Bristol, North Somerset and South Gloucestershire
Integrated Care Board

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

Minutes of the meeting held on 1st February 2024 at 12.30pm, held at University of the West of England, Enterprise Park 1, BS34 8QZ

DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
John Cappock	Non-Executive Member – Audit	JCa
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Jon Hayes	Chair of the GP Collaborative Board	JH
Maria Kane	Chief Executive Officer, North Bristol Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Sue Porto	Chief Executive Officer, Sirona care & health	SPo
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Apologies		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Jaya Chakrabarti	Non-Executive Member – People	JCh
Jessica Cunningham	Executive Director of Operations and Deputy Chief Executive, South Western Ambulance Services NHS Foundation Trust	JCu
Aishah Farooq	Associate Non-Executive Member	AF
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
John Martin	Interim Chief Executive, South Western Ambulance Services NHS Foundation Trust	JM
Stephen Peacock	Chief Executive Officer, Bristol City Council	SPe
Stuart Walker	Interim Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust	SWa
Steven West	Non-Executive Member – Finance, Estates and Digital	SWe
In Attendance		

Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JB
Mark Cooke	Director of Strategy and Transformation, NHS England	MC
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Sebastian Habibi	Deputy Director of Transformation, BNSSG ICB	SH
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
Ruth Hughes	Chief Executive Officer, One Care	RH
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Tracie Jolliff	Chair of the Independent Advisory Group	TJ
Rhys Lewis	Digital and BI – Executive Director, One Care	RL
Lucy Powell	Corporate Support Officer, BNSSG ICB	LP
Emma Wood	Chief People Officer and Deputy Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	EW

	Item	Action
1	**Welcome and Apologies** Jeff Farrar (JF) welcomed all to the meeting and the above apologies were noted. Emma Wood (EW) was welcomed as deputy for Stuart Walker (SWa). JF welcomed Chris Head (CH) and Mark Cooke (MC) to the ICB Board as regular attendees and welcomed Tracie Jolliff (TJ) who was attending this meeting as an observer and would be presenting item 6.5.	
2	**Declarations of Interest** MC noted that his interests had not yet been added to the register and declared he was a Trustee for the Robins Foundation. There were no new interests and no declarations pertinent to the agenda.	
3	**Minutes of the 7th December 2023 ICB Board Meeting** The minutes were agreed as a true record of the previous meeting.	
4	**Actions arising from previous meetings and matters arising** The action log was reviewed: **Action 79** – Deborah El-Sayed confirmed that the trend analysis work had started but remained an ongoing process. The action was closed. All other due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items within the report: • ICB Organisational Structures • Winter Update • ICB/Integrated Care Partnership (ICP) Workshop – Next steps for the Integrated Care System (ICS) **ICB Organisational Structures** SD confirmed that in line with NHS England requirements the ICB was reviewing its organisational structure to reduce running costs by 30%. The staff consultation closed last week. Consultation responses were being reviewed and considered and the final structure would be developed by the 19th February 2024. SD confirmed that	

	Item	Action
	should changes be made following the consultation, these would be presented to the ICB Board for information. The expectation was that the changes would be implemented by May 2024. SD noted that this was a challenging time for the organisation. **Winter Update** SD explained that the system had agreed a considerable investment of approximately £40m recurrently to support winter pressures. This funding had been invested in high impact urgent/emergency care and discharge/rehabilitation interventions. SD reported that the January position indicated that performance had improved in several areas, however the pressure during January had been significant with high volumes of patients attending A&E and the continued challenge associated with patients with no criteria to reside. On the 25th January 2024, North Bristol Trust (NBT) declared a critical incident relating to the numbers of attendances. SD commended the effort of all partners during winter and noted the significant challenge of patients with no criteria to reside but the flow of patients was improving and this was positive. **ICB/ ICP Workshop – Next steps for the ICS** The ICB and ICP Boards met last month to determine how the Boards worked together within the system. The Boards had discussed how the ICP Board set the strategy of the system which was then delivered by the ICB Board. The workshop had considered how both the ICB and ICP would interface to support the delivery of the four key ICS aims and the Boards had discussed how the ICP could be involved with shaping and guiding the system and considered the role of the Health and Care Improvement Groups (HCIGs) in delivering the strategic direction. Ellen Donovan (ED) asked for more information about the progress being made regarding those with no criteria to reside. SD confirmed that a process had been developed and the system had invested in transfers of care and discharge to assess programmes. The system needed to understand why these initiatives were not performing as expected and possibly step back and reevaluate. SD explained that the patient run rate was often balanced but this flow did not address the considerable number of patients with no criteria to reside already within the system. The system was reviewing pathways and considering the voluntary and community sector support available. Maria Kane (MK) highlighted the importance that population health data was considered and that the system provided services for the different profiles of patients attending. MK noted that a significant number of patients were complex and therefore there may be many reasons why initiatives were not effective. MK highlighted the opportunities for patients to be seen elsewhere as appropriate and noted the opportunity for the system to work together to support patients. MK highlighted that the consensus at the ICB/ICP workshop had been that the sign of a	

