BNSSG ICB Board Open Meeting

Minutes of the meeting held on 3rd October 2024 at 12.30 held 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
Hugh Evans	Director of Adult Services, Bristol City Council	HE
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Alison Moon	Non-Executive Member – Primary Care	AM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Mark Cooke	Managing Director, NHSE South West	MC
Aishah Farooq	Associate Non-Executive Member	AF
Jon Hayes	Chair of the GP Collaborative Board	JH
Jo Hicks	Chief People Officer, BNSSG ICB	JHi
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JM
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Jo Walker	Chief Executive Officer, North Somerset Council	JW
Stuart Walker	Chief Executive Officer, University Hospitals Bristol and Weston NHS Foundation Trust	SW
In attendance		
Simon Bailey	Strategy and Planning Coordinator, BNSSG ICB	SB
Becky Balloch	Head of Communications and Engagement, BNSSG ICB	BB

Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Loran Carter	Team PA, Corporate Services, BNSSG ICB	LC
Philip Clatworthy	Consultant Stroke Neurologist, North Bristol Trust *For item 6.2*	PC
Helen Edelstyn	Head of Project Development, BNSSG ICB *For item 6.3*	HEd
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Paul Flood	Transformation and Commissioning Manager, Bristol City Council *For item 6.2*	PF
Helen Gilbert	Director of Improvement, North Bristol Trust *For item 6.2*	HG
Corry Hartman	Senior Workforce Analyst, BNSSG ICB *For item 7.2*	CH
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Samantha Hill	Senior People Business Partner, BNSSG ICB	SH
Ruth Hughes	Chief Executive Officer, One Care	RHu
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Kate Lavington	Head of Design, BNSSG ICB *For item 6.2*	KL
Rhys Lewis	Digital and BI – Executive Director, One Care *For item 6.3*	RL
Fiona Mackintosh	VCSE Alliance Representative	FC
Vicky Marriott	Chief Officer, Healthwatch Bristol, North Somerset and South Gloucestershire	VM
Nicola North	Business Partner, BNSSG ICB *For item 7.2*	NN
Lucy Powell	Corporate Support Officer, BNSSG ICB *minute taker*	LP
Gemma Self	Programme Director – Strategic Projects, BNSSG ICB *For item 6.1*	GS
Nic Saunders	Head of System Strategy and Planning, BNSSG ICB *For item 6.4*	NS
Richard Smale	Interim Director of System Coordination, NHS England South West	RSm
Toria Wrangham	Workforce Redesign Facilitator, BNSSG ICB *For item 7.2*	TW

	Item	Action
1	**Apologies** Jeff Farrar (JF) welcomed all to the meeting and the above apologies were noted. Richard Smale (RSm) was welcomed as deputy for Mark Cooke (MC).	
2	**Declarations of Interest** No new interests were declared and there were no interests pertinent to the agenda.	
3	**Minutes of the September ICB Board Meeting and Annual General Meeting** The minutes of the 5th September meeting and the minutes of the Annual General Meeting held on the 5th September were agreed as correct.	
4	**Actions arising from previous meetings and matters arising** There were no actions to review.	
5	**Chief Executive Officer's Report**	

Shane Devlin (SD) outlined the three items within the report:

- The Independent investigation of the NHS in England – Lord Darzi report
- Winter Priorities
- NHS IMPACT Clinical and Operational Excellence Programme: Learning and improvement networks and improvement in analytics and working guides

Independent investigation of the NHS in England – Lord Darzi Report

SD noted the publication on the 12th September 2024 of the Lord Darzi report. A summary of the key issues were outlined in the Chief Executive report. The outcome of the report would be a 10-year health plan to move the NHS forward. This aligned with the BNSSG system work for Healthier Together 2040. SD noted that the Lord Darzi report, and the feedback from staff, patients and the public would inform the 10-year plan. SD highlighted the three key themes from the report: acute into community, analogue to digital, and delivery of healthcare treatment to prevention. The report highlighted the need to increase the funding to the NHS particularly for capital expenditure to ensure that staff were working in buildings which were fit for purpose. SD highlighted that the most important aspect of the report was the opportunity to improve the health and prosperity of the population particularly as the NHS was the enabler to support people to get back to work and continue to work. The ICB would consider how to build the key themes from the report into plans for 2025/26 and Healthier Together 2040.

