol City Council	SP
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
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		
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Jaya Chakrabarti	Non-Executive Member – People	JCh
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
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
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
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

In attendance		
Zilla Anderson	Faculty AI	ZA
Jen Bond	ICB Deputy Director of Communications and Engagement,	JB
Ros Cox	Delivery Director Weston and Worle Villages Locality Partnership	RC
Paula Clarke	Executive Managing Director Weston General Hospital, University Hospitals Bristol and Weston NHS Foundation Trust	PC
Sarah Carr	ICB Corporate Secretary	SC
Sue Doheny	Regional Chief Nurse (South West), NHS England	SDo
Deborah El-Sayed	ICB Director of Transformation and Chief Digital Information Officer	DES
Mandy Gardener	Chief Executive Officer Voluntary Action North Somerset	MG
Rob Hayday	ICB Associate Directorate Corporate Services	RH
Tim James	ICB Strategic Estates Manager	TJ
David Jarrett	ICB Director of Primary and Integrated Care,	DJ
Jon Lund	ICB Deputy Chief Finance Officer	JL
Lisa Manson	ICB Director of Performance and Delivery	LM
Becky Maxwell	Deputy Medical Director, (WGH), UHBW	BM
Keith Robertson	ICB Senior Performance Improvement Manager (Urgent Care)	KR
Beth Swan	Young Director, North Somerset Council	BS
Ruth Taylor	Chief Executive Officer, One Care	RT
Carrie Yeates	Head of Corporate Parenting North Somerset Council	CY

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1	**Welcome and Apologies** Jeff Farrar (JF) welcomed all to the meeting and noted the above apologies.	
2	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda.	
	Address from host Locality Partnership Ros Cox (RC) One Weston, Worle and Villages Locality Partnership Delivery Director and Mandy Gardner (MG), Chief Executive Officer Voluntary Action North Somerset (VANS) were welcomed to the meeting. RC took the meeting through the presentation pack and explained that North Somerset had the third largest inequality gap in England with some areas falling in the most deprived 1%. The locality was cover by one Primary Care Network: Pier Health. RC highlighted the locality philosophy which included creating a clear vision, working collaboratively with partners and local people, and learning from people with lived experience. The locality was action focused and had locality had learnt together and looked forward to the coming challenges. Attention was drawn to the most impactful conditions by age in the locality. Mental health was a dominant issue affecting all age groups; mental health issues were a major cause of ill health among people aged under 50 years old. Alcohol and substance misuse was a significant. Long term conditions were a	

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	major cause of ill health among younger people. Dementia, diabetes, COPD and arterial fibrillation were prevalent and had a major impact on the population's health. RC highlighted the work undertake to date including the establishment of the Integrated Mental Health Team Hub and expansion of the Care Homes Hub. The co-design of the five-year strategic model for Aging Well created with partners including the Voluntary Sector and the development of a virtual hub to connect communities that would be launched in May 2023. The Integrated Mental Health Team Hub had been created as part of the response to the Community Mental Health Framework to address the gaps in early prevention and provision. The aim was to ensure that people had the right support, in the right place, at the right time. Initially the Hub was virtual; it had evolved and now had a physical base. The model had been designed with people with lived experience and partner organisations. The Hub had led the way for integrated localised working, with agreements enabling partners to work together including a Data Protection Impact Assessment across partners and shared digital systems. Early indications were that the Hub helped to improve people's outcomes. The Hub worked with people who did not meet the referral criteria for secondary care services. GP direct referrals had launched in February 2023 and this roll out would continue to June 2023. The development of the Hub was being closely followed by NHS England who were providing support for training, organisational development and evaluation. Future developments included expanding referrals to include the 111 service. A full evaluation to understand the impact of the service was planned. The development of the Care Home Hub was highlighted. Weston had the highest concentration of care homes in the south west with 1,700 care home beds across 65 care homes. The aim of the Hub was to reduce pressure on 999 calls, ambulance conveyances and reduce the number of avoidable hospital admissions. The model has helped to develop trusted relationships through a collaborative approach and cultural changes were beginning. To date the Hub had expanded to cover 50% of the care homes with the aim of achieving 100%. Attention was drawn to the Age Well forward View which would join up existing services to support improving people's outcomes. A Later Life Co-ordination Hub was being developed. The complexities of developing this approach were highlighted in the slide presentation. the range of partners working together as the locality partnership was highlighted. JF asked if the Community Mental Health Hub was based on a model developed elsewhere and asked if there were case studies that could be shared across the locality partnerships. RC explained that the Community Mental Health Framework had been used for guidance and a good practice	

