NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG Integrated Care Board (ICB) Board Meeting (Open Session)

Minutes of the meeting held on 2nd May 2024, at the University West of England, Enterprise Park 1, Lecture Theatre, Long Down Avenue, Stoke Gifford, BS34 8QZ

DRAFT Minutes

Present		
Alison Moon	Deputy Chair of the ICB Board and Non-Executive Member – Primary Care (Chair)	AM
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
John Martin	Chief Executive, South Western Ambulance Services NHS Foundation Trust	JMa
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JMe
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
Stuart Walker	Interim Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust	SWa
Steven West	Non-Executive Member – Finance, Estates and Digital	SWe
Apologies		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Jon Hayes	Chair of the GP Collaborative Board	JH
Maria Kane	Chief Executive Officer, North Bristol NHS Trust	MK
Stephen Peacock	Chief Executive Officer, Bristol City Council	SPe
In Attendance		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Mark Cooke	Director of Strategy and Transformation, NHS England	MC
Steve Curry	Chief Operating Officer, North Bristol Trust	SC

Loran Davison	Team Administrator, Corporate Services, BNSSG ICB	LD
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Hugh Evans	Executive Director, Adults and Communities Directorate, Bristol City Council	HE
Aishah Farooq	Associate Non-Executive Member	AF
Helen Gilbert	Director of Improvement, North Bristol Trust	HG
Chris Head	VCSE Alliance Representative	CH
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
Ruth Hughes	Chief Executive Officer, One Care	RHu
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Lucy Powell	Corporate Support Officer, BNSSG ICB	LP
Layla Toomer	Patient Safety Lead Maternity and Neonatology, BNSSG ICB	LT

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed all to the meeting and the above apologies were noted. Steve Curry (SC) was welcomed as deputy for Maria Kane (MK) and Hugh Evans (HE) was welcomed as deputy for Stephen Peacock (SPe). AM explained that she would Chair the meeting in Jeff Farrar's absence.	
2	**Declarations of Interest** No new interests were declared and there were no interests pertinent to the agenda.	
3	**Minutes of the 7th March 2024 ICB Board Meeting** The minutes were agreed as a correct	
4	**Actions arising from previous meetings and matters arising** All due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items within the report: • ICB Organisational Structures • General Practice Risk • The Future of Locality Partnerships **ICB Organisational Structures** SD confirmed the Shaping our Future programme had concluded. The programme had been developed to reduce running costs and define the function of the ICB. SD explained that an all-staff event had been arranged for the 15th May 2024 to present the new operating model and role of the ICB to staff. It was expected that the event would provide the impetus to bounce forward into the new organisational needs. SD acknowledged this had not been an easy process for staff and many had been in uncertain positions but this had stabilised with the conclusion of the programme. **General Practice Risk** SD confirmed a letter had been received from the Chair of the British Medical Association (BMA) notifying of the risk of industrial action within primary care. The	

