NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting

Minutes of the meeting held on 2nd November 2023 at 12.00pm, held virtually via Microsoft Teams

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DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
Jaya Chakrabarti	Non-Executive Member – People	JCh
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Aishah Farooq	Associate Non-Executive Member	AF
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Jon Hayes	Chair of the GP Collaborative Board	JH
Maria Kane	Chief Executive Officer, North Bristol Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Sue Porto	Chief Executive Officer, Sirona care & health	SPo
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Steve West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
John Cappock	Non-Executive Member – Audit	JCa
Sue Doheny	Regional Chief Nurse (South West), NHS England	SDo
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
Ruth Hughes	Chief Executive Officer, One Care	RH
Stephen Peacock	Chief Executive Officer, Bristol City Council	SPe
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		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB

Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JBo
Colin Bradbury	Director of Strategy, Partnerships and Population, BNSSG ICB	CB
Ros Cox	Associate Director (Partnerships), BNSSG ICB	RC
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Bev Haworth	Deputy Head of Primary Care Development, BNNSG ICB	BH
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Samantha Hill	People Business Partner, BNSSG ICB	SH
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Rebecca Mear	Chief Executive Officer, VOSCUR	RM
Lucy Powell	Corporate Support Officer, BNSSG ICB (Minute taker)	LP
Layla Toomer	Patient Safety Lead- Maternity and Neonatology, BNSSG ICB	LT
Emma Wood	Chief People Officer and Deputy Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EW

	Item	Action
1	**Welcome and Apologies** Jeff Farrar (JF) welcomed all to the meeting. The above apologies were noted. JF thanked everyone for their patience with changing the meeting to online. This was due to the amber weather warning which may have resulted in difficulties travelling.	
2	**Declarations of Interest** There were no new declarations of interest and no declarations pertinent to the agenda.	
3	**Minutes of the 5th October 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 76** – Joanne Medhurst (JM) confirmed that the burden of national reporting would be raised at the Winter Group later in the week. An update would be provided at the next meeting. All other due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items within the report: • ICB Organisation Structures • Innovation Hub • Neurodiversity Improvement Project **ICB Organisation Structures** The Executive Directors have been consulted on the proposed executive structure and the final executive structure and operational model would be shared with ICB staff on Monday 6th November. SD explained that the voluntary exit scheme had now closed, and the panel were reviewing the applications. The expectation was for staff to be consulted on the new structure during December and January with the reorganisation complete by the 1st April 2024.	

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	Innovation Hub SD highlighted the work BNSSG ICB was undertaking to create a culture of innovation. Working with the West of England Academic Health Science Network (AHSN), four key workstreams have been identified: • Developing innovation mindset and supporting culture at all staff levels • Innovation push • Innovation pull • Create an infrastructure that will enable the fast-track adoption and spread of new innovations and improvements **Neurodiversity Improvement Project** SD highlighted the significant system challenge around neurodiversity and diagnosis of autism and explained there was a piece of coproduction work ongoing to reengineer the way the system supported people. The waiting list for autism diagnosis consisted of 3,500 people and the service could not be delivered unless the pathway was managed differently. SD noted that this was a whole system challenge to overcome. SD highlighted the other significant challenges to the system including winter pressures, and past and possible future industrial action and noted that the report highlighted the ways that the ICB was addressing other challenges. Deborah El-Sayed (DES) noted a health technology acceleration bid which would support the local population who had both cardiovascular disease (CVD) and respiratory concerns to deliver their care at home and empower self care. Aishah Farooq (AF) welcomed the innovation hub approach as this would lead to people thinking dynamically about the changing needs of the population. AF also welcomed the coproduction approach to the neurodiversity work but asked whether the needs of the population who are not engaged with services had been considered. SD confirmed that coproduction had taken place with parents and carers groups, and therefore families who were waiting for diagnosis or already on the pathway. DES noted that the scope of the work had been intentionally narrow to ensure focus was on the problems to be solved. DES confirmed that a broader piece of work which included the whole life piece around neurodiversity was continuing but the outlined work was focused on designing the pathway the carers and families wanted. Ellen Donovan (ED) welcomed the work on the autism diagnosis pathway and asked when patients would see the impact of the work. SD confirmed that the work was currently in the discovery phase to understand the problem and why previous solutions have not been sustainable. DES noted the next phase would be design, this would likely be longer than 6 weeks to ensure that the design included all the necessary elements needed by the health and education systems. DES expected	

