BNSSG ICB Board Meeting

Date: Thursday 2nd October 2025

Time: 12:45 – 16:00

Location: MS Teams

Agenda Number:	5
Title:	Chief Executive Report
Purpose: For Information	
Key Points for Discussion:	
The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives. The main areas of discussion this month are; • Strategic Direction and Transformation of BNSSG ICB • Neighbourhood Health Progress • Public Health Assurance Visit	
Recommendations:	To discuss and note
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Agenda item: 5

Report title: Chief Executive Report

Introduction

The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.

The main areas of discussion this month are;

- Strategic Direction and Transformation of BNSSG ICB
- Neighbourhood Health Progress
- Public Health Assurance Visit

Strategic Direction and Transformation of BNSSG ICB

Transition Committee

The first meeting of the joint Transition Committee took place on the 10th September. It was a positive meeting with a consensus from all members that clustering is an opportunity to not simply merge our existing ICBs but to create a new organisation over time that builds upon our collective strengths.

We discussed the requirement to develop a new organisation that responds to the national ask of shifting our role and focus as strategic commissioners. In doing so we will pay close attention to our culture, how we work together, learning from each other and looking at best practice elsewhere.

We approved the Committee's Terms of Reference and we also considered a programme structure and a list of proposed workstreams we will need in place to support transition.

Finally, the Committee also reviewed the emerging risks associated with the transition process and noted the need to maintain a strong oversight of these risks and linkages to the work of some of our other Committees. We also acknowledged the challenges and emerging risks to our transformation priorities and business as usual activities as we manage these alongside transition requirements.

Executive Workshops

The executive team of both Gloucestershire and BNNSG have met on three occasions to begin to develop a proposed operating framework for the new Cluster. We explored behavioural compact between the two teams and then explored a potential vision and design principles for the creation of the new Cluster.

To be a *world-class strategic commissioner* which:

- Has a deep understanding of the population.
- Has developed strong partnerships, in service of the community, that supports the shift to neighbourhood health.
- Has a relentless focus on health and care outcomes, equity and high-quality services.
- Delivers value through everything.
- Can determine 'the how' and evidence impact.
- Has a skilled, professional, and diverse workforce that delivers.

The output also led to a set of principles that will guide and develop the design of the Cluster

- Be strategically aligned with our vision for population health, care and equity.
- Focus on the future by prioritising population health and health equity, avoiding a focus on structures or past ways of doing things.
- Prioritise culture and ways of working creating the conditions for collaboration, transformation, inclusive leadership, agile ways of working, transparency and accountability.
- Learn from existing strengths in strategic commissioning, community partnerships and culture.
- Focus on skills and a diverse workforce, creating an inclusive environment, developing talent, valuing generalist and specialist skills, fostering continuous learning to build a resilient and adaptive workforce.
- Encourage bravery and calculated risk that is built on robust governance and a culture of psychological safety.
- We will be safe and compliant to protect people from harm, building on a culture of safety, continuous improvement and responding to risk.
- Optimise the new resource envelope to deliver value, productivity and sustainability.
- Reduce duplication by doing what we can do, once only, across our cluster. Sharing services on a wider footprint where this makes sense, and in collaboration with our communities, to deliver services that work together.

The workshops also supported a deeper understanding of the 'Functions' and 'Enablers' needed to make the new clustered ICB a success, prior to a formal merger. Together they support an agile culture, which drives workflow through the strategic commissioning cycle,

assuring a relentless focus on health and care outcomes, equity and high-quality services, delivering the vision for better local health and care.

Our approach is that 'form follows function'. The discussions from the executive workshops have been used to develop a draft Executive Structure that aligns with the agreed design principles, functions and enablers. The proposal for the draft structures will be discussed at the new Transition Committee meeting on the 3rd October.

Neighbourhood Health Progress

We continue to advance our Neighbourhood Health Agenda, building on the strategic intentions previously endorsed for the working age population and in alignment with the Voluntary, Community and Social Enterprise (VCSE) Strategy. This update provides a holistic view of progress, challenges, and next steps as the system moves towards a more integrated, community-focused model of health and care.