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	example in Somerset had been used to inform thinking. The Hub and the team had been developed in the locality from scratch based on the needs of the population. Regards outcomes; metrics were used to measure people's outcomes which was based on service user feedback. JF asked what support the locality would ask from the Board. RC explained the locality had a small budget and had harnessed the goodwill of partner organisations and their commitment. The devolution of resources to localities would support the development of new approaches to delivering more effectively; the question that should be asked was whether something could be delivered at locality level and if not why? MG explained that the voluntary sector did not always have the resource to support approaches; a sustainable resource to support the voluntary sector contribution would help build the long-term relationships needed. Steve West (SW) asked what the impacts of the service were and whether there were 'blueprints' for the Community Mental Health Hub that would enable the model to be scaled up and developed elsewhere. RC commented that one measurement of success was whether people presented at their GP and in social care following referral to the service. The service was newly developed and the University of Bristol was completing an evaluation in October that would provide more detail on the impact and success of the service. RC confirmed that detailed plans for the development of the service existed and these could be upscaled. The model had been shared across the BNSSG localities. John Cappock (JC) observed it would be interesting to understand each locality approach. Sue Doheny (SDo) noted that the Community Mental Health Hub opening hours were 9-5 Monday to Friday and asked if the evaluation would look at this and whether this needed to be extended. RC confirmed this and commented that services for people in crisis needing support were available 24/7. Dominic Hardisty (DH) reflected he had initial reservations regarding the approach when launched. He now believed this work had set the 'standard' model and it should be replicated across other localities. RC commented that there was core element to the model that could be replicated across localities taking into account local variations. David Jarrett (DJ) applauded the development and delivery of the Community Mental Health Hub. The model had received recognition across the BNSSG localities and the core model was being adopted across locality teams. DJ thanked One Weston, Worle and Villages Locality Partnership for their innovative approach. MG highlighted that the partnerships developed through the Hub were now supporting the development of partnerships working in other areas. Shane Devlin (SD) acknowledged the culture and relationship building	

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	that enabled the development and delivery of the model and reflected that cultural and relationships were essential elements. SD thanked the locality. Ellen Donovan (ED) congratulated the team and asked about the breadth of the partnership. RC confirmed all partners, including the acute trusts and Sirona were involved and engaged. JF thanked RC and MG for their presentation.	
3	**Minutes of the 2nd March 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** –Jo Medhurst would provide an update to the May Board meeting. **Actions 44 and 45**– Rosi Shepherd (RS) explained that there had been a helpful discussion at the Health and Care Professional Leadership Group regarding risk and risk escalation. RS would meet with Lisa Manson (LM) to discuss this with regarding the quality escalation framework. The actions were closed. **Action 54 –** SD explained this had been discussed at the previous Board meeting and the ICB was committed to producing a single reporting dashboard. This would be taken forward. The action remained open. **Action 57 –** DH confirmed this had been discussed with Sarah Truelove and work with the South West Mental Health Collaborative was on going. The action remained open **Action 58 –** DJ confirmed an oversight group was being established and a report would come to the May Closed Board meeting. The action remained open All other due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) highlighted the areas covered in the report: ICB organisational structures, ICB running costs reductions and Junior Doctor – Planned Industrial Action. **ICB Organisational Structures** Phase four of the reorganisation was ongoing. Interviews with affected staff were ongoing and the transition would be finalised by the end of April, beginning of May. SD noted this had been a difficult period for the ICB and that some staff would be at risk. **ICB Running Cost Reductions** SD drew attention to the letter received by all ICBs setting out the running costs efficiency requirements and the real term reduction of 30% to be achieved by 2025/26. This was an important moment for the ICB; the reduction would not be achieved by a 30% reduction in posts and a new business model for the ICB was required. It was proposed that the role and function of the CIB would be reviewed and a new delivery model developed using an organisational development approach. This would involve looking at the system as a whole and working with partners to understand where functions would be best delivered.	

