BNSSG ICB Board Open Meeting

Minutes of the meeting held on 4th July 2024 at 12.30 via Microsoft Teams

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
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
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, NHS North Bristol Trust	MK
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JM
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Stuart Walker	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	SW
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Rob Hayday	Chief of Staff, BNSSG ICB	RH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Paul Martin	Interim Chief Executive Officer, Bristol City Council	PM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
In attendance		
Jenny Bowker	Deputy Director of Performance and Delivery, Primary Care and Children's services, BNSSG ICB	JB

Will Bradbury	Communications Manager, BNSSG ICB	WB
Loran Carter	Team PA, Corporate Services, BNSSG ICB	LC
Anne Clarke	Director – Adults, Housing & Community Development, South Gloucestershire Council	AC
Paula Clarke	Executive Managing Director, Weston General Hospital, University Hospitals Bristol and Weston NHS Foundation Trust	PC
Mark Cooke	Managing Director, NHSE South West	MC
Fiona Cope	VCSE Alliance Representative	FC
Kirstie Corns	South Gloucestershire Locality Director, BNSSG ICB	KC
Caroline Dawe	Deputy Director Performance and Delivery, Acute and Integrated care, MHLDA and EPRR, BNSSG ICB	CD
Helen Edelstyn	Head of Project Development, BNSSG ICB	HEd
Hugh Evans	Director of Adult Services, Bristol City Council	HE
Aishah Farooq	Associate Non-Executive Member	AF
Bev Haworth	Deputy Head of Primary Care Development, BNSSG ICB	BH
John Heather	Chair of the Pier Health Board	JHe
Judith Hernandez del Pino	Hospital Director, Weston General Hospital, University Hospitals Bristol and Weston NHS Foundation Trust	JHP
Ruth Hughes	Chief Executive Officer, One Care	RH
Vicky Marriott	Chief Officer, Healthwatch Bristol, North Somerset and South Gloucestershire	VM
David Moss	North Somerset Locality Director, BNSSG ICB	DM
Lucy Powell	Corporate Support Officer, BNSSG ICB *minute taker*	LP
Emma-Kate Reed	Deputy Medical Director, University Hospitals Bristol and Weston NHS Foundation Trust	EKR
Michael Richardson	Deputy Chief Nursing Officer, BNSSG ICB	MR

	Item	Action
1	**Apologies** Jeff Farrar (JF) welcomed all to the meeting and the above apologies were noted. Fiona Cope (FC) was welcomed to her first meeting as the Voluntary, Community and Social Enterprise (VCSE) Alliance Representative. Anne Clarke (AC) was welcomed as deputy for Dave Perry (DP) and Hugh Evans (HE) was welcomed as deputy for Paul Martin (PM), the interim Chief Executive Officer for Bristol City Council.	
2	**Declarations of Interest** No new interests were declared and there were no interests pertinent to the agenda.	
3	**Minutes of the May 2024 ICB Board Meeting** The minutes were agreed as a correct record.	
4	**Actions arising from previous meetings and matters arising**	

	Action 84 – The response was nearly complete and would be sent out when finalised. 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: • The future of Locality Partnerships • Maintaining focus and oversight of quality of care and experience in pressurised services • Collective Action in General Practice SD explained that as the ICB Board had been held during the pre-election period, the report contained less detail than usual. **The future of Locality Partnerships** The BNSSG Integrated Care Partnership (ICP) Board had committed to undertaking a review of the role of Locality Partnerships and the approach and Terms of Reference would be discussed in further detail during item 6.2 of the agenda. **Maintaining focus and oversight of quality of care and experience in pressurised services** A letter had been issued to all ICBs, ICPs, Trusts, Regional Directors and copied to Local Authorities which highlighted the pressures and challenges within hospitals and asked every Board across the NHS to assure themselves they were working with all system partners to ensure: • Alternatives to emergency department attendance were provided especially frail older people who would be better served with a community response in their usual place of residence • Maximisation of in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge. SD explained that Ruth Hughes (RH) was leading the work on alternatives to the emergency department and the system Chief Executives and Chief Operating Officers would meet tomorrow to discuss the letter to determine whether the current actions were good enough or whether additional actions were needed. **Collective Action in General Practice** The ballot to understand whether GPs wanted to support collective action had opened and would close on the 29th July 2024. Ellen Donovan (ED) was reassured that the Chief Executives were meeting to discuss the letter and asked them to consider whether the significant work currently happening in the system was sufficient to address the challenges.	