	Item	Action
	good system was ensuring that a patient never had to hear "we don't commission that service" as the system wrapped around to provide it. MK agreed with SD's comments that the system needed to be brave and reshape investment if not effective. Dominic Hardisty (DH) explained that the pressures in the acute mental health system were equally as great as patients were clinically ready for discharge but 25% did not have onward support following discharge. The result of this was that there were patients waiting for beds which were not available. Joanne Medhurst (JM) agreed with MK's comments about identifying the service models needed to support the various populations within BNSSG. JM confirmed that the Directors of Public Health were keen to participate in this work. Ruth Hughes (RH) agreed and welcomed the points raised about how population health management information could support the services and identify where populations were vulnerable. RH noted the importance of admission avoidance and noted that this data could support this. SD confirmed that the system focus was freeing up beds and reiterated the message that the "best bed is your own bed." Keeping patients out of hospital and finding the appropriate care through primary, community and social care was paramount. **The ICB Board received and discussed the report**	
6.1	**Update on Industrial Action and Harm** JM explained that the national Chief Executives meeting had identified that organisations had reviewed harm but not reviewed collaboratively to ascertain the impact over a long period. A group had been convened of individuals from ICB's across England to consider what had gone well and less well as part of incident response. The reflections of the group had been that all organisations and system partners had stepped up to the challenge but delegation processes had been difficult and unsatisfactory and there had been tension between the accountable clinicians and the British Medical Association (BMA). The group had considered the difficulties in identifying harm using local systems as well as difficulties in identifying the various impacts of harm on patients. JM explained that the longer elective waits were an obvious area to review and although organisations were finding innovative ways to continue providing, there had been a loss of quality improvement work. JM explained that the group identified that staff were weary with covering work for colleagues and work was needed to repair these relationships and this work had started. The group identified a clear financial impact with one system quoting a direct cost of £10.3m up to and including September 2023. The group also noted the indirect impact on primary care with more people	

	Item	Action
	attending and contracting their GP practice to discuss their secondary care appointments. JM highlighted that the group had been convened to identify the issues and present these to Boards to ask whether there was additional work the systems wanted to consider supporting. JM noted that patient safety had been managed throughout the periods of industrial action but the impact on patients and staff continued. Although the ask was whether there was value in following up the points identified in the report, work had started with the People Officers and HR Directors regarding the strained relationships. This issue had been acknowledged and work had started to improve this. RH appreciated the consideration of the impact on primary care and noted the opportunities for further discussions about the implications of planned care delays at the primary and secondary care interface group. Alison Moon (AM) welcomed the work particularly the view across England and agreed that the relationship issues needed to be addressed. AM noted the importance that the considerations of the group were included as part of a wider harm piece which focused on the local population. JM confirmed that the group had developed a framework, which with some analytical review, could be presented to the Outcomes, Performance and Quality Committee. John Cappock (JCa) welcomed the report and the light touch approach taken as a more comprehensive evidence based approach would likely have come to the same conclusions. JCa noted the report as a way to influence conversations within the system. JM agreed and explained that the Chair of the Group had asked colleagues to present the report at Board meetings to trigger conversation. This had happened and the system was having those discussions and acknowledging the indirect harm. Sarah Truelove (ST) welcomed the spotlight on the effect industrial action had on the quality improvement work as a reduction in this work impacted everything the system was trying to achieve. Jon Hayes (JH) noted the link between harm and relationships and explained that this also pertained to the relationship between staff and patients. JH noted the increase in aggression from patients had increased across the system as patients became more frustrated with secondary care. JH noted that this was a risk for the workforce which needed to be captured as part of the work. DH noted that mental health services had not been considered in the report and although less impacted than acute care, mental health services were balancing risk from across the whole pathway. DH explained that acute mental health cases were prioritised but with less routine care in secondary care these cases may not be	**JM**