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	letter outlined the current challenges and concerns of GPs. The ICB needed to consider what the Integrated Care System (ICS) needed to put in place to keep patients safe should industrial action be taken. The ICB was considering what learning was applicable from the acute sector industrial action and the ICB Primary Care Committee (PCC) would review mitigating actions. **The Future of Locality Partnerships** The ICB was reviewing locality partnerships with the Integrated Care Partnership (ICP) and feedback continued to be received. The ICP had commissioned a review and there were a number of key groups who needed to consider the draft proposals before the ICP agreed that the proposals were the right approach for localities. AM confirmed that PCC had discussed the potential issues arising from primary care industrial action and David Jarrett (DJ) and his team were reviewing the emerging risk profile. Ellen Donovan (ED) recognised the hard work of staff as part of the Shaping our Future programme and explained that the work had been exceptionally well managed with good engagement with staff. ED asked for more information regarding the Locality Director appointments. SD explained that these posts had been recruited and the review was determining what next for locality partnerships. Stuart Walker (SWa) reported that the trainee doctor dispute remained and the dispute with Speciality and Associate Specialist (SAS) doctors was unresolved and so preparatory work for further industrial action was taking place within the acute sector. SWa noted the importance that actions taken were aligned across the different professions as sequential action was likely. SD confirmed that the ICB Emergency Preparedness, Resilience and Response (EPRR) team were considering plans for industrial action applicable to any group. DJ highlighted that at PCC the Non-Execs from other organisations had provided valuable feedback on the significant consequences for their organisations should primary care take industrial action. DJ explained that all the learning from previous action would be considered and the ICB would work with partners to understand the consequences. **The ICB Board received and discussed the report**	
6.1	**Local Maternity and Neonatal System (LMNS) update** Layla Toomer (LT) was welcomed to the meeting to provide the update. LT explained that the LMNS was made up of the various system partners involved in maternity and neonatal care. LT noted that an update had been presented last year which highlighted the changes to strategy and monitoring. LT reported that both BNSSG maternity units had been inspected by CQC and both received good ratings. LT noted that North Bristol Trust (NBT) had increased the safety rating from requires improvement to good and was only one of five Trusts nationally to achieve this.	

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	A new version of Saving Babies Lives guidance had been released last year with the challenge to achieve 70% compliance before the end of the 2024/25. The BNSSG system had achieved 80% compliance and continued to make good progress. A version 4 was not expected this year and so the system would continue to embed the work outlined in version 3. Both NBT and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) had achieved all ten safety actions and were fully compliant with the recommendations outlined in the Year 5 Maternity Incentive Scheme. The Year 6 Maternity Incentive Scheme has been released alongside an implementation tool to support Trusts with providing evidence. The LMNS would review the evidence for submission. LT reported that the BNSSG system had been chosen to be part of the Race and Health Observatory Action Network with the project to reduce health inequalities for black and Asian mums and babies. This was a 15 month project with the focus on pre term births and intervention differences between white and other populations. The Maternity and Neonatal Equity and Equality action plan had been published on the ICB's website. The current priorities were working towards the objectives set out in the 3 year delivery plan and the Year 6 Maternity Incentive Scheme and continuing the progress against the Saving Babies Lives recommendations. Work would continue on the Equity and Equality action plan as well as support education into midwifery and apprenticeships. Both Trusts were undertaking work to identify where there were inequalities in care. AM asked SWa and SC to pass on the ICB Boards congratulations to the maternity services for their regulatory ratings. Rosi Shepherd (RS) explained that the ICB was working closely with Health Innovation West of England on Black Mothers Matter and suggested that the evaluation work and the work in collaboration was presented to a future seminar session. Jaya Chakrabarti (JCh) congratulated the teams' ability to maintain the standards and consider the future of services. JCh asked whether there were any concerns regarding the continued improvement work and resource availability. RS noted that birth rates had reduced but this had been offset by complexity and explained that the BNSSG maternity units were tertiary providers for mums and babies with special needs. RS noted that the volumes of activity and outcomes prediction modelling needed to be improved for maternity services.	