	John Cappock (JCa) noted that at a recent NHS Confederation event, Amanda Pritchard, Chief Executive of NHS England, had talked about leadership development and asked how this would impact BNSSG ICB. SD highlighted the emphasis on the importance of professionalising and respecting the management roles within the NHS and the leadership development comments had been around improving management and whether managers should be regulated. SD explained that many people become managers in a healthcare setting because they were good at the clinical work but the Integrated Care System (ICS) needed to consider what learning and development needed to be in place to develop the skills needed for management. Jo Hicks (JHi) confirmed the expectation of a leadership competency framework for all levels of line management which would create pathways and portfolios for development as well as consistency of approach. The NHS Graduate Scheme was well regarded and always oversubscribed and the BNSSG system was well engaged with the scheme. **The ICB Board received the report**	
6.1	**Healthy Weston Update** SD provided the background to the Healthy Weston 2 Programme and explained that the paper provided an update on phase 1 and the next steps for future phases. Phase 1 of the programme had put in place processes to ensure that the people of Weston had equity of access to the very best urgent care and outcomes as other people in BNSSG. Paula Clarke (PC) explained that the paper outlined the continued work and impact of the programme and noted the risks around resilience and sustainability of adult medical inpatient services and providing access. PC explained that the services needed to be relevant to the local population which had a significant proportion of older people. There was a commitment to keep momentum for service improvement and deliver the clinically led plans for phase 2 of the programme. Implementation of the plans would take a staged approach to support a continuous improvement test and learn model. Judith Hernadez del Pino (JHP) outlined the performance increases which had been seen across the Weston General Hospital (WGH) emergency departments including a 20% increase in patients seen within 4 hours and 64% increase in the patients treated and discharged on the same day. There had been a significant decrease in length of stay and due to the expanding portfolio of services there was reduced reliance on agency staffing and nursing staff retention was the best across University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). The staff engagement score benchmarked at the top for all Acute Trusts. JHP noted that the escalation space which had been in	

	place had been closed and the space utilised for a surgical day case unit which had significantly improved waiting times for patients. PC noted that positive feedback from service users indicated that the changes were improving the experience for patients. PC explained that the phase two plans had been reviewed by the ICB Health and Care Executive and the Acute Health and Care Improvement Group (HCIG) and included increased care provided at the hospital for lengths of stay up to 72 hours. PC noted that for longer specialty input then patients would be appropriately moved to hospitals with specialist care facilities who could better serve their needs. It was noted that the plans were considerate of the capacity of receiving sites and would align with the ICB's refresh of the urgent and emergency care strategy. Emma-Kate Reed (KTR) explained that the phase 2 plans were about creating the right inpatient services for the people of Weston and reflecting the local population needs. This meant access to specialist gastroenterology, respiratory, and cardiology services with the opportunity to transfer those patients with other specialist and longer-term needs to the appropriate place. EKR explained that five wards in WGH would be dedicated to elderly care to ensure that appropriate, patient centered care was provided closer to home. EKR noted the challenges in recruiting and retaining consultant workforce within WGH and highlighted the move to different models of workforce including rotational approaches and in reach hot clinics. Julie Sharma (JS) highlighted that the Sirona team in Weston were well established in terms of workforce, and agency staffing had reduced. The Geriatric Emergency Medicine Service (GEMS) would attend Sirona teams for the most complex cases and Sirona was achieving the targets for pathway 1 discharges to home. JS recognised the multi-disciplinary approach described in the paper and confirmed that Sirona was a part of this. Stuart Walker (SWa) highlighted the significant improvements and the support received from the system to implement the needed changes. SWa noted the importance that the teams involved reflected on all the good work and congratulated themselves for the work undertaken. More improvements could be made and the good work would continue. JCa noted the rapid process and asked which innovations had made this possible. PC noted that a whole cultural change agenda had been implemented and international recruitment had been a significant success. A successful approach to wrap around support for those international recruits had been put in	