	Item	Action
	identified in a timely manner which may lead to an increase in suicides. JM welcomed the point and noted that the group had not had a mental health representative which was an oversight. EW noted the comments on relationships and highlighted the link between staff relationships and work place safety. EW explained that it was beneficial for people directorates to consider how to support staff rather than undertake more data analysis of the situation and therefore work had started to support staff. JM agreed and highlighted that these discussions fit into culture conversations. **The ICB Board received the update and considered the following elements: system effectiveness, safety, people and finance.**	
6.2	**Update on Digital Strategy Delivery** Sebastian Habibi (SH) and Rhys Lewis (RL) were welcomed to the meeting. Deborah El-Sayed (DES) explained that the strategic outline paper had been approved last year and it had been agreed that business cases would be developed for each of the six components outlined. It was noted that the funding position had changed and less funding was now available. It was important that any funding had the largest impact for the system and therefore the strategy focused on establishing a strong digital foundation, delivering what clinicians and professionals have asked for. DES noted that the associated projects were identified as opportunities to make tangible changes. DES brought the ICB Boards attention to the elements of the strategy which if approved as the priorities, would be developed into business cases. JCa confirmed that the Finance, Estates and Digital (FED) Committee received regular updates on the Digital Strategy work and had endorsed the priorities as presented. The draft paper had demonstrated robust benefits realisation and engagement with clinicians, patients and the public. JCa noted that significant risks remained around affordability and operability but FED were comfortable with the mitigations. DES noted that should these portfolio projects be prioritised then some areas of work would need to cease. These projects, and those that would continue, would be outlined in organisational digital strategies. DES emphasised that all projects across the system would have a data and digital aspect and these projects needed to be embedded within the digital space rather than kept separate. ED welcomed the approach to utilise the funding to add the most value but asked whether cyber security had been considered as a priority. DES confirmed that cyber security was funded centrally through a separate allocation. CH highlighted that the strategy referenced data sharing agreements and noted the importance that system partners without NHS email addresses could be part of these agreements. CH asked whether the strategy considered those members of the	

	Item	Action
	population who could not access digital services. DES noted the digital inclusion approach within the strategy which supported people who were unable to engage digitally. This work linked with the local authorities who recycled and provided equipment to those who needed it. DES explained that the strategy reflected and respected individual choice but recognised that digital access could be area which increased health inequalities. RL confirmed that each provider would be undertaking digital inclusion work to ensure that decisions did not increase health inequalities. Digital inclusion as a system was noted as fundamental and this was a focus. AM noted that the digital strategy was an all age strategy which was important. AM also noted the importance of evaluating the impact of the projects and welcomed the discussions around stopping projects not adding value. AM asked whether risk assessments had been considered for the projects which were transferring to other areas of the system and highlighted the reference to electronic prescribing and noted that this was an important project. DES confirmed that electronic prescribing would continue within the acute trusts and noted that there were several smaller projects which needed to be considered as part of this work. DES explained that where evaluation had shown that take up of projects was low, following approval of the strategic priorities, the implications of stopping these projects would be assessed. AM asked whether the organisations had agreed the transferring projects. DES confirmed that the system Chief Digital Officers had endorsed the paper for approval and those conversations would continue once the paper was approved as there would be some issues to unpick. Sue Porto (SPo) noted the previous Board discussions around benefits realisation and asked whether the system had the transformational capabilities available to realise the priorities outlined in the strategy. DES explained that these projects had been chosen as the benefit realisations were simple in terms of pathway but noted that there was additional work to do particularly around which organisations were responsible for the costs. DES noted that in terms of resource, the transformation and BI teams in the ICB would be smaller following the reorganisation and therefore efficient system working was important. RH noted that the paper referenced the delay to reprocurement of the electronic patient record for primary care and highlighted this as a risk. DES confirmed that work was ongoing to determine the financial envelopes for 2024/25 and discussions were needed across the system to confirm projects. DES noted that it was likely that the reprocurement costs would be included in the 2025/26 envelope. **The ICB Board approved the proposed Digital Strategy portfolio for 2024/25 and supported the funding principle that the digital components of transformation projects should be built into the design process, and reflected in the business case approvals and budgets for those projects**	
6.3	**Commissioning Policy – Varicose Veins and Venous Ulcers**	

	Item	Action
	JM explained that under the current BNSSG ICB commissioning policy, an individual with a venous ulcer would not be eligible for NHS treatment without the presence of a wound which had not healed within 6 months. Following evidence review and discussions with local vascular surgeons, there was strong evidence that earlier assessment and treatment led to quicker healing and recovery. Under the revised policy, patients could be referred if a venous ulcer had not healed with 2 weeks. JM noted that should the policy be approved by the ICB Board, it was expected that there would be a short term spike in referrals. Rosi Shepherd (RS) strongly supported the update to the policy as varicose veins and venous ulcers impacted significantly on people's lives and long term treatment had a significant impact on community services. MK supported the policy and asked how the increase in referrals would be managed through the available elective resources. JM confirmed that there were standard mechanisms in place to communicate the policy throughout the system and noted that the commissioning policy group had the appropriate membership to manage the impact. ST noted the initial challenge in supporting surgeons to temporarily increase capacity but it was important to recognise that this was the right action to take for this cohort of patients in the long term. CH highlighted to the Board the Nailsea District Leg Club who provided support to people with these conditions. CH noted the importance that the Board recognised that there was additional support within the wider system. **The ICB Board noted the changes to both the policy and the current treatment pathway and approved for adoption the commissioning policy presented and would support, where possible, the implementation of new service models**	
6.4	**All Age Mental Health and Wellbeing Strategy 2024-2029** DH presented the All Age Mental Health and Wellbeing Strategy to the ICB Board for endorsement. The strategy had been developed through coproduction and engagement across the system. DH outlined that an away day was planned to discuss next steps which would include complex issues such as keeping people safe within the secondary care environment and how statutory provision of services could work with the voluntary sector. DH confirmed that a delivery plan would be developed which considered pressure on resources to outline plans which were deliverable. SD commended the work of the Mental Health HCIG in developing the strategy which incorporated the complete range of mental health and wellbeing services. SD highlighted the opportunity outlined in the strategy to move inpatient care to the community and asked how the ICB Board could support this. DH confirmed that these considerations would be part of the delivery planning and explained that the plans would be aligned with the system operational planning.	