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	the pathway in place at the start of 2024 with tangible measures and outcomes during 2024/25. It was confirmed that assurance on the programme would be provided through the Outcomes, Performance and Quality (OPQ) Committee and ICB Board when appropriate. Sue Porto (SPo) confirmed that Sirona supported the neurodiversity work and was committed to working with the system to improve performance in this area. **The ICB Board received the report for information**	
6.1	**Local Maternity and Neonatology System Update** Rosi Shepherd (RS) explained that the update was being presented to the ICB Board to provide assurance of the infrastructure of the Local Maternity and Neonatal System (LMNS). RS was the Chair of the LMNS which provided support to the wider system to improve outcomes for women, children and families. The local Trusts, North Bristol Trust (NBT) and University Hospitals Bristol and Weston Foundation Trust (UHBW) were responsible for their performance and patient outcomes but the LMNS brought together system partners with a focus on collaboration. RS explained that this included joint learning in; improving outcomes, improving services and hearing the voice of the population as well as peer review and continued oversight of patient safety incidents and performance. Layla Toomer (LT) was welcomed to the meeting to provide more information on the strategic drivers for maternity. It was explained that LMNS meetings alternated each month between a safety and quality focused meeting and a meeting focused on responses to national strategies and targets. LT explained that the safety and quality meetings focussed on the Trusts perinatal quality surveillance matrix which tracked various datasets including incidents and reviewed national investigations. The response group meetings focussed on the local responses to national strategies and targets. Alongside these two meetings, there had been a LMNS perinatal loss and still birth review study day which promoted shared learning across the system and followed local investigations and review through the Perinatal Mortality Review Tool. The system was on target to reduce still births by 50% by 2025 with a BNSSG still birth rate of 2.43 per 1000 births, the national average was 3.3 per 1000 births. LT noted that the system continued to work on the local and national initiatives to reduce this further. LT outlined the three main strategies maternity and neonatal services were focused on: Three-year delivery plan, Saving babies' lives version 3 and Maternity Incentive Scheme Year 5. The Three-year delivery plan acknowledged all the work undertaken as part of the maternity transformation programme with the focus nationally on safety. LT highlighted the importance of the LMNS within these plans as the three-year delivery plan outlined the work to join up maternity and neonatal services through	

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	the leadership of Chief Nursing Officer, Director of Midwifery, Neonatal Consultant and Divisional Manager. This leadership model was replicated within the LMNS structure. The Three-year delivery plan prioritised safer, more personalised and more equitable care and combined all the actions from the Ockenden Report, Kirkup Report and the Long-Term Plan. The four areas of focus within the plan were listening to and working with families, growing, retaining, and supporting workforce, developing a culture of safety, learning and support, and standards and structures which underpin safer, more personalised and more equitable care. Each priority was made up of three ambitions outlining what good looked like and what Trusts and LMNS's must do to achieve the targets. The plan also included qualitative and quantitative outcomes and measures which would demonstrate achievement. LT noted that these have been streamlined and simplified to reduce the administrative burden on both Trusts and systems. The LMNS was working with the Acute Provider Collaborative to support Trusts to agree individual and system level plans in response. LT noted that the system had already being working towards many of the objectives outlined in the Three-year delivery plan. LT explained that maternity services had been following the Saving babies' lives programme since version 1 but noted that due to the delay of version 3 publication, the Trusts now only had 9 months to implement all the targets. Version 3 included a refresh of the existing elements and included both national guidance and frontline learning to reduce unwarranted variation. A national implementation tool provided a standardisation of the evidence used for submission of compliance and the maternity teams were working on providing this evidence. The Maternity Incentive Scheme year 5 standard was launched in May 2023 and system meetings were being agreed to ensure consistency of evidence and sharing of best practice between the Trusts. The BNSSG system was currently focusing on three of the ten safety actions for compliance, saving babies' lives, the foetal growth, and risk assessment and management actions with the LMNS leading on review of scan capacity and the increased requirement of statutory training for all perinatal staff. The required training was increasing from 2.5 to 5 days a year which would put pressure on Trusts to release staff for training and maintain safe staffing levels. LT explained that several high profile reports including the second Ockenden report and the results of the statutory enquiry following the Lucy Letby case were expected which may result in further changes to processes and policies. LT noted that although there had been a national reduction in birth rate there had been a significant increase in complexity so the pressure on maternity services continued particularly for the local system whose Trusts provided the highest level of neonatal care to the most poorly and complex mums and babies.	