	place and staff recognised and understood the vision of Healthy Weston which provided stability. JHP also noted the importance of learning and development which if successful encouraged people to stay. Healthy Weston had implemented a mixed recruitment approach recruiting both people with the skills required immediately and those who needed additional training. Alison Moon (AM) recognised the significant improvements and noted the importance of reflection on phase 1 as this provided assurance that phase 2 would be managed and delivered to the same standard. AM noted that the outlined risks to achievement were external Weston and asked if there were any internal risks to achievement. AM asked about the sustainability of the work implemented and whether being more ambitious had been considered given the success of the previous work. AM asked the ICB Board to consider the learning for other areas of work. PC explained that the risks were those for the Healthy Weston programme itself rather than the work and noted that the project held a risk register for the specific areas of work. The biggest risk was the resilience of the inpatient services as there was still a high number of temporary staff and there implementing the continuous improvement test and learn continued to be challenging. These challenges had been considered as part of the phase 2 work. PC noted that some of the work could be replicated across the system but was dependent on the populations being considered. John Heather (JHe) noted the queries around sustainability and learning and explained that NHS Confederation had included the team in a project to support development of the frailty service and ensuring this was not limited to the primary and secondary care interface. It was expected that the project would support significant improvement in the frailty service. JHe noted the work would maximise potential across all Weston services which was supported by the locality referring into one hospital. JF highlighted the previous concerns following the merger of UHBW and noted that the Weston system was now an important part of the acute and wider care system for patients. PC explained that there had been a number of drivers behind the merger, but it had been recognised that unless WGH was a successful acute hospital for local people the system would not have thrived and there would have been a significant impact on other nearby hospitals who would have seen increased patients. ED welcomed the work as an excellent example of return on investment and highlighted that the performance milestones outlined the successes. ED asked whether the continuous learning had been incorporated into the work around flow and whether patient experience reflected the milestone successes. PC	

	confirmed that colleagues from across UHBW included all the learning from Healthy Weston in all urgent and emergency care work and noted that the pathways within WGH had changed to better support patients. PC confirmed that the inpatient national survey scores for WGH had significantly improved and there had also been improvements in the friends and family test particularly for A&E. Healthwatch remained fully engaged with the Healthy Weston programme and the programme was part of the North Somerset Health and Wellbeing Board which included members of the community. Jo Walker (JW) described the Healthy Weston Programme as a great piece of system working and thanked the system for the investment in Weston. JW noted that an organisational approach was important but the programme had highlighted the equal importance of a place based approach to support local people. JW noted that some areas of Weston were some of the most deprived across BNSSG and therefore some of the learning would not be applicable to other less deprived areas. The Healthy Weston programme work had positively impacted the perceptions of the hospital which had positively affected staffing as well as system partners and local residents. Dominic Hardisty (DH) described the work as hugely impressive and an example of how strong leadership, collaboration and extra resource could generate significant impact. DH suggested that a similar approach may need to be considered for mental health services in the future. The Weston mental health services team was a strong team with capable leadership and a good model of multi-agency working. However, this method of team working was not replicated throughout other older adults services which were under resourced. The mental health ward in WGH achieved the shortest lengths of stay, however it was not a pretty environment to work or be treated in. DH also noted that children's mental health services were under achieving in Weston. DH requested that the system consider putting a spotlight on mental health services and consider how to apply the learning from Weston across other locality mental health services. SD highlighted that the challenge for the system was being able to move into phase 2 despite the current financially constrained environment and sustain the work. It was acknowledged that demand had increased at the front door for all hospitals and therefore the work described in phase 2 was absolutely the right thing to do. SD noted the role of the hospital group model in distributing resources in the best interests of the population. The next steps would be incremental to allow the system to reflect on the best way to invest and keep momentum.	

