BNSSG ICB Board Open Meeting

Minutes of the meeting held on 16th January 2025 at 9.30am held via Microsoft Teams

DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Hugh Evans	Director of Adult Services, Bristol City Council	HE
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	MK
Dr Jacob Lee	Chair of the GP Collaborative Board	JL
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JMe
Alison Moon	Non-Executive Member – Primary Care	AM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB *(Left at 10.30am)*	ST
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
John Cappock	Non-Executive Member – Audit	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Mark Cooke	Managing Director, NHSE South West	MC
Aishah Farooq	Associate Non-Executive Member	AF
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JMa
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Jo Walker	Chief Executive Officer, North Somerset Council	JW
In attendance		
Loran Carter	Team PA, Corporate Services, BNSSG ICB	LC
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES

Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
Samantha Hill	Senior People Business Partner, BNSSG ICB	SH
Ruth Hughes	Chief Executive Officer, One Care	RHu
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Fiona Mackintosh	VCSE Alliance Representative	FM
Denise Moorhouse	Deputy Chief Nurse, BNSSG ICB	DM
Lucy Powell	Corporate Support Officer, BNSSG ICB *minute taker*	LP
Richard Smale	Interim Director of System Coordination, NHS England South West *(Left at 10.30am)*	RSm
Neil Turney	Head of Mental Health and Learning Disabilities and Autism, BNSSG ICB	NT

	Item	Action
1	**Apologies** Jeff Farrar (JF) welcomed all to the meeting. Apologies were received from Healthwatch and the above apologies were noted. Denise Moorhouse (DM) was welcomed as deputy for Rosi Shepherd (RS). Richard Smale (RSm) was welcomed as deputy for Mark Cooke (MC).	
2	**Declarations of Interest** No new interests were declared and there were no interests pertinent to the agenda.	
3	**Minutes of the 3rd October 2024 ICB Board Meeting** The minutes of the 3rd October 2024 meeting were agreed as correct.	
4	**Actions arising from previous meetings and matters arising** The ICB Board reviewed the action log: **Action 87** - Deborah El-Sayed (DES) explained that feedback regarding the NHS App would be discussed with the national team later in January 2025. All other due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items within the report: • Reforming Elective Care for Patients • Developing a New Model for Community Health Services • System Planning 2025/26 **Reforming Elective Care for Patients** New guidance was released on the 6th January 2025 regarding the reform of elective care for patients. The guidance outlined the target of 92% of patients receiving treatment within 18 weeks by March 2029. The key areas of commitment included empowering patients, addressing health inequalities and reforming delivery. The report outlined the responsibilities of the ICB which included addressing health inequalities and patient awareness. SD noted the importance of utilising the NHS App which would support elective care. The	

system wide operational delivery group for elective care would be reviewing the work, and this would be presented to the ICB Board through performance reporting. The BNSSG system was in a positive position on referral to treatment time compared to other systems but not at the 92% target.

Developing a New Model for Community Health Services

SD explained that developing new models of care were linked to the three shifts within the 10 Year Strategy. For BNSSG the development of a new model of community health services was connected to the review of localities and the role of localities in the system. The ICB continued to work closely with the Local Authorities to develop the new model of health and social care which was based on the value of primary, community and multidisciplinary teams in the neighbourhood. SD noted that there would be questions around what the definition of a neighbourhood was. The creation of a new community model of locality-based neighbourhood health and social care would be a focus of the ICB during 2025/26.

SD noted the challenges facing the NHS over winter with 20 Trusts in critical incident last week. For BNSSG, there was considerable and consistent pressure on the system and on the 9th January 2025 a Gold meeting was convened and the local health partners discussed the actions needed, within the resource available, to alleviate the pressure on the system. The actions identified had been implemented.

Ellen Donovan (ED) welcomed the focus on reforming the model of community care and noted that with the locality partnership review, the system was in a good place to undertake this work. ED asked for an update on the Community Diagnostic Centres (CDCs) and how these were affecting elective targets.

Fiona Mackintosh (FM) confirmed that the Voluntary, Community and Social Enterprise (VCSE) sector was actively involved and engaged with the locality partnership review and development of community health.

Richard Smale (RSm) thanked the BNSSG system for their efforts over Christmas. RSm noted the importance that the BNSSG system and NHS England remained connected on the financial incentives related to elective performance. RSm also welcomed the opportunity to work with and support the ICB on developing what the community neighbourhood health model looked like.

Steve West (SW) noted the importance of the shifts in delivering what ICBs were developed to deliver particularly around addressing health inequalities. SW noted that reforming community healthcare would require investment and

suggested that the system start to consider how to utilise research funding to fund pilots.

Alison Moon (AM) noted the importance that the ICB Board understood the information it would be expected to review and see when outcomes were realised in relation to the reforms and targets. AM asked system leaders to consider and manage expectations.