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	Junior Doctors – Planned Industrial Action Plans were in place with partners to support services during the planned industrial action. SD noted that the action would have an impact on both patients and staff working during the strike period and the NHS as a whole. The strike action would come after the Bank Holiday period and immediately before the weekend. Alison Moon (AM) welcomed the update and asked if the evaluation of the process used during the ICB Transition was available. SD explained there had been discussed as to whether the running costs requirements would form stage five of the transition. It was important to learn from the ICB transition and apply this to the next organisational development piece. This would be led by Jo Hicks. The next phase would be different to the previous stages and would involve understanding where best to deliver the function. AM commented on the proposed timescale for Stage One of this transformation and asked if it was over ambitious. SD confirmed the timescale reported should have read May/June 2023 and not April/May 2023. The aim was to have a robust model in place for September to align with the nationally set timeframe. SW asked if the proposed review would take into account the Hewitt Report. SD noted that one of the report's recommendations was that NHSE withdrew the requirement for a 30% reduction in running costs. The report highlighted the rationale for the creation of Integrated Care Systems. ED asked if there had been discussions with other system leaders. SD confirmed discussions had started with other system leaders and with NHS England to explore how the ICBs in the south west could work better with NHS England. **The ICB Board received the report**	
6.1	**The Role of Corporate Parents** Jo Walker (JW) introduced Beth Swan (BS) Young Director, North Somerset Councill and Carrie Yeates (CY) Head of Corporate Parenting. JW observed that discussion often focused on older people and adults and it was important to talk about children and young people and their needs. The local authorities had responsibility for corporate partnering and this extended to partner organisations. JW highlighted the challenge to ensure that this role was discharged to help children and young people reach their full potential. BS and CY took the Board through the Corporate Parenting presentation, what a corporate parent was, and the seven principles set out in the Children and Social Work Act 2017 to: • Act in the best interests, and promote the physical, mental health and well-being, of children and young people in/leaving the care of a local authority • Encourage those children and young people to express their views, wishes and feelings. • Take into account the views, wishes and feelings of those children and young people.	

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	• Help young people gain access to, and make the best use of services provided by the Locality Authority and partners. • Promote high aspirations, and seek to secure the best outcomes, for those children and young people. • For children and young people to be safe, and for stability in their home lives, relationships and education or work. • Prepare those children and young people for adulthood and independent living What makes a good corporate parent was highlighted. It was important to listen to young people and not make assumptions. Honesty and trustworthiness were important as was reliability. BS drew attention to questions that a good corporate parent should ask, 'would this be good enough for my child?': • "Would I make the same decision if it were my child • Would I write about my own child like this – language used could be potentially harmful and upsetting to the young person, • Would my child understand the language I am using – language could be confusing and "jargon". It was important that young people understood the language used about them so that they understood the decisions that were made." BS and CY were thanked for their presentation. JW commented that North Somerset Council had discussed how it could support Children in Care and Care Leavers and one example identified was the creation of ringfenced apprenticeships for care leavers. There were real opportunities for partners to create practical pieces of work that could make a difference. JF welcomed the presentation and asked if the local authority chief executives had considered practical approaches to support children in care and care leavers which could be shared with the Board? JW explained this was being presented to the Board as a first step. Dave Perry (DP) thanked the team for the presentation commented that each local authority had action plans and programmes of work in place to support people with experience of care. South Gloucestershire Council was investigating making care experience a protected characteristic. DP agreed there was an opportunity to consider a joint action plan that could be shared across the system. There was an opportunity to link this to workforce shortages for example. LM observed the presentation had been brought to the Board to help and support raising awareness across the partnership. LM noted it was important to review ways of working such as access policies which included clauses that meant people who failed to attend appointments twice were sent back to their GP. It was important that processes were reviewed to ensure that people were supported. Deborah El Sayed (DES) commented that the engagement of young people was important for the success of the ICB digital strategy.	