Winter Priorities

NHS England issued a letter to all ICBs and Trusts outlining the priorities for the end of the year. These priorities would drive the work of the system partners and ICB executive team. The report outlined the responsibilities of the ICB which included developing a robust winter plan and coordinating this for the system. The winter plan would be presented to the ICB Board. SD highlighted the importance that the ICB undertook the work it was responsible for, and system partners managed the work they were responsible to deliver.

NHS IMPACT Clinical and Operational Excellence Programme

SD explained that IMPACT was the overarching approach to innovation and colleagues from across the NHS have been developing improvement guides and supporting improvement infrastructure. Four initial improvement guides have been published in the following areas:

- Improving flow through the emergency care pathway
- Generating greater value for patients from theatres, elective surgery, and perioperative care
- Generating greater value for patients from outpatients services
- Improving medical consultant job planning

	At a recent event, the system explored what those themes meant for ICBs, system partners and NHS England. There was a lot of work to do to implement continuous improvement cultures and methodology to maximise use of these improvement guidelines. Alison Moon (AM) thanked SD for his report and noted that nationally vaccination rates had decreased and asked whether this trend had been identified locally and what the ICB was doing to encourage vaccination uptake including for system partner staff. AM also asked whether the NHS England winter priorities had included anything surprising or new for the system to focus on. SD noted there was nothing new in the winter priorities. This had been deliberate to support systems to see the benefit from current workstreams. SD highlighted that the ICB was working through the aspects of the winter plan related to vaccinations. Ruth Hughes (RHu) noted that although the vaccination rates locally were good, they could be better, and the Strategic Immunisations Oversight Group worked with system partners to increase public uptake. RHu highlighted the recent focus on MMR and reported that for babies receiving the MMR vaccination BNSSG ICB had the 4th best increase as a result of the cross-system work. Joanne Medhurst (JM) explained that two of the ICB's performing better than BNSSG had achieved the increase with additional funding whereas BNSSG had achieved the increase within the current funding envelope. JM explained that the vaccination programme had been built and developed from the COVID-19 programme and JM was confident that the infrastructure supported those populations who encouragement to vaccinate. JM noted that the infrastructure also supported staff vaccinations and the ICB would work with system partners. Jen Bond (JB) explained that the communications team had produced tailored videos and social media posts to reach those communities and were working across staff groups to encourage staff to take up the vaccination offer. Vaccination was a key element of the communications winter plan. **The ICB Board discussed and received the report**	
6.1	**Healthier Together 2040** Dave Perry (DP) introduced the item as the Chair of the Steering Group for Healthier Together 2040. The programme had been developed to consider the future models of integration to build a better future platform and was at the heart of what ICBs and Integrated Care Systems (ICSs) had been set up to achieve. Healthier Together 2040 aimed to look forward to 2040 and beyond and consider whether the current resources would continue to support future populations. The programme looked at different models of delivery across the whole system taking into account local and national priorities, moving to digitalisation, community prevention, the wider determinants of health and the way	

	infrastructure was deployed. DP noted that although the paper described a system led approach it was expected that delivery would be through place and therefore different models of care may be required for different areas. Links to the Locality Partnerships were noted as really important. The paper described the significant work undertaken so far to identify the priority cohorts and the paper recommended one as a starting point to test the methodology as the system did not have the resource to test them all. Sarah Truelove (ST) explained that Healthier Together 2040 was the mechanism to address the key challenges and deliver the long-term strategic plan. It was clear that the demand for services would change in the future and services would need to be redesigned to support this. Healthier Together 2040 spanned a 15-year timeline to provide alignment and outline the shared purpose for the system. ST noted that the Lord Darzi report reinforced the work, and the system had undertaken an evidence review of both national and local evidence which aligned to the key issue of more people living with multiple health conditions. ST explained that this was a projected 37% growth of people living with major illness. The system needed to address this to ensure that the resources were available to both deliver the care needed and support people to live fulfilling lives. The approach was to delay the onset of these major illnesses and improve healthy life expectancy. The work had identified key cohorts within the population where people were currently seeing poorer outcomes but at a high cost for services. A core part of the work was population engagement and collaborating with those cohorts to understand how the system can better meet their needs. ST explained that at the most severe the three adult cohorts represented those people experiencing disadvantages such as drug or alcohol misuse, mental health needs and unstable housing. Then there was a cohort of people living with multiple long-term conditions who were working and often carers, who tended to live in deprived areas and were disproportionally women. There was also an identified cohort of older people living with multiple long-term conditions. ST explained that the evidence had indicated that there was a significant number of people who would be part of these cohorts within the next 15 years. Children and young people had been identified as the fourth cohort and this was more challenging to consider as there was currently no way to segment the population of children and work was ongoing to identify a way to do this. The recommendation was to focus firstly on people living with multiple long-term conditions as this would identify and embed the work needed to prevent future frail populations. It was recognised that issues facing this cohort would include families, communities, housing, employment, and health and therefore an	