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	LT noted that workforce was the most significant challenge to maternity services nationally and locally. This has been recognised and a dedicated retention and recruitment midwife had been identified in each Trust and bespoke anti racism training has been developed with the BNSSG Black Maternity Matters and the training was currently running with its second cohort of multi-disciplinary staff. Alison Moon (AM) thanked LT and RS for the assurance on the governance processes in place. The high-profile reports had emphasised the importance of listening to staff and families and understanding their experiences. AM asked for more information on how the local system was listening to staff. RS explained that LT managed the LMNS but as a registered midwife, also worked regularly alongside the clinical teams. The Trusts regularly had patient safety walkabouts which included members of the Maternity and Neonatal Voice Partnership (MNVP) and patient safety champions had been identified. The MNVP was hosted by Healthwatch and alongside the discussions with women and clinical staff in the Trusts, the MNVP also met with community groups. RS noted that recruitment was taking place to ensure that the MNVP represented the local communities effectively. Insight visits also took place with a wider team and as part of those visits, the culture and experiences of team working were discussed. Study days had also been arranged involving wider system colleagues to explore specific areas as well as culture. LT noted that the last Insight Visit had been focused on the Ockenden immediate and essential actions, whereas this year it was for the system to decide and BNSSG has agreed to review experience and culture. Vicky Marriott (VM) welcomed the additional investment for the MNVP of which the intention was to make a positive difference to engage more widely and lead to quality improvements, and more personalised care. Steve West (SW) asked whether the local system supported and trained staff differently to empower them to scrutinise governance and processes and asked whether Boards and Executives would have the skills to identify issues early and intervene as appropriate. RS explained that the infrastructure for the maternity system in BNSSG was robust and reporting of incidents was strong and therefore the emphasis was on listening and understanding the culture. RS confirmed that the system Chief Nurse Officers would be presenting an ICB Board seminar on how the ICB Board can understand and identify any areas of concern. The seminar would outline the approach for any area of safety and quality not just maternity. **The ICB Board noted and discussed the report and agreed an update would be provided to the ICB Board in March 2024**	
6.2	**Voluntary, Community and Social Enterprise (VCSE) - Update on Current Arrangements** Ros Cox (RC) and Rebecca Mear (RM) were welcomed to the meeting. RC highlighted the importance of improving VCSE engagement as both a system and	

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	at locality partnership level. The VCSE Alliance was starting to take shape and had been designed to fulfil several roles. £200k of pump priming money had been invested and a Memorandum of Understanding (MoU) had been developed. RM explained that the VCSE sector was able to support the aims around improving health and wellbeing at community level but was often disadvantaged by the short-term funding available. VOSCUR, supported by similar organisations in North Somerset and South Gloucestershire, has been nominated by other VCSE organisations as the host organisation to lead the establishment of the VCSE Alliance. The 200k investment would support this and additional funding from NHS England and Pathfinder was expected. The ICB set out a 10 point plan to support the sector to operate as a strategic partner and as part of this the VCSE Alliance Steering Group has been established which had representation from 18 organisations. Future plans include the establishment of a Partnership Liaison group, Chaired by the VCSE Alliance, which would improve engagement and coordinate all the different opportunities including funding, grants and provision of services. It was expected that a new model for working with VCSE organisations would be in place for March 2024. RM outlined the three aims of the VCSE Alliance: • To encourage and enable the VCSE sector to work in a coordinated way to inform policy, strategy and decision making around health and social care; • To provide health and social care colleagues with a single route of engagement and contact; • To better position the VCSE sector to contribute to the design and delivery of integrated care. RC noted the recommendations of the report which included the proposal of a VCSE representative to attend the ICB Board as non-voting member. JF noted the importance that any VCSE representative was decided by the VCSE organisations and added that there was a challenge to ensure that the single voice on the ICB Board was representative of the whole sector. It was noted that the current level of investment was not sustainable and the system needed to have further conversations about future investment. SD welcomed the support a VCSE representative could provide to the ICB Board but agreed with JF that the approach needed to be considered as the VCSE sector was a series of networks which needed to be fully represented on the ICB Board. Dominic Hardisty (DH) asked whether mental health VCSE organisations were fully engaged and offered the support of Avon and Wiltshire Mental Health Partnership Trust (AWP) to the VCSE Alliance. DH confirmed that future mental health service provision was planned to be provided by the VCSE sector and the NHS seamlessly. RM thanked DH for the offer and confirmed that the Mental Health Alliance were members of the steering group.	