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	AM commented it was important to consider wider life outcomes alongside health outcomes. AM flagged dentistry as an area of concern and it was important to consider how the system engaged with young people to support them achieve wider life outcomes. SDo explained there was a regional Children and Young People Board and it would be helpful to understand how this involved children and young people with care experience. JF asked that a future report on the practical actions to take as a system be presented to the Board. SD explained that he chaired this regional board and that it had not specifically look at the corporate parent role children and young people with care experience. SD confirmed he would raise this at the regional board. SD commented on creating employment opportunities and the role of partners as anchor organisations; it was important to consider how organisations could support reducing inequalities. SD agreed to bring this back to a future board meeting. JF thanked BS and CY for the presented which had prompted a lively discussion and a commitment to take action. **The ICB Board received the presentation**	**JW/DP/ SP** SD
6.2	**Healthy Weston 2 Phase 1 Full Business Case (FBC)** Paula Clarke (PC), and Becky Maxwell (BM) attended for this item. SD explained he chaired the Healthy Weston Steering Group. The business case had been discussed by the ICB Board in closed session in March and further detail on the realisation of benefits and the links to funding had been requested. SD highlighted that the additional resourcing required had been approved as part of the overall budget. PC thanked SD and welcomed the news regarding the additional funding. The FBC represented a significant step to realising the Healthy Weston ambition to ensure that Weston General Hospital is a thriving hospital able to provide acute care appropriate for local people and ensure local people have equity of access to the best urgent care. Heathy Weston 2 provided a platform for the hospital to be an exemplar in high quality, safe, integrated services that met local people's needs now and into the future. Establishing an equitable and sustainable urgent care 'front door' model was fundamental and would be the foundation for further transformation and innovation for Healthy Weston Phase 2, inpatient care and Phase 3 surgical care. Attention was draw to appendix A Benefits Addendum, setting out the benefits. The core benefits of developing an enhanced ambulatory and front loaded urgent and emergency care service were derived from improved flow and the associated positive improvements in safety, quality and performance, reduced admissions, and reduced length of stay. The financial savings arising from the reduction in agency staff were highlighted. There was confidence in the delivery of the benefits based on the evidence from the early success of the Phase 1 enhancements. Since the merger creating University Hospitals Bristol and Weston as a single Trust in 2020,	

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	nursing vacancy rates had reduced from 26% to less than 2% and the number of substantive medical grade posts had increased with recruitment to hard to recruit to posts improving. The number of patients diverted to other hospitals had reduced. BM highlighted the quality and safety benefits described including timely admission where appropriate, and decreased length of stay. BM advised on evidence that indicates for every 82 patients who waited beyond 6-8 hours for a bed there was one excess death within 30 days. Based on this national analysis the current excess death rate that applies to Weston Hospital was 204 deaths a year; this would be reduced to 145 excess deaths due to 'time to be seen' improvements. The benefits of the ambulatory element of the clinical model for the local population were highlighted alongside the investment in Geriatric Emergency Medicine service which would extend the service to better meet the needs of the aging population. JF commented on the positive changes at the hospital since the merger. SW observed the transformation and noted the significant lift it gave to people in Weston, delivering the services that people deserved and needed. RS commented that hospital atmosphere very different and the ability to manage flow through hospital was a sign of significant progress which should continue to be supported. ED asked how the vacancy rate had been reduced and could learning be replicated elsewhere in the system. PC explained that international recruitment made a significant contribution to the reduced vacancy rate. Alongside this was an approach to ensure retention. There was a sense that there was a future for the hospital with different career pathways. There were elements that could be replicated as well as local variations. The approach provided the basis for how to integrate services. RS noted that staff also felt valued and listened to. JW welcomed the proposals and the transformation given the challenge some residents faced and noted how this sat alongside the developments described in the locality presentation. AM observed the impact of the reduced vacancy rate and asked if the underpinning principles of the overall model were transferable to other system transformations. JC welcomed the benefits analysis completed. SDo commented on the improvements to vacancy rates and the change in culture that was becoming evident. Eugine Yafele (EY) reflected on the impact of the leadership at Weston General Hospital, commenting that this should not be underestimated and thanked the team. **The ICB Board approved the Full Business Case (FBC)**	**ALL**
6.3	**Central Weston Development Full Business Case – relocation of Graham Road Surgery to new Weston Rugby Club Development** Tim James (TJ) attended for this item. DJ introduced the item explaining the proposal was to relocate the Graham Road Surgery GP practice to a purpose-	