	Maria Kane (MK) noted that the joint clinical strategy would be an important part of enabling considerations going forward but noted that there were a number of other services such as ambulance services which needed to be considered. Great work to support demand and capacity continued across BNSSG and it was important that the ambitions focused on populations to ensure that future models of care improved patient flow. MK noted that the hospital group would have a significant part to play in determining system investment. SWa noted that the system was responsible for supporting the Healthy Weston programme and managing demand and flow. This was alongside individual responsibilities for delivery. It was noted that the acute system had a pivotal role to play but the whole system needed to collaborate to achieve. **The ICB Board noted:** • **The vision for wellbeing, health and care in Weston** • **The plans for a thriving, sustainable hospital at the heart of the community and how these plans meet local population need now and in the future** • **How we are turning our plans for Weston General Hospital into a reality** • **How we are working together across acute, primary and community care to improve local health and care outcomes** • **The plans for the future, and the need for sustained commitment to full delivery of the Healthy Weston vision to secure sustainable, quality services and to continue to mitigate the risk of unplanned service changes at Weston General Hospital that have the potential to destabilise the system and affect patient care**	
6.2	**Update on Delivery in Localities** Kirstie Corns (KC) provided an update on the progress of the review of the role of Locality Partnerships in BNSSG. The review terms of reference and high-level approach had been approved by the ICP Board. The approach included a timeline which outlined activities from July 2024 to the end of November 2024. An expressions of interest approach would be held to appoint an independent provider to lead the review and a small core group would drive the process to ensure that milestones were delivered in accordance with the terms of reference. A series of stakeholder workshops would take place throughout September to canvass what Locality Partnerships needed to be for the system. It was expected that the work of the Locality Partnerships would align with various system workstreams including the ICS Strategy and the Healthy Together 2040 service plan. The review would consider culture and resources as well as management and the governance models within the system. The review would consider the previous work of the system as well as national and international learning from working at place. KC confirmed that the core group to oversee the	

	review would be convened in July and members of the system and ICP Board had already requested to join. The group would include members from the three domains of system leadership, Local Authority, VCSE and Health and members would meet fortnightly through to November. It would be the responsibility of the working group to present the outcome and recommendations of the report to the ICP Board. Three funding models for the review had been presented to the ICP Board and the option agreed was a population based proportionate contribution from the ICB and three Local Authority partners. The cost was expected to be around £15,000 to £20,000. SD explained that the review had been commissioned following the running costs reductions within the ICB. The reduction in staffing had sparked a conversation at the ICB Board about what was the best way to manage a Locality Partnership. SD highlighted that the Locality Partnerships were so much more than ICB staff and the review would consider how to mobilise the resource already available within a locality across a wide range of organisations. JCh welcomed the involvement of VCSE colleagues and noted the opportunity the review provided to consider how VCSE organisations were engaged with each Locality Partnerships and whether economies of scale could be applied to further support communities. FC explained that Locality Partnerships were a conduit for VCSE organisations into communities and the review had the support of the VCSE Alliance. **The ICB Board noted the decisions made by the ICP Board on 27th June:** • **The BNSSG ICP Board approved the terms of reference included in the paper** • **The ICP Board supported the outline timeline which seeks to have completed the work by the ICP Board meeting on 28th November 2024** • **Three options were given for consideration of the funding model for the review and the ICP Board selected Option 2** • **The Expressions of Interest and Working Group approach was supported by the ICP Board and work was now underway to confirm the names of those to be involved in the working group**	
6.3	**Primary Care System Access Report** Jenny Bowker (JB) explained that the report provided an update to the ICB Board on the System Access Improvement Plan. A significant amount of work had taken place during year 1 of this 2 year programme. JB highlighted that the plan considered access in the broadest sense and included online access, the NHS App and access to pharmacy and dental services.	