	Item	Action
	JW welcomed the work as a strong piece of system working and noted that achievement of the six ambitions involved all partners within the system. JW highlighted that identifying who was accountable for the work would be a challenge. DES welcomed the strategy and noted the significant work in its development. DES highlighted the whole system connection throughout and particularly liked the appendix which outlined the measures the system would review to understand the impact of the strategy. ED also welcomed the consideration of metrics within the strategy and asked how involved finance leads had been with the strategy in terms of delivery of the ambitions. ST confirmed that the ICB finance team had worked closely with the developers of the strategy and JW confirmed that the conversations with the ICB finance lead had supported a shared understanding of the resources available which supported the prioritisation conversations. JW noted that a similar strategy was expected to be developed for learning disability and autism services as another priority area for the system. **The ICB Board recommended and supported the final strategy to the Integrated Care Partnership Board and the three Health and Wellbeing Boards**	
6.5	**Introduction to Independent Advisory Group** The ICB Board welcomed Tracie Jolliff (TJ) who was the Chair of the Independent Advisory Group (IAG) on Race Equality. JF confirmed that TJ's role was that of a critical friend to the ICB Board to advise on any gaps and a seminar session on race inequality would be arranged for 2024/25. TJ explained that her professional career had been focused on race equality and it was unfortunate that the situation had not improved. TJ welcomed the support of the ICB Board in considering this area in more depth. TJ noted that there was no central issue around equality, diversity and inclusion to solve and more nuanced than the emotional issue of race. TJ welcomed the opportunity to focus initially on race and explained that race was always an intersectional issue. TJ noted that consideration needed to be given to how the IAG worked with the Board and outlined the importance of recognising the value of lived experience. TJ explained that there had been a slow pace of change in race equality within the NHS and it was reasonable to say that the NHS was not where it needed to be. TJ confirmed that lots of little pieces of work had taken place in this space with little improvement. TJ explained that as a good communicator with lived experience who had also worked in the fields of organisational and leadership development, she was looking forward to developing a narrative which shifted leadership behaviour. TJ highlighted the importance that the IAG and ICB Board worked together to shift the way the system worked and recognised that there was often an emotional	

	Item	Action
	response when issues were challenged but noted the importance of having the capability and skills to discuss race as well as understanding the need for change as well as the importance of having open and honest conversations. JF noted that the ICB Board was predominantly white and these conversations would continue to test the maturity of the Board. JW welcomed the challenge and agreed the importance of people being confident in their use of language. JW noted that this needed to be taught in organisations and important that leadership led by example. North Somerset Council was reviewing this space to represent all its communities. DH suggested that work was happening in this area across the system and it was important that this work was connected. SPo agreed and noted that significant work was taking place in Sirona to better represent the communities served. Better representation led to increased confidence for both staff and patients and therefore better service provision. JHi welcomed this work for the People Programme Board and noted the future equality, diversity and inclusion work which would be presented to the Board. JHi highlighted that this work was not yet connected across the system and felt like a check box exercise with no changes developing from it. JHi noted that anti-racist approaches had worked in other organisations and learning from these systems would be useful. JM noted as lead Executive for health inequalities that guidance around language needed to be developed which would support meaningful conversations. DES noted the difference between equality of outcomes and the equality of access and explained that the ICB needed to take an informed approach and consider the impact of experiences. DES also noted that the system needed to understand the difference between racism and the well-intentioned but inappropriate response to something. MK welcomed the challenge and noted the importance of diversity of senior leadership so staff saw themselves represented. MK noted that there needed to be better ways to recruit and interview staff as there was an inherent bias in the standard process. CH explained that the experience of the hyper local community groups was an important voice when considering this work particularly in understanding health outcomes.	