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	SPo supported the work and offered the support of Sirona. SPo noted the importance that the full range of VCSE organisations were engaged and mapped to ensure that local services could support improving the outcomes for the population. Jaya Chakrabarti (JCh) welcomed the VCSE Alliance noting that this had been discussed at People Committee as one of the enablers to understand the system level workforce and capacity as well as understand the opportunities of the Alliance. Dave Perry (DP) supported the work as it created the opportunity to build and strengthen relationships and the infrastructure of the locality partnerships. **The ICB Board:** • **Noted the progress to date and the next steps in VCSE development** • **Approved the proposal for VCSE representative to attend the ICB Board with the right processes put in place to determine who this will be**	
6.3	**BNSSG System Level Access Improvement Plan** David Jarrett (DJ) explained that the paper outlined the response to the NHS England plan for recovering access to primary care. The BNSSG plan was ambitious and designed to improve experience for patients. The local plan outlined a significant amount of work and was part of an iterative process which would continue to develop. DJ confirmed that ICBs were formally required to present local plans to the ICB Board. A further update on progress would be provided to the ICB Board in March 2024. Jenny Bowker (JBo) and Bev Haworth (BH) were welcomed to the meeting to provide the detail behind the plan. BH noted that the plan consisted of a significant work programme but explained that the local GP practices had been working towards improving access before the plan was published. The paper outlined the baseline position as well as activity data. BH noted that the BNSSG system was above plan in several key areas including numbers of appointments delivered. As part of the plan GP practices were training staff to manage the changes and to offer effective triage and utilising multi-disciplinary teams (MDTs). Practices were communicating that patients would see the most appropriate person for their needs, which may not necessarily be a GP. BH confirmed that the ICB had access to GP practice level data which supported a targeted approach to recovery. The paper outlined where the GP practices were within the deprivation levels across BNSSG. 71 of 76 practices have attended the training and using the learning, specific health inequality work has been identified. The ICB was working closely with Healthwatch to undertake some targeted work with 7 PCNs in areas of deprivation to support sharing of good practice. BH noted the successful Community Pharmacist consultation service which had 5,000 referrals a month with a stretch target of 7,500. It was important to consider this activity when reviewing workforce requirements. BH noted that recruitment was	