SD noted the high performance for diagnostics as a system which was supported by the two CDCs. Maria Kane (MK) explained that the CDC's had delivered 28,000 extra appointments with 40,000 booked in totality. The CDCs were able to offer a full range of diagnostic tests in local communities and patient feedback has been incredibly positive. MK confirmed a surgical centre was due to open in May 2025 which would have four theatres, 11 medirooms, and 40 beds. This centre and the CDCs were additional capacity within the system to support elective care. Other work continued to support this area such as patient initiated follow ups and advice and guidance. MK acknowledged there was more to do and work was ongoing with the local universities. MK confirmed that for diagnostics North Bristol Trust (NBT) was one of the best in the country.

Alongside elective care, MK highlighted the increased pressure on emergency care and noted that both areas needed to be constantly monitored. MK thanked the ICB for its responsiveness during the recent pressures and noted that the additional input had relieved the pressure from the system of which flu and infection control measures had been significant factors.

SD highlighted that VCSE input into the reform plans was important and explained that he had fed back that VCSE organisations should be included in any national guidance relating to the community model reform. SD noted the importance of financial incentives to support elective care as it was known that 2025/26 would be a challenging year financially and the system wanted to increase elective care for the benefit of the population. SD agreed that the system should utilise research funding and outlined the excellent work of the research and development team in the ICB. SD noted that the system had not yet defined the work on health inequalities but there was ambition to push this further. SD noted that other systems were making innovative changes to their waiting list processes to enable equity of outcomes for patients, and this was something the local system needed to explore. JF noted that Health Inequalities should be the strand running through the Committees and to ensure this focus a new ICB Board Sub-Committee had been convened.

The ICB Board received and discussed the report

6.1	**Addressing Health Inequalities and update on delivery of Long Term Plan** Joanne Medhurst (JMe) provided the background explaining that in terms of health inequalities there were areas of excellent work across the system but no organised, systemic way to review this as a wider Integrated Care System (ICS). To support the core commitments to improve outcomes and health equity the Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee had been convened. The Committee was made up of a wide mix of people from across the system and would critically review health data and drive actions. The Committee would also consider whether actions were delivering the expected outcomes, and where there was under delivery, improvements would be recommended. Jeff Farrar was the Chair of the SHIPPH Committee. JMe noted that the seniority of Committee members was important as they could drive the decision making and commitment in this area from across the system. The Committee also included three public participants who were adding significant value and fresh insights into the discussions. The Committee had approved the long-term plan with a focus on cardiovascular disease (CVD) which was the greatest cause of mortality in the local population. There was a wide disparity in outcomes for those more and less privileged and the data indicatesd that improvements could be made in this space within three years. Diabetes and respiratory disease would be the next areas of focus. At the last meeting of the Committee, Tracie Jolliff, Chair of the Independent Advisory Group for Race Equity in Health and Care noticed the lack of comment about racial disparity and action was taken to address this. JF confirmed that the members of the Committee were encouraging an action-based approach on the priorities identified. SW welcomed the approach as focusing on preventative measures was a core responsibility of the ICB. SW highlighted the current financial challenge as headroom would be needed to work on the shifts identified for prevention and chronic disease monitoring. This was difficult financially when the shifts identified were to services that were currently running and needed funding. RSm noted that NHS England welcomed the focus of the Committee and the message that addressing health inequalities was everyone's responsibility. NHS England welcomed the references to alcohol and drug dependencies and healthy weight but noted that although Core20PLUS5 was implied, it was important that this work was explicitly included. JMe explained that the system had been chosen to undertake an evaluation of the Core20PLUS5 work which outlined five key areas with specific interventions and as the BNSSG system was fortunate to have excellent population health data, those considerations plus	

	additional had been identified within the SHIPPH work. JMe explained that the Core20PLUS5 work continued but the ICB was looking at more than those specific interventions outlined. JMe noted the importance that any work to address health inequalities or improve population health needed to be linked to the local data rather than nationally mandated. FM confirmed the VCSE sector welcomed what they could contribute through discussion and co-design of services. FM noted that the discussions around terminology and language had been really important and echoed earlier thoughts about the opportunities to undertake innovative work in this space through research projects. JMe explained that the Research Strategy had been reviewed to include focus on equity, health equity and inequalities. Dave Perry (DP) outlined the importance that this work was aligned with the Healthier Together 2040 work. Dr Jacob Lee (JL) highlighted the noted risk that it could be perceived that the Committee was responsible for delivering change when the most important element was embedding cultural change and principles so that the various groups in the system could deliver change. JL noted that many of the wider determinants of health were outside the remit of health services and therefore it was vitally important that social care was fully integrated with the work. JMe agreed and confirmed that the Directors of Public Health (DPH) were members of the Committee, and they worked closely with the Directors of Social Care. Hugh Evans (HE) confirmed he worked very closely with the DPH of Bristol City Council and was confident that the DPH's were representing social care effectively on the Committee. JMe noted that the Committee had highlighted the confusions in the system. Every organisation was undertaking work but there were questions around who led, who contributed and who advocated? The ICB was expected to drive the improvement of health inequalities and the Committee would support this work by reviewing data and driving actions. **The ICB Board:** • **Noted the proposed changes to the Scheme of Reservation and Delegation to formalise the Committee as a Sub-Committee of the ICB Board** • **Considered and approved the SHIPPH Committee Terms of Reference, which have now been finalised by the Committee** • **Noted that the ICB Board would receive regular updates from the Chair of the Committee**	