Neighbourhood Health represents a transformative shift in how services are delivered across BNSSG. Rather than relying on traditional, institutionally driven models, the new approach prioritises prevention, early intervention, and personalised care delivered close to home. Central to this transformation is the empowerment of local communities, fostering trusted relationships and shared decision-making, and integrating services across health, social care, and the voluntary sector. The ambition is to halve the gap in healthy life expectancy across BNSSG by targeting those cohorts most likely to benefit from integrated, community-based support.

We, the ICB, is expected to lead this change, aligning resources and commissioning processes to support neighbourhood health. However, success depends on effective collaboration with a wide range of partners, including Health and Wellbeing Boards, local authorities, and VCSE organisations. Progress will be dependent on establishing a joint Programme Group to oversee the neighbourhood health programme, deepening alignment with Health and Wellbeing Boards, evolving the ICB's strategic commissioning plan, and implementing a refreshed approach to clinical leadership.

Recent months have seen significant activity. Strategic intentions have been agreed and endorsed, and BNSSG has completed a system-wide discovery phase to identify key barriers and conditions for change. Woodspring and South Bristol have been selected as wave one sites in the National Neighbourhood Health Implementation Programme (NNHIP), with onboarding underway and a launch event planned for November. Local Integrated Neighbourhood Health Plans are being developed, led by Health and Wellbeing Boards, and a five-year strategic commissioning plan is in progress.

Financially, the shift towards outcomes-based funding models, such as "Year of Care" budgets, will have implications for contracting and financial flows. Resource needs include workforce training, digital infrastructure, and community investment, with costs expected to be offset by reduced acute demand over time. Procurement models will evolve to support VCSE and neighbourhood-based approaches, and all plans are aligned with the NHS Ten Year Plan and national requirements.

Reducing health inequalities remains a core ambition. The neighbourhood health model is designed to identify and support those populations most at risk, ensuring services are tailored to local needs. Proactive, community-based care will also contribute to sustainability goals, reducing reliance on acute hospital services and supporting the ICS Green Plan and Carbon Net Zero targets.

Extensive communications and engagement have already taken place through the Healthier Together 2040 programme, and ongoing coproduction with communities, patients, and VCSE partners is embedded throughout the programme. Governance arrangements are robust, with no direct conflicts of interest identified and a comprehensive risk register in development.

In summary, the Neighbourhood Health Agenda is progressing well, with strong foundations in place and clear next steps identified. The Board's continued support and endorsement will be crucial as BNSSG moves towards a more equitable, effective, and sustainable health and care system for all.

Public Health Assurance Visit

On an annual basis the Office of Health Improvement and Disparities (OHID) carry out a Public Health Assurance Visit to review how the ICB is carrying out its duties with regards to public health. Appendix A is the letter received following the most recent visit. I have summarised below the key findings.

Strengths Highlighted

- **Exemplary Partnership Working:** The letter commends the highly collaborative and transparent relationship between the ICB and local councils, describing it as an exemplar of partnership working. There is clear alignment of strategies across organisations to improve outcomes for patients and citizens, with providers actively engaged as partners in both strategy and delivery
- **Strategic Use of Data and Insight:** The ICB's approach to using data and insight to drive action and improvement is praised, particularly in addressing health inequalities and supporting population health management
- **Strong Place-Based Relationships:** Investment in relationships at Place, through ICB Place/Locality Directors and Health and Wellbeing Boards, is recognised as a key strength. These relationships are seen as vital for navigating local governance and community interfaces
- **Integration of Public Health Expertise:** The visibility and influence of Directors of Public Health (DPH) within ICB governance is highlighted as a positive, supporting clinical governance, risk management, and neighbourhood system development.
- **Innovative Commissioning and Service Design:** The ICB's approach to strategic commissioning, including the use of JSNA, joint work on individual funding reviews, and tailored pharmacy needs assessments, is commended. The ICB-funded consultant in public health post within the acute provider group is also noted as a strength
- **Tangible Outcomes:** Examples of impact include focused work on liver disease and mortality, improvements in clinical pathways, and visible progress in reducing the percentage of women smoking at the time of delivery. The system-wide approach to healthy weight and compassionate care is also highlighted
- **Preparation and Assurance:** The quality of preparatory materials and presentations for the assurance visit is specifically acknowledged as strengthening confidence in the ICB's approach and leadership