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	a challenge, as additional role and GP numbers were reducing alongside decreasing numbers of nurses and administrative staff. The paper outlined the current initiatives in place to support recruitment and retention as well as health and well-being for staff. A communication plan has been developed to support practices and help patients understand the pressures facing GP practices and the new ways of working. The recovery plan outlined a total digital triage aim which would free up time for clinicians and admin staff and, in line with digital plans, 63 GP practices were proving access to health records online. 7 GP practices were currently onboarding and the ICB was supporting the remaining practices to implement this. Work continued to support GP practices to offer online appointment booking and it was confirmed that all practices had cloud based telephony and 75% of practices were on track to have call waiting and call back functionality by March 2024. Practices who implemented this functionality expressed that it helped reduce the 8am rush. BH described the primary/secondary care interface group which was Chaired by JM. The group discussed topics such as culture, planned care and fit notes, advice and guidance, prescriptions, and discharge summaries as well as urgent care. BH noted that this work was important as around 20% of general practice activity related to secondary care access, particularly waiting lists and outpatient appointments. BH noted the significant work required to meet the targets set out in the plan and highlighted the additional financial pressures for GP practices resulting from increased supplier and estates costs, and staff pay rises. SD asked whether there was any support the ICB Board could provide noting the challenges around the primary and secondary care interface. BH thanked the Board for the offer and noted that alongside the Interface Group an Integrated Care at Home Board was being established. Both groups were new and once these were embedded the groups would be able to understand the support needed from the ICB Board. Jon Hayes (JH) asked the system to reconsider the current role of GP Practices as the hub organisation required to access services. JH noted that it added extra work to GP staff and having direct access to services would make healthcare more accessible to patients. AM thanked the team for the work and highlighted that achievement of the plan would support the system to be successful and therefore it was in the interest of the system that the plan succeeded. AM noted the importance of the interface group and welcomed the approach JM had taken in prioritising a robust and positive relationship between primary and secondary care. AM highlighted that there were some quick successes which could be achieved through the group such as consultant to consultant referrals.	

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	JH highlighted practice reception staff as first contact for patients and explained that supporting wellbeing at practices was essential to delivering good access. JH explained that these reception roles were often demanding as when people were ill they understandably felt greater levels of anxiety and frustration. Reception staff were often managing expectations of patients in areas where they also lived and therefore retention of administrative staff was difficult. JH explained that a core part of improving services was working together as patients and care providers to treat each other with mutual respect and support. JCh asked whether the work in progress was visible to the public as wider communications to explain the changes and manage expectations as a system may ease some of the frustration felt by patients. BH confirmed that the strategy contained a local communications and engagement plan which included videos and going out to speak to local communities to explain the changes to services. The communications aligned with the national communications and the ICB had also developed bespoke communications to support GP practices to understand and communicate the messages themselves. JB added that communications would continue and how to make this more effective would be considered. ED noted that GP numbers continued to fall and asked whether this had been modelled for the future, and if this was a national issue and if so, whether any systems had any successful campaigns which could be replicated. BH confirmed that it was difficult to model workforce in Primary Care but this continued as part of the operational planning and review of the joint forward plan. The workforce plans included mentors and fellows and the ICB triangulated the current workforce with the trainees. BH confirmed this was a national issue and noted that monthly meetings continued with South West system partners to share good practice and a series of webinars had been developed to focus on specific challenges. DJ highlighted that workforce data was often difficult to collate as GP practices were independent businesses and suggested that the Primary Care Committee undertakes a deep dive into primary care recruitment and retention. BH highlighted that the primary care team was linked with the People Directorate to ensure that system workforce plans included primary care. **The ICB Board approved the BNSSG System Access Improvement Plan**	**DJ**
6.4	**Freedom to Speak Up Policy** SD highlighted the importance of the policy given the outcomes of the high-profile reports in NHS failings. The Corporate Policy Review Group, Staff Partnership Forum and People Committee had reviewed the policy which was being presented to the ICB Board for approval. The policy was in line with NHS England guidance which included updates to the contact information. The training element had been updated to reflect that Speak Up, Listen Up and Follow Up would become a mandatory training requirement. DJ noted, as a Freedom to Speak Up guardian, the importance of communicating the policy to staff as the ICB staff survey had	

