NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

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

Minutes of the meeting held on 7th March 2024 at 12.15pm, held virtually via Microsoft Teams

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DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
John Cappock	Non-Executive Member – Audit	JCa
Jaya Chakrabarti	Non-Executive Member – People	JCh
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
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
John Martin	Chief Executive, South Western Ambulance Services NHS Foundation Trust	JMa
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Sue Porto	Chief Executive Officer, Sirona care & health	SPo
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Steven West	Non-Executive Member – Finance, Estates and Digital	SWe
Apologies		
Stephen Peacock	Chief Executive Officer, Bristol City Council	SPe
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Stuart Walker	Interim Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust	SWa
In Attendance		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JBon
Jenny Bowker	Deputy Director of Primary Care, BNSSG ICB	JBow
Jono Broad	Senior Manager in Primary, Community and Personalised Care, NHS England (Observer)	JBr
Mark Cooke	Director of Strategy and Transformation, NHS England	MC

Alun Davis	Chair of the Bristol Mayoral Disability Equality Commission and Co-Chair of the Physical or Sensory Impairment Working Group	AD
Loran Davison	Team Administrator Corporate Services, BNSSG ICB	LD
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Aishah Farooq	Associate Non-Executive Member	AF
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Chris Head	VCSE Alliance Representative	CH
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
Ruth Hughes	Chief Executive Officer, One Care	RH
Geeta Iyer	Deputy Chief Medical Officer, Primary and Community Care, BNSSG ICB	GI
David Jarrett	Director of Primary and Integrated Care, BNSSG ICB	DJ
Vicky Marriott	Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Lucy Powell	Corporate Support Officer, BNSSG ICB	LP
Jason Sarfo-Annin	Clinical Lead for Value and Population Health, Sirona Care & Health	JSA
Nwando Umeh	Programme Manager – Supplementary Services (Interim), BNSSG ICB	NU
Adwoa Webber	Head of Clinical Effectiveness and Research, BNSSG ICB	AW
Sarah Weld	Director of Public Health, South Gloucestershire Council	SWel
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). Sarah Weld (SWel) was welcomed as deputy for Dave Perry (DP). JF welcomed John Martin (JMa) who had been recruited as the Chief Executive of South Western Ambulance Services NHS Foundation Trust. JF welcomed Jono Broad (JBr) to the meeting as an observer shadowing Mark Cooke (MC). Apologies were received as above.	
2	**Declarations of Interest** Jon Hayes (JH) declared an interest in item 6.3, Supplementary Services for General Practice. JH noted that as a practice partner for Hanham Health Care which incorporated Hanham, Oldland and Almondsbury Surgeries, he had a financial conflict of interest in the item. It was noted that JH would take part in the discussion but abstain from the vote. JF added that every ICB Board member registered with a BNSSG GP Practice had an interest in the outcome of the review. It was not expected that this would be declared and was not considered a conflict. Chris Head (CH) confirmed that the organisation he worked for was the recipient of health inequalities funding referred to in the appendix of the report for item 6.1, Addressing Health Inequalities.	

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	Sue Porto (SPo) and John Martin (JMa) both noted that their declarations were not included on the register but both confirmed they had no interests in the agenda items.	**RHa**
3	**Minutes of the 1st February 2024 ICB Board Meeting** CH noted that his name had not been included in the attendees list, with this amendment the minutes were agreed as a true record of the previous meeting.	
4	**Actions arising from previous meetings and matters arising** All due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items within the report: • ICB Organisational Structures • Financial Position 2024/25 • The Future of Locality Partnerships **ICB Organisational Structures** The Shaping our Future programme had concluded following a period of staff consultation. 131 responses had been received regarding the proposed structures. All comments and feedback had been reviewed by the Executive Team and a continuous improvement document had been developed. This document outlined the actions and recommendations to support the organisation to develop an operational model which the reduced staff base could deliver. **Financial Position 2024/25** The ICB and system was currently developing the plans for 2024/25 and it was clear that the current resources would not be enough to deliver system ambitions. The recurrent position was challenging and a number of outstanding savings had not been achieved. SD explained that the system may need to explore a new rigorous approach to manage resources given the productivity challenge. **Future of Locality Partnerships** As part of the Shaping out Future programme which reduced ICB resources by around £5m, it had been necessary to reduce the available ICB locality partnership resources by around £300k. This had sparked discussion on how locality partnerships should work and what parts of the system were responsible for what elements. With Integrated Care Partnership (ICP) Chair agreement, a commissioner review would take place to understand the requirements of locality partnerships, what resources were needed and what outcomes were expected. Locality partnerships remained important for the system and how they fit into the Health and Wellbeing and ICB Boards needed consideration. Alison Moon (AM) asked about the scope and length of the locality partnership review and whether this would include external best practice or internal review of current processes. AM asked about the definition of effectiveness of a locality partnership and whether the review would result in something to support locality	