	Bev Haworth (BH) noted that the system access improvement plan represented a significant piece of transformational work which had been designed to tackle the 8am rush at GP Practices and to ensure that health care needs were met in the right place and by the right person. The improvement plan also considered how to reduce health inequalities across the system and how to support practices with their workloads. The plan contained four key aspects and BH provided an update for each: **Empower patients** There had been a push to improve take up of the NHS App which had improved functionality and was free for both patients and practices. 60% of the population had signed up and the focused communications were encouraging people to turn on notifications so they would receive messages from their practice. Community pharmacy services had been expanded to include several minor ailments and BNSSG was a national leader for the number of referrals into pharmacy consultation services. **Implement new Modern General Practice Access approach** BH confirmed that all BNSSG GP Practices had cloud-based telephony and 85% of practices had additional functionality which included call backs. The practices and patients had provided positive feedback regarding the additional functionality which decreased the 8am rush. BH noted that all the usual ways to contact practices remained and the ICB had promoted all the different ways including digital mechanisms. All practices had chosen their preferred online consultation provider and there had been a rise from 35 to 92 online consultations per thousand population. The ICB continued to support practice teams and patients to use this technology. BH highlighted same day access and explained that this aimed to ensure that a patient's needs were addressed on the same day which could be referral to a pharmacy, self-care or an appointment with the appropriate person in the practice. All practices had completed training in this area and valued the approach in providing continuity of care. Care Navigation was noted as an important element of the work to support same day access. **Build capacity** In 2023/24 the number of appointments increased by 4% and met the national target, with 84% of these appointments consistently within 14 days. The workforce had been increased by 3%, predominantly within the Multi-Disciplinary Team (MDT) roles. There were significant challenges in recruiting GP and nurse roles, and several initiatives were in place to support recruitment. Alongside this	

	the ICB continued to communicate how the additional roles supported practices and patients as it was recognised that these MDT roles were a big change to patients. **Cut bureaucracy** The ICB Chief Medical Officer had convened a primary and secondary interface group to improve relationships between practices and acute hospitals. The group would ensure communication routes were correct and decrease barriers to patient pathways. So far, the group had updated the access policy and started to make improvements to discharge summaries to ensure that the patient and health provider had access to the required information. This included data such as medications, and sick notes, as well as recall processes to ensure that the patient didn't need to go back and forth between clinicians. BH explained funding had been identified to support practices to undertake the work and all practices had been successful in receiving the funding. Primary Care Networks (PCNs) were developing plans which would be reviewed on a 6 monthly basis to determine that practices were making progress as expected. There was a long list of areas monitored and any practices facing consistent challenges would be offered support. The number of practices receiving support had decreased. BH noted that patient feedback was an important part of the monitoring, and this included the annual patient survey, Patient Participation Groups, Friends and Family Test and feedback from Healthwatch. BH explained that year 2 of the work would focus on embedding and sustaining the work completed to date and continuing to increase equity across the system. RH thanked the team for the comprehensive report and reflected on the significant achievement of primary care to increase activity by 4% despite the changes to the way staff were working and the decreased recruitment of GP and nurse roles. RH highlighted the number of primary care appointments from patients on long secondary care waiting lists and noted this as an area of opportunity to support capacity within general practice. RH noted that the interface work had not progressed as rapidly as hoped but there was continued commitment from the group to improve the interface. Jon Hayes (JHa) thanked the team for all the hard work in partnership with primary care but noted that general practice remained significantly challenged in terms of resilience, affordability of service and its ability to pay staff. JHa explained that this was the impact of the significant increase in activity on top of business as usual and although there had been an increase in healthcare	

	assistant professionals, there had been a decrease in front of house practice staff which had a negative impact on access. SWe noted that Health Innovation West of England and the University West of England had established a primary care lab designed to deep dive and test innovations in general practice. SWe highlighted the importance of the work within the report in creating a culture which could be built upon to support prioritisation of investment. ED highlighted the work of the innovation hub and suggested that the ICB Board receive more information regarding its work. ED thanked the team for the report and asked whether patients had provided positive feedback on the work and how the success of cutting bureaucracy would be measured. BH confirmed that the early adopters of the advanced telephony functionality such call backs had noticed a difference in workload but also a positive change in patient and staff behaviour. The primary and secondary care interface group was noted as the area where cutting bureaucracy would be measured and currently there was a focus on identifying the areas which would be most beneficial. Measuring the outcomes and impact was acknowledged as a work in progress. JCh asked what functionality was available within the NHS App and whether it was clear what could be actioned dependent on your practice and whether there were any automated processes which could be utilised. BH confirmed that practices were working through how the functionality of the NHS App could be applied to existing processes. BH noted that online appointment booking was a challenge as practices were focused on moving to an effective triage process and so online booking was only available for certain services. AM highlighted that the progress of the plan was reviewed at the Primary Care Committee (PCC) regularly. AM confirmed that the challenges raised by JHa had also been raised by Primary Care Colleagues who sat on the Committee. AM asked Jo Medhurst (JM) what the ambition of the primary and secondary care interface group was now those relationships had been developed and suggested that an update be provided at the PCC. JM confirmed that the Deputy Chief Medical Officer led the Group which was working through complex actions and agreed to undertake a deep dive and provide an update. AM welcomed the data sets which provided a good foundation to develop work from and noted that PCC was keen on making the connections between the data and patient experience. AM noted the importance of the work and thanked the team for the significant amount of work undertaken to support practices and patients.	**JM**