6.2	**Integrated Care System (ICS) Equality, Diversity and Inclusion Report** Jo Hicks (JH) confirmed the report had been reviewed by the People Committee and the changes to the reporting had been guided by Tracie Jolliff. The report outlined the Equality, Diversity and Inclusion (EDI) activity from 2023/24 and highlighted the actions which continued to be a focus. These actions were aligned to the strategic objectives, and the Core20PLUS5 work. The report integrated the workforce activity with staffing and health inequalities data. JH added that although there was no requirement to report on the ethnicity pay gap this data had been included in the report as there were areas which needed to be addressed. JH highlighted the work still do to around the gender and ethnicity pay gaps. There had been improvements but there remained issues around the male/female split and the higher proportion of racial minorities in lower to mid pay quartiles. There remained a gender issue around part time working and a similar concern around part time working between lower and higher bands. The report outlined the identified actions to improve these areas. JH highlighted that the data around bullying and harassment and staff training was included in the report. There had been some improvements in these areas, but more was needed. Work continued in the inclusive recruitment space to convert shortlisting to appointments. JH noted that there was also more work needed in the discipline and capability route as it remained more likely that racial minorities would be subject to these processes. This was mirrored in the disability data. Staff were underrepresented against community demographics and there was more work to do in this area as there was a strategic objective to align the workforce with population. JH noted that the improvement work identified required resource to manage and action and this was limited across system providers. The system had a highly active and engaged EDI group who were working hard to take forward the actions in the report. However, this was a small group and therefore there was a risk to how much could be completed in a year. JH thanked Samantha Hill (SH) and Calais Hutchins who had changed the way work was reported across both the ICB and ICS. JH reported that the EDI report had been externally reviewed and shared as an example of good practice. JF thanked JH, SH and the team for their work collating the report and explained that he had been asked to be the regional lead for EDI. JF noted that the BNSSG system organisations were varied in relation to staff and there was a lot of activity organisationally as well as system wide and it was important that the identified work was actioned by everyone in those organisations.	

	AM highlighted the variation in willingness to declare a disability and asked what needed to change about an organisations culture to ensure people felt comfortable declaring. What work was needed for people to feel safe to be themselves at work. AM noted the importance that the statistics around appointments and disciplinaries were improved. ED noted that although there was small resource centrally for the work, it was important that all staff recognised their role in improving experience. ED asked how the organisation was using the tools available within the development plans for senior and middle managers in the organisations. ED noted that there was lots of good practice elsewhere the ICS could replicate. FM noted the points made around changing cultures to improve reporting and highlighted that the there was little analysis available about the culture of the system which could at times feel hierarchical. A shift in this may build confidence for the workforce. FM noted that workforce was the greatest asset to the system and highlighted the work of Wellspring who had implemented asset based community recruitment which had removed some of the barriers of recruitment for the local population. Ruth Hughes (RHu) highlighted that general practice, and wider primary care was not well represented in the report which was likely a result of lack of data. RHu asked that more work was undertaken to consider how data about the primary care workforce could be collated as this was a significant area of the local health workforce. DES welcomed the benchmarking data which indicated where the system could share good practice. DES asked the system to consider what data was missing and offered the support of the System Intelligence team to develop a single dashboard for this data. DES asked whether the three identified areas of focus were the same areas the collective networks would prioritise. JH explained that the areas of focus would have been discussed with the networks and developed as an amalgamation of network priorities and system requirements. JH noted that there was ongoing work with the System Intelligence team to develop other dashboards which were currently higher priority but a single dashboard for the 2024/25 reporting would be welcomed. JH explained that the team had extrapolated as much information from primary care as possible but there was a requirement for enhanced data in this area and ongoing work was taking this into account. JH noted that in terms of culture, there were development programmes in place for line managers and support programmes for all staff but there was a disconnect between what was in place	

	and the experience of staff and improving this was work in progress. The idea of a cultural audit was good, and JH agreed to raise this at the EDI group as a focus on culture would see the report enhanced. SH added that the development plan was clear about the high impact actions that were a requirement of delivery. An NHS Employers focus was leadership and embedding this within the core objectives of leaders, and there was work to feed this into the extended leaderships across the system. SH noted that the work around culture fed into the People Promises across the system and the networks leads and EDI leads worked closely together and there was a system wide network which had fed into the work around recruitment by describing the recruitment challenges faced by people in the community. SW asked how the ICB worked with and tracked the progress in other organisations and joined up all the ongoing work and learnt from each other. JH confirmed that organisations were engaged and willing and the ICB had encouraged the system working to identify what was happening in each organisation. The work was varied but the BNSSG system had a good approach to learning from other systems and regions and implementing this work collaboratively. System learning was shared at the network meetings and good practice and implementation advice was reviewed and shared. JF asked how the system could receive more primary care data. JL noted that for most general practices had less than 250 employees and so it was not mandatory to report and therefore the data was not as robust. Primary Care was willing to review the data but would need support from the system to help with the resource required to do so. JL also noted the importance of monitoring the measures put in place and determining the outcomes needed for success. JF noted that there were national trajectories, but the true measure of success would be a positive experience for everyone working or hoping to work with the local NHS. SD explained that the role of the ICB was one of coordination and to enact change. The ICB Board could not performance manage each organisation and therefore the system Chief Executives and Boards would own this work for their organisations and the ICB Board needed to be assured that the work was happening. SD noted that it would be right to include the information from primary care and so there was consideration needed on how the system, One Care and the GP Collaborative Board (GPCB) worked together to support this. JH noted that through the People Committee, the system non-executive directors provided updates on their organisations in this space.	**JH**