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	John Cappock (JCa) welcomed the assurance parents would receive from the compliance rates and also welcomed the use of apprenticeships. JCa noted the perinatal insights visits and asked how the outcomes of the visits could be fed back to higher education. RS explained that there was an annual cycle of visits to support contact with the clinical workforce, RS agreed that this information would be useful data for higher education. Chris Head (CH) explained that there was currently a gap in mental health services following the closure of voluntary services which supported those with antenatal depression. RS explained that the ICB commissioned partnership services between the Trusts and Avon and Wiltshire Mental Health Partnership Trust (AWP). LT explained that there was work ongoing through the ICB contracts team and perinatal mental health services to identify where Voluntary, Community and Social Enterprise (VCSE) groups could fill any gaps in provision. Steve West (SWe) praised the collaboration work and noted that engagement with various groups and local communities would support delivery of good services. SWe highlighted the opportunities of drawing expertise from across the system in implementing the three national programmes of work. Aishah Farooq (AF) highlighted the Race and Health Observatory Action Network project and noted that the long term outcome realisation would take longer than 15 months and asked if the teams could continue the project after 15 months in addition to their roles and other commitments. RS noted that the programme was supportive and would continue, and there were short term outcomes to measure. LT explained that the other systems were focused on other areas such as diabetes and the systems met monthly to share learning. This sharing would continue so all nine systems would benefit from the outcomes from all the projects. RS thanked NBT and UHBW for the work in delivering services, being innovative and targeting areas for improvement. RS noted the importance of the Equity and Equality action plan which outlined details on supporting mums whose first language was not English, which was an area which needed improvement. RS explained that these conversations needed to be wider across the system and RS would support and encourage these discussions. **The ICB Board noted the reports including any risks, mitigating actions and responsibilities as appropriate**	
6.2	**NHS Impact** The ICB Board welcomed Helen Gilbert (HG) to the meeting. Deborah El-Sayed (DES) outlined the system belief that improvement was a science and all organisations needed to continuously drive the improvement approach and embed this into the culture of the system. DES noted the importance that national and local policy aligned with local ambition and this led to the development of the NHS	

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	IMPACT approach. NHS England reviewed the improvement needs across the NHS and locally the BNSSG system had reviewed how the improvement approach could improve care for people. The paper outlined a robust proposal on implementing an approach to support capacity to embed improvement. DES explained that the NHS IMPACT programme outlined a set of principles and several methodologies. DES noted that although health and social care worked in different ways and had different priorities, there were ways to support the use of the same improvement tools and improvement leaders and directors were reviewing how to align the principles for delivering improvement across the system. HG explained that part of the work was understanding the culture of an organisation and implementing toolkit training to support staff. The approach was about learning and the focus was on what can you learn about the organisations culture. DES highlighted the importance that organisational leaders advocated the approach. HG noted that the process would support the design of services and put in place principles to understand what good looked like, rather than make assumptions. The approach took all the data available to generate ideas and support the capacity of staff in transforming services. It was expected that the approach would work across the system partners although DES explained that engagement had not taken place with South Western Ambulance Service NHS Foundation Trust (SWAST) or the VCSE sector and this would be planned following approval of the approach. DES noted that the Shaping our Future programme highlighted that the ICB needed an aligned approach to drive efficiency on transformation and explained that the three horizons model had been considered, with the ICB currently in the second space and thinking about how to practically start the work needed. AM noted the NHS focus and explained that the system could be not defined through only the health lens. DES explained that the system had reviewed the NHS England IMPACT policy guidance and shifted the wording from patients to people. There was a focus on ensuring that the improvement principles worked for all system partners and provided connections. HG noted that the principles were effectively a maturity matrix assessment to support development of this type of approach in organisations. SC explained that the South West representative for NHS IMPACT had approved the BNSSG approach and the system expected that the principles would apply to any setting and provide a standardised approach for the system. Ruth Hughes (RHu) was supportive of the approach particularly the considerations around common language and the interface between organisations. CH noted the peloton training which had taken place and explained that every organisation being engaged in development of system processes had significant benefit and it was important that this engagement approach was sustained.	