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	built facility at the Weston Rugby Club development which would also be occupied by Sirona and AWP creating a new health hub in the centre of Weston. The FBC related to the GP element of the development and would be submitted to NHSE for approval to release the capital grant if approved by the ICB Board. The background to the proposal was described. The initial capital bid was made by North Somerset CCG in 2016 to support the development of Strategic Outline Case for the transformation of primary care estate in Weston. In 2028 a capital funding bid was submitted to NHSE by BNSSG CCG and the Outline Business Case was approved by the CCG in July 2020. Planning permission for the site was granted in November 2022. Subject to approval construction was planned to start in October 2023 with a two-year construction period. Attention was drawn to the blended funding model which included prioritised system capital funding, an NHS STP Wave 4 capital grant and the ICB revenue budget currently allocated to rent costs associated with the Graham Road site. The main risks and mitigating actions were highlighted including the impact of market uncertainty on the development of the wider site and the impact of inflation on costs. DJ explained there had been soft market testing of costs which had confirmed that outfitting costs remained within the cost envelope. The Business Case had been supported by the North Somerset Council Health Overview and Scrutiny Panel and the ICB Finance Estates and Digital Committee. SW commented that this was an obvious decision and it was important to consider processes to ensure future developments could be expedited. Julie Sharma (JS) observed that this was an exciting opportunity and an example of how the model of delivery was changing. The Sirona Board had supported in principle the leasing of accommodation within the development. JC commented on the wider regeneration of the area that would be supported by the development and the role of the ICB to support local social and economic development. ED asked about construction charges and costs and what mitigations were in place should costs continue to escalate. TJ explained that the developers had sought a number of quotations and were confident the scheme could be delivered within these. The ICB had been given a “not to exceed” price on the rent of the building. Inflation was an issue for the project. The uncertainty faced by investors and the expectation for a higher yield on investments was a key issue. AM asked if there was learning to be taken regarding the length of time the project had taken. TJ explained that a key issue had been the identification of a suitable site for the relocation. Once the Rugby Club site had been identified the project had gathered momentum. The impact of covid 19 on the market also impacted on the design of the scheme with less demand for office space. TJ noted that there were elements of the process that could be reviewed in terms of proportionately. JL explained that the opportunity to access capital funds for	

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	future projects was unclear and it was important that the Board was sighted on this. JW acknowledged the joint working with the council and welcomed the level of engagement. SD reflected that the Board agenda items had engaged with the core aims of the ICB to improve outcomes, tackle inequalities in outcomes, experience and access, enhance productivity and value for money and support broader social and economic development. It was noted that the Board had agreed investment of approximately £5 million for the Weston area which had been identified as one of high levels of health inequalities. **The ICB Board approved the Full Business Case (FBC) for the relocation of Graham Road Surgery to the proposed new development at Weston Rugby Club**	
6.4	**Care Traffic Control (CTCC)** Keith Robertson, (KR) ICB manager and Zilla Anderson (ZA) attended for the item. DES explained that board members would receive an email asking them to sign up to the care traffic control ap. The system had successfully transitioned from the Alamac system to the new solution delivered by Faculty AI. This new service insourced information to the Business Intelligence service. DES explained that Kiaran Flanagan (CTCC Clinical Lead) was unable to attend the meeting. KR gave an update on the roll out of the system and highlighted the ambitions which included: the provision of 111 call information with Severnside, the provision of live information concerning section 36 data by mental health colleagues and the addition of primary care data to give whole system visibility. Data was being used in operational meetings and 'nowcasting' tools were being launched. ZA explained the next phases which involved supporting BNSSG to use data to generate insights, drive more informed decision making and collaboration. A core ambition was to provide individuals with a 'line of sight' from service to organisation to system. Building data foundations was crucial to this and BNSSG data assets were being developed with continued produce release through the summer. The dashboard had been developed and launched in four weeks due to the strong foundations and relationship in place across partners. DES drew attention to the Risk of Harm work being taken forward which was an approach that indicate harm through data dashboards. This innovative work was being led by clinicians who were engaged with the development. CTCC would support decision making and the management of risk. The next step would be to build this capacity for care and safeguarding teams. DES highlighted the recent media reports and assured the Board that there had been no increase in the resourcing for the programme which was within the recurrent cost envelope of the previous system.	

