NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 6th July 2023 at 12.15pm, held via MS Teams

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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
Maria Kane	Chief Executive Officer, North Bristol Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Jon Hayes	Chair of the GP Collaborative Board	JHa
Stephen Peacock	Chief Executive Officer, Bristol City Council	SP
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Will Warrender	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	WW
Eugine Yafele	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EY
In attendance		
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Anne Clarke	Director of Adult Social Services, South Gloucestershire Council	AC
Michelle Darch	Lead Learning Disabilities and Autism Nurse at Southmead Hospital, Sirona care & health	MD

Loran Davison	Team Administrator, BNSSG ICB	LD
Sue Doheny	Regional Chief Nurse (South West), NHS England	SDo
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Hugh Evans	Executive Director of the Adults and Communities Directorate, Bristol City Council	HE
Steven Hams	Chief Nursing Officer, North Bristol Trust	SH
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
Ruth Hughes	Chief Executive Officer, One Care	RH
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Mary Lewis	Chief Nurse, Sirona care & health	MLe
Lesley Le-Pine	Associate Learning Disabilities Projects, BNSSG ICB	LLP
Lisa Manson	Director of Performance and Delivery, BNSSG ICB	LM
Gifty Markey	Head of Patient Experience, North Bristol Trust	GM
Sue Porto	Chief Executive Officer, Sirona care & health (From 17th July 2023)	SP
Lucy Powell	Corporate Support Officer, BNSSG ICB (Minute taker)	LP
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Stuart Walker	Chief Medical Officer and Deputy Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	SWa
Ellie Wetz	ICS Development Programme Manager, BNSSG ICB	EW

	Item	Action
1	**Welcome and Apologies** Jeff Farrar (JF) welcomed all to the meeting. The above apologies were noted. JF welcomed Ruth Hughes, Interim Chief Executive for One Care and Sue Porto, Chief Executive of Sirona (from the 17th July) to their first meeting of the ICB Board. Apologies had been received from the three Local Authority Chief Executives who were attending the Local Government Association conference. Representatives had been sent from the Local Authorities and JF welcomed Anne Clarke, Hugh Evans, and Matt Lenny to the meeting. JF also welcomed Stuart Walker who was representing University Hospitals Bristol and Weston Foundation NHS Trust (UBHW).	
2	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda.	
3	**Minutes of the 4th May 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:	

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	Action 54 – Deborah El-Sayed (DES) reported that the BI Team were working with Ellen Donovan (ED) to design the report. Lisa Manson (LM) confirmed that a dummy run using the report would be actioned during the August Outcomes, Performance and Quality (OPQ) Committee and feedback would be provided in September. **Action 58** – David Jarrett (DJ) confirmed that additional funding had been approved to support migrant health in the medium term. The action was closed. **Action 64** – Shane Devlin (SD) confirmed that the decision-making framework was on the agenda. The action was closed. **Action 65** – Children's services had been discussed at the May OPQ Committee. Work continued through the Children's Health and Care Improvement Group (HCIG) and actions reported through the OPQ Committee. The action was closed. **Action 67** – Rosi Shepherd (RS) confirmed that a seminar session on maternity services was planned for the September Board meeting. RS confirmed that consideration had been given to how the lessons learned from the maternity review could be applied to other services. The action was closed. All other due actions were closed.	
5	**Chief Executive Officer's Report** SD highlighted the five areas covered in the report: ICB organisational structures, delivering the operational plan, long term workforce plan, Charlotte Keel procurement and reflections on the first year of the ICB. **ICB Organisational Structures** SD confirmed that work with staff and partners continued to support the 30% running cost savings outlined by NHS England. There had been a large all staff event and a smaller event with staff and system partners to reflect on the purpose and role of the ICB. The ICB had secured external support to meet the challenge and the system requirements within the cost envelope. **Delivering the Operational Plan** The Operational Plan has been submitted and the paper summarised the actions the ICB was taking to deliver the plan. **Long Term Workforce Plan** The NHS launched its long-term workforce plan, and a summary was included in the paper. SD confirmed that the plan was national and there was no local plan for BNSSG yet. The national plan was focused on training, retention and reform of the work and workforce. The system was reviewing and developing a response to the ask, considering opportunities for training and development of staff and staff retention. The ICB would have a central role in the coordination and success of the workforce plan. Processes were being developed which included how the People Committee would monitor the plans. Jo Hicks (JHi) was working across the South West to identify how this would be addressed. A paper would be presented to the September ICB Board meeting with more detail.	