Areas for Improvement / Considerations

- **Clustering Transition:** The upcoming clustering of BNSSG ICB with neighbouring Gloucestershire ICB (resulting in four local authorities sharing one ICB cluster) presents challenges. There is a need for proactive planning to address changes in leadership roles, potential duplication or imbalance in NHS advice, and to maintain strong Place-based relationships
- **Maintaining DPH Influence:** As the cluster model develops, it is important to ensure the continued presence and influence of DPHs within ICB governance and decision-making structures.
- **Hyper-local Focus:** The letter notes the importance of continuing to develop hyper-local partnerships and responses to address inequalities, especially as systems evolve and cluster arrangements are implemented.
- **Shared Commissioning Unit:** While progress has been made in developing a customer board and service culture, the shared commissioning function is still evolving. There is recognition that further work is needed to strengthen relationships with Place and ensure effective engagement with local authority scrutiny and health and wellbeing boards

- **Addressing Hidden Inequalities:** The ICB is encouraged to maintain its focus on understanding and addressing inequalities, particularly those that may be hidden within more affluent or ageing populations.
- **Sustaining High Standards:** The letter encourages the ICB to maintain its high standards of collaboration and to ensure that these are coherently merged with other areas as the cluster forms, maximising efficiencies and shared learning while anchoring improvements at Place and Neighbourhood levels

Overall the letter identifies many strengths to be proud of but also provides a very strong roadmap to help us with organisational design for the new Cluster arrangements.

Office for Health Improvement & Disparities

NHS

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30 July 2025

Sent via email:

- Shane Devlin, CEX
- Joanne Medhurst, ICB CMO
- Sarah Weld, DPH South Gloucestershire
- Matt Lenny, DPH North Somerset
- Christina Gray, DPH Bristol

Dear Shane, Jo and DPH colleagues,

Thank you for your time meeting with me as part of the Public Health Assurance visits to discuss the public health relationships with the ICB. Jointly you gave a good demonstration of the collaborative partnership approach that represents BNSSG and the South West Way. I appreciate the effort and resource that has gone into preparing for the visit and it was a good reflection of the commitment of the ICB to its public health responsibilities and the strength of the partnership working between you.

It was great to spend time discussing with you the approach the ICB currently has to working collaboratively with Public Health in the Local Authority and explore some of the opportunities and challenges as we move to the Cluster ICB model.

Throughout our discussions it was good to see the strategic understanding of Public Health and the role of the DPH within the ICB at a senior level and feel the

commitment to addressing health inequalities and improving healthy life span in partnership at the multiple layers of communities of identity, experience and geography, especially in a time of significant organisational churn in many parts of civic society and reflects well on the ICB and its leadership.

I want to commend some of the good practice that was shared during our discussion, especially the highly collaborative and transparent relationship between the ICB and the Councils, this is an exemplar of partnership working and to be commended and is reflected in the clear alignment of interconnecting strategies to improve outcomes for patients and citizens. It is also commendable the approach reaches beyond the ICB to ensure providers are active as collaborative partners in strategy as well as integrated delivery. The approach to the JSNA underpinning strategic commissioning is very clear and you demonstrate fully the clear benefits of close relationships with Primary Care and Communities working hand in hand in Neighbourhoods.

One of the particular elements that came through was the investment in relationships at Place through the ICB Place/Locality Directors and Health and Wellbeing Boards and the strong links with Local Authorities that have formed through the evolution from CCG to STP to ICB configurations. These relationships are key on many fronts and are something to consider carefully in the clustering as they may be really helpful in navigating interface with scrutiny and health and wellbeing boards and the local political interface as well as with community organisations. There was clear articulation of how data and insight drives action and improvement in the ICB and how inequalities are considered. I also want to commend the ICB funded consultant in public health post hosted within the acute provider group, and strongly linked to the local Public Health teams and system, which further strengthens these inter-relationships with acute pathways.