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	partnerships to become fit for purpose. SD confirmed that the review was expected to be completed within months. A small group of representatives had been convened who would develop terms of reference to be approved by the ICP and the ICB Boards. These would then drive the review forward. **The ICB Board received and discussed the report**	
6.1	**Addressing Health Inequalities** CH confirmed that the organisation he worked for was the recipient of health inequalities funding referred to in the appendix of the report for item 6.1, Addressing Health Inequalities. It was noted that the paper was a briefing paper for consideration. Adwoa Webber (AW) was welcomed to the meeting. Jo Medhurst (JMe) provided the background to the paper and explained that one of the core aims of the ICB was to reduce healthcare inequalities. JMe noted the importance of language and explained that there was a difference between health inequalities, linked to the wider determinants of health which the Directors of Public Health had a statutory duty to respond to, and healthcare inequalities. The ICB was responsible for reducing healthcare inequalities, the inequalities in outcomes from the delivery of healthcare within the system. JMe added that this was not linked to green spaces, housing or education but acknowledged that there were connections. JMe explained that in this space, funding had been received to support migrant health and just over £1m had been allocated to the locality partnerships to utilise at their discretion over a 3 year period. A template would be completed as a system for the ICB Annual Report. The template reflected the metrics for healthcare inequalities but the submission would have gaps. It was recommended that the remaining discretionary funding was used to target and improve these gaps. JMe noted that there was opportunity and scope for the system to consider whether there was more to do and if so what. JMe highlighted that there were areas such as interpreting services which the population were saying was a concern, and the system needed to consider whether this was a priority and how to improve through a system wide approach as well as the role in this work of the ICP. JMe noted that the system would also benefit from considering Equality Impact Assessments (EIAs) at the start of projects. JMe asked members to consider whether their organisations had provided staff with the skills and tools needed to confidently consider healthcare inequalities. The whole system was responsible for working together and there needed to be trust between organisations that the actions taken were robust and not duplicated elsewhere. CH noted that the definitions of health and healthcare inequalities did not include other areas which impacted on these inequalities such as transport. AW noted that	

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	although these activities were taking place healthcare providers would not know about gaps unless these were raised by patients. AW noted that should healthcare providers notice that a certain cohort of patients was not attending then this was an area where collaboration and integration across the wider system was important. AW noted the importance that the system understood who was responsible and who needed to be involved to address the issue. JF highlighted that the challenge to ICPs was a good one as the ICP Board created the opportunity to discuss issues across the wider system. SWel noted that there were some actions which were must dos for the NHS which would involve all sovereign organisations and highlighted that the role of the ICP was the forum where the system could work together to improve public health and reduce health inequalities. SWel noted that Health and Wellbeing Boards were an important mechanism in local level discussions to address health inequalities in communities. SWel highlighted that the South Gloucestershire Council Inequalities Plan considered internal actions and reflected on the role of the organisation into the partnerships. MC thanked AW for all her hard work in this area and acknowledged the contribution BNSSG ICB was making towards reducing health inequalities. MC welcomed the definitions outlined in the paper as this was a grey area, however there was much the NHS could do in terms of reducing inequalities for access and outcomes. MC highlighted that local NHS organisations were significant local employers, purchasers of local products and investors in estates and technology and therefore had an input into addressing those wider determinants. This supported the 4th objective of the ICB to support broader social and economic development. SD highlighted that the Integrated Care System (ICS) had a clear improving health inequalities plan and through the ICP work could take place to map out who was driving the individual parts. SD would welcome an overall system plan as well as individual organisation plans and this was something the ICP could support. SWel agreed that there needed to be an ICP level conversation but rather than a system plan, suggested that the ICP developed a framework which recognised the roles of the individual organisations and how these connected across the system. Aishah Farooq (AF) welcomed the work and highlighted that the paper outlined the data dashboards which would be used to support the work. AF asked whether the ICB had access to robust children's data across primary, secondary and community care. AW confirmed that the ICB did not have sufficient data for both children and adults and this was an area of continued work. AW explained that this included data related to access but also experience and outcomes. The NHS statement asked ICBs to consider existing data by ethnicity and deprivation and the system was not yet mature enough to routinely review this data. JMe noted that this work was happening in sovereign organisations but not shared across the system. DES noted	