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	Charlotte Keel Medical Practice provision update SD explained that One Medicare had been the preferred bidder to provide services at Charlotte Keel Medical Practice. However, during the post contract award due diligence process, the ICB had to abandon the procurement and the contract could not be implemented. A review and lessons learned project was underway to understand why it was difficult to procure a sustainable service for the practice. SD confirmed that the ICB focus was on the continuation of care for patients and BrisDoc as the incumbent provider had agreed to continue to provide services whilst the ICB determined how best to procure services for the local population. **ICB 1st Year Reflections** SD noted that the NHS was 75 years old and the ICB had celebrated this alongside the 1-year anniversary of the ICB. BNSSG ICB has been successful, and staff should be proud of the work undertaken in the first year. The relationships between the system have been strengthened and services were started to be developed in partnership. BNSSG ICB had good support and engagement from the partnership organisations. SD noted the importance of reaching out to the community groups and highlighted his day with Square Food Foundation who taught adults with learning disabilities how to cook and understand more about food. SD highlighted that although billions of pounds was spent on health and social care each year, providing these courses, and educating people to support themselves was a significant part of the Integrated Care System (ICS) Strategy in keeping people well and healthy. ED praised the ICB on the achievements, noting that there had been a lot of good work in the first year. ED highlighted the NHS workforce plan and the local plan to be developed and asked whether any support was needed from the partner or non-executive members to develop this. SD explained that resourcing for the workforce plan had not been agreed but the ICB would work with NHS England to deliver the plan and the importance of developing the right people function to deliver the workforce plan was noted. JHi confirmed she was working with system Chief People Officers to determine what the workforce plan meant for the system in terms of current workforce and culture plans. Support from the non-executive members would be needed when the discussions and ideas were presented at Committees. JHi noted the importance that the local workforce plan included the whole health and social care system. Dominic Hardisty (DH) agreed that the ICB could be proud that it had addressed the priorities and the system had started to behave differently. This was thanks to Shane and his stewardship of the system. Steve West (SW) believed the ICB had started to build solid foundation into working as one system. Joint working mitigated risks and delivering improvement as a system was becoming the way of working. SW noted the importance that the	

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	system focused on reducing health inequalities and this work was starting to develop through data sets, investments, and models of care. The importance of including local authorities in these conversations was noted. Alison Moon (AM) agreed that the work of the ICB had been positive. AM highlighted how the core purpose of the ICB would shape the organisational structure and asked how Board and partner members could provide comment on the ongoing work. SD confirmed that a design team had been set up within the organisation and workshops which the partners were invited to had been set up. SD noted that the role of the non-executive members had not been included in those discussions as they provided an importance independent view into the decisions being made. JF expected the non-executive members and the Board to provide check and challenge as part of the redesign process. Matt Lenny (ML) noted that there would be other organisations within the system which had undergone similar budget reductions and suggested that the ICB ask the system for learning. JF asked Ruth Hughes (RH) how primary care colleagues perceived the ICB. RH confirmed there was a spectrum of views but highlighted that the locality partnerships were a great way to engage with practices and noted that there was general opinion that general practice was now considered more of a participating partner but there was more work to be done. Anne Clarke (AC) noted that frontline social workers understood working with the locality partnerships but asked the ICB to consider how the ICS Strategy could be communicated to frontline staff. AC noted that the messages around prevention and helping people to help themselves would resonate with staff. Hugh Evans (HE) noted that through the ICB the conversations between organisations were better and had highlighted the issues that were known within the operational and strategic systems. HE believed that the work to support the system was effective and genuine. The ICS would take a few years to embed but was a positive step forward. **The ICB Board received the report**	
6.1	**Item deferred**	
6.2	**BNSSG ICS Operating and Decision-Making Framework, including Risk Management** It was noted that without the Local Authority Chief Executives at the meeting it would be inappropriate to agree the recommendations. SD agreed to discuss the outcomes of the discussion with them in the next Chief Executives meeting. SD noted the importance of decision making as individual organisations and as a system and this paper had been developed to bring together those discussions	