It was also reassuring to understand the clear visibility of the Director of Public Health within the ICB governance and there are some good examples where this senior level engagement has supported the approach to clinical governance and risk as well as some of the positive framing of the evolution of Neighbourhood systems and integrated data utilisation. As we move towards clustering I am keen to see the DPH presence actively considered in the configuration of the Board and its supporting governance in order to enable the senior public health advisor role to the NHS be maintained.

We discussed some of the examples of how the ICB has benefited from Public Health insight and intelligence to mobilise change and I was particularly impressed by the depth of understanding on both sides of how data and evidence can drive change and materialise the ambitions of population health management approaches to improve outcomes. There are several examples we touched on including the mortality analysis leading to focused work on liver disease and mortality and identifying clinical challenges and demand and addressing the root causes as well as the clinical pathway improvements needed to achieve better outcomes and reduce

demand. There was also good evidence of joint working around individual funding reviews and utilisation of the pharmacy needs assessment building beyond the national frameworks to a product that is more tailored to local needs and local strategic commissioning.

Recent announcements over the clustering of the ICB with BNSSG neighbouring Gloucestershire ICB will result in four local authorities sharing one ICB cluster. Plans were already underway to ensure proactive communication and planning between the DsPH affected, to best respond to the upcoming support required by the ICB cluster, and to address challenges presented by changes in ICB leadership roles, and potential imbalances or duplication in NHS advice provision between each local authority team. It was good to hear the strong level of engagement and understanding of the risks and opportunities of the changing NHS landscape and the clear recognition of the importance of Place relationships within the emerging model ICB cluster arrangements.

There is recognition of the difference between patients and citizens in conceptualisation of population need and the importance of integration of the understanding of geography and communities in place alongside the interactions with services within the system. This is something that will need to continue to develop as the systems to evolve to consider how to ensure the hyper-local partnership and response needed to address inequalities and support Neighbourhood systems to deliver real changes in citizens lives. We discussed the relationship with the shared commissioning unit and some of the learning in the journey of a shared function to understand the needs of place and hyper local commissioning response. This has led to a customer board being established and a stronger service culture relationship between the unit and the ICBs but there is a recognition that this is still a journey and this may need to be revisited in light of the new structures to emphasis the need to focus on relationship with Place. This will also need to consider the relationship with the local authority overview and scrutiny committees, and health and wellbeing boards, in the different local authorities and the shared ICB commissioning function.

There has been some excellent work with primary care at many levels of the ICB and it was particularly good to see the close links with public health around health inequalities as well as strong foundations for Neighbourhood system thinking that are being laid. This is particularly important in the context of your dispersed rural and urban populations with significant inequalities, often hidden within a larger more affluent ageing population. This anchoring of commissioning to the detailed understanding of Place will be key as the cluster model evolves and reinforces the important role of the DPH within the ICB advocating for the health and wellbeing of their specific population within the Cluster arrangements.

We reflected on some of the success including visible improvement in the percentage and number of women smoking at time of delivery improvement which

demonstrates the collaboration between the CMO and DPHs with partners to drive real impact on outcomes and improve lives. There is also good work on the system wide approach to developing a compassionate healthy weight system utilising innovation within system and strong link to the variation in place. This strong system approach has been key to navigating some potentially tricky challenges such as the future of the ACER unit and procurement challenges within the re-tendering of a new model for sexual and reproductive services.

In terms of the future approach to these relationships I hope that you will continue to maintain the high standards that you have for collaboration in BNSSG and that as the ICB cluster forms this is something that is merged coherently with other areas to build on the good examples that are coming together to maximise the efficiencies but also gain from the shared learning to anchor driving integration and better outcomes at Place and in Neighbourhoods. The joint working across the ICB, ICP, Health and Wellbeing Board and Council focuses heavily on communities and collaboration and this is great and something others can draw on as things evolve.

Finally I want to acknowledge the significant work in preparing the packs for me ahead of the visit and in the presentations, these were really insightful and strengthened my sense of assurance in the ICB's approach and the DPH's leadership.

I look forward to returning to visit the ICB and some of the providers in the area for an informal visit in the future to see more of the brilliant work, and look forward to our continued collaboration.

Yours sincerely

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