	The ICB Board discussed the BNSSG ICS Workforce EDI Report 2023/24 and approved its publication	
6.3	**Intensive and Assertive Community Mental Health Services Review** David Jarrett (DJ) welcomed Neil Turney (NT) who was leading the review work to the meeting. The review had taken place last summer working closely with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, VCSE organisations, people with lived experience, local authorities and primary care. The review had been nationally mandated and enabled the ICB to identify and support improvements. The review outcomes and the progress had been shared with the Mental Health & Learning Disability and Autism Health and Care Improvement Group (MHLDA HCIG) and the outcomes of the review were identified as an area of focus for the ICB. NT provided the background to the review of the Intensive and Assertive Community Mental Health services particularly the opportunity to reflect on whether services effectively engaged those people who may disengage when they became unwell and potentially pose a risk to themselves or others. The two key purposes of the review were to ensure that services were meeting the needs of the local population and to support future NHS England policy and investment planning. It was a requirement for ICBs to discuss the review at a public Board meeting. The review was aimed at individuals who presented with psychosis who may struggle to use routine services and may be vulnerable to relapse. These individuals may also have social, housing or financial needs, self-neglect, and have drug or alcohol co-dependency. It was a group of individuals who may have had negative experiences of services previously and so the review had taken a very wide and collaborative approach in seeking views from all services who could work with these individuals. Areas of good practice were identified which included the early intervention service and the AWP Rose Recovery teams who were able to offer highly personalised support for people. The Links team brought together professionals from across services to support people who were homeless or at risk of homelessness. The Bristol City Council Changing Futures programme and the My Team Around Me approach were supporting people who experienced multiple disadvantages and in the VCSE sector St Mungo's were recognised for their approach to working with diverse communities in Bristol. The review found 11 areas of improvement and the themes and specific areas of improvement formed the action plan to ensure services can fully meet the needs of the local population and those individuals in scope for the review. AWP had convened a project group to start the work at pace and policy and guidance	

reviews had started. Work continued with VCSE organisations to discuss caseloads and the system intelligence teams would be prioritising a deep dive into Did Not Attend data and non-engagement analysis.

Feedback would be provided to NHS England on a 3, 6 and 12-month cycle. The work would be reviewed through the local system groups, the Mental Health Operational Delivery Group and the MHLDA HCIG as well as working with the AWP Enhanced Quality Oversight Group. The work would continue with the support from the system as well as those with lived experience. To support this work, NHS England were developing a peer learning approach and new national guidelines to inform consistent service models nationally.

Dominic Hardisty (DH) explained that over 20 years ago the NHS issued National Service Frameworks which standardised models of care and included the Assertive Outreach model to support these individuals in scope of the current review and prevent them from being a risk to themselves and others. DH highlighted that these models were superseded by the requirements for local decision making and therefore the models changed with AWP previously evolving 6 different models for each Clinical Commissioning Group. DH welcomed this review as an opportunity to evaluate existing models but noted the importance that NHS England was clear on whether the models needed to be developed locally using local insights or based on a national model. AWP were waiting for national guidance but also planning to set local strategy and undertake a gap analysis to assess risk if the national guidance was not received soon.

DES noted that the shared care record was an important element of the work and noted that although local data sets were mentioned in the paper, it would be worth ensuring that crisis plans were included on Connecting Care.

ED asked whether there were any immediate concerns raised in the review that needed immediate action.

AM welcomed the engagement and work which had gone into the review and asked for more information regarding the risks to delivering the improvements and whether the actions needed timescales added so that the system was clear on what was a short or long term action.

NT responded that the team would review the action plan to ensure that the digital elements were sufficiently covered. NT noted that the assurance documentation had a yes/no format and the ICB had answered no as there was only partial assurance that the services in the area were able to identify,

	maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up. There was no quick solution and the action plan outlined a range of improvement actions to be delivered as a system. NT highlighted that the BNSSG System had processes in place but there was more that could be done. DH confirmed that these were not new concerns as there have always been patients who presented with significant risks and the system undertook a risk based approach so risks were being minimised on a continuous basis but the ability to dynamically risk assess needed to improve. DJ explained that the next iteration of the action plan would include reflection of AM's comments about clear time frames and detailing the operational risks for each of the planned actions. ED noted the partial assurance and confirmation that many of the actions were not immediate and asked the ICB Board to consider whether there was a governance oversight gap. There had been discussion about the framework being presented to the Outcomes, Quality and Performance (OQP) Committee. DH welcomed as both Chief Executive of AWP, and Co-Chair of the MHLDA HCIG, involvement in the appropriate Committee to ensure the oversight was robust. DH confirmed that the systems across the South West had similar challenges, and work was taken place regionally to improve service models. DJ agreed with the suggestion to embed the OQP Committee as part of the governance processes. SW welcomed the review outcomes and noted that he would have been more concerned if the ICB had declared full assurance as there were so many variables to consider and only so many areas which could be fully controlled. SD noted that although not all risks had been mitigated, the ICB Board should be assured that the issue to solve was understood and assured that the action plan would provide improvements and mitigate risks. **The ICB Board noted the following:** • **BNSSG ICB, AWP and partners (including General Practice, VCSE, Local Authorities and Lived Experience) would continue to work together and oversee progress made against areas identified for improvement through our local action plan.** • **The action plan would be monitored through the BNSSG Community Mental Health Programme Board and BNSSG ICB OQP Committee. The Mental Health Operational Delivery Group (MH ODG) would oversee this work with support provided through the MHLDA HCIG.**	

	• **Updates would continue to be shared with the AWP Enhanced Quality Contract Oversight Group for alignment.** • **Continue to work in collaboration with BSW ICB and AWP on progress against trust wide improvements.** • **The communications team was engaged and would support messaging**	
6.4	**Scheme of Reservation and Delegation and Update on Constitution** SD explained that the Scheme of Reservation and Delegation (SoRD) had been reviewed and amended to include the creation of the SHIPPH Committee. The ICB Constitution had also been amended to reflect the Partner member numbers as MK, Joint Chief Executive of NBT and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) now represented both secondary and tertiary care on the ICB Board. With agreement by the Board, the Constitution would be sent to NHS England for approval. **The ICB Board:** • **Endorsed the revised Scheme of Reservation and Delegation to authorise the SHIPPH Committee as a formal committee of the ICB** • **Agreed the minor changes to the revised ICB Constitution which would be notified to NHS England for approval**	
6.5	**Corporate Risk Register** Rob Hayday (RHa) explained that the presented risk register had been reviewed by the Audit and Risk Committee in December. Six risks were recommended to be removed. These related to LeDeR completion, primary care prescribing, primary care, data coverage, transfer of costs from social care and non- clinical contracts. These risks had been mitigated sufficiently and would be managed within the ICB directorates. One new risk had been added to the register around completion compliance activities associated with the Oliver McGowan training programme. ED asked whether the Strategic Risk Register would be presented to the ICB Board. SD confirmed that the Strategic Risk Register would be presented to both the System Executive Group (SEG) and the ICB Board. ED noted the recommended closure of the LeDeR risk and highlighted that the OQP Committee would discuss LeDeR performance at the January meeting and suggested that the risk was removed following the discussion at this meeting. This was agreed. **The ICB Board:** • **Received the Corporate Risk Register and noted the details** • **Accepted the risks escalated to the Corporate Risk Register**	**RH**

	• **Approved the closure/de-escalation of risks from the Corporate Risk Register as indicated except the risk around LeDeR which would be reviewed by the OQP Committee prior to closure**	
7.1	**Outcomes, Quality and Performance Committee** ED noted the discussions from the November OQP Committee which included winter plan arrangements, review of a funded care policy, safeguarding reporting, a neonatal and maternity update and the performance and quality reports. ED noted the update on performance and CDCs as part of the Chief Executives report item. **Winter Plan Arrangements** ED provided an update on winter planning and the 10 high impact interventions identified by NHS England such as same day emergency care flow. The care coordination team were working across networks to focus on keeping people at home and avoiding admissions. DJ explained that the system had been unable to fully implement this scheme this year. Elements would be deployed through the rest of this winter with full mobilisation next year. ED noted that the ICB had been able to clinically support winter through the Joint System Quality Group and the Health and Care Professional Executive (HCPE). The full winter plan had been received including a plan for integrated care at home and the OQP Committee in January would be reviewing the actions that were put in place for the winter plan. **Approval of Funded Care Commissioning Policy** ED brought the Board's attention to the Commissioning Policy for All Age Continuing Care which had been reviewed by the OQP Committee. The policy outlined the ICB process for commissioning funded care and reflected how the new all age approach would be implemented. The Committee had discussed the policy in detail and noted that it clarified some grey areas and strengthened processes. **The ICB Board approved the revised Commissioning Policy for All Age Continuing Care** The Committee had received a full update from the safeguarding team. The ICB alongside statutory partners has published revised children's safeguarding partnership arrangements in compliance with the working together guidance. The accountable officers from across the Avon and Somerset Police footprint would meet on a regular basis to discuss safeguarding issues at a system and at the local level, children's safeguarding partnerships would work through the Local Authorities.	