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	that priority work was ongoing to reshape the Business Intelligence team and the connections with the wider system. AM noted that the system needed to consider what the ICS could support over and above what individual organisations could achieve and this would outline the benefit of working as a system. AM noted that the ICB did not have full data sets and asked whether the ICB could make assumptions about the population to target particular areas without waiting for perfect datasets. AM noted that the ICB Board needed to review good quality data in order to make well informed decisions. AM highlighted that completing an EIA well was a skill and asked what organisations could do to support staff to think differently about this process. Vicky Marriott (VM) highlighted that the work of Healthwatch was about feedback and a people and communities strategy had been put together which outlined the way healthcare needed to develop to support the local population. VM noted the importance that the relationships with communities and the local voluntary sector was strengthened when considering the plans for the work. CH agreed and explained that there was no one size fits all approach. VCSE organisations worked at the hyper local level with communities, families and individuals and there needed to be a flexibility of approach and trust to work with these organisations to solve the issues which existed. Jaya Chakrabarti (JCh) reminded the ICB Board that the workforce was a subset of the local population and it was important the system remained sighted on the health inequalities within the workforce. Jo Walker (JW) highlighted that the system needed to consider where the value was in the connections between the organisations and produce a timeline of what each organisation was doing. JMe thanked the ICB Board for their feedback which provided a sense that the system had an appetite for the work needed to reduce healthcare inequalities and that the ICP may support in developing the system picture. JMe noted that the ICB had a quality control element through the metrics outlined in the annual report. The paper recommended a health inequalities oversight group and this would be a useful conduit between the ICP into the ICB and to providers and partners. AW noted that the system was ultimately accountable to the public and reflected that the conversation had raised some questions about what practical work could happen to make a difference to the people using healthcare services. AW highlighted the strategy and the commitment made by the system to invest resources in reviewing the problems raised by patients and those with lived experience and welcomed the support of the ICP.	

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	The ICB Board discussed the report and considered the questions set out in the recommendation section of the paper	
6.2	**Update on Physical or Sensory Impairment Developments** SD welcomed Alun Davies (AD) to the meeting. SD reminded members that previously the ICB Board had approved and committed to delivering 10 recommendations to improve services for disabled people with physical or sensory impairments. Each provider had agreed a lead to attend the monitoring and implementation group. The group had refocused on three important aspects: accessible information, engaging in appointments and review of wheelchair provision. AD highlighted that the leads from the providers had been committed to the improvements and the group had received strong representation and involvement from health and social care colleagues. AD explained that accessible information was the priority and there was a commitment from each organisation to implement the Accessible Information Standard (AIS). This supported the work around appointments and ensuring that appointments were communicated in a way patients could access and interpreters were booked in advance of appointments. AD explained that the group was working with the Deaf Health Partnership to support the work. AD noted that the work around wheelchair access and provision was progressing but would take more time to achieve. It was noted that a further update on the progress of the recommendations would be presented to the ICB Board in 6 months. AD explained that he had met with ICB colleagues to discuss the ethical issues around the Respect agenda and Do Not Resuscitate. The meeting had been positive and a further meeting would be arranged to discuss how to engage those with lived experience and carers to coproduce the ongoing work. AF thanked AD for using his experience to shape and change the way services developed. John Cappock (JCa) welcomed the system wide work and progress made. JCa noted the benefit in disseminating the learning to other large employers within the system to improve the experiences in all aspects of life for those with physical and sensory conditions. AD noted that the learning would be collated for the next ICB Board update and so this would be good time to consider engagement with the wider communities on the learning around communication and coproduction and this would be reflected in the recommendations. JCh asked whether transport to appointments had been included as an area to review. AD confirmed that it had not been included as a single issue but transport remained a significant problem. The three focus areas had been prioritised for this year but AD expected transport to be a factor within the next set of priorities. Steve	