	Deborah El-Sayed (DES) reminded the ICB Board that the approved digital portfolio had included NHS App developments. Work needed to take place to ensure that practices were ready to amend their business processes and digital inclusion work would take place to ensure that patients were ready. This work would be connected to the healthcare inequalities agenda. DES explained that work continued within the Acute Trusts on digital appointment review which was aimed to reduce Did Not Attend's. This was expected to be available as part of the NHS App which would align the health and care journey for individuals. MK asked if there were any concerns with the roll out of digital telephony and capability, capacity and networks to support the work. RH confirmed no as BNSSG had been digital for a while, but the changes had been felt moving to cloud based services. BH explained that the learning from the early implementers had been shared across primary care which included best practice processes and communications to patients. A portion of the funding was used to support the build up so that practices could plan for going live. BH explained that some practices were waiting for existing contracts to cease so they could move to the full technology. **The ICB Board noted the Year 1 progress in delivery of the BNSSG System Access Improvement Plan**	
7.1	**Outcomes, Performance and Quality Committee** ED highlighted that the June Outcomes, Performance and Quality (OPQ) Committee had discussed No Criteria to Reside (NCTR), productivity, and the Getting it Right First Time (GIRFT) programme. The Committee had received the quarter 1 Safeguarding Report and an update on the Autism and ADHD waiting lists. NCTR had been discussed in detail as it impacted on the quality of care patients received and affected both urgent and elective care performance. An update had been provided on the actions taken which included a focus on the back and front door and the convening of a meeting between system colleagues including Chief Executives. There had also been focus on frailty, assessment coordination and transfer of care hubs. It was expected that there would be a steep reduction in NCTR by September 2024. The Committee raised concerns that the target for September was too ambitious but recognised the significant work that continued to improve the situation. ED welcomed the imminent meeting between Chief Executives to reflect on the actions. ED noted that the outcomes from the Performance Delivery Board would be fed back to the next OPQ Committee. UHBW and North Bristol Trust (NBT) colleagues had been welcomed to the Committee to discuss productivity and the Committee had received confirmation that BNSSG remained in segmentation 3 with the key areas of focus being cancer Faster Diagnosis Standard (FDS),	

	elective 78 week waits, 65 week waits, ADHD and Autism waiting lists, virtual wards, inpatient learning disability and autism, and agency spend. Michael Richardson (MR) explained that nationally incidences of Health Care Acquired Infections (HCAI) were increasing. There were a multitude of possible reasons which were being explored and included the aging population, and higher complexity waiting lists. BNSSG had seen an increase in all bloodstream infections. MR explained that despite the increases BNSSG benchmarked as a high performer in the Southwest in reducing infections except for MRSA. However, MRSA infections looked to be decreasing. Regional working groups had been set up for each infection to share best practice and learning. NHS England had confirmed that the BNSSG system had strong governance in this area with excellent engagement from providers on the System Infection Prevention Management Group. Caroline Dawe (CD) highlighted performance and explained that the system was under the operational plan target for emergency department 4 hour wait and work continued to support the front door and back door as explained previously by ED. The system remained the best in terms of type 1 emergency department in the South West. The system had continued performing despite the junior doctor industrial action and work continued to recruit the right mix to support virtual wards and elective services. Challenges remained within the system including long waiting patients and higher patient complexity for procedures. CD expected ultrasound performance to improve which had been challenged whilst the Community Diagnostic Centres were implemented. The current way of working would remain for a few weeks and it was recognised that this was creating a burden for local admin teams in Acute Trusts. There had been a decrease in the cancer FDS performance due to a surge in referrals and the increase in skin referrals had occurred earlier than anticipated. A tele-dermatology project had been set up which had been rolled out to around half of the system PCNs and roll out of the project would continue. CD explained that the data showed the risks related to the bank holidays in May 2024 as well as the industrial action for mental health. The report did not contain the national data as there had been digital issues with obtaining this. CD highlighted service access for children and young people and explained that it was expected that performance would increase. The ICB continued to work with Sirona on waiting list management processes and there was significant system work ongoing to improve performance. CD noted that the agreed 52 week wait trajectory remained too high but there were plans for an accelerated pilot in place to support the neurodiversity waiting list. The pilot would not affect	