	DJ confirmed that the system was managing winter pressures as per the plan. DJ highlighted that alongside the system engagement and operational delivery, there had been increased clinical engagement approach with significant support from RS and JMe as well as the system Chief Nursing Officers and Chief Medical Officers. SD highlighted that the ICB and three Local Authorities had signed off the local Safeguarding Partnership Plan for the year and the Chief Executives met regularly with the Chief Constable to ensure delivery of the local safeguarding plan. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	
7.2	**People Committee** JH noted that the main focus of the ICS People Committee had been the EDI system report, but monthly workforce monitoring continued with a focus on temporary staffing and the elimination of agency. This had been successful for nursing and the focus was now on other professional groups. The impact of winter pressures on temporary staffing was being monitored and would be presented to the next People Committee. JH confirmed she had been working with trade union Chairs to reestablish he Social Partnership Forum (SPF) which had been paused due to the enhanced engagement of trade union colleagues into broader people meetings. This would continue but it was agreed that reestablishing the SPF would provide focus on specific collective issues where there were potential system solutions. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** **Standing Financial Instructions** The Finance, Estates and Digital (FED) Committee reviewed the revised Standing Financial Instructions (SFIs) and recommended these for ICB Board approval. The revised SFIs reflected the new grant agreement Standing Operating Procedures (SOP) and clarified the thresholds of competitive tendering and the use of single tender waivers. **The ICB Board approved the revised Standing Financial Instructions** The FED Committee had discussed the finance report and the need to achieve the agreed outturns by the end of 2024/25. The system was currently £10m off plan and work continued as a system to close this gap. The significant pressures were being managed through non-recurrent funding. The Committee had	

	received a deep dive on Funded Care which was an area of concern, and the Committee would review this again soon. Other areas of focus included high-cost drugs and devices and at the January meeting there would be a focus on Section 117s. The Committee was working to identify where the costs were and identifying any mitigating actions. The main driver for the deficit remained the under delivery of the savings targets at 79% and related to the underperformance against elective delivery plans. 2025/26 was expected to be more challenging and the system was still awaiting the planning guidance. SD noted that the management of the financial position was through the Performance and Recovery Board and explained that if providers were unable to deliver on their savings plans and the system was unable to break even, then the ability to spend resource to shift to community care or prevention was limited. SD noted that although the planning guidance had not been received it was expected that 2025/26 would be a challenging year and the Board would need to consider and explore what needed to stop as much as what needed to be implemented. DES highlighted the discussions at the FED Committee regarding the intelligence centre and the team had been meeting with system partners and the ICB was in a position to go out to advert next week. DES noted that should any Board members be approached by bidders then there was an email address to direct them to. DES agreed to circulate this address. DES noted that the next step was seeing how the market responded. There had been focus on reducing the budget without missing out on the important elements that the system needed the data for. The Full Business Case would be presented to the ICB Board in April 2025 prior to any financial commitments being made. AM noted the role of the ICB Board in making difficult decisions and the importance of having a clear decision-making framework to support the Board to make decisions and a strong evaluation process to understand whether the actions implemented added value. SD agreed and highlighted the COPD work which had a strong focus on benefits realisation and had built in robust evaluation at the beginning. SD noted that in terms of decision making there may be national mandates as to how the NHS would deliver services with potential reduced resources as this would be a national issue. SW highlighted the opportunities within existing research teams who could provide funding for projects in areas prioritised by the system, such as long-term conditions and remote monitoring.	**DES**

	The ICB Board received the update from the Finance, Digital and Estates Committee	
7.4	**Primary Care Committee** AM provided an update on the October and December Primary Care Committees (PCCs). The PCC had received the annual research report. This was a strong area for primary care and there had been excellent achievements in practices receiving funding for undertaking research and grant applications. AM highlighted the work of the GPs at the Deep End Network which provided peer support, training and research opportunities to practice staff from 17 practices within the most deprived areas of BNSSG. There had been progress around the National Patient Safety and Incident Reporting Framework although there was a lot of work to do locally around visibility of data. There were national trends which indicated that primary care tended to report incidents about other providers rather than themselves. PCC was encouraging the visibility of more local data and considering what the national data might infer about improvements needed in BNSSG. AM noted the consideration of reducing the level of risk for the dental commissioning hub to support the ICB, and PCC had reviewed the draft Dental Strategy, providing support and challenge. The Strategy would be presented to the March ICB Board meeting. PCC had supported the need for SMART objectives breaking it down into years 1 and 2. There was detailed BNSSG data for dental and improvements for the local population had been identified such as reducing visible tooth decay and improving services for the under 5's. AM noted the progress against the GP Access Recovery Plan which would be presented to the ICB Board in March 2025. The focus of the plan was to support the population before they attended A&E or were admitted to hospital. AM noted that some of this work would be hindered by the collective action but noted the strength of relationship between the local primary care system partners and the rest of the system. DJ explained that collective action had started and the ICB was mitigating the actions that are being taken. The ICB has maintained excellent relationships with the Local Medical Committee (LMC) and the primary care system. There had been challenges across the primary and secondary care interface but the ICB had an extensive governance and work stream process to work through each of the actions and mitigate them. The SEG operated as Gold command and would review the actions and progress. There had been no formal announcement of a further phase of collective action, but the ICB was preparing for any future action.	