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	AM welcomed the work on the Risk of Harm capability. Commenting on the risks reported in the paper AM asked if the mitigation to the risk of users not signing up to the new dashboard was sufficient. DES agreed that further mitigations were required and agreed to review this. JF commented on the importance of this developed and it was agreed that the Board would continue to receive progress updates. **The BNSSG ICB Board noted the contract award for the provision of an Urgent and Emergency Care Intelligence System for the BNSSG ICB to Faculty AI and continued to endorse CTCC as a system flow project priority**	**DES**
6.5	**Acute Collaborative** EY noted that the Acute Collaborative was the precursor to the Acute Health and Care Improvement Group. The development of the Joint Clinical Strategy was highlighted; this would be signed off at the end of April. This would help shape the delivery of acute services in the future. There would be further engagement with regional NHSE colleagues and the ICB and would be presented to the Board. SD commented that the clinical strategy was a key element of service delivery. JS asked when the Joint Clinical Strategy would be shared with partners noting the potential shift towards community and primary care settings and closer collaboration. It would be helpful to bring together the Joint Clinical Strategy with the Community and Primary Care Strategy. EY agreed it was important to have a collective discussion. ED asked when wider collaboration was planned. EY commented that it would be helpful to have a workshop discussion about the Joint Clinical Strategy to understand crossovers and opportunities. RT voiced concern that the strategy would be signed off without a wider discussion with partners regarding integration. EY explained the sign off was not the end of the development process and there would be further focus on specialties. SD commented that the new acute clinical model would remove duplication and variation across the two sites. There would then be a further discussion that would focus on what does a BNSSG Collaborative approach look like. SD commented it was important for the board to be involved in that discussion. JF noted this would continue to be a standing agenda item. **The BNSSG ICB Board received the report**	
6.6	**Revised Scheme of Reservation and Delegation (SoRD)** SD drew attention to the changes highlighted in the paper relating to the delegation of Pharmacy, Ophthalmic and Dentistry services to the ICB by NHS England and changes relating to the approval of policies. Rob Hayday (RH) explained that the policies referred to non-contractual policies and that contractual and statutory policies would continue to require Board level approval. Sarah Carr (SC) explained there were a number of changes required to align the delegations to committees. These were not included in the papers. SC explained that these were not material changes and would not impact on	

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	the committee terms of reference. SC asked sought the Board's approval to make these changes without referral back to the Board for approval. It was noted that there would be further discussions about the remit of committees and any resulting changes would be reported back to the Board. ED supported the amendments and commented that there was some further work to be completed to understand all of the groups that reported to the committees. JF commented that this was a further discussion to hold with the executive. SD agreed to take this forward. RS flagged potential changes to the Outcomes, Performance and Quality Terms of Reference in relation to the Health and Care Professional Group**.** AM supported the amendments proposed with the caveat that this may lead to further changes to the committee terms of reference. **The BNSSG ICB Board approved the changes to the Scheme of Reservation and Delegation (SoRD):** • **Reflecting the additional delegated responsibilities conferred to the ICB by NHS England from the 1st April 2023 and** • **delegated authority regarding the approval and development of corporate policies** • **the non-material changes highlighted in the Board discussion**	**SC** **SD/all execs**
7.1	**Outcomes, Performance and Quality Committee** ED reported that Sue Geary, Health Watch had presented the Patient Voice at the last meeting and this had generated discussions about GP access, the transfer of care and system first approach. In 2023/24 the committee would focus on the delivery of the operational plan alongside system performance and quality of service. The committee understood the need to balance this focus on in year performance with longer term outcome metrics. Committee member Sarah Weld, Director of Public Health, South Gloucestershire Sarah Weld played an important role challenging the committee to consider the longer term. The committee had discussed performance issues including performance against the A&E 4 hour wait target, and 2-week breast cancer waiting times. Cancer 2 weeks waiting times were a concern with BNSSG performance at 56% compared to the national average of 82%. Performance against the cancer 62 day wait standard was at 43% against the national target of 85%. The committee would explore these in more depth and ED suggested a deep dive in conjunction with the Primary Care Committee. AM welcomed this and suggested a whole pathway review from presentation, noting that a recent survey had highlighted that access to primary care continued to be a concern with patients either unable to get timely access or delaying making appointments. Performance in relation to both endoscopy and dermatology was challenged. LM explained that dermatology, in terms of cancer targets, was an issue across both acute sites. Work to realign the pathway and optimise the use of tele dermatology was underway. The Board was aware of capacity issues in	