	integrated community approach was important. It was noted that current numbers in the cohort were not significant, but it was recognised that this was a growing population and therefore a manageable test for the methodology. Work would take place with the cohort over the next 6 months to work through optimisation of care and improving wellbeing, identifying opportunities to release capacity, taking actions to prevent people coming into the cohort and predicting future needs to plan accordingly. The engagement work with the people would begin and a focused review of best practice from elsewhere would be undertaken as well as a mapping exercise of the current service use and infrastructure. It was proposed to take all this insight into a series of workshops using the three horizons model to identify a leadership team. As part of the work the differences between those in the cohort would be understood in more depth and the workshops would identify a set of medium- and long-term strategic intentions for ICB Board to approve. JF confirmed that the Integrated Care Partnership (ICP) Board were supportive of the approach and prioritisation. John Cappock (JCa) asked how long it would take for the ICB to identify the impact on the cohort and undertake the work for the larger cohorts. ST confirmed that it was expected that by Spring 2025 there would be a clear set of strategic intentions to inform medium term planning after which the detailed work would begin. ST noted that in terms of impact to patients, it was likely to take a couple of years. The current work would continue but it was expected that the outcomes from the Healthier Together 2040 work would inform future iterations of the Joint Forward Plan. ST noted the importance of building momentum and movement as the population cohort approach was a different space for the system to consider. Maria Kane (MK) agreed with the chosen cohort as the increase in chronic multi-morbidities would have a disproportionate impact on patients, family carers, their ability to contribute to society and the cost of services. MK believed that focus on this cohort would provide opportunity to reshape services outside of acute hospitals. MK noted that there would be some required actions outlined in the 10-year plan and the Healthier Together 2040 plans would need to fit with those prescriptive actions, but it was hoped that these national plans would provide an indication of funding envelopes. ST agreed that the work would need to fit into the 10-year plan and confirmed that with all the evidence based work undertaken it was hoped that the system could influence some of that planning to support a community based approach. ST confirmed that a core element of this work was moving from acute services to community services.	

	AM welcomed and supported the work and the recommended cohort but noted the importance that the system did not assume what was a good outcome for the population but undertook the engagement work to ask people what this meant for them. AM highlighted that one of the risk implications outlined was that activity may have to cease and resources reallocated and asked when this would be considered. ST confirmed that those considerations would be part of live and dynamic decision-making processes and that discussions with NHS England had emphasised that Healthier Together 2040 was about taking a new population driven approach. There may be times when NHS England asked the ICB to undertake something and when the local evidence suggested focus should be elsewhere, it was important that the system could say no. The system needed to be clear on the approach being taken to shape the system over the next 10 years. ST noted that in terms of outcomes, engaging and working with communities was an important next step. Ellen Donovan (ED) agreed with the recommended cohort but asked how the work would support a sustainable system for patient flow. ST explained that the programme was future thinking and the current work around frailty would not stop but it was hoped that the Healthier Together 2040 work would prevent people from moving into the frailty cohort as this was happening at an early age for some of the local populations. ED highlighted the links with the transformational work and item 6.2 on the agenda and asked the ICB Board to consider whether there was scope to do both. RSm welcomed the population data driven approach to the change process and noted the ambition to drive the national agenda through the work. As well as the opportunities for possible payment options and the data challenges and offered the support of NHS England in the work. RSm highlighted the link to the acute strategy and the move to community care. Hugh Evans (HE) welcomed the work and echoed the points made by ED to consider concurrently addressing the different issues as the older people challenge was significant. HE welcomed the data driven approach and the engagement and coproduction with communities and asked the ICB to ensure that those with the greatest health inequalities were captured within that engagement to include poverty and deprivation. JF agreed and it was confirmed that this would be considered as part of the new Health Inequality Committee. **The ICB Board approved the recommendation to progress onto the next phase of work; to develop Strategic Intentions for the Working Age Population with Multiple Long Term Conditions**	