	DJ confirmed that community pharmacy members had approved collective action. This had not started and the ICB was awaiting further information, but actions had been proposed which included opening minimum hours and withdrawing free delivery services. DJ noted that collective action would likely have an impact on providers due to the excellent work community pharmacy undertook for local populations. The ICB had a strong relationship with the Local Pharmaceutical Committee and would work with them to consider mitigation of any action. JF asked who was communicating with the public regarding collective action. DJ confirmed that individual practices were providing communication alongside One Care and the GP Collaborative Board and the ICB was providing updated information on the website. JL welcomed the proactive support from the system and the changes which had been made and explained that the collective action was defining a baseline of working for practices to ensure that General Practice was sustainable for the future. The general feeling was that practices required more resource. RHu acknowledged that collective action had been difficult for partner organisations and thanked them for their work. RHu noted the risk of deterioration of relationships between the different health organisations and although there had been some issues, the system had been keen to maintain dialogue and keep the good relationships between primary, secondary and community care. JMe highlighted the research within primary care and the strong relationships between the universities and researchers in the health system. JMe noted that across the acute sector, there was more research through Oxford, Cambridge and London. The HCPE reflected that there was more to do to leverage the current work to encourage other parts of the system to undertake change work. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Audit and Risk Committee** No update this month	
7.6	**Strategic Health Inequalities, Prevention and Population Health** An update on the SHIPPH Committee was provided at item 6.1. The next meeting was planned for February 2025. **The ICB Board received the update from the Strategic Health Inequalities, Prevention and Population Health Committee**	
8	**BNSSG Integrated Care Partnership Updates**	

	JF provided the update noting that the Integrated Care Partnership (ICP) Board was responsible for setting the strategy of the ICB and this was being reviewed. The South Gloucestershire Health and Wellbeing Board (HWB) Chair was currently Chairing the ICP Board, with this moving back to the North Somerset HWB Chair in May 2025. The devolution white paper included the role of ICPs in the future and how Chairs were appointed to ICBs and more information may come out around this. The paper also discussed what healthcare might look like within the regional footprint. The ICP Board continued to review the locality partnerships and the ICP Board was committed to both a bottom up and top down approach. SD believed that the content of the White Paper should be discussed at a seminar or workshop for the ICB Board and in terms of the locality partnerships review, the ICP Board had been asked to provide feedback to the Chair of the ICP with this being reviewed at the next meeting. SD noted the importance of strong localities and the ICPs role in defining these through the locality review. SD noted that there had been no national guidance on the definition of a neighbourhood and therefore it was important the review was robust to avoid needing to review again. JF agreed and explained that having the Local Authorities Chair the ICP Board was integral to this. JF noted that although there was no legal duty for the ICP Board to hold the ICB Board to account, there was a moral responsibility to ensure the ICB Board was taking the right action for the local populations. DP outlined the opportunity for the system to drive forward the next iteration of what works at place level and, although being mindful of national guidance, it was important that the system created something local that worked for the population. DP noted that the ICP Board was the forum to discuss this with all system partners. The English Devolution white paper was a significant shift in the direction of travel for local government into the longer term with the most important focus on the aim to strengthen the health system and strategic authorities who linked into the wider determinants of health. **The ICB Board received the update from the Integrated Care Partnership Board**	**RH**
9	**Questions from Members of the Public** JF noted that the ICB Board had received questions from four members of the public but unfortunately there was no time to respond to these at the meeting. It	

	was agreed that the members of the public would receive responses in writing and the responses would also be included in the minutes. - Question To enquire if you have received the funding from NHS England yet and if so, have you forwarded this to Vita Minds who deliver 'NHS Talking Therapies'? The government accepted a 5.5% pay increase recommendation from the from the NHS Pay Review Body (NHS PRB) to be backdated to April 1, 2024. Unfortunately, my colleagues and I have not received this, despite working for 'NHS Talking Therapies' and doing the same roles as our other colleagues in different NHS Trusts. Response In 2019, a competitive procurement process to commission and deliver NHS Talking Therapies in BNSSG was completed and Vita Health Group were the successful bidders. As an independent provider Vita Health Group are responsible for managing and agreeing the rates of pay for their staff in their organisation. As Vita Health Group are not an NHS organisation, their staff are not automatically eligible to receive Agenda for Change pay scales. This is not unique to Vita Health Group and many non-NHS providers set their own pay scales whereas some non-NHS providers will choose to mirror the NHS pay scales. There are exceptions for example staff who have TUPED their employment from an NHS provider to a non-NHS provider where terms and conditions are protected such as Agenda for Change. The Integrated Care Board's Finance & Contract teams work closely with our non-NHS providers on a commercial and in confidence basis, including on annual contractual uplifts. This work with Vita Health Group concluded recently for the current financial year and this is in line with NHS Contracts. - Question In August 2023 the ICB announced that Community Diagnostic Centres would be established at Cribbs Causeway and at a site that yet to be determined in Weston Super Mare. What progress has been made in establishing these Centres and when is it planned that each of them will be open to patients? Response The BNSSG system has two operational CDCs. The first, North Bristol Community Diagnostic Centre is based in Cribbs Causeway at Asda Patchway Super Centre, Bristol, BS34 5TL. This is a large CDC that offers MRI, CT, X-RAY, Endoscopy, Respiratory, Ultrasound, Echocardiography. The site is open	