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	West (SW) noted that there were multiple organisations outside of health and social care responsible for transport including the West of England Combined Authority (WECA) who would need to be involved in those conversations. AD confirmed that WECA were working with people with lived experience to improve access to services and it was expected that there would be developments over the next year. ED asked if there was any additional support the group needed. AD explained that the wheelchair issues were more complex and sat mainly within NBT as the provider of the service. AD highlighted that the staff at the wheelchair service were doing a good job but there were areas of discussion needed between NBT and the ICB to untangle some knotty issues. AD noted that the other area which needed more support was the idea that coproduction and codesign were embedded across all processes and more was needed to consider how this was implemented across the system. **The ICB Board reviewed the update and committed to supporting the members of the Monitoring and Implementation Group to implement the necessary changes**	
6.3	**Supplementary Services for General Practice Review** JH declared a financial conflict of interest in this item as a practice partner for Hanham Health Care which incorporated Hanham, Oldland and Almondsbury Surgeries. It was noted that JH would take part in the discussion but abstain from the vote. SD explained that the paper was important not just to the population but because it indicated a direction of travel for the ICS in driving population health needs and reducing health inequalities. SD highlighted that the decision would be difficult as it could be perceived that there were winners and losers but ultimately this was about making informed decisions about allocation of resources to ensure the best outcomes for the population. SD thanked David Jarrett (DJ), his team, the GP Collaborative Board (GPCB), One Care and everyone who had been involved in defining the process utilised. DJ welcomed Jenny Bowker (JBow), Geeta Iyer (GI) and Jason Sarfo-Annin (JSA) to the meeting. These three had led the work alongside colleagues at One Care, the GPCB and the Local Medical Committee (LMC). DJ noted that the review of the supplementary services had been a significant, complex and difficult piece of work. The ICB had arranged the review of the supplementary services fund to address the significant inequality of funding and services which existed across the system. The ICB Board was asked to endorse the proposal for allocation of the funding to practices utilising the Cambridge Multimorbidity Score (CMS) noting the impact on practice resilience and approve the revised service specification. The feedback from the Primary Care Committee (PCC) had been included in the paper.	

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	DJ explained that the original decisions regarding the funding had been made by three separate PCTs, Bristol PCT, North Somerset PCT and South Gloucestershire PCT and therefore the review was addressing inequalities which have continued in the system for many years. The three separate PCTs allocated £9.1m to supplementary services and the South Gloucestershire basket as part of a five year Personal Medical Service (PMS) investment agreement. These services were not part of the core contracts and represented a critical element of GP work. BNSSG CCG previously established a programme of work to review how best to reinvest the £9.1m which amounted to under 5% of total general practice investment. There was significant variation across the three areas in the way the money was allocated to these services. The supplementary services review had agreed key principles at the start of the programme which included that the funding envelope was fixed at £9.1m but ring fenced for general practice and therefore the review was looking at redistributing this fixed funding across BNSSG to address the inherent inequalities. A steering group had been established by GI which engaged widely with key stakeholders. GI explained that four different methods of allocation had been reviewed, each had advantages and disadvantages. The aim was to allocate funds in a fairer way which was more reflective of the population needs and practice workload. The CMS had been developed in 2020 to improve existing scoring methods for multimorbidity. The CMS had been validated for secondary care data and coding and had since been validated for use in primary care and reflected that care happened outside of hospitals. The CMS used 20 different conditions and weighted them in terms of the impact on primary care presentations for unplanned admissions and mortality. GI highlighted that there was no perfect way to allocate the funds but the CMS allowed for triangulation between patient complexity and the activity within the supplementary services to better allocate funding and determine expected activity. Engagement had been undertaken with practices over the last 18 months and the CMS had been accepted as the most robust way of reviewing population need and practice workload. However, the CMS had not been developed using data from people under the age of 21 and was not an exact match for the service activity. The data had been applied to individuals across BNSSG and a practice score established. The assumptions regarding practice population had been tested and JSA and his team were confident in the data and methodology. The scores for practices were correlated against levels of deprivation and the more deprived an area, the higher the practice score was. GI confirmed that of the four options considered, the CMS provided the fairer allocation method as some of the other options created far greater swings in allocation which would more significantly test practice resilience.	