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	from around the system and included consideration of risk and risk appetite. The paper outlined a framework, and it was important to consider whether it outlined the preferred direction of travel. Ellie Wetz (EW) explained that the key principle was that the system should have a good understanding of the risks of the decisions made and an understanding of the shared appetite for risk within the system. EW noted that individual organisations have undertaken a lot of this work already. The first section of the paper outlined the options for risk appetite statements which had been developed through workshops and surveys. The ICB Audit and Risk Committee had reviewed the domains and the feedback had been included in the paper. EW confirmed that the second section of the paper structured the system partners to align with the decision-making framework and the delegated authority of the individuals within the groups as set out in the ICB Scheme of Reservation and Delegation. This supported the HCIGs which had a broad range of objectives. The ICB needed to establish a sensible group of operational delivery groups which aligned with the current programme boards and steering groups which would feed into the HCIGs. EW noted that the expectation was that the actions would be completed by task and finish groups with very specific areas of focus. It was important that the framework was flexible and supported the groups already established within the system. EW confirmed that mapping these groups continued. EW outlined the way the two frameworks would work together and explained that the idea was that decision-making was bound by risk management. If a decision needed to be made, the appropriate oversight group would support the operational delivery group to understand what the right decision might be in terms of the broader system. DES highlighted technology and digital data noting that this was an enabler which didn't align with one HCIG and therefore needed to be considered across all these groups to ensure no duplication of work. EW noted that in terms of enablers, the HCIGs would be expected to identify specific issues and communicate these to the appropriate oversight group who would convene a working group to discuss solutions. DH noted that the approach outlined was a start to unpicking some of the difficulties in system decision making but explained that sometimes it wasn't clear what the next steps in decision making and accountability were. John Cappock (JCa) welcomed the work so far noting the complexity. The workshops had been open and democratic and there had been lots of opportunity for partners to provide feedback. JCa noted the importance of moving from development into delivery and partnership working aligned with this. JCa noted the	

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	importance of trusting the judgement of the Chief Medical Officer and Chief Nurse Officer to make decisions but also having the right structures in place to check and challenge these decisions. JCa believed that the risk appetite domains where broadly correct and the challenge was to identify different ways of working. The internal auditors had raised that the ICB had been slower in developing these processes than other ICBs but for the right reasons and had supported the continued system level discussions. LM provided examples of the decision-making processes including the work around children which was focused on the ICS Strategy priorities so the HCIGs could own these priorities and drive the improvements. CB asked that the Board consider capacity noting that it had been raised previously that staff were overloaded with meetings and groups. With the cost envelope reductions, the resource needed to support these groups should be considered. CB also highlighted that the HCIGs needed to be clear what outcomes they were responsible for delivering within the 4 ICS aims and how the associated metrics would be delivered and monitored. ML explained that there were additional layers of complexity around decision-making in local authorities and appreciated the decision to discuss this further with the local authority Chief Executives. ML asked where the Integrated Care Partnership (ICP) Board sat within the framework and how the decisions made could be challenged by local populations. Health inequalities was highlighted as a key element which needed to be considered in all decisions. JF confirmed that the ICS Strategy had been approved by the ICP Board which was chaired by the Health and Wellbeing Board Chairs, so the local authorities had already approved the priorities as set out in the Strategy but there needed to be clarity around what decisions needed to be presented to the Cabinets. JF suggested that the processes around decision making at local authority level be presented to the Board to promote better understanding. AC welcomed this and suggested that this be presented with decision case studies as well as an explanation of what the change of administration for councils meant in practical terms. ED welcomed the work but asked if this was over ambitious given the complexity, investment needed from partners and the required reduction in running costs of the ICB. ED also asked whether there were any recommendations which needed decisions so that the work could continue. AM agreed and asked the system Chief Executives what their thoughts were. AM asked that whatever principles were agreed that a plan on the page was developed to support wider understanding of the framework. EW confirmed that a discussion had been held with the Communications team on the development of a plan on a page as there were various audiences, including the population who needed to understand decision making processes.	**JF/SD**