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	Jo Hicks (JHi) explained that the work would align with the BNSSG People and Culture plan which was set in the wider system context. The plan outlined upskilling staff and how to develop other programmes of work to support the cultural change. DES noted that nationally improvement training needed to be highlighted, JHi agreed and explained that improvement training would be part of induction in the future. Vicky Marriott (VM) highlighted that the principles outlined the elements to ensure the programme succeeded and noted that coproduction was an important enabler and the more engagement undertaken during service design and decision making the more robust services would be. VM welcomed the scientific approach to develop a mechanism which supported the whole system. Jo Medhurst (JM) asked the system to consider what change was wanted and which improvement approach would be required to develop and drive the cultural shift required. The system should celebrate both successes and failures and JM asked the members to consider what this looked like at an ICB Board and system level. Celebration of pan system improvement could be considered as an annual ICB Board seminar session. JM highlighted the importance that the system made a tangible commitment to improvement so that staff felt able to consider improvements without fearing failure. DES agreed and noted that trust was a significant factor and it was important that the system asked staff what ICB Board support would look like to them. SWe noted that investing in the programme would improve effectiveness and efficiency which supported delivery of the core objectives of the system. SWe explained that shared system learning was integral to the programme and would support efficiency and quality improvements across organisations. Sue Porto (SPo) welcomed the approach and asked that the programme develop a transformation map and change load to consider the amount of improvement activities the current system capacity could manage. SPo also asked for consideration of the interconnectedness between organisations and how that mapped with the current medium and long term investment. DES welcomed adding those considerations into the scope of the programme. HG agreed and noted that it was often easy to make a decision but it was important that the consequences for other organisations was considered within this. HG explained that the principle element of the programme was focusing on less to embed a good environment of improvement within the system. Dave Perry (DP) explained that Local Authorities had improvement frameworks in place. These frameworks had created capability, skills and resource and embedded the underlying principles with staff. DP noted that it was important that linking this work across sectors added value.	

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	ED outlined the continuous change journey the ICB had been on since July 2022 and asked whether staff would be tired of change and suggested that any work was kept simple. ED also asked how the patients within the system would recognise tangible benefits of the approach. DES highlighted the importance that any work was undertaken as a system and that the improvement methodology was robustly considered and improvement science applied. This approach was an opportunity to invest in a change initiative where the benefit was expected to be system wide in terms of improving quality and efficiency. DES noted that the NHS improvement leaders would use the programme to work closer together and avoid duplication with the main principle being what are the commonalities and how these are shaped. HG expected that there would be a genuine impact on patients with possible reductions in waiting times. HG explained that progress would be little and often and improve efficiencies in chunks of time each time. HG noted that one of the barriers to improvement was language and the maturity matrix supported focus on the five critical components which were around embedding the principles and investing in people. HG outlined that this meant being open about how improvement may lead to failure and should still be celebrated. DES noted that improvement in access to service would support reduction in healthcare inequalities. It was important that the core aims of the ICB and ICS were considered as part of improvement conversations. SD noted that NHS IMPACT had been discussed at the recent meeting of NHS Chief Executives. SD noted the importance that what the system wanted from the programme was considered as well as how any changes would make a difference for and support front line staff. AM summarised that there was ICB Board support to develop a strategic approach and that the discussion had raised several items for consideration. It was agreed that an update would be provided at the September ICB Board meeting. **The ICB Board approved a mandate for work to develop a strategic approach to Improvement**	
7.1	**Outcomes, Performance and Quality (OPQ) Committee** ED highlighted the items which had been discussed at the last Committee meeting. These included safeguarding, No Criteria to Reside (NCTR), mortality reporting, annual reporting, segmentation performance, and the Getting it Right First Time (GIRFT) programme. There had been good discussion and good contribution from all members. The Committee had discussed the Safeguarding Internal Audit report which had received partial assurance. The recommendations would be shared with ICB Executives and the wider system for action. It was noted that the report had been presented to and reviewed by the Audit and Risk Committee and that the actions resulting from the audit would need to be reviewed by the OPQ Committee regularly.	