6.2	**Developing BNSSG Transformation, Improvement and Innovation Capabilities** Deborah El-Sayed (DES) reminded the ICB Board of the five principles of improvement and explained that this paper outlined the approach to start the improvement work to move from the current ways of working whilst supporting staff. DES thanked the improvement community who had coproduced the work to ensure there was a system wide approach to transformation. DES highlighted the diagnostic work which had taken place to determine the barriers to transformation and set of 12 components had been developed which would inform the transformation framework. The ICB was asked to support testing the 12-point plan in a key area of improvement. DES noted that this could be Healthier Together 2040 or another area of strategic transformation. Helen Gilbert (HG) highlighted that the start of the 12-point plan was establishing a system compact or leadership agreement for the system to determine how delivery plans would work in the sovereign organisations. The motivation was to be population and organisation driven, and the compact would mitigate some of the barriers to transformation. The compact would include challenge for the future and the accountability mechanisms to create the guardrails to protect improvement development for the future. DES highlighted that the second area was the establishment of a Transformation Academy which would encompass a number of elements in the plan to provide advice to organisations and evaluate the work to determine benefits realisations. Oversight of the redesign of services was important to determine whether the resources were available and to track the transformation load of the system. Philip Clatworthy (PC) highlighted learning from the stroke transformation project including the importance of learning and evaluation and needing to build the space for this into any transformation project. The importance of considering transformation projects as a system and across whole pathways was noted, as was the need for continued user engagement and continuous improvement processes. PC highlighted the importance of digital by default rather than design and embedding this at all stages. Data was an important part of any project and PC explained that the data needed to reflect the population and person perspective rather than reinforce the organisational perspective. The Intelligence Centre was a key system repository in centralising data sharing and there was a significant element of cultural change needed to maximise the benefits. Paul Flood (PF) explained that the framework moved staff out of being reactive and being more proactive with transformation. PF noted that partnership working	

	was challenging, and the framework would reconcile similar but competing demands and priorities. DES highlighted that the framework would be coproduced by the system and outline the action needed to ensure the system was more successful in enacting the significant transformation, change, improvement and innovation agenda. SD welcomed the development framework as the guidance which supported the system to become involved in adaptive change. It was critical that the system developed these rules so that the work moved out of the transactional element into the true innovative space. Julie Sharma (JS) welcomed the principles but had concerns about the capacity of a transformation resource limited organisation to undertake the significant work outlined and the challenges with individual organisation Board development to ensure everyone was supportive. JS also raised concerns regarding the cultural change journey when there were competing priorities in organisations and outlined the need for some wider groundwork first. Dominic Hardisty (DH) believed that if the system wanted change to happen then it was sensible to give the responsibility of driving it to those most effective and affected. DH outlined 4 levels of transformation, team level where quality improvement as a standard methodology were rolled out for large scale projects and small scale projects where people were taught and empowered to undertake the improvement. The divisional level was providing tools and not too much oversight of the work. At Trust level, the improvement activities would be engineered and receive the oversight needed to achieve and at system level transformation would not happen unless multiple system partners collaborated to do something similar. DH noted the importance that change was placed at the right level and balanced against the available resource and the expected benefits. RSm noted the emphasis on cultural changes was really important and noted the strength of the paper in highlighting the need for experimentation, testing and learning. There was an opportunity for NHS England to capture the learning as this approach was ahead of what other systems were considering. RSm also noted the resource challenge and offered the support of NHS England with the Transformation Academy and suggested that the commissioning support units may be able to support this work as well as other wider system partners. Steve West (SWe) asked whether the system had the capability, capacity and resource and whether this resource could be tracked and monitored.	

	MK explained the importance of ensuring that the duplication of improvement methodology in the system was reduced and noted the opportunities for the system from the Universities and Bristol Health Partners, as well as local and national learning and innovation networks and the importance to interface with this work. JM supported the approach and asked the system to consider whether innovation was being undertaken without redundancy and waste as currently processes were slow and some services continued despite not achieving the benefits expected. JM welcomed empowering the experts in the system to make the continuous change improvements needed and cautioned against undermining the experience and expertise by making assumptions. JM recognised all the system expertise and best practice which had been included in the framework and paper. DES highlighted that consideration of balance between resource and expectations was important as well as the different types and scale of improvement that was needed at different levels. DES also noted that part of the work had been determining the barriers to efficient system transformation and the system experts had developed the 12 points to mitigate these barriers and improve transformation processes based on their experience and knowledge. The approach had deliberately stepped away from organisational methodologies so that a full system approach could be developed. DES agreed with the point around monitoring the transformation load and explained that when the organisational transformation programmes and information was shared, the duplication within the system could be identified addressed. The framework would drive efficiency in terms of the costs, but it was important to note that this work was not about more money but doing things differently. JF asked about the governance of the process and DES confirmed that there was none in place yet but this would be considered further. It had been proposed that a governance group around transformation was set up which repurposed another group already in place, and it was likely that this would feed into the System Executive Group. JF noted that it was important for the ICB Board to be sighted on the development of the work and asked that an update paper be presented to the Board in the future. **The ICB Board:** • **Considered the discovery and the recommended 12 point approach to develop a framework** • **Endorsed the next steps to develop a system leadership compact**	**DES**