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	MK appreciated the transparency but felt the current plans were too complicated and needed to be simplified or people would not engage. HCIGs were noted to be at an early stage and processes would be developed as the HCIGs were tested. MK noted that there was risk within the interface with other areas and asked how the framework would support this. MK noted that capacity was an issue and less meetings would increase engagement. Jaya Chakrabarti (JCh) welcomed the further understanding of local authority governance processes and agreed that consideration of staff time was important. Julie Sharma (JS) highlighted the importance of the connections between operational delivery groups. It was important that the decision makers fully understood the impact of the decision on the system and were able to demonstrate that the implications on the system had been considered as part of the process. RH thanked EW for supporting One Care by working through some practical examples of decision making. RH shared MK's concerns around the interfaces and noted that there were some areas such as pathways which would not fit within the framework and would need additional consideration. LM explained that the oversight groups were the pathway groups which would report into the HCIGs which would provide the assurance. LM responded to the capacity concerns by confirming that the current meeting groups were being tested to review which ones needed to remain and which could be stood down. ST thanked the Board for their feedback and noted the importance of reviewing how the structure outlined in the paper supported the annual planning process which would start in September. SW welcomed the case studies and testing and asked the system to consider the 'must dos' and how to reduce duplication. JF highlighted the complexity of working in a system where each organisation had different priorities and noted that that inevitable outcome of this was longer decision-making processes. EW thanked the Board for their helpful feedback and noted that an ICP Board development day was planned during which the future role of the ICP Board within the BNSSG system would be discussed. SD confirmed that there needed to be a pause on approval of the recommendations but from the discussions believed that in general the principles were reasonable. Following the conversation with local authority Chief Executives, SD asked that virtual approval was considered via email. ED expressed concern with the deliverability of the complex framework but supported the discussions and recommendation outlined by SD.	**SD**

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	AC asked that the comments or actions requested by the local authority Chief Executives were communicated to the ICB Board members to ensure that any decisions were made with the appropriate context included. ML agreed and noted that the elected member structure may mean that feedback may not be received by next week. JF confirmed that there needed to be further discussions as it was important that the whole system agreed with the framework, or it wouldn't work. EW confirmed that testing of the HCIGs would continue, and the practical application of these groups may provide further assurance on future working. **The ICB Board reviewed the recommendations and agreed these in principle but asked that additional comment and challenge was received from the Local Authority Chief Executives before any decision could be made.**	**SD**
6.3	**Learning Disability and Autism** Michelle Darch (MD) was welcomed to the meeting alongside Gifty Marky (GM) and Steve Hams (SH) to talk about the improvement activity which had taken place for patients with learning disabilities and autism. MD explained that a leadership course had supported the idea that improvements needed to be considered at a higher level to make a difference throughout the hospitals. A learning disability and autism steering group was set up in 2019 which continued to be held quarterly and was attended by various leads across Southmead. Projects and action plans had been implemented to improve services for this cohort of patients, including identifying learning disability champions and reasonable adjustment boxes. MD highlighted that engagement with patients, carers and their families was an integral part to developing any plans. MD outlined the challenges faced during the pandemic as patients with learning disabilities were noted as more susceptible to respiratory problems. MD explained that as carers were no longer able to stay with patients, the service was increased to 7 days a week, 8.00am – 6.00pm, Monday to Friday and 8.00am – 4.00pm, Saturday and Sunday. MD confirmed that the eligibility also widened to any patient with a learning disability diagnosis. During the pandemic, the team had an increased presence in A&E and supported admissions processes. The team made sure that patients had care plans, hospital passports and offered liaison services with families. The team used yellow branding for visibility as masks made it difficult to identify people and this had remained. MD explained that referrals to the team could be made by phone, email, or just face to face in the corridor. There were no barriers for a referral. The forms used by the team were also on yellow paper, so they were visible within patient notes. MD highlighted the importance of Care Flow Connect which allowed the team to add information to the patients record. This included any enhanced care required, hospital passports and eating and drinking guidelines. MD also noted the Alert Subscriptions system which meant that the team received a notification when a	