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	ED reported that NCTR was the biggest challenge for the system and work continued between the ICB and Sirona. Three priority areas had been identified, admission avoidance, Transfer of Care Hubs and Technology Enabled Care, and reduction in community length of stay. DJ explained that the improvement plans for A&E standards were linked to NCTR and the approach was to set clear ambitions for reductions in NCTR and bed occupancy with the expectation that the regional average reduction was 15%. The ICB and Sirona were assessing the impact of the current plans and reviewing what needed to happen to achieve the trajectories. The teams were reviewing the discharge processes across the whole system and Better Care Fund Support had been helping with capacity and demand modelling. The system was focused on the Home First concept rather than solely focused on discharge pathways. SPo reported on an event with partners where organisations had considered what work could be undertaken effectively as a system to improve the NCTR position. The aim was to shift resources and discharge people as quickly as possible and SPo explained that not all patients would be discharged to community pathways. Sirona was reviewing how to extend work to understand the capacity available to move people from a community bed to home and reduce the length of stay within a community setting. ED confirmed that NCTR would be a focus for the OPQ Committee in June. The BNSSG system reported 73% achievement against the 4hour Emergency Department standard of 76%. This represented a significant achievement for the system and work continued to achieve the 78% target by March 2025. Elective care performance had improved throughout 2023/24. Both NBT and UHBW had zero 104week waiters and a small number of 78 week waiters in known specialities. Cancer performance remained high. ED provided an update on segmentation noting that a new system would be implemented soon. The system was aiming to be in Segment 2 for performance within cancer and elective services. Children and young people's access to mental health services remained a challenge as was access to learning disability and autism services. Actions were in place to improve the performance in these areas. RS highlighted the recent system quality group meeting regarding sepsis following national concerns related to treatment and care. Martha's Law, which provided families with a second opinion when concerns were raised, now applied to NHS providers and work continued to implement this. The plans were being jointly evaluated to understand what these meant for other areas of the system. SWa confirmed that UHBW welcomed Martha's Law and had progressed in the delivery of this in the Children's Hospital outreach team to provide the opportunities for a second opinion. UHBW was more advanced in this area than other Childrens Hospitals. It was noted that the process would be different for adult services and UHBW had submitted a national bid to be a pilot site for Martha's Law. RS highlighted the high level of coproduction with families in developing the plans. SC	

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	explained that this work was moving at pace within NBT alongside work regarding processes when patients start to deteriorate. JM highlighted the annual mortality report which had been presented to the OPQ Committee. This report indicated that excess mortality was above average for BNSSG and had been getting worse. Reducing Cardiovascular Disease (CVD) was a priority for the system and this included significant hypertension screening work ongoing in primary care, voluntary organisations and pharmacies. JM outlined the differences in outcomes related to liver disease and highlighted that those in the most deprived areas of BNSSG were likely to die 16 years earlier from liver disease than those in more affluent areas. This was significantly worse than the national average. The system was working to understand where this was an issue and target prevention support in the right places. A local mortality dashboard would be developed which would be easier for the system to access. SC thanked DJ for his work leading the work around NCTR. A 15% decrease was noted as an ambitious target but the work being undertaken to understand the position was encouraging. SC noted the importance that a holistic view was taken to understand the issues from across the system as one organisation alone could not solve the problems. DP noted the children in care section of the report highlighted concerns around access to dentistry for children in care and care leavers and welcomed the focused work to address this. DP welcomed local authority engagement with the ICB to solve the issues. ED reported that the OPQ Committee had approved the EPRR Policy which had been provided to the ICB Board for information. **The ICB Board received the update from the Outcomes, Performance and Quality Committee and noted the reports including any risk, mitigating actions and responsibilities as appropriate**	
7.2	**People Committee** JCh reported that there had been some challenge around attendance at the People Committee and the Terms of Reference would be amended to support attendance. The ICS and ICB People Committees had reviewed very robust pieces of work around staff which were critical to the success of the core objectives of the system. The People Committees supported connections between the ICB and the ICS. The Committees had reviewed the People Survey results and monitored the key workforce metrics monthly. Month 11 had been positive in terms of turnover and the work to reduce agency spend continued at pace. The People Committee had received an action to expand the social care workforce data available to the Committee and this was in train. Productivity remained a focus and the Committee had received an update on the work of the People and Culture Plan Task and Finish	