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	indicated that staff did not know how to speak up or would not feel comfortable doing so. JF welcomed the policy's emphasis on the executive level guardians and the importance of training. Sam Hill (SH) confirmed that the key changes had been listed on the cover sheet and explained that the content within the policy had been made more robust. The importance of anonymity was noted and JCh explained that the highlights of any concerns raised would be presented to the People Committee to support the Committee to identify themes without violating privacy. SH explained that the information would be held by People Team in the same way grievance information was held. SD noted that although the policy was ICB only, the People Committee may want to consider how the system receives assurance that the ICB processes are in place to listen and learn from staff. SW noted that the measures which showed the policy was working as intended was seeing actions coming out of staff speaking up. DH highlighted that AWP had 150 Freedom to Speak Up Guardians and the AWP lead Chaired the regional Freedom to Speak Up Guardian forum. DH noted that there were questions in the national staff survey relating to speaking up and it was a helpful way to track organisational knowledge and attitude. DJ noted the importance that the routes to speaking up were regularly shared with staff and explained that any actions resulting from speaking up would be shared to provide assurance and encourage more people to speak up. **The ICB Board approved the updated Freedom to Speak Up policy**	
6.5	**Item deferred**	
6.6	**Update on Strategy Developments** CB highlighted the proposal for the ICB Board and Integrated Care Partnership (ICP) Board to have a development session to further understand the Boards roles and responsibilities within the Integrated Care System (ICS). The Local Government Association (LGA) has been engaged to facilitate a session provisionally agreed for the 11th January 2024. It was hoped that this initial session would lead to a wider event involving Health and Wellbeing Boards (HWBs) and Health and Care Improvement Groups (HCIGs). CB noted the strategic investment principles which had been agreed to be tested and, with Board approval, it was suggested that an amendment be made to the Board covering paper to include a section asking how the content considered strategic investment principles. CB noted that consideration needed to be given to the development and implementation of the strategic priorities and how these would be practically	

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	actioned within the system. CB highlighted the nine commitments included in the strategy which was a mixture of behavioural issues and condition based elements, including the first 1000 years of life and aging and dying well. Over the five years of the strategy, a rolling process of prioritisation was required to enable focus on specific areas. Review of need had taken place to support the prioritisation process. CB explained that next steps included testing the priorities with the Health and Care Professional Executive (HCPE), HCIGs and HWBs to develop a first set of priorities to be agreed by the System Executive Group (SEG). Work continued to develop the support networks in place to deliver the priorities, which included the development of a community health worker model. CB highlighted that the model would support recruitment from local communities and would be led by VCSE organisations. CB explained that the model had been used in other ICSs and had been successful. A pilot run by the AHSN in the Weston Locality would provide valuable learning for the system. SD welcomed the ICB/ICP Partnership work and supported the change to the ICB Board cover paper to consider strategic investment principles. SD explained that the priorities had been presented to SEG and the system Chief Executives had agreed that the priorities needed further discussion to consider the contribution for each organisation for each priority as well as how the HCIGs would contribute. SD noted the importance that the nine commitments were communicated and socialised into each organisation so the system understood the priorities. Jo Walker (JW) cautioned that often the priorities were outlined as medical and it was important that these were emphasised as about impact for the population, which priorities would have the biggest impact for the population rather than purely health outcomes. JW noted that the considerations needed to be system wide as well as targeted for communities. DP noted that although the ICB Board would be targeting some priorities first, it was important to recognise that work was still ongoing to improve outcomes relating to the remaining priorities. DP highlighted how important locality working would be and encouraged the models and priorities to be explained to the localities. The outcomes and lessons learnt from the Weston model would need to be shared with all the localities who were best placed to model the impact on their own communities. DJ noted that the next step was to engage with the localities as the expectation was that the model of care would be developed in collaboration with Locality Partnerships. VM noted that the process did not include engagement with communities once the priorities had been agreed and asked that this be considered. **The ICB Board, subject to the feedback provided:**	