	Item	Action
	JF confirmed that it was the role of the ICB Board to undertake the work and TJ to challenge. JF acknowledged the significant work in the system in this area, which include specific groups, and noted the importance that duplication within the system was reduced. TJ confirmed that it was important to identify the work happening in the system and identifying a baseline, what mattered was learning and moving forward and changing people's lives to have equity of outcomes. TJ noted that the composition of the Board was irrelevant if the right people were appointed, racial justice was the outcome required and therefore all leaders needed to be measured on their ability and commitment. TJ welcomed the conversations regarding language and confirmed that confident use of language led to more meaningful conversations. **The ICB Board welcomed Tracie Joliff as the Chair of the Independent Advisory Group on Race Equality.**	
6.6	**Dental Strategy** Jenny Bower (JB) was welcomed to the meeting for this item. David Jarrett (DJ) explained that although delegation of dentistry services had been less than a year ago, the ICB had undertaken a significant amount of work to develop a dental strategy as it was recognised that this was a priority area. DJ outlined that access to dental services and good oral health for the population was not where the ICB wanted it to be and the Primary Care Committee (PCC) had discussed this in terms of reducing health inequalities within the BNSSG population. DJ explained that the national contract for dental services had been developed in 2006. The ICB could not amend the national contract and was therefore limited to what could be changed and flexed within the national framework. DJ reported that since delegation in April 2023 incremental steps had been taken to increase access, including the rapid response to the dental practice closure in St Pauls. The ICB has been working with stakeholders to improve service development and strategy built around the frameworks of improving access and addressing variation, workforce, population level oral health interventions, and integration and collaboration. DJ noted that there had been extensive engagement in developing the strategy but more was needed. Access had been considered as part of the core 20 plus 5 data which provided a concerning picture for access for the most vulnerable populations and children under 5. JB brought the Board's attention to the plan on a page which outlined the priority actions which needed to be taken within 12 months and those within 2 years. The ICB was committed to a targeted population health management approach to reduce health inequalities within the population. JB noted that the strategy emphasised the need to increase primary dental service access for residents and outlined the opportunities to reduce the secondary care waiting lists for dental specialities. JB explained that part of the strategy was focused on understanding workforce and	

	Item	Action
	developing initiatives to support workforce retention and attraction. It was noted that this work needed to align with regional and national workforce programmes. The strategy described how oral health promotion needed to be increased including the championing of good oral health in schools, care homes and amongst vulnerable groups. This work would be undertaken with the local authorities although understanding that the public health resource for dental was low. The strategy reflected the need to review digital access to dental services, improve dental pathways and improve public awareness in accessing oral health services. The strategy had been reviewed by PCC and following feedback more emphasis had been given to the population outcomes and increasing access for the areas of greatest need. The complexity in contract arrangements had been raised and it was clear that although the ICB could not amend the contracts, dental services needed additional clarity and support regarding contracts. JB noted that PCC had raised the importance of horizon scanning particularly relating to workforce, supported smart delivery of the strategy and highlighted the importance of ensuring that this dental strategy was connected to enabling strategies and workplans such as those for digital and workforce. DJ explained that the dental strategy was presented to the ICB Board for approval so the team could develop the implementation plan and next steps. DJ noted that the ICB Board was also asked for a shared commitment to influence and support the work outlined in the strategy including the plans to improve services for those with the most need as a priority. JF highlighted that more work needed to be undertaken with the local patient groups and DJ agreed with this. JF outlined that the system would be making difficult decisions around dental care with reducing health inequalities in this area as the focus. AM reported that PCC had commended the strategy as the right direction of travel. AM noted that data regarding the oral health of the population had been stark but identified the areas of focus. AM highlighted a questionnaire which local dentists had completed, 60% responded that they did not see themselves working in the NHS within 2 years because of the difficulties. PCC had welcomed the ambition of the ICB to support and flex local arrangements as far as possible. AM explained that the national issues particularly around funding were complex and the ICB was committed to escalating the concerns of dentists. AM welcomed the support of Matt Lenny, Director of Public Health, at PCC to connect the dots between health and social care and welcomed the common interest in improving oral health for the population. CH noted that voluntary sector organisations were working with children and older people regarding oral health but noted that the strategy outlined the scarcity of	