	• **Agreed to pilot the approach with a strategic priority cohort such as those identified via the Healthier Together 2040 process**	
6.3	**Digital Strategy Delivery – Quarterly Update** DES reported that the update focused on the NHS App and explored the opportunities presented by the NHS App for patients to engage with NHS services. The App was developed centrally by NHS England and local work continued to drive utilisation of the App in the population. There was a central programme called the Wayfinder Programme which was building interfaces with the other systems NHS organisations used to connect with patients. Patients were now able to see and change appointments with North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). The NHS App was critical to the Digital Strategy and had provided cashable savings particularly through the use of the notifications feature, which reduced the amount of money organisations paid on text messaging. DES highlighted the local and national communications campaign to encourage members of the public to switch on notifications. Rhys Lewis (RL) explained that the NHS App reduced the time taken for admin tasks and highlighted that repeat prescriptions processes and receiving test results could both be completed through the App. The NHS App empowered patients to own and manage their healthcare needs and contact with the NHS. The uptake in BNSSG was over 60%, above the national average, but there was more to do to increase uptake and encourage people to turn on the notifications function. RL highlighted the barriers to using the NHS App which include lack of trust and digital literacy and explained that the team was working closely with partners to support digital inclusion work programmes and identify the appropriate organisations to reach those populations with lower uptake. RL explained that the discovery work had identified a number of benefits through GP Practice use of the App and this was expanding to other system partners as the central functionality increased. The team were sharing the learning about the integration into existing patient portals across the system. It was important that there was a system wide approach to the NHS App to ensure that the benefits were maximised. It was envisaged that the NHS App would be the channel for initiatives and messages to be communicated and this was the driver for increasing the uptake nationally. RL outlined the next steps which included launching a local communications campaign, producing toolkits for GP Practices, engagement with underserved groups, actively addressing digital exclusion and ensuring standardisation of access for all patients. RL noted the importance of partner and system collaboration to engage staff and patients in the use of the NHS App.	

	ED asked for examples of what more was needed from partners in terms of engagement. RL explained that the NHS App did not replace existing patient engagement portals but as the functionality for the App increased those portals would be channeled through the App as the one face for NHS engagement. RL highlighted that NBT and UHBW portals were now through the App and this was being rolled out for other organisations as the functionality increased. It was important that organisations promoted the App. The team were working with general practice to consider how the function of the App could be maximised and the local authorities were working to understand how the functionality may support them as well. RL noted that the design and integration work was completed at national level but BNSSG was able to make suggestions to the national team of the type of integration needed. AM highlighted that the functionality of App was not equitable currently as some practices had not signed up to the full functionality and explained that if those who were digitally enabled did not have the full functionality available, they would not use the App. AM noted that the paper described the reasons that GP practices thought people had not signed up to the App and asked whether any public engagement had taken place. AM noted the concerns around English as a second language and asked what BNSSG had put in place to address this. RL confirmed the team was working with practices to standardise the functionality including work with practices to support staff and explain the benefits of NHS App utilisation. RL acknowledged that the team had not undertaken any direct engagement with the public but was working with voluntary sector organisations who already worked at the community level and had existing relationships with these populations to encourage uptake. DES explained that the language barrier issue was being reviewed and considered at the national level. SD noted that despite the NHS App being a national product there had been little communication through social media feeds to encourage people to use the NHS App and it was important to reach those more digitally literate people who were likely to use the App. SD asked that this be fed back to the national team. SD also noted the thousands of patient contacts everyday in health and social care and encouraged all staff members to use the opportunity to promote the NHS App. RL welcomed this and asked partner organisation to feed this back to their staff if appropriate. Jaya Chakrabarti (JCh) noted that the greatest area of patient interest in the App was booking appointments and there was significant opportunity available in terms of communicating with patients when functionality would be available which would support and encourage uptake. RL agreed and explained that those practices with more functionality, including appointment booking, had seen	**DES**