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	• **Approved the approach set out in Section 2 of the paper to develop an agreed set of roles and responsibilities with the Integrated Care Partnership** • **Adopted as a first set of principles the investment approach described in Section 3 and Appendix 2 of the paper – to be refined in practice** • **Approved the amendment of the ICB Board's covering paper template to ask each author to explain how their proposal relates to the Board's Strategic Investment Principles** • **Approved the development of the system's first round of strategic priorities using the approach laid in Section 4, to be implemented through the new system architecture and monitored through the Strategic Delivery Dashboard** • **Noted the work to develop a proposal regarding a VCSE led Community Health Worker programme across BNSSG**	
7.1	**Outcomes, Performance and Quality Committee** ED confirmed that the OPQ Committee had discussed the winter plan, the LMNS, cancer performance and the Getting it Right First Time (GIRFT) programme. The Committee had reviewed the winter plan and national submission and had provided significant check and challenge. The Committee agreed that the plans were robust and were assured that ongoing review would take place by JM and RS, who would provide a written submission to the Committee throughout winter. The Committee agreed that this had been an excellent example of system working with the Trusts, Sirona, Local Authorities and the ICB working closely to develop the plans. It had been noted that the ICB developed three documents, the winter narrative template, an operational plan, and a breakdown of investments. NHS England had rated the plans green and amber, and they compared favourably to other systems. ED noted that areas of focus reported had been transfer of care hubs, NHS at home and the urgent community response. Executive leads would keep oversight of these areas. ED noted that workforce and recruitment challenges had been raised throughout the meeting. ED highlighted that although the Committee provided oversight of cancer performance this was also scrutinised by NHS England and the Trust Boards and so the role of the OPQ Committee was to ensure that the actions and processes in place were effective in improving performance. ED noted that information regarding dermatology performance had been received and this was likely to improve following transfer of referrals. NHS England had indicated no concerns with the grip and performance within BNSSG. JM highlighted a positive meeting with the national GIRFT team where the ask was to increase pace and productivity. It was noted that moving the simpler procedures to the independent sector may have a negative effect on junior doctor training as there was a requirement to include lower complexity procedures within their	

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	portfolios. Patient Initiated Follow Ups (PIFU) was noted as another area of focus to decrease demand and give patients control of their care. JM confirmed that the actions and feedback from the meeting would be followed through the Elective Care Recovery Operational Delivery Group. JM confirmed a monthly Mortality Review Group had been set up as there were 7% more deaths than predicted for BNSSG and Bristol had the highest rate of preventable deaths in England. The Group was reviewing BNSSG data and identifying patterns. The Medical Examiner for the system attended the Group to discuss themes arising from death certificates and discussions with families and clinicians. A deep dive into cirrhosis of the liver took place as the Group had identified a young age for death for this condition. The reports would continue to be presented at the OPQ Committee, but JM noted that once recommendations for actions and improvements had been identified a summary paper would be presented to the ICB Board. JM noted that the OPQ Committee had received a presentation from Sirona about virtual wards who had shared their frustrations with the lack of a shared care record. A summary has been produced outlining the concerns around a shared care record and JM as Caldicott Guardian (CD) and DES as the Senior Information Responsible Officer (SIRO) were linking with system CDs and SIROs to unblock the issues as the lack of shared care record was negatively impacting productivity. JM clarified that the current shared care was read only and it was important that clinicians could update with actions taken. DES confirmed that system wide sessions had been arranged and with the support of legal advisors, data sharing agreements would be developed. These would be aligned with the shared data and planning platform. JM noted that the issues were difficult to resolve as patient confidentially was a critical aspect of service delivery and so it was important to take the time to get it right. JM highlighted dermatology activity and explained that during the pandemic UHBW had provided some mutual aid to Somerset by receiving some of their dermatology referrals. NHS England requested the activity was repatriated, as the performance in Somerset was better than that of NBT and UHBW. JM noted that although the referral of patients back to Somerset had been completed, there would be residual impact for the BNSSG system which the local system was working through. JM noted the complexity of dermatology and confirmed a workshop had been planned to review the increase in demand which was related to the aging population of BNSSG. The workshop would provide clarity on the preferred clinical option after which the diagnostic approach could be considered. ED noted that the OPQ Committee had also discussed the need for cultural change throughout the system to support the Hospital at Home programme and the electronic patient record. ED asked the ICB Board to consider whether there was	