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	patient with learning disabilities or autism was admitted. The team would then directly engage with the patients and their carers to offer support. The team also provided awareness of learning disabilities and autism, guidance and support, help to plan and attend appointments and also delivered training across the hospital with specialist support to clinical wards. This training was tailored for specific teams and was scenario-based. The team provided resources for staff such as hospital passports and checked reasonable adjustments and also provided resources for patients and spent time preparing information and videos for patients to help them understand their procedures. There were 126 learning disability champions in North Bristol Trust (NBT) and a reasonable adjustments box in every clinical area of the hospital. These boxes contained information about supporting patients with learning disabilities and autism, including pathway information, and managing complex behaviour. This information was also available on the intranet. MD noted that there was plenty of sensory equipment to support patients. The team also had an expert by experience who was supporting improvement of the hospital passports and training. MD confirmed that the services provided by the team in Southmead had been replicated in the Bristol Royal Infirmary (BRI) and Weston Hospital. The teams were managed by Sirona, had good working relationships with the clinical teams in the hospitals but with the added advantage of a good knowledge of community initiatives which supported the work. MD noted the recent review from NHS England and the audit of A&E services by the Bristol Autism Service. The feedback from both would be implemented to improve the service. The Board thanked MD for her excellent presentation and fully supported the work of the team. Lesley Le-Pine (LLP) confirmed that the LeDeR programme had reviewed 62 deaths from 2022/23. The key themes had been reviewed and coproduced projects developed. LLP thanked GPs for their significant work on annual health checks, 82% had been completed by 31st March 2023 and 98% of those had health actions plans in place. 33 reviews cited obesity as a factor and projects associated with reducing obesity had been developed. These included a cookery school for people with learning disabilities with Square Food Foundation. The course emphasised the importance of cooking together and making healthy choices. LLP noted that all the participants	

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	of the course had continued to cook at home and everyone lost weight over the 12 week course. This course continued for new participants. LLP noted the importance of addressing health inequalities and following review it was found that in Muslim communities, the management of health needs fell to the women and this could lead to the breakdown of the family. The ICB funded Autism Independence to develop training for fathers with local Imams and community leaders to address this. The ICB has also funded care navigator roles to work with families whose first language was not English to support access to health services for people with learning disabilities and autism. 39 reviews had constipation as a factor and work had been undertaken to develop shared language as people with learning disabilities had been embarrassed to talk about poo with their GPs. LLP highlighted that cancer was in the top four causes of death and it was often undiagnosed. Funding had been secured for a screening practitioner within Sirona who would work solely with people with learning disabilities to deliver training on self-examination and provide advice on how to build this into routines. LLP noted that choking continued to be a theme in LeDeR reports and a dysphagia project has been developed to support awareness of the common signs. RS noted the importance of LeDeR was to understand the factors towards death to support the living and noted the disparity between people with learning disabilities and the general population. RS thanked the partners in the system for the drive and passion to support these patients. RS noted that only through continuous funding would the inequalities be reduced. SH acknowledged the positive collaboration between NBT and the learning disability team which showed the value of learning disability nurses. Michelle and the team did important work and at the recent review by NHS England, David Harling, National Deputy Director for Learning Disability Nursing, had said that the team were the gold standard in learning disability nursing. MLe highlighted that the teams had been extended to the other system acute hospitals and noted the importance of developing and sharing good practice. MLe highlighted the flow of information between the hospitals, learning disability services and the community and noted that this fluid management of patients who needed specific support was a model of care which could be utilised in other areas. RS thanked colleagues from NBT and Sirona for sharing the significant improvement activity to improve access and outcomes of care for the population who were autistic and/or have a learning disability.	

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	Board members would be aware that in October 2020 the Independent Review into Oliver McGowan's LeDeR Process Phase 2 was published. The review had been commissioned from NHS England following unresolved concerns expressed by Oliver's family about the previous investigations. The CCG was deeply sorry for the mistakes it made during Oliver's original LeDeR review and recognised that the systems and governance that were in place at that time were not good enough. Since Oliver's first LeDeR review was completed the LeDeR processes and governance have been significantly improved. Executive oversight has been strengthened and operation of LeDeR processes have been robustly managed and reviewers received significant support. In order to provide assurance that the BNSSG system had made sufficient progress with the recommendations of the independent review, Claire Murdoch, National Director of Mental Health for NHS England, commissioned David Harling to undertake an Independent Assurance Review in November 2021. The review included two parts, the first of which was a desk top review of arrangements and the improvement activity which had been undertaken. This had been triangulated through on site quality checking through an independent Quality Checkers site visit to Southmead Hospital by people with lived experience supported by the Brandon Trust. This was followed by a programme of site visits to BNSSG, focus group discussions with system partners and site visit to NBT. David Harling's report concluded that it was evident that BNSSG ICB had actively implemented all of the recommendations from the independent review. The governance to support the delivery of the recommendations was found to be robust and there was found to be effective monitoring in place to assure the onward delivery of each of the recommendations. DH noted the CQC requirement for staff to undertake Oliver McGowan training and asked when this could be actioned. RS confirmed there had been technical issues which were now fixed and the training was underway. LLP added that a new team had been recruited to support the training and team would work with providers to ensure the training was undertaken. ED thanked everyone for their work and noted that the LeDeR annual report and the Oliver McGowan review had been discussed at the OPQ Committee. ED welcomed the system approach to the work noting that without full system engagement, learning would not be embedded. ED was pleased that processes were in place to ensure the learning was embedded and that these improvements would continue. RS confirmed that learning had been embedded in the quality and safety work programmes and RS would continue as the Executive Lead and Chair of the LeDeR Governance Group. Coproduction of plans continued with NBT and Sirona and recurrent funds were available. RS noted that additional work was needed to fit the improvement activity within the HCIGs, and this would likely take	