	benefits in reduction of work load but also better patient experience feedback. There were issues in some practices where the current software did not yet integrate with the NHS App, and these issues were being fed back to the national team who would work with the suppliers to integrate into the App. **The ICB Board noted the outputs from the discovery process, including current uptake of the NHS App within BNSSG, and the barriers to access including digital exclusion and the scale of the opportunity in terms of both efficiency and patient experience.** **The ICB Board supported the development of next steps across the BNSSF system to increase the uptake of the NHS App as a key part of our ambition to 'allow citizens to access their health data and communicate with NHS organisations'.**	
6.4	**Corporate Risk Register** ST explained that the ICB was undertaking a refresh of the Corporate Risk Register (CRR) processes and this had been discussed and welcomed by the Audit and Risk Committee. The CRR had been reviewed by the Committee and was now being presented to the ICB Board to seek approval to close the risks proposed for closure and review the remaining risks. The risks on the CRR were focused on the risks of the ICB as a statutory organisation. There was more work to do to review the system wide risks. Nic Saunders (NS) noted that new risks had been highlighted within the CRR and asked the ICB Board to consider whether these risks should be included on the register. The ICB was currently ensuring that the individual directorate risk registers were consistent to support CRR processes. JCa noted the significant work which had been put into improving the CRR processes and the Audit and Risk Committee had welcomed the reset and refocus. JCa highlighted that the ICB had received reasonable assurance from the Head of Internal Audit Opinion but this was lower than previous years. The September Audit and Risk Committee had received a demonstration from NS on the development of a new tracker for audit recommendations and management actions which would be enacted. A series of deep dives into directorate risks would be timetabled for ICB Board Sub-Committees with the Audit and Risk Committee as the group with oversight. ED added that ST had confirmed that individual registers for Committees were not needed and any appropriate risks for review would be lifted from the master CRR. ED noted the importance that the deep dive programme was communicated to Committee Chairs to ensure there was time on the Committee agendas for appropriate discussion. ED asked that at a future ICB Board meeting, hard copies of the Risk Register were	

	available for review. This was agreed and it was noted that the CRR had also sent to Board members via email so that the original version in Excel could be viewed. JS asked where the lower rated system risks were held. ST confirmed that the ICB did not have a complete list of the system risks and work continued to ensure the right process was in place to understand the risks across the system and ensure consistent scoring of these. The next step was to bring system risk leads together to test what risks would need to be escalated across the system. JS asked whether this process would recognise that a single risk could sit across many organisations, and would the process define an organisation to manage the risk? ST confirmed that this was planned to be part of the process and agreed as part of the next update to provide a list of the system risks held by the ICB and where in the system the risk was being managed. SD noted that some of these system risks were being held by groups and the ICB wanted these to be held at senior executive level and the initial discussions held previously made the risk discussions very complicated. The ask from the ICB for this next review from system risk leaders was to take a common sense approach so that when a risk was identified, an appropriate organisation would hold and discuss the risk, and monitor the mitigation and improvement work. **The ICB Board:** • **Received the BNSSG ICB Corporate Risk Register** • **Noted the details** • **Accepted the risks escalated to the CRR and approved the closure/de-escalation of risks from the CRR where indicated** • **Noted the approach to conduct Deep Dive reviews into the Directorate Risk Registers by relevant Board Assurance Committees**	**RH** **ST**
6.5	**BNSSG ICB Constitution** The ICB had received notification from NHS England in July 2024 about suggested amendments to the ICB Constitution. SD confirmed the amendments had been made and included references to the Senior Independent Non-Executive Member and Deputy Chair roles, the removal of information relating to the establishment of the ICB and embedded the Joint Forward Plan within the Constitution. Rob Hayday (RHa) confirmed that if the changes were recommended by the ICB Board, the proposed Constitution would be sent to NHS England for approval. **The ICB Board endorsed the BNSSG ICB Constitution for NHS England approval**	
6.6	**Managing Conflicts of Interest Policy**	