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	DJ noted that the ICB recognised that this decision came at a difficult time for general practice. The ICB would continue to work with practices to maintain and support resilience and the proposal included a three year transition period. The paper outlined the risks associated with the redistribution of the funding allocation and mitigating actions had been developed which included the potential discontinuation of services in some area. The ICB had committed to providing additional support to those practices most impacted. DJ drew the Boards attention to the EIA which outlined negative financial impacts within Bristol Inner City and East locality where there were known higher concentrations of ethnic diversity. The CMS recognised multimorbidity's as a key factor in determining workload for practices and as a result the funding allocations positively impacted older people and those with a disability. The CMS did have a strong correlation with deprivation however the Inner City and East practices would see a reduction as there were fewer multimorbidity's, however funding for those practices remained above the ICB average and the impact would be monitored as set out in the EIA. JF asked for more information about the three year transition. JBow confirmed that the funding would change by a third each year with the final allocation position received in year 3. JF asked MC whether there had been other ICBs who have tackled this issue and the actions taken. MC confirmed that there had been a history of reviewing allocations to reflect population and health needs. MC noted that the use of the CMS formula was less common but other areas had successfully used methods other than the Carr-Hill formula to allocate funding. Ruth Hughes (RH) thanked the ICB team for the thorough work and engagement with primary care in a positive and collaborative way despite the difficult and complex conversations. RH expressed support for the methodology although noted that use of the CMS was unique and untested for this work. 69% of the GPCB had expressed concerns with the methodology and RH explained these concerns. It had been acknowledged that North Somerset had received lower payments historically for the supplementary services but it was important to note that these practices may have received higher investment in other services. There had been concerns regarding the impact on health inequalities as 10 of the 11 practices within the Inner City and East locality would see a reduction in payments. RH confirmed that general practice supported the direction of funding to those most in need but RH asked whether the unintended consequence of implementing a methodology which reduced payments to deprived populations needed to be rethought. RH also noted that the value for money data was not robust and asked whether the system should consider levelling up the funding. RH noted that should practices decide not to	

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	provide the fundamental services within the specification this would have an impact on the wider system. RH highlighted the proactive support for practices facing the largest impacts and noted that there was no increase in funding under Section 96 and the well regarded Access, Resilience and Quality (ARQ) programme which provided support to practices would receive reduced funding next year and therefore the support may not be available to practices. RH raised the possibility of levelling up payments to support general practice but noted the importance that North Somerset practices who had been underfunded in this area for some time, received payments as quickly as possible. JF asked that DJ and team respond to the questions raised at the end of the discussion but noted that in terms of levelling up there was no new money and any funding would need to be found from elsewhere in the system or within primary care. Jon Hayes (JH) thanked the team for all the work and emphasised the potential unintended consequences of the work. JH outlined that the proposal meant there were net gains and losses for practices and welcomed the proposals for North Somerset practices who were keen for the plans to be implemented. JH explained that the reductions in funding would need to be found within practice finances and therefore practices may decide to opt out of or cap activity for these services which made broaden the gaps in healthcare inequalities. Primary Care Networks (PCNs) may not be able to support practices if all the practices in a PCN were receiving reduced allocations and JH asked how the ICB would mitigate these risks. JH also reiterated the concerns that there were reductions in allocation for some of the more deprived areas in BNSSG. SPo noted concern that an unintended consequence may be pressure on other parts of the system should services in primary care reduce. Sarah Truelove (ST) highlighted the significant financial challenge and explained that the medium term plan had been developed to address this and as part of this the core primary care allocation had been protected. ST noted that allocated growth funding would not be received until 2027/28 and therefore if the decision was made to review again when investment was available this would be a significant amount of time in the future. SWel noted that the system needed to consider the long term allocation of resources towards prevention, and primary and community care otherwise the challenges faced in these areas would be moved to secondary care. DES explained that the methodology had been utilised to move away from the geographical based Carr-Hill formula towards an individual needs approach. DES noted that doing nothing may	

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	result in significant hidden health inequalities and the CMS balanced this against population needs. AM highlighted the importance that the mitigations were robust and noted that the ARQ programme funding would be reduced and although PCNs were encouraged to support practices, this would be difficult when all practices were receiving reduced funding. AM asked how the impact would be monitored and what practical work would take place based on the information. JCh asked whether primary care colleagues had objected to the methodology and asked whether there was an underspend which could be utilised within the ringfenced funding. RH noted the importance that any discussion regarding reallocation of funding towards preventative care needed to consider timescales. RH noted that the primary care system needed to see the benefit of being part of the ICS and explained that the concerns about the proposal stemmed from the capped funding allocation which had been decided by the previous CCG at the start of the project. ED asked for more information on how the mitigations would support the quality concerns. SW noted that reducing health inequalities was a core purpose of the ICB and given the significant financial challenges, the ICB needed to consider how to manage available resources to support this aim. SW noted the support for the methodology but noted the importance that primary care was not destabilised as this would not improve health inequalities. SWel highlighted the importance of being clear on what specific health inequalities were being addressed as health inequalities could be related to inequalities concerning ethnicity or access to services. DJ noted the questions regarding performance and quality tracking and explained that the quality and resilience primary care dashboard was a well-established method for reviewing practice performance on a month by month basis through a range of indicators. DJ noted that Section 96 funding was discretionary funding and there was no fixed budget for this and the ICB would manage use of this funding as a cost pressure. JSA responded to the points raised regarding the methodology and explained that although the methodology had not been used in this way before, he had spoken to the creators who had confirmed that the CMS had been intended to be used for resource allocation. JSA explained that the CMS was not perfect but as a tool to compare practices within a geography it was robust. JSA noted that the model could	