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	the form of task and finish groups. RS noted the importance that there remained resource and funding for the work. AM welcomed the system wide approach and was pleased to see people were committed and passionate in helping this cohort of patients. AM asked how consistent improvement could be achieved across the patch and noted the importance that the ICB remained committed. RS explained that the work would continue across the system and be embedded within the wider system team. The system understood that that this was work that would continue. SH confirmed that the staff talked about Oliver's legacy at NBT and noted that GM was the lead for learning disability, autism and mental health and therefore the clinical strategies signalled the work which was to continue, and everyone agreed this was the right approach. RS confirmed that the provider network included primary care and the voluntary and community sector and this would be reviewed to ensure it was broad enough. MLe noted that the service was fully embedded throughout NBT but a rapid spread of learning to UHBW would be undertaken and how the approach could be used in other areas would be considered. Colin Bradbury (CB) noted the similarities between the experiences of learning disability patients and other cohorts of patients and wondered whether there were any opportunities to replicate the work for other groups. SD agreed and noted that having a true commitment to a group of individuals, which has resulted in such a rich learning and development exercise, should be applied elsewhere. MD explained that the training at NBT had the same principles for anyone with additional needs and could be applied to other patient groups. LLP noted that the pan-disability model has not always worked for people with learning disabilities and was concerned that this would lead to the voices of people with learning disabilities not being heard. SDo welcomed the great work and leadership but noted that numbers of nurses training was reducing nationally and BNSSG needed to provide an optimal working environment to ensure that the workforce was available. SDo noted that BNSSG had a framework which would support the area to be a national leader in this and asked to meet with the Chief Nursing Officers to further discuss this. **The ICB Board received the update and supported the recommendations to:** • **Accept the Independent Assurance Report Findings** • **Ongoing system development through the Learning Disability Health Provider Network reporting to the Mental Health, Learning Disability and Autism Health and Care Improvement Group** • **Ongoing oversight of LeDeR Governance through BNSSG OPQ Committee** • **Note the content of the LeDeR Annual Report 2022/23 and approved for publication**	**SDo/ RS**
6.4	**Assignment of Leadership Roles**	

	Item	Action
	SD confirmed that ICBs were required to nominate lead roles for certain areas. SD noted that these had been outlined in the paper however one was incorrect. The suggested lead roles for BNSSG ICB were: • Children and young people (aged 0 to 25) – Lisa Manson • Children and young people with special educational needs and disabilities (SEND) – Lisa Manson • Safeguarding (all age), including looked after children – Rosi Shepherd • Learning disability and autism (all age) – Rosi Shepherd • Down Syndrome (all-age) – Lisa Manson SD explained that the guidance issued by NHS England had proposed that these leads were voting members of the Board. Lisa Manson was not a voting member of the BNSSG ICB Board however the above areas were within Lisa's portfolio and the knowledge and expertise was held by Lisa who also Chaired the improving the lives of children HCIG. SD felt it was more important that the lead executive had the correct skill set rather than voting rights on the Board. JS agreed that Lisa had the skills required and asked whether every ICB would have this issue. JF confirmed that ICB Boards were made up of a range of executive teams and directors. JS asked whether the decision was based on person or role. SD confirmed that this was about the person, if Lisa left the ICB, the ICB Board would be asked to approve another lead. **The ICB Board approved the lead roles identified above.**	
6.5	**ICS Green Plan** ST explained that the Green Plan was planned to be published by March 2022, however this had been delayed as system engagement had been a challenge during the pandemic. Further engagement was needed to embed the plan across the system especially as there had been changes since the plan was first developed. A workshop was planned for July 2023 to work with the Local Authorities to share learning and it was expected that by September there would be more detail available to cost the plans to ensure that the system was able to engage with national plans. ST noted that to secure funding the system needed to understand the issues and have further discussions with the regional teams. ST highlighted page 15 of the plan which outlined the sources of carbon emissions in the system, which included medicines and medical equipment use as well as pathways and patient travel. JF noted the importance that this work wasn't being duplicated across the system and as this was a system level plan, the monitoring of performance would be undertaken at the ICB Board.	