	The proposed changes to the Constitution also outlined the changes ICBs needed to consider when reviewing conflicts of interest processes. The BNSSG ICB Managing Conflicts of Interests policy had been reviewed and the amendments made. These included references to the Provider Selection Regime, changes to the principles to support management of interests, strengthening and clarifying the requirements of the members of the ICB Board and Sub-Committees who are not ICB employees and considerations of interests for Joint Committees. The Policy had been reviewed by the Audit and Risk Committee and JCa as Chair, confirmed the Committee recommended the policy to the ICB Board for approval. **The ICB Board approved the Managing Conflicts of Interest Policy**	
7.1	**Outcomes, Performance and Quality Committee** ED reported that at the September Outcomes, Performance and Quality (OPQ) Committee the members had received the Annual Safeguarding Report, The Special Educational Needs and Disability (SEND) Quarterly Report, and a report on research. The Committee had discussed performance and quality as well as Learning Disability and Autism out of area placements which had been discussed as part of the Safeguarding Annual report. The most significant concern raised was around data sharing and the Committee had received assurance that this was being reviewed with DES and other system colleagues. The Committee members asked for assurance on the preparedness for Winter and it was confirmed that planning was the same as last year but with additional initiatives. The Winter Plan would be presented to the ICB Board before the end of 2024. The challenge from the Committee had been around whether community services were ready and fully recruited. ED reported that excellent progress had been made on the cancer faster diagnosis standard (FDS) with diagnostic testing being near top in the country. NBT had made excellent progress in elective 65 week waits, UHBW remained challenged in the areas of dental and corneal transplants which was the result of a national tissue shortage. Urgent care remained slightly off the planned trajectory and category 2 ambulance conveyances were on target. The most significant challenge facing the system were patients with No Criteria to Reside (NCTR) and this had been discussed at length at the Closed ICB Board previously and the system had agreed some actions for a sustainable solution. David Jarrett (DJ) reported that the performance report had been presented to the Senior Executive Group (SEG), in advance of the OPQ Committee, who reviewed the position and assessed the key risks outlined in the report. The SEG noted NCTR for escalation to the OPQ Committee as well as challenge to the system to flex capacity for the stroke pathway. The system was also	

	experiencing challenge in the heart failure pathway and work continued between Sirona and NBT to improve patient flow. SEG was keen to have a deep dive into children's services and performance standards and following presentation at SEG, this would be presented to the ICB Board. The risks related to the GP collective action continued to be monitored by the Primary Care Committee (PCC). DJ noted the continued sustained strong performance against the mental health standards predominantly through the work of Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) who were ahead of target against most of the standards and those others were going in the right direction. DH highlighted that credit should also be extended to Vita Minds and the Devon Partnership. DH explained that the long term plan metrics for mental health services were unambitious and although these remained challenging, they were based on achieving a percentage coverage of the population which was lower than the system deserved. Work continued to do more to reach over and above that population target. **The ICB Board received the update from the Outcomes, Performance and Quality Committee**	
7.2	**People Committee** JCh confirmed the People Committee had received the usual updates related to workforce monitoring, provider temporary staff, resource recovery plans and NHS at Home. The financial position remained challenging, and partners were working hard to ensure they are off framework and agency use compliant. JCh highlighted the significant positive work on nursing which was now fully compliant, and the focus had shifted to medical, dental and other specialist areas. Work had begun to correlate additional bank agencies to support mitigations during times of escalation. This would be reported to the Strategic Workforce Oversight Group who would monitor this against vacancies, sickness and bank usage. There were currently lower levels of sickness over the summer and winter arrangement were in place and would be continually monitored. The Committee received a presentation from the NHS at Home team who supported recruitment activities. This area had been flagged by the OPQ Committee as an area the People Committee should review. This had now taken place and additional staff were joining. A Memorandum of Understanding (MoU) had been created by a collaborative group which included trade union colleagues and this had enabled both the recruitment and clarity of roles and responsibilities being shared across system partners.	

	The Committee had also received a presentation from colleagues in the local authorities on the Workforce Strategy for Adults and Social Care. Many areas of joint working were identified and social care workforce was a key element in the People and Culture Plan. Nicola North (NN) highlighted that one of the aspects of this was considering how to support moving of staff and skill sharing between organisations. Corry Hartman (CM) explained that social care workforce was included in the report to the People Committee and improvements were being made to ensure that updates were received regularly. There was also engagement with Skills for Care to align the short term strategic workforce planning work with NHS England to determine how the region and the BNSSG system can plan the workforce needed for the future. JCh noted the importance of partner Non-Executive Director (NED) attendance at the Board Sub-Committees as it facilitated the sharing of system learning and identification of collaboration opportunities. JCh asked the Board members to continue to encourage NED attendance at the Committees. SD highlighted the importance of including paramedics in those system support conversations as these were roles which were ideal for working across systems. SD confirmed that he had discussed this with Jo Hicks (JHi) in terms of how paramedics could become part of the future of the workforce. Paramedics were currently oversubscribed for undergraduate courses so there was an opportunity in this which the People Committee should review. JCh agreed noting that paramedics were an important part of mitigating the risks existing between handover points. ED thanked JCh for reviewing the NHS at Home work and noted that this was an example of the Committee working well together. ED explained that this work fed directly into NCTR so the People Committee was impacting on one of the most challenging elements in the system. ED also noted the importance of the People Committee in monitoring the winter planning through the workforce plans. JF noted that the NHS at Home work was an excellent example of collaboration across the system and asked that a brief update on the work was presented to the ICB Board in the future. **The ICB Board received the update from the People Committee**	**JHi**
7.3	**Finance, Estates and Digital Committee** SWe reported that the Finance, Estates and Digital (FED) Committee had recommended the Infrastructure Strategy for ICB Board approval, as well as the procurement approach for abortion care services. Both of which had been approved by the ICB Board. SWe explained that the financial position remained	