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	Groups. NHS England were set to cap the agency spend from 1st July 2024, and the nursing rate card for BNSSG was already in place. JHi noted that the Sexual Safety in Healthcare Charter had been due to come to the ICB Board, but this would be more appropriate for the People Committee and this would be presented to the Committee in due course. **The ICB Board received the update from the People Committees**	
7.3	**Finance, Estates and Digital Committee** SWe provided an update from the Finance, Estates and Digital (FED) Committee. The procurement policy had been reviewed by the Committee and was being presented to the ICB Board to note. SWe reported that the system had delivered a balanced budget for 2023/24 and had been able to write off the historic debt although this position had been supported by utilising non recurrent funding. SWe explained the importance that the system now looked at moving to a sustainable position. SWe thanked everyone in the system for achieving the breakeven position. SWe confirmed that the BNSSG ICB Annual Report was work in progress and teams were working through the challenges to produce an Operational Plan to submit to NHS England. SWe explained that the Plan had been developed with some unmitigated risks and continued savings plans would be required. 2024/25 would be a significantly challenging year financially and the savings built into the Operational Plan would be monitored and actions taken to ensure the system remained on track. SWe explained that an enabler of the Operational Plan was good identification of data and digital systems and increased connectivity to support the system access to the data needed to inform data science and analytics to review the right areas. This would support clinical colleagues to support people. Professor Phil Clatworthy Chaired the Clinical Informatics Cabinet which provided clinical input to shape the local digital infrastructure. SWe explained that an identified area of concern within the Operational Plan was funded care and the FED Committee had undertaken a deep dive into funded care. The ICB was considering how this could be managed in a different way to reduce costs. Sarah Truelove (ST) highlighted the procurement policy and explained that this reviewed policy reflected the new legislative changes and had been approved by the FED Committee. ST explained that the ICB Infrastructure Strategy continued to be developed and this would be presented to the ICB Board following FED Committee review. JCh noted that the Procurement Policy did not mention slavery within the supply chain and asked what measures the ICB was taking to ensure that suppliers undertook due diligence in this area. ST agreed to provide an update as part of the	**ST**

	Item	Action
	action log. CH outlined the opportunity within the policy for the ICB to strengthen and invest in economic growth and social value. ST confirmed that those discussions were in place within the ICB and CH noted that the community mental health partnership was the area driving those discussions in the community. SWa highlighted the significant risk associated with the limits related to the Infrastructure Strategy and noted the need for the foundation and basics of digital infrastructure to be in place to support organisations. SWa explained that the Capital Departmental Expenditure Limit (CDEL) was a significant constraint on decision making. ST explained that the Infrastructure Strategy considered estates, digital and workforce and using these areas to inform the spending review and to fully understand the priorities for the system and how these would drive forward the services the system is able to deliver. SWe highlighted the significant financial challenge for 2024/25 and noted that the ability to invest to save was limited this year. SD asked whether the efficiencies savings for CDEL would be lifted and ST explained that this would be considered as part of the next comprehensive spend review but not during this financial year. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
7.4	**Primary Care Committee** AM highlighted the emerging maturity of relationships with Local Medical, Optical, Dental and Pharmaceutical Committee members who engaged with the PCC to discuss the significant challenges within primary care. AM confirmed that the Committee had discussed the emerging risk of primary medical services industrial action and explained that SD had covered this in his Chief Executive report. AM noted that following the development of the ICB Dental Strategy, the ICB was developing Pharmacy and Optometry Strategies. The PCC had received a presentation on the primary medical services dashboard maintained by the ICB. AM explained that practices were able to view their data but not all practices were sharing data. AM noted that being able to compare data with other practices was a benefit for GP practices and the ICB would encourage practices to share data and provide the support required to enable this. AM highlighted the risk related to the capacity of the Dental Commissioning Hub and its ability to support the ICB ambitions for dentistry. Resource was needed to implement the plans and this may not be available from the Commissioning Hub. DJ explained that BNSSG ICB was working with Somerset ICB as the host ICB on supporting the Hub and focusing on the priority areas as agreed by the Southwest ICBs. RHu explained that the lack of data sharing may be due to technological limitations as some of the larger Primary Care Network (PCN) reports took longer to produce.	