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	ST outlined that the green plan was for all the NHS organisations with the expectation that the rest of the system including the Local Authorities would be involved. ST noted that the NHS system experts sat within the acute trusts. JS welcomed the plan noting that the ideas were transferrable to the other organisations in the system. The Green Plan was a good example of a system plan which linked all the organisations. SW highlighted that there was an opportunity to think wider to include the universities and have a bigger impact across the city. SW noted the opportunity to embed this thinking into future training for new staff and those in education. ML noted that Local Authorities continued this work through the Climate Emergency Action Plan and welcomed the input from the NHS organisations. **The ICB Board noted:** • **The changes made to the Healthier Together ICS Green Plan** • **That a resource plan would be developed by September 2023 to outline resources required to deliver the Green Plan and achieve Net Zero Carbon by 2030** • **Approved the updated ICS Green Plan**	
7.1	**Outcomes, Performance and Quality Committee** ED explained that the June Committee had discussed the balance of focus between long- and short-term work. There was a focus on learning disabilities and autism as well as the short-term challenges around the operational plan and current performance. Jo Medhurst (JM) presented the work from the Health and Care Professional Executive around Tobacco. The Committee discussed endoscopy performance in detail which was an area of significant challenge for the system in terms of waiting lists and elective performance. The ICS was committed to highlighting performance challenges and assurance was provided regarding the actions being taken to address some of those challenges. These included independent sector support to endoscopy, expediting clinical training and more specific work from NBT and UHBW. ED reported that the Committee had reviewed cancer performance specifically the 28 days faster diagnosis standard (FDS). Performance remained challenged and JM agreed to provide the data regarding dermatology at the next Committee meeting so the members could fully understand the challenge. JM noted that the numbers for dermatology were higher than other cancer sites and work continued with the performance team to disaggregate the data and drill down into that area. JM highlighted a workshop on smoking cessation, where using population health data, the attendees had reviewed the trajectories of harm and the impact of	

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	smoking across our system. The attendees included people who worked in the fields of smoking cessation from across the system. It was agreed to set up the BNSSG Smokefree Alliance which would set targets and the longer-term vision of smoking across the wider system. JM confirmed that next workshop would focus on weight and weight management. LM confirmed that monitoring of the elective plan continued and noted that the ongoing industrial action was having an impact on elective recovery. Both NBT and UHBW were managing this risk against the delivery of the elective recovery plan. RS reported that the System Quality Group was undertaking a focussed piece of work on understanding delay related harm to identify what improvement and mitigation activity needed to take place. Work continued with the system to triangulate the work. JF explained that the Non-Executive group was meeting monthly to ensure there was connection between the Committees and less duplication. AM noted potential future industrial action and asked whether the system needed to communicate to the public in advance of this. JM confirmed that working with the Communications team, she had recorded two videos with advice to the public. This had been included on several social media platforms and the regional news. JM confirmed that the messaging was clear, be prepared, get repeat prescriptions, if you need care use NHS 111 and only use 999 for emergencies. JCh asked whether a countdown to the industrial action was included in the communications. JM confirmed the communications were cyclical, and there was a nationally led rhythm to ensure patients received the communications they needed at the right time. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	
7.2	**People Committee** JCh noted that the People Committee timing in month was changing which would support the Committee receiving real time financial and digital information. JCh explained that this would have an impact on the meeting minutes which were presented to the Board. JHi confirmed that the People Committee would be moving to the last week of the month. This would allow the Committee to monitor workforce against the latest financial reports which would highlight any risks to the plans. JHi noted the importance that the Committee received the right information to provide assurance to the Board. JHi also confirmed that the system workforce report would also be reviewed at the ICB People Committee so that the report was reviewed monthly. A deep dive into recruitment was planned for July and this would include international inclusive recruitment and a report on the system NHS Equality,	