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	anything related to workforce and recruitment that needed system support. RS explained the Workforce Board reviewed the workforce numbers and noted the importance that workforce was considered as part of the planning cycle and that the workforce implications of the system plan was understood. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	
7.2	**People Committee** JCh confirmed that the ICB People Committee had received an update from the Staff Partnership Forum and had discussed the inclusion council, the workforce dashboard and the ICB People Plan. The People Plan would need to be updated to align with the operating model being designed and would be refreshed ready for implementation in April 2024. The People Committee had reviewed the Equality, Diversity and Inclusion Annual Report for the ICB and ICS. The Committee also reviewed the ICB focused report with the ICS focused report being presented at the November meeting. The workforce position had been received, and this had remained stable but there had been positive improvements in the areas of recruitment and turnover. Since March 2023 the workforce had increased, and this was due to the growth in clinical support roles. The international recruitment plan was noted as strong and being delivered. JCh highlighted that sickness rates had increased with 23% of the absence attributed to mental health and this had been identified as an area of focus. Vacancies had decreased and although agency remained overspent this was as per plan. Planning for a reduction in temporary and agency staffing for 2024/25 was underway. JCh noted the importance that the People Committee received the detailed data as there were some areas where workforce was impacting specific services. RS explained a session funded by NHS England had been well attended by nurses across the system. The session had focused on internationally recruited nurses and the importance that they were welcomed to stay and thrive. JCh noted the importance that recruited nurses were able to embed into services and positively impact productivity. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** SW explained that the Finance, Estates and Digital (FED) Committee had started to see the system working more effectively and collaboratively to solve problems. The Committee had a deep dive programme for organisations and at the last meeting Sirona had informed the Committee of current programmes of work and where the pressures and opportunities were.	

	Item	Action
	SW highlighted the financial pressures related to industrial action and the lack of clarity on whether these costs would represent an additional financial pressure. The ICB has discussed the system financial pressures with individual organisations to identify whether there were any additional savings which could support the system position. The Committee had discussed how the financial position was affecting the system's ability to undertake the work around reducing health inequalities and this was noted as an issue for the local authorities as well as the health system. SW highlighted the excellent collaborative work across the system to support new services and service plans had been reviewed and approved by the FED Committee. Sarah Truelove (ST) explained that the system was off plan by £18.3m at month 6, £13.6m of this was the impact of the industrial action. The ICB was waiting for a national response to understand the full impact of the £13.6m in the financial position. The focus was on the other variances and ensuring these were mitigated. ST confirmed that these included under delivery of saving plans, temporary staffing, primary care prescribing and funded care placements. The ICB was working with individual organisations to understand the challenges to delivery of the plans. ST noted that the consequence of non-delivery was significant this year due to the potential write-off of the brought forward debt and so the focus was on successful delivery of the medium term financial plan. Emma Wood (EW) acknowledged that UHBW was off plan explaining that this was due to industrial action, elective services, and recovery processes. EW confirmed that delivering the plan was the focus of the UHBW Board who had identified the divisions who were the furthest off plan. JF noted that there had been a discussion at FED Committee about the cultural change within divisions following the pandemic and the funding that had been available. The Committee had noted the importance of applying a forensic view to the finances to support plan delivery since there was now no additional funding available. Maria Kane (MK) noted that peer review between the Acute Trusts would be taking place to share learning and discussions were being held between Chief Nurse Officers and Chief Medical Officers around management of clinical spend. MK noted work continued to review Corporate Services which could be accelerated and which may provide an in year impact. JCh asked whether the estates review would provide any additional assets to support the position. ST noted that there was significant piece of work ongoing to develop an Infrastructure Strategy across the system which would provide clarity on the challenges and opportunities regarding estate. ST noted that this was unlikely to provide any assets to support the position.	

	Item	Action
	DES confirmed that the Shared Care Record was out for advert and the Full Business Case would be presented to the FED Committee and then ICB Board. DES noted that although the advert was on a like for like basis, it included an element to understand how next steps could be developed. DES noted that the system had been successful in securing £650k in digitisation funds which were prioritised for AWP and Sirona to ensure that functionality was right for clinicians. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
7.4	**Primary Care Committee** No update this month	
7.5	**Audit and Risk Committee** No update this month	
8	**BNSSG Integrated Care Partnership Updates** JF confirmed that the ICP Board meeting minutes would be provided to the ICB Board in the future. JF emphasised the importance of the ICB/ICP Board development session and asked members to prioritise attendance. JF noted the future change in Chair for the ICP Board, Councillor Helen Holland would be standing down and handing the Chair to a representative from South Gloucestershire. **The ICB Board received the update**	
9	**Questions from Members of the Public** There were no questions.	
10	**Any Other Business** There was none.	
	Date of Next Meeting 7th December 2023 *(post meeting update) To be held via Microsoft Teams*	

Lucy Powell, Corporate Support Officer, November 2023