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	Suggestions had been made to mitigate this and the teams were currently testing solutions. DES confirmed that the ICB was working through various concerns and issues and presenting solutions and explained that data sharing throughout the system was being considered as part of the Data Sharing Charter developed with the support of system Caldicott Guardians and Senior Information Risk Owners (SIROs). JM highlighted the expectation that primary care would share data but understood the responsibility of the system to provide assurance that data would be managed appropriately. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Audit and Risk Committee** JCa reported that at the February 2024 meeting, the Audit and Risk Committee had discussed digital delivery and the internal audit report for the Project Gateway which had been an advisory audit to support the development of the project. At its April meeting, the Committee had received a positive Draft Head of Internal Audit Opinion and received an update on the external audit of the annual accounts. The Committee had received the final internal audit reports for Safeguarding and Funded Care, both of which received partial assurance. JCa explained that the ICB had used the audit process to highlight and receive recommendations for areas which were known to need improvement. JCa welcomed this use of internal audit and congratulated the ICB on its mature approach to improvement. **The ICB Board received the update from the Audit and Risk Committee**	
8	**BNSSG Integrated Care Partnership Updates** SD provided an update noting that the ICP Board had discussed the Locality Partnership Review and the outcome of the ICB Board to ICP Board development session. Slides would be developed to reflect the discussion held at the development session and these would be presented to both Boards. The ICP Board would be part of the wider conversations related to system partners involvement in service strategy and the ICP Board had been excited to be part of those conversations to consider the system service requirements. SD confirmed that rotation of the Chair had moved from Bristol City Council to South Gloucestershire Council for the next meeting. CH noted that the ICP Board meeting had been good and added that the work was everyone's responsibility to support and maintain, and it was important that the right infrastructure was in place to support this. CH explained that the Partnership Manager had left and this was a concern as it may lead to a lack of connection. ST confirmed that Partnership Manager was now part of her role and it was helpful that the previous Partnership Manager remained within the system. **The ICB Board received the update from the Integrated Care Partnership Board**	

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9	**Questions from Members of the Public** A member of the public asked: 1. Is it intended that there will be a public AGM meeting of the BNSSG ICB in 2024, I know that there was not one in 2023. I am not sure if the ICS since it was formed, has held an open meeting, with questions from the floor. 2. Irrespective of whether a public meeting is held, would it be possible for the ICB to produce a summary report for general circulation (not exceeding) two or three pages, extracting information from the formal annual report covering such subjects as, total income from NHS England, how much money has been spent on its various activities and the performance against the government targets. In addition a formal statement on its achievements against its target to be carbon emission free by 2030. 3. I note in item 7.3 of the agenda there is a report to note the approval of the "procurement policy". In this policy in para 8.7. Greener NHS Delivering a "Net Zero" National Health Services, there is a requirement that the ICB will "Drive the supply chain to net zero" using the present ICB Green Plan as the basis to achieve this. I would be rather interested in how this will be done, as the plan as it is issued at the present, has not even yet made a formal statement on its present emissions. The member of the public added that it was perceived that ICB connection with the public was remote and a face to face AGM was a good way to involve the local population. They noted that a shortened version of the annual report was also a good way to connect with the public. They also congratulated ST and her team on achieving a balanced position to write off the historic debt. SD confirmed that there would be an AGM in 2024, and last year the ICB had summarised the 2022/23 annual report in both hard copy and online formats and the same approach would be taken for the 2023/24 annual report. SD noted that the system engagement was through specific activities as well as the Health Overview and Scrutiny Committees. SD highlighted that although few members of the public attended the ICB Board meetings, the ICB wanted to celebrate the previous year with an engaging AGM to be held in September. ST explained that reducing emissions was work in progress and all the actions had been set out in the Green Plan. The Green Plan Steering Group had made a commitment to train all procurement specialists in being able to evaluate and make informed decisions on carbon issues. SD confirmed that the Green Plan would be included in the AGM planning and ST confirmed that a letter would be sent to the member of the public with a fuller response.	**ST/SD**
10	**Any Other Business** There was none.	
11	**Date of Next Meeting** 4th July 2024, to be held via Microsoft Teams	

Lucy Powell, Corporate Support Officer, May 2024