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	Diversity and Inclusion (EDI) Action Plan. The Committee was also developing the strategic response to the NHS Long Term Workforce Plan which included establishing a system retentions group. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** SW reported that the Committee was monitoring the system savings plan with particular focus on the workforce element as there was significant spend for agency staff. There had been a deep dive at the June meeting to support understanding of the workforce challenges facing Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). The Committee had also reviewed the outcome of the non-emergency patient transport procurement, the elective care centre work and also the work around Connecting Care. All of the items were given robust finance consideration and the Committee focussed on the system rather than individual organisations. SW noted that the Committee had also been considering the asset base of the system in terms of digital and estates. ST reported that year to date the system had deficit of £2m which was driven by the industrial action however the system was not delivering all of the savings to date and this was offset by slippage on investments and nonrecurrent funds. A refreshed version of the medium-term financial plan would be presented in September as the system was dependent on delivering all the savings in year. The system remained overspent on agency staff and this was a key issue. ST and JHi would be working with system Chief Finance Officers and Chief People Officers to review the data quality in this area to ensure that reported figures were accurate. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
7.4	**Primary Care Committee** AM outlined the work of the Primary Care Operational Group (PCOG) which had provided a report to the Primary Care Committee of the decisions made and the assurance of the consideration taken in making these decisions. AM noted the significant activity which also included decisions regarding dental and pharmacy. The June Committee had received a briefing on the national GP Recovery Plan and the actions the system was taking which included tackling the 8.00am rush, the restoration of patient satisfaction levels and supporting the move to a more digitally enabled operation model. The Committee received an update on the baseline for these three key areas. It was noted that the Committee would receive regular updates, but a detailed update would be provided to the ICB Board in October. The plan contained lots of deliverables and included improving the interface between secondary and primary care which would require secondary care support. DJ noted that it was a national requirement that the GP recovery plan be presented to the ICB Board. The plan represented a significant programme of transformational	

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	change within primary care and wider. The ICB has undertaken significant engagement with stakeholders and the next steps would be shared in October. JHi confirmed that primary care including GP practices, pharmacies, optometry and dentistry would be considered as part of the BNSSG response to the Long-Term Workforce Plan as well as the local workforce and cultural strategy. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Audit and Risk Committee** JCa confirmed that as per the duties delegated to the Audit and Risk Committee from the ICB Board, the June Committee meeting focused on the close down of the 2022/23 financial year. The Committee received the CCG and ICB annual reports and accounts, and letters and reports from the internal and external auditors. The first ICB internal audit opinion had been positive and recognised a good first year of operation. One area noted for improvement had been the ICB risk processes and the development of this had been discussed earlier in the meeting. The Counter Fraud annual report reported a green assessment which was positive. The Committee had also received the reports from external audit which described the final 3 months of the CCG and the first 9 months of the ICB. The CCG and ICB annual reports and accounts, and the letters of representation had been approved. **The ICB Board received the update from the Audit and Risk Committee**	
8	**BNSSG Integrated Care Partnership Updates** JF noted the upcoming ICP development day which would discuss the purpose and direction of the ICP Board now the ICS Strategy had been approved. JF thanked Mike Bell for Charing the ICP Board, this would now pass to Helen Holland. JF noted that AWP, NBT and UHBW would not be represented at the development day which was unfortunate as it was important that the Trusts were involved in these conversations. JF asked that Board members feedback to their Chairs the actions taking place at the ICB. SD highlighted that the ICP Board had been focused on developing the ICS Strategy and although the ICP Board would not be monitoring the delivery of the Strategy, the members of the ICP Board would be responsible through delivery of the Strategy as part of the system organisations. SD and JF noted the strong voluntary and third sector organisational voice within the ICP which was important but equally important was that all organisations within the system were represented. CB noted the potential role for the ICP Board to continue to iterate the ICS Strategy and suggested that the ICP Board continued to receive updates on delivery in order to inform any future changes to the strategy. **The ICB Board received the update**	

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9	**Questions from Members of the Public** There were none	
10	**Any Other Business** There was none	
11	**Date of Next Meeting** 7th September 2023, The Vassall Centre, Gill Avenue, Bristol, BS16 2QQ	

Lucy Powell, Corporate Support Officer, July 2023