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	not be used for children and although this was not relevant for the supplementary services, this was something to consider if used for other areas. JBow explained that the ARQ programme was funded through strategic development funding and a decision was still to be made on the prioritisation of these funds. The ARQ programme was considered a valuable programme which had undertaken a lot of good work. JBow explained that where practices met the criteria for Section 96 funding this was approved and supported. It was noted that where practices chose not to offer the services then the ICB would look to PCNs and wider services to support. JBow noted that where a PCN was impacted then there would be considerations about economies of scale that could be viable at PCN level or other providers, practices and PCNs would be considered. It was noted that the North Somerset practices had been providing the services with lower funding than other areas and it was important this disparity was solved. JH noted that the concerns were not only the financial resilience of practices but also the wellbeing of the workforce and the risk to relationships. JH explained that working in a GP Practice was challenging and reducing resource would increase these challenges. JH acknowledged the challenges facing the system in terms of finances and resource allocation but noted the importance that the concerns from primary care colleagues were articulated. JH noted that the system could often find resources to support other services but this funding had been capped rather than levelled up. JH highlighted the importance of primary care services in terms of admission avoidance and improving the health of the local populations. JF summarised the discussion noting that the initial decision to cap the funding had been raised and asked whether there were any additional monies which could be used to increase the funding. ST confirmed there was no discretionary funding available until 2027/28 and any levelling up approach would have to wait for several years during which the current inequalities would remain. JF highlighted that unintended consequences had also been raised as a concern and asked whether all the mitigations possible had been considered. GI explained that the outlined risks were comprehensive and engagement had taken place with primary and community care colleagues to identify these risks. GI noted the importance of the evaluation and monitoring plans which would be reviewed by the Local Enhanced Service (LES) Steering Group. RH noted that there may be opportunities to review the funding before 2027/28 as decisions were being made through the planning process about prioritisation of funds. JH noted that the most significantly impacted practices were reviewing internal finances and budget management as well as activity and it was possible that these practices would need to cease activity not related to the supplementary services to support other services. JH explained that this may lead to unpredictable	

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	outcomes including movement of activity and increased hospital admissions. JH also noted that the supplementary services were outside of the core contract and therefore inflation relating to salaries was not included in the funding. JF asked members to confirm whether they approved the proposal. JH confirmed that due to his financial conflict of interest he would provide no opinion and abstain from any vote. RH found it difficult to support the recommendation as two thirds of practices had stated that the implications of the proposal would be challenging to manage. RH recognised that the North Somerset practices were supportive of the proposal. ED was broadly supportive of the recommendations but highlighted the importance that the practices identified as significantly impacted through the dashboard received robust support. SD agreed that the support for resilience needed to be in place for practices and explained that monitoring was in place so that proactive support could be provided. SD noted the points made by RH regarding funding and highlighted that the allocations needed to consider the whole system impact and welcomed the future planning work which would consider each part of the system in isolation but also alongside the system consequences of funding allocations. SD noted that the system needed to continue to review this funding each year and have the courage to reconsider if the unintended consequences became untenable. CH highlighted that one unintended consequence of the proposal could be increased admissions at A&E which had been noted as a focus for improvement. SWel noted that monitoring the impact would be hugely important and that the data should be shared with other systems who could reflect on the learning from the use of the CMS. JF noted that as part of the discussion concerns had been raised and the importance of understanding the impact and outcomes from the transition was extremely important. **The ICB Board approved:** • **The revised specification for introduction from 2024/25** • **Allocation of funding to practices across BNSSG by employing a weighted population option derived from the Cambridge Multimorbidity Score Index** • **To offer a 3-year phased transition period of funding to support practice resilience during this period** • **To offer a 3 + 2 year contract to practices to enable planning over the short-medium term**	
7.1	**Outcomes, Performance and Quality Committee** The Outcomes, Performance and Quality (OPQ) Committee had received a positive update regarding maternity services, North Bristol Trust (NBT) and University Hospitals Bristol and Weston Foundation Trust (UHBW) had both gone live on the electronic patient record and both received full compliance on their Saving Babies Lives plans. BNSSG had been chosen as one of nine systems in England to be part	