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	endoscopy services. Work to increase capacity in community diagnostic capacity had been delayed and the June implementation plan had been pushed back. Colleagues were looking to source additional capacity from the Independent Sector to provide the additional capacity required. LM highlighted that endoscopy activity would not support the diagnostic standard the ICB wanted for the population. RS informed the Board that the committee had discussed excess mortality rates. JM would review data with public health colleagues and present this to a future committee meeting. This data would help to inform future decision making. JF noted there had been an overall improvement in performance compared to previous years. JS observed that the minutes of the meeting included discussion about children's services. JS commented that the dashboards had a focus on adult services and asked if the committee felt that the discussion of children's' services was on a par with that of adults. LM explained that the dashboard presented to the committee included children's services although there had not been a deep dive into these at the meeting. JS and RS noted that it was important to have regular reporting to the committee. RS commented that the report did not include maternity services. ED agreed to take this matter back to the committee and would discuss this with JS outside of this meeting. LM commented that the reports to the Board did not include detailed information about children's' services. **The ICB Board received the update from the Outcomes, Performance and Quality Committee and the minutes**	**ED**
7.2	**People Committee** JF drew attention to the minutes **The ICB Board received the minutes of the committee**	
7.3	**Finance, Estates and Digital Committee** SW explained that the reported deficit the end of 2022/23 had put pressure on the budget setting for 2023/24. A balanced budget had been reached. SW highlighted the savings target of approximately 3% across the system. The committee would continue to track progress across 2023/24 and ensure a focus on closing the gap. Key risks included workforce and agency expenditure. This was the major challenge in 2022/23 and would continue in 2023/24. Addressing this would help to create the financial headroom for investment and innovation. The capital investments and digital strategy discussed by the Board had been considered by the committee. JL commented that the committee had conducted a deep dive in to Continuing Healthcare (CHC) noting this budget was experience pressure as the number of high cost, high acuity cases increased. This pressure was also seen in local authority budgets and it had been agreed to discuss this with colleagues from across the system outside of the committee. This meeting would include colleagues from the mental health services. JW commented that these cost	

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	pressures had been discussed by the local authority chief executives and welcomed the further discussions. ED noted the importance of avoiding duplication of discussions. SP noted there were no figures in the column for local authorities on page two of the report and asked if this was an aspirational addition for the future. JL confirmed this, explaining that discussions were on going with section 151 officers. SP observed that this would be a welcome addition that would provide partner organisations with a more system wide understanding of the position. SD agreed and encouraged local authority colleagues to support their Section 151 officers. **The ICB Board received the update from the Finance, Estates and Digital Committee and the minutes**	
7.4	**Primary Care Committee** AM drew attention to the committee discussions relating to the delegation of Pharmacy, Ophthalmic and Dentistry services and the work completed by the ICB team. AM highlighted the benefits to the wider system of the delegation of services. Attention was drawn to the amended committee Terms of Refence which now covered the delegated services. These changes were reflected in the SoRD and the Board was being asked to approve these. AM explained there had been a discussion focused on the Community Pharmacy Consultation Scheme where patients were referred to community pharmacy services. Currently referrals came from GP and this was being reviewed to potentially extend cover to secondary care referrals. DJ highlighted the delegation paper formally briefing the Board on the due diligence and processes undertaken prior to the formal delegation on the 1st April. This was an opportunity to better integrated Pharmacy, Ophthalmic and Dentistry services back into the wider health and care system. The formal Delegation Checklist had been overseen through the Primary Care Committee and the Finance, Estates and Digital Committee. The formal Delegation Agreement had been signed by SD on the 23rd March. This was underpinned by a Memorandum of Understanding with NHS England. The transition period continued and a transition plan was in place with NHS England. This including further clarification regarding governance arrangements for regional and local decision making, complaints management and the clinical leadership architecture. The Primary Care Operational Group, chaired by DJ, was reviewing its Terms of Reference to ensure it covered the full range of activities. DJ highlighted the active engagement of the Local Dental, Ophthalmic and Pharmacy Committees. RT commented on the work led by One Care to support the development of a Primary Care Collaborative Board. **The ICB Board received the update from the Primary Care Committee and the minutes, approved the Committee Terms of Reference, noted the formal delegation of Pharmacy, Ophthalmic and dental Services and**	