	8am-8pm 7 days a week. The services have been open to patients since April 2024 but were for a time delivered through a 'mobile village' based on the site while the building was constructed. The services were then transitioned into the CDC through the late summer/early autumn 2024. The second, Weston Community Diagnostic Centre, is based at Coniston Crescent, Weston-super-Mare, BS23 3RX. This is a standard size CDC that offers MRI, CT, X-RAY, Respiratory, Ultrasound, Echocardiography. The services have been open to patients since April 2024, and some were available through mobile units ahead of this time also. <u>Question</u> Will the two Community Diagnostic Centres be staffed by redeployment of existing NHS staff or recruitment of new staff? <u>Response</u> The CDCs are each separate contracts between our NHS Trusts and InHealth (an Independent Sector provider). Weston CDC contract is held by UHBW and North Bristol CDC contract is held by NBT. The arrangement in both contracts is that all CDC staffing is provided by InHealth. <u>Question</u> As part of its recently announced NHS plan, the Government stated that Surgical Hubs would be established. Does the ICB intend to fund the creation of such Hubs in this area? If so, where will they be sited, what types of surgery will be carried out at each site and when are the Hubs likely to begin operating? <u>Response</u> BNSSG committed some time ago to the development of an Elective Care Centre (which is the same as a surgical hub). Our Centre, based near Southmead Hospital, is currently in the final stages of construction and will be open to patients in the first half of 2025. The Elective Centre will offer 4 surgical theatres and 40 beds and medirooms as well as X-Ray facilities. The model is designed to optimise capacity and productivity for T&O surgery on the Elective Care Centre site, which will simultaneously release theatre capacity in both Southmead and the BRI to deliver other elective speciality surgeries. This model will facilitate an additional 6,500 elective operations per year. - <u>Question</u> As the adoption of AI continues to shape the delivery of healthcare, what is the ICB's approach to leveraging these tools to enhance outcomes, improve efficiency, and ensure equitable access to services? Additionally, if you are a	

	third-party that is able to support the ICB's strategy and priorities, who would be the best person to contact regarding this matter in the first instance? Response As with many organisations part of our development plan for efficiency included an element of AI and automation. We are currently one of the ICBs selected for national pilot for Microsoft co-pilot as part of the national tenancy agreement. This is enabling us to explore how we can leverage AI to improve our productivity and efficiency as an organisation. We do not have any current plans to procure any additional products for the organisation at this stage and will be influenced by the pilot work. However, we will be soon publishing an ITT for our intelligence centre that we expect will include elements of AI and automation to support our system intelligence function. Deborah El- Sayed is our CDIO who would be the best person to contact in the first instance. - Question Why is there such a huge discrepancy between pay rates provided to Care Agencies contracted by the ICB Brokerage teams and the rates fixed at £13.13 per hour provided for Personal Care Budgets. It's very difficult to recruit/compete for staff, particular for waking nights and weekends. For example, the pay rate for an agency carer working nights at the weekend is £19 per hour. Additionally, the agency charges its own fees, a minimum of £7 hour. Compare this with the current £13.13 and the cost differential is between £6 and £13 per hour. The holiday and sick pay don't explain the gap and often this is a bonus that many people we've interviewed would, given the choice give up for better hourly rate especially at night and weekends. Response BNSSG ICB has developed a costing tool to calculate pay rates for carers employed through a Personal Health Budget (PHB), which we refer to as the "Pay versus Task" tool. This supports us to consider the complexity of care required and benchmark that against NHS Agenda for Change pay rates for a similar level of complexity. The tool has helped us to provide a better structure to pay rates for Personal Assistants (PAs), supporting the process of annual pay increases for carers, and has meant that we have increased rates, in some	

	cases, to better reflect the highly complex nature of some of the people that we work with, therefore improving the likelihood of PAs being recruited to a PHB package. In addition to carers pay, it is important to remember that there are additional costs which are built into the PHB package, which can include provision for training, consumables, payroll etc. The ICB acknowledges that PAs are not employed by the NHS directly so do not have the same terms and conditions which entitle them to enhanced rates for unsociable hours, however we are actively looking at ways in which pay rates can be adjusted in future to account for unsociable hours, recognising that this may be a factor in recruitment and retention on PHBs. <u>Question</u> Why is it so difficult to communicate with CHC Bristol? The phone is rarely answered and relies on a voicemail system and it can take two days or more for people to get back to you? Surely direct contact between the service and clients is essential? <u>Response</u> The team do their best to make sure all calls are responded to as quickly as possible. Due to the volume of calls, voicemails are triaged and directed to the appropriate team member. The ICB has received other feedback about the current system and so the team will be undertaking a review to improve the experience for callers.	
10	**Any Other Business** There was none	
	Date of Next Meeting Thursday 6th March 2025 at the Vassall Centre, Gill Avenue, Bristol, BS16 2QQ	

Lucy Powell, Corporate Support Officer January 2025