	the waiting list initially but would support those waiting. CD highlighted the good waiting list validation taking place in community paediatrics. CD noted the challenges around learning disability inpatient beds and noted that actions had been put in place to support these beds. CD confirmed that some long staying patients would be leaving the beds soon and work continued to develop a strategy and a new unit would be coming online this financial year. The ICB was considering how the patient and family and carer voice could be included in those pathway discussions. CD noted the importance of community wrap around services and noted that an Inpatient Transformation Quality Plan had been submitted to NHS England. The plan outlined how the system would support patients within the community and reduce inpatient admissions. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	
7.2	**People Committee** JCh confirmed that significant improvements were being made in reducing agency usage across the system with the focus on nursing and medical staffing. The Workforce Strategic Oversight Group had been established to ensure there was strategic leadership of the issues. The NHS at Home staff movement Memorandum of Understanding (MoU) had been negotiated across provider partners and trade union colleagues and agreed. The MoU would support the Hospital at Home workforce. The People Committee received regular updates from system partners and organisations were continuing to improve sickness, turnover and retention rates. JCh noted that updates had also been received from One Care and social care which was supporting the Committee to review areas of shared risk. Jo Hicks (JHi) explained that the ICB was coming to the end of the Shaping our Future programme and following a successful staff event in May, the ICB continued to consider how to develop the organisation and change ways of working. The ICB would respond to the 2024/25 and 2025/26 long term workforce plan requirements when these were received. The information had been delayed due to the General Election. ED highlighted the importance of the Committee Chairs being part of other Committees as there had been intelligence from the OPQ Committee which had been appropriate to raise at the People Committee. JHi explained that because of the information, a workshop had been set up to specifically discuss the workforce in that space. JF noted the importance of ensuring the non-executives	

	and Committees were connected and explained that the non-executives met regularly to connect the discussions at Committee meetings. **The ICB Board received the update from the People Committee**	
7.3	**Finance, Estates and Digital Committee** SWe explained the Finance, Estates and Digital (FED) Committee had discussed the financial challenge facing the NHS in 2024/25. The areas of focus had been set out in the minutes, but the Committee had also discussed the ambition of the system to balance finances and health inequalities improvements. SWe explained the system was starting to identify areas currently not gaining access to services and so costs were rising to address those gaps. The FED Committee had undertaken deep dives into organisations across the system to understand how they were supporting cost savings. UHBW had been the latest attendee of the Committee who had explained their costs savings programme. For all the organisations, the focus had been on increasing productivity, innovating and making improvements which would support the financial position. SWe confirmed that the Committee had noted variances in months 2 and 3 and deep dives would be undertaken to ensure the Committee understood the position and the actions which needed to be taken to deliver the financial position. SWe explained that the Committee had recognised the value of the digital investments particularly the data use through the Intelligence Centre and how this would identify gaps and improve the way data was used in the system. This was expected to identify any areas that needed investment. SWe highlighted that financial balance and good quality services would only be realised through system collaboration. Sarah Truelove (ST) explained the system was £9.5m off plan and this was driven by three issues. The system had only delivered 60% of the planned savings at month 2, elective care remained challenging and high medical agency spend. ST explained that efficiency savings and elective care would be discussed at the Performance and Recovery Board. **The ICB Board received the update from the Finance, Digital and Estates Committee**	
7.4	**Primary Care Committee** AM explained that at the May 2024 PCC meeting, the Committee had discussed the importance of prioritising the work to be delivered in 2024/25 as there were significant capacity constraints. The capacity of the South West Dental Commissioning Hub to support the ICB effectively had been (captured on the Corporate Risk Register. AM noted the two areas of concern related to dentistry,	