	Item	Action
	delegated the ongoing assurance in relation to the delegation of these services to the Primary Care Committee	
7.5	**Audit and Risk Committee** JCa explained that the February meeting was part of the planned meeting cycle. The March meeting was an additional meeting to receive the External Audit Annual Audit Plan which was delayed due to the complexities of the end of year process for 2023/23. JCa drew attention to the invitation sent to members to join Risk Management workshops and encouraged colleagues to attend these. **The ICB Board received the update from the Audit and Risk Committee and the minutes**	
8	**BNSSG Integrated Care Partnership Updates** JF noted that there had been an update on ICS strategy at the last meeting - this is main focus of the partnership – had a useful workshop on prioritisation. The strategy would be signed off by the ICP in June and presented to the ICB in July. SD noted the energy and desire to be part of something expressed at the last ICP meeting.	
9	**Questions from Members of the Public** JF noted a written question had been received from a member of the public who was unable to attend. SC explained this related to the delegation of Primary Care Services and also to the changes highlighted in the SoRD. A full written response would be sent to the questioner which would be placed alongside the minute as a post meeting note [below]. **Post Meeting Note** The following questions were emailed to the ICB for the Board meeting 1. What does delegation mean in practice to the ICB, especially in regard to dentistry, which in Bristol appears virtually impossible for patients to access an NHS dentist? 2. Concomitantly, how will patient access to ophthalmology and pharmacy services be affected by delegation from the NHSE? 3. Lastly on section 3 of the paper concerning "Decisions and Functions", the following text is being proposed for deletion: "Approve any urgent decisions taken by the chair of the ICB Board for ratification in public session ....." What is the rationale for this deletion? The ICB responses to questions 1 and 2 The ICB took on the responsibility for pharmacy, dental and optometry services on 1 April 2023. We are aware that access to NHS dentistry in Bristol, North Somerset and South Gloucestershire is challenging and we will be working hard to try and improve the situation for residents. Overseeing services at a more local level will allow us to make decisions which will, in time, help us to improve provision. Taking on the service just a few weeks ago, we are now in the process of starting to work with key stakeholders to help us review current services and understand population need. This work will help to inform a local	

	Item	Action
	strategy. Work is also ongoing on a wider South West Dental Reform programme, which is offering practical support to enable dental practices to take on more NHS dentistry in the area. Updates will come through the ICB Board in due course. The ICB response to question 3 This was recommended for removal, to be replaced with “Receive any urgent decisions taken by the Chair and Chief Executive as set out in Standing Orders”. The phrase replacing this should have read “receive for formal ratification …..” There were a number of other amendments noted to the SoRD at the meeting which were of a non-material nature and these changes will be completed and the SoRD published our website.	
10	**Any Other Business** There was a discussion about the Board meeting format after the conclusion of the round of locality presentations at the May meeting. JF noted the opportunity to include an item focused on the patient voice. DH noted there was an opportunity to include items on innovations led by system partners. JS reflected on the theme of cultural change highlighted throughout agenda items, noting some of these were significant change programmes with resources. It was important to ensure there was no duplication of effort. JF observed the ICB Board had looked at how it worked together at its first meetings. It was important that this approach extended beyond the Board and was a matter to explore further. SD agreed and noted that all items required culture change.	
11	**Date of Next Meeting** 4th May Somerset Hall, The Precinct, Portishead	

Sarah Carr, Corporate Secretary April 2023