	Item	Action
	dentists in rural areas and stated that low public transport would affect people's ability to attend the dentist. CH noted that it was important to recognise that a wide variety of services would impact on the priorities outlined. SD noted the importance of understanding what the strategy was signalling as the future direction of travel. The ICB and ICS had been created to drive equity of outcomes and to achieve this the ICB may need to provide access for some and not others. SD noted that the health of children's teeth was worse in parts of North Somerset and Bristol and therefore resources may need to be allocated to provide for those populations above others. SD explained that the strategy outlined that to improve health inequalities, the ICB needed to focus on equity of outcome, improving dental outcomes for those areas of the population with low outcomes rather than providing the whole population with access to services. SD noted that this was important in a limited resource environment and difficult decisions would have to be made. JW welcomed the strategy and welcomed the reducing health inequalities focus. JW asked that additional consideration be given to care experienced young people who often had low outcomes in relation to oral health. JW reminded the ICB Board of the system's corporate parenting responsibility for these young people. ED reflected on the positive conversations at PCC and welcomed the transparent approach to explaining the need for difficult decisions regarding dental service provision as the ICB was unable to afford everything it might want to do. ED noted the importance of prioritisation of elements and JF agreed that the plan on a page outlining the prioritisation timeline was an important document. MK welcomed the strategy and highlighted the importance of long term prevention programmes as losing teeth resulted in loss of confidence and it was important to consider the other factors resulting from poor oral health. MK welcomed the equity of outcome approach and noted that the strategy was an example of what reducing health inequalities actually meant. DJ raised that capacity, both at ICB and Commissioning Hub level, was a risk in delivering the plan and explained that the implementation plan would be developed and reviewed to evaluate what plans could be actioned with existing resource and what ambitions needed additional resource. JF highlighted the maturity of the ICB Board in discussing these difficult issues and noting the difficult future decisions. **The ICB Board:** • **Reviewed the information included in the draft strategy and noted that further patient and staff consultation was required**	

	Item	Action
	• **Noted the verbal update from the Primary Care Committee of 30th January 2024** • **Discussed and agreed the actions within the strategy (noting the regulations described within the paper)**	
7.1	**Outcomes, Performance and Quality Committee** ED noted the discussions at the December Outcomes, Performance and Quality (OPQ) Committee which had included safeguarding, the outcomes framework and cancer performance. Viv Harrison, Consultant in Public Health, had attended the Committee to present the system outcomes framework. The OPQ Committee had noted the significant progress and welcomed the focus on outcomes embedded within the framework. ED noted that the system outcomes framework was a key part of the ICS Strategy. There was scope for the ICB Transformation to team to support this work. It was noted that the developing system dashboard could also be used to support the work and it was confirmed that a future ICB Board seminar on how to utilise the dashboard had been agreed. The OPQ Committee had received assurance that performance had improved within the areas of 52 and 65 week waiting patients and there had been focus on five key areas: the Getting It Right First Time (GIRFT) programme, winter planning, system safeguarding, children's services and segmentation of performance across providers and the ICB. JM noted the OPQ Committee had been informed that cancer performance in some areas was below where the system wanted and there had been a focus on improving performance. Following review there were clear plans and projections for oncology work and work continued to achieve these, JM was assured that the developed plans would improve performance. MK noted the importance that plans considered the potential impact on other services and this was agreed. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	
7.2	**People Committee** JHi noted that the minutes from the November 2023 ICS People Committees minutes had been included in the papers however a meeting of the ICS people Committee had been held yesterday, 31st January 2024. JHi confirmed that at the latest meeting, the People Committee had received the monthly workforce report and the Committee had received updates on the delivery of the current operational workforce plans. JHi confirmed that the substantive workforce numbers were as per the annual plan and there had been robust international recruitment. The system was within the target range for vacancies and turnover and the staff numbers during winter had been positive. JHi confirmed that workforce would remain a key focus for the system. The BNSSG system was fully engaged with regional work including the collaborative system approach to bank staff and using the system framework to	

	Item	Action
	reduce use of off framework agency staff. JHi highlighted the volunteering for health programme which encouraged people to volunteer across the health and social care landscape, the programme was multi-generational and encouraged those with experience as well as those who were considering careers within the sectors to volunteer. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** JCa provided an update and explained that the FED Committee had discussed digital extensively including the digital strategy and related procurements. The FED Committee had also reviewed the ICB's system planning assumptions which had been communicated to the system and provided clarity on the financial position for 2024/25. ST provided the month 9 finance report and explained that it was assumed that the deficit resulting from the cost of the industrial action would not impact on the write off of the historic accumulated ICB debt. An update would be provided to the FED Committee once formal communication had been received from the national team confirming the position. ST highlighted that the system was focusing on savings delivery within its control which included the provider risk in delivering against elective recovery and ICB risks. ST confirmed that papers had been presented to the Executive Team and FED Committee outlining the actions set out in the operating protocol. DES confirmed that information relating to the shared planning data and planning platform would be shared with the FED Committee in April 2024 and then to the ICB Board in May 2024. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
7.4	**Primary Care Committee** AM welcomed the partner engagement of the PCC which always provided a lot of value. AM explained that the PCC had discussed the dental strategy which had been presented to the ICB Board. A paper regarding the provision of primary care supplementary services would be presented to the ICB Board in March 2024 for approval. AM explained that this would collate the significant amount of work taken in reviewing the differing service provision in Bristol, North Somerset and South Gloucestershire. The aim of the review had been to reduce health inequalities and AM confirmed that this had resulted in some difficult decisions to determine some financial modelling options which targeted health inequalities. AM highlighted that the PCC had expressed concern regarding the increase in violence and aggression towards primary care staff. A deep dive into the concerns	