	one was around dental contracting arrangements and supporting dental practices and the other was the delivery of the dental strategy and fulfilling the ambition of the system to improve access to services. PCC heard the concerns were being actively addressed with SD meeting with the Chief Executive of the lead ICB (Somerset ICB) to understand in what capacity the dental commissioning hub could support BNSSG ICB. JB explained that the ICB was currently undergoing a period of engagement for the draft Dental Strategy. The ICB was working with local authorities, public health, and the VCSE Alliance, and had received active participation from the North Somerset Health Overview Scrutiny Committee and the Bristol Health and Wellbeing Board. The final version would be presented to the ICB Board later this year. The Strategy would require significant capacity to implement and discussions continued with the Dental Commissioning Hub to determine whether the hub had any capacity to support the transformational elements and if not, what capacity was needed locally. The PCC had received a report regarding medical primary care incident reporting and the Committee had noted a trend in incident reporting related to provider incidents rather than self-reporting. It was also recognised that there was low sign up from medical practices of the new Safety Framework. The Committee recognised that the safety framework represented a significant culture change in general practices and therefore the Committee considered whether there were further issues which needed addressing and whether a deep dive into the themes was appropriate. AM noted that there was cross over with the OPQ Committee in this area. AM attended OPQ Committee and ED attended PCC to ensure those connections were in place. The PCC members had been keen to understand what the Committee would receive for assurance as the new safety framework was embedded. The PCC also received the Primary Care Assurance Framework which would be submitted to NHS England. The Committee had suggested that the Primary Care Assurance Framework be presented to a future ICB Board. JB noted that the Assurance Framework supported the ICB to understand whether the right controls and governance were in place to discharge the ICB's responsibilities for the full range of delegated commissioning. SD confirmed that himself and David Jarrett (DJ) had met with the Chief Executive of Somerset ICB. SD explained that there had been a lack of clarity on the resource and the support ICBs could expect from the Hub. It was agreed that a MoU would be developed which would provide the clarity on what resource was available and the expectations of both organisations.	

	The ICB Board received the update from the Primary Care Committee	
7.5	**Acute and Risk Committee** JCa confirmed that the focus of the April 2024 meeting had been confirming the various workplans for 2023/24 had been delivered and approving the workplans for 2024/25. At the Audit and Risk Committee held in June 2024, the Committee had received a positive Counter Fraud annual report which had received a green rating. The Committee also received the finalised Head of Internal Audit Opinion which outlined the ICB had adequate and effective controls in place but a number of recommendations to improve had been recognised and plans were in place for the ICB to address these. The Committee also received the External Audit report and some areas of weakness had been identified and plans were in place for the ICB to address these. JCa confirmed that following delegation from the ICB Board, the Committee had also approved the Annual Accounts, Annual Report and various supporting documents for submission.	
8	**BNSSG Integrated Care Partnership Updates** JF explained that the recent ICP Board meeting had focused on the Locality Partnership review which had been discussed earlier at the ICB Board meeting. The ICP Board had been well attended and the Joint Chair for UHBW and NBT, Ingrid Barker, had attended the meeting for the first time.	
9	**Questions from Members of the Public** There were no questions from members of the public.	
10	**Any Other Business** JF noted that the next open session meeting would be on the 5th September 2024 after which the BNSSG ICB Annual General Meeting would be held. An Extra-Ordinary ICB Board meeting would be convened in August to discuss an item in closed session.	
	Date of Next Meeting Thursday 5th September 2024 AGM: Thursday 5th September 2024, 6.00pm – 7.00pm	

Lucy Powell, Corporate Support Officer July 2024