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	of the Race and Health Observatory which was a network designed to address disparities in maternal, perinatal and neonatal health outcomes for black, Asian and ethnic minority mothers. ED noted that the Committee had a session focused on children's services, particular those areas which were challenging including community paediatrics and ASD and ADHD waiting times. ED highlighted that reducing the growing list sizes would require a system approach. The Committee had been updated on the possibility of implementing an interim innovative model based on successful work in Portsmouth. JMe highlighted that ADHD service standards and public expectation was a clear focus for the national teams and the ICB was working to ensuring that local plans aligned with the national work. SPo noted the work of Sirona and the system to tackle the wider challenges within children's services in particular demand. Children's services colleagues from across the system had met to collaborate on the development of new vision and overarching improvement programme. SPo highlighted that part of this programme included staff morale due to the pressures related to demand. SPo noted that there had been positive progress around the targets including 104 week waits. ED noted that the Committee had reviewed the segmentation letter and the system was currently in segmentation 3 of 4. There were 7 areas under consideration. ED highlighted that the cancer Faster Diagnosis Standard (FDS) was an improving area as was 78 week waits, however there was more work to do to improve mental health and disability targets. The Committee was planning to review these two areas in more detail at the next meeting. ED noted two significant challenges to performance; patients with no criteria to reside and four hour waits. There was system commitment to improve but ED was keen to understand the bed base, workforce and how the BNSSG system benchmarked in these areas against similar systems. MC confirmed that his team would be able to provide benchmarking information and associated learning for the South West as well as national systems. MK agreed that the system needed a good understanding of the population demographics and who was attending each organisation. MK explained that NBT often had high lengths of stay but this was expected as NBT was a hyper acute stroke unit and had a high proportion of complex specialist services and therefore there were additional complexities which needed to be understood alongside the performance metrics. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	**MC**
7.2	**People Committee**	

	Item	Action
	JCh confirmed that the February People Committee had been focused on the ICB and had received updates from the Shaping our Future consultation, the Staff Partnership Forum and the Inclusion Council. The new ICB structure would be effective from 1st April 2024 and JCh thanked Jo Hicks (JHi) and her team for the sensitivity which had been built into the process. JCh noted that the Committee had received the embargoed staff survey results and in comparison to the 2022 results, the ICB had scored significantly higher in 3 questions, significantly worse in 10 questions and no significant difference in 83 questions. The responses would be used in the wider organisational development plan. JHi explained that the 2023/24 People Programme Plan included recruitment, retention and productivity as specific area of focus and explained that practically this meant supporting staff to upskill and identifying areas of waste within the system. JHi explained that discussions had been had about supporting productivity through increasing freedom of movement for staff so time was not wasted accessing other organisation buildings. The productivity agenda was complex and this would be a greater focus in 2024/25. The planning guidance indicated that productivity would be a separate measure and the system was working on building this into the people programme. JCh noted that the People Committee had received five policies for approval and recommendation, Alcohol, Drug and Substance Misuse, Travel and Expenses, Secondary Employment, Grievance, and Appeals. The latter two needed ICB Board approval and so these had been presented for approval. JF noted that the People Committee had discussed collating the system staff survey results which would provide a view across the whole BNSSG NHS system. JHi confirmed that this would be presented to the appropriate Committees and the People Programme Board as part of the wider people plan. **The ICB Board received the update from the People Committee and approved the Grievance Policy and Procedures, and the Appeals Policy.**	
7.3	**Finance, Estates and Digital Committee** SW provided an update from the Finance, Estates and Digital (FED) Committee noting that 2023/24 had been a challenging year for finance. Although performance was better than 2022/23, the system continued to carry a deficit and some of the gaps have had to be covered through non-recurrent means. SW highlighted the comments made by SD regarding the difficult decisions which would be required as a result of the financial pressures. The FED Committee were focussed on the operational plan for 2024/25 and were working closely with SD and ST to focus and grip the system finances to support closure of the gaps. SW highlighted that there were potential opportunities within the digital space as there had been good progress in developing this area. SW noted the importance of utilising technology to improve productivity and redesign the way services were shaped and delivered.	