	Item	Action
	had been agreed and this would include assurance on the steps being taken to ensure primary care colleagues were being supported. AM also noted that the PCC had discussed workforce, and the value being added by the Additional Roles Reimbursement Scheme (ARRS). The PCC had also reviewed the risk register which now included the Commissioning Hub risks. The PCC had welcomed the dynamic development of the register. Lastly, AM noted that Boots Pharmacies had taken the commercial decision to close several of their pharmacies, three of which were within the BNSSG area. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Audit and Risk Committee** JCa confirmed that the Audit and Risk Committee in December 2023 had reviewed and recommended several ICB governance policies for approval by the ICB Board. It was confirmed that these policies had been reviewed as per ICB review timescales. JF asked if there had been any significant changes to the policies. It was confirmed that there had been no legislative changes or significant changes to processes within the policies. Rob Hayday (RHa) explained that there had been one amendment made to the ICB Records Management policy following the Committee meeting which the Audit and Risk Committee had been sighted on. This was an addition to the policy to include the ICB Information Governance Group as an additional part of records management processes. **The ICB Board received the update from the Audit and Risk Committee and approved the following policies:** • **ICB Freedom of Information Policy** • **Gifts and Hospitality Policy** • **ICB Individual Rights Policy** • **Records Management Policy** • **Risk Management Framework**	
8	**BNSSG Integrated Care Partnership Updates** JF thanked everyone who took part in the ICB/ICP Board to Board meeting. JF confirmed that the next meeting was at the end of February 2024 and would be Chaired by Helen Holland. It was noted that Helen would be leaving Bristol City Council soon and the rotation of the Chair would be passed to South Gloucestershire Council. **The ICB Board received the update from the Integrated Care Partnership Board**	
9	**Questions from Members of the Public** JF confirmed that the ICB Board had received two petitions and three public questions for consideration as part of this item. RHa explained that in line with the ICB Constitution the petitions would be presented to the Board, noted and the	

	Item	Action
	responses minuted. These minutes would constitute the formal response to the petition. On 22nd January 2024, the ICB received a petition from members of the public about the shortage of NHS dentists in the Bishopston and Ashley Down areas of Bristol. The ICB Board noted receipt of the petition in line with the ICB's constitution. DJ highlighted that the ICB Board had discussed access to dentistry as part of item 6.6, Dental Strategy, and as part of this item, had acknowledged the significant access challenges. The developed dental strategy outlined the plans of the ICB to commit to reducing health inequalities and prioritised access to those with the greatest need. JF noted that NHS dental provision was a significant concern and explained that the ICB would need to make difficult decisions on where access was supported and noted the importance that these decisions were made collectively and openly. On 30th January 2024, the ICB received a petition from members of the public about the planned closure of Boots pharmacy in Bournville, Weston-super-Mare. The ICB Board noted receipt of the petition in line with the ICB's constitution. DJ confirmed that the ICB had been notified of the closure late December 2023. This had been a commercial decision taken by Boots Pharmacies as a private business. Since notification, the ICB had been working with North Somerset Council and the Public Health team to support provision. DJ confirmed that an application had been received for a new pharmacy on the site of the closed Boots pharmacy. The North Somerset Health and Wellbeing Board would be considering the response to the consultation for the new pharmacy at its meeting on the 14th February 2024. A member of the public asked: Nationally and locally, there is an initiative of rapid discharge from hospitals under a 'No Right to Reside' policy in order to free up beds in acute hospitals. *Post meeting note: Nationally there is a Discharge to Assess Hospital discharge and community support guidance - GOV.UK (www.gov.uk) and Home first approach (Home First / discharge to assess | Local Government Association) with the aim to provide short-term care and re-ablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home resulting in people no longer waiting unnecessarily for assessments in hospital. In turn this reduces delayed discharges and improves patient flow.* As part of the policy, on leaving hospital, patients should be given a copy of their own Care Plan, whether leaving for their own home, a care home, a nursing home or other alternative and this should be signed off by a social worker. Questions 1.) Are all patients, without exception, given a copy of their Care Plan upon being discharged from hospital? *Post meeting note: Following a period of admission, on discharge from hospital, all patients are copied into a copy of their discharge summary, which is sent to their General Practitioner. A discharge summary is a handover document*	

	Item	Action
	explaining to any other healthcare professional the reason for admission, what happened while in hospital, and all the information required to pick up care of that patient quickly and effectively. The Discharge summary is not a formal medical care plan, however. Patients are not discharged with a care plan. *On discharge from hospital via a Discharge to Assess pathway either to the place they call home or in an interim bed in a community location, the patient's needs will be assessed by a community practitioner and collaboratively with the patient, carers and family, a care plan will be created with the aim of supporting recovery. Note that not every patient will need a care plan, and not every patient will need input from a Social Worker.–If it is necessary to meet their long term needs, the person will undergo a Care Act assessment by a Social worker.* *Social workers no longer assess a person's needs within a Hospital setting, as the environment is not indicative of their usual home setting and this makes hospital base assessments less meaningful than those undertaken in a community setting. Social workers commence their Care Act Assessment once the patient is ready to be assessed ideally within 28 days of discharge into a D2A bed, often following a period of rehabilitation or reablement. The Care Act assessment undertaken with the patient, their carer's and family will assess the patient's longer term care and support needs and inform any ongoing care requirements.* 2.) In the event of the patient arriving home and finding that appropriate care arrangements, as detailed in their care plan, are not in place for them, is the patient given a telephone number or point of contact to report this and call for help? *<u>Post meeting note:</u> All patients discharged from Hospital that require the support of Discharge to Assess services on the day of discharge will have a visit from a community partner on that day. Many people who have complicated discharge needs will also be supported home by Voluntary organisations to ensure a safe discharge.* *People are provided with instructions on what to do on arrival home if they have concerns / questions. This may include advice to speak with community partners if there are concerns, to contact the discharging ward if needed, to speak with their GP or with 111 if appropriate.* 3.) How is the BNSSG Integrated Care Board auditing the instances where the circumstances for the patient after discharge are not in accordance with the patient's Care Plan? *<u>Post meeting note:</u> The ICB is not currently undertaking an audit of discharge arrangements. However, the acute Trusts, community services and local authorities respond to any complaints or incidents in accordance with local governance procedures.*	

	Item	Action
	4.) Are the results of such an audit, assuming it is carried out, available to the general public and if so, where? *Post meeting note: The ICB has not carried out an audit of discharge arrangements as described above.* JF confirmed that the member of public would receive a written response. This response would be included in the minutes as a post meeting note. A member of the public asked: I am writing from North Star Academy Trust in North Bristol. We would like to know if the Bristol ICB and the LA will be delivering the PINS programme to 40 local primary schools as per the DfE provision plan, *Post meeting note: ICB has been accepted as PINS Early Adopter and will be delivering support to 40 Primary Schools across BNSSG from September 2024 - March 2025* and if so, how do we express our interest in providing the support/training for schools as a provider of SEND Outreach and SaLT training? *Post meeting note: Project Manager will send North Star Academy Trust, and other prospective providers, a template for completion and registration so they will be added to potential providers resource list.* DJ confirmed that BNSSG was an early adopter in the Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme and information would be provided from September 2024 on how to access the programme. It was confirmed that the member of public would also receive a written response. This response would be included in the minutes as a post meeting note. A member of the public asked: I understand there is a consultation underway on the Framework for Medical Associates. As a patient I am particularly concerned about the degree and level of supervision that Physician Associates and other Medical Associates will be subject to. Questions 1.) How will Board guarantee patient safety as Physician Associates (PAs) and other Medical Associates (MAs) are deployed? *Post meeting note: A patient's journey will necessitate that they encounter staff at all levels and experiences. Patient safety will be managed in line as at present and the Board will welcome the move to MAs as regulated professions and the associated assurances as they work within the multi-disciplinary team. All staff within our system work within a scope of practice as part of teams delivering care.* 2.) Will the Board provide clear guidelines on the deployment of PAs and other MAs, including those covering their specific roles, a requirement they be supervised by a licensed doctor and that patients be informed they are being seen by a PA or any other Medical Associate?	

	Item	Action
	Post meeting note: As the National Frameworks are being developed and we are awaiting legislation at the end of the year, we await these to inform our future workforce strategies. The current situation is that PAs and MAPs are supervised by licenced doctors. As with all episodes of care, the patient will remain the responsibility of the appropriate registrant whilst delegating tasks to others who are suitably qualified. These delegated individuals will have a duty of care but the ultimate responsibility will lie with the delegating registrant. 3.) Will the Board monitor and audit the supervision of Medical Associate Professionals, in particular PAs, and if so, how? *Post meeting note: The Board will maintain its usual relationship with Trusts and provide support as needed as the whole workforce is developed to train, retain and reform to meet the needs of our communities. Each profession within our system has different needs for development and the workforce development information will come via the People Committee to the Executive Board as appropriate.* JF noted that the clinical regulatory bodies also had a role to play in these conversations including how these posts were supervised by a senior doctor and by the General Medical Council (GMC). It was noted that the GMC had not concluded how the roles would be supervised and clarity would be received through the Acute Trusts and regional response. JF confirmed that the member of public would receive a written response. This response would be included in the minutes as a post meeting note.	
10	**Any Other Business** None	
11	**Date of Next Meeting** 7th March 2024, MS Teams meeting	

Lucy Powell, Corporate Support Officer, February 2024