	Item	Action
	ST drew the Board's attention to the system finance report and noted that at the end of January 2024 the system was reporting an adverse position of £7.6m, £6.4m of this was the cost of the industrial action. It was expected that the ICB would receive £5.5m to cover the actual costs but not the lost income. The ICB was also expecting funding to cover this the additional industrial action in February 2024. The system was forecasting a breakeven position but there were some significant risks relating to elective recovery income and funded care. ST explained that the efficiency plan remained under delivery by £10.5m. Although this was being offset by non-recurrent funding this would have significant impact on 2024/25. Governance processes would be strengthened to contain further cost growth which was an issue within the system. DES confirmed that the contract award for the shared care record services was due within the next few weeks. As part of the programme of work agreed at the last ICB Board meeting, the Clinical Informatics Cabinet was reviewing the project plans to ensure these were aligned with clinical leadership. DES highlighted that a significant component of the spring budget was around digital and technology enablers which aligned with the digital strategy so that was positive. ED asked if there was anything which could be actioned differently next year to support delivery of the financial position. ST confirmed that this linked to the conversations earlier about how challenging the situation was and how there were consequences for other organisations when one part of the system was not delivering. ST noted the importance that organisations were able to challenge each other otherwise the system would not be able to make progress on the strategy work and achieve the aims of the ICS. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
7.4	**Primary Care Committee** AM highlighted that PCC had reviewed the dental strategy as part of the January 2024 meeting and at both the January and February meetings, the Committee had discussed the supplementary services proposal approved at the ICB Board today. The Committee had provided challenge on behalf of the Board and the feedback had shaped the paper presented today. The GPCB and LMC had provided robust challenge and had been professional, articulate and well engaged in the discussion. AM highlighted that following the review of the dental strategy, the Committee had asked about the progress of the pharmacy strategy and optometry strategy. The Committee had received a presentation about Pharmacy First which aimed to help people without needing to attend general practice. JF asked ICB Board members to encourage their Non-Executive Directors (NEDs) to attend their committees as it led to broader debate. JF highlighted that there would	

	Item	Action
	be an update session for system NEDs to provide information on system developments. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Audit and Risk Committee** JCa noted that the December minutes outlined some slippage in the internal audit work programme and the responses to follow up actions, however this had improved and internal audit was on target to deliver the work for the year. At the February meeting, the Committee had reviewed the external audit plan and had received the initial internal audit into the gateway project. The internal auditors had also provided a report into building resilience which included learning and best practice from other NHS organisations which was very helpful. **The ICB Board received the update from the Audit and Risk Committee**	
8	**BNSSG Integrated Care Partnership Updates** JF noted that the joint ICB/ICP Board session had been positive but noted that the attendance from the Acute Trusts Chairs at the ICP Board had been reducing. JF highlighted that the better the attendance at the ICP Board the better the debate. JF explained that the local authority Chairs were an important part of the ICP Board and due to the attendees it was an important group which needed to be utilised to best effect. CH agreed and suggested that the ICP needed briefer papers and more time for discussions. CH welcomed the cross over between the ICB and ICP Boards and highlighted that there had been a number of discussions at the ICB Board which the ICP Board would benefit on being sighted on. SD highlighted the ICB/ICP workshop and explained that the ICB was producing a paper to outline what the ICB and ICP would look like in the future and as a result what the system should look like. This would be presented to the May ICB Board meeting. SWel welcomed any review into purpose and noted that the system was looking to reinvent the Strategic Network which was a potential forum for discussion and workshopping. JF noted that the value of the ICP Board was in the system level discussions which had a narrower focus on health but there needed to be consideration on how to use the time more productively. **The ICB Board received the update from the Integrated Care Partnership Board**	
9	**Questions from Members of the Public** A member of the public asked the following questions of the ICB Board: • Is this Board aware of the lack of communication between itself and the neighbouring Gloucestershire ICB?	

	Item	Action
	• How this lack of communication impacts on those people living in South Gloucestershire but registered with a GP outside the area, i.e. Wotton Under Edge. • How service users have difficulty in getting patient assessments, Hospital@Home services, and other services which may be available to them. • Is there and who provides the care pathway for these people leaving hospital? • What is the ICB doing to address these issues where everything is a battle to get some service provision for vulnerable people and people are not dealt with in an equitable manner? SD confirmed that there was informal engagement on a regular basis between the ICB Chief Executives and Senior Executives and formally the ICBs met with each other and NHS England to review the key actions required across the region. There was a whole programme of regional work and information sharing to ensure that ICBs were working collaboratively. DJ noted that there were often challenges relating to patients who lived on the borders of ICBs and confirmed that a written response to the specific questions would be provided directly to the member of the public. CH highlighted the challenges and confirmed that these included access to primary care as well as cross border transport concerns.	
10	**Any Other Business** None	
11	**Date of Next Meeting** 2nd May 2024, University of the West of England, Enterprise Park 1, Lecture Theatre, Long Down Avenue, Stoke Gifford, BS34 8QZ	

Lucy Powell, Corporate Support Officer, March 2024