	challenged and highlighted the importance that the system delivered the savings planned in 2024/25. If not delivered there would be consequences for the system including reduced funding and increased scrutiny from NHS England. The system position was currently 12.4m in deficit and the system was focused on recovery of the position. SWe highlighted that the deterioration had been managed early and the system was currently holding the position and the focus of the system was closing the gap and this would continued to be monitored. Three significant risks remained, the financial challenges faced by the local authorities, the challenges of managing funded care costs and the non-emergency patient transport contract. These risks continued to be monitored and mitigated. JF highlighted that the BNSSG system was one of the better systems nationally in managing finances but there is more to do. ST acknowledged that the system was performing better than others financially but noted that non-delivery risked losing the incentives which had been planned for in 2025/26. ST noted the commitment and pressure on staff to deliver the savings in order to act with autonomy and receive the incentive payments in 2025/26. SD noted the financial position was discussed at the Performance and Recovery Board, and the providers developed plans to mitigate the risks. These would be presented to the ICB Board for decision at a future meeting. **The ICB Board received the update from the Finance, Digital and Estates Committee**	
7.4	**Primary Care Committee** AM confirmed that there had not been a PCC since the last Board meeting but reminded members that the PCC reviewed the detail behind the GP collective action and highlighted the need to maintain good system relationships throughout and after the action. DJ explained that the ICB continued to work collaboratively with the Local Medical Committee (LMC), One Care and practices to discuss openly the approach to be taken. The LMC had met with all practices and the proposed actions were collated and reviewed. A summary of the agreed actions have been shared with practices with a rollout of potential action for the practices should they wish to take action. Further actions were expected to be implemented over the coming months. DJ reported that as of now, practices were able to move to 25 appointments a day and were reviewing use of a standardised referral form and review what areas were considered unfunded against the core contract. The ICB was working with the LMC, One Care and system partners to develop mitigating actions in response to the collective action. The ICB was undertaking an assessment of individual practices as it was for practices to decide how they implement the proposed actions. An Equality and Health Inequality Assessment (EHIA) has been completed for each	

	proposed action and the mitigations. The full risk assessment would be presented to the PCC next month and the ICB Board for further assurance. AM agreed that NEDs were an important part of the Committees and JF noted that there would be a future meeting with NEDs to discuss the importance of system working. **The ICB Board received the update from the Primary Care Committee**	
7.5	**Acute and Risk Committee** JCa confirmed that the update had been included as part of item 6.4. **The ICB Board received the update from the Audit and Risk Committee**	
8	**BNSSG Integrated Care Partnership Updates** JF highlighted the sense of enthusiasm at the previous ICP Board meeting and noted that the local authority Charing arrangement provided a different dynamic to other system groups. The ICP Board had discussed the significant financial challenges facing the local authorities and the Healthier Together 2040 work. The ICP Board had provided positive contribution and feedback. The ICP Board and ICB Board would meet again in 2025 to ensure that the Boards were not duplicating effort. The ICP Board had received an update on the review of the locality partnerships which had been driven by the reduction in running costs for the ICB. A facilitated discussion had taken place and following this there had been consideration of how well sighted the ICB Board was on the review process to ensure that there was consistency across the system as needed. Fiona Mackintosh (FM) noted that the was some disconnect between Locality Directors, Partnership Chairs and the ICB Board and there had been a suggestion for a standing item on the ICP Board for localities. FM noted the significant work being undertaken by the Localities and the Voluntary, Community and Social Enterprise (VCSE) organisations and noted that these was a key element of the transformation work discussed earlier. FM explained that the Locality Partnerships were the architecture of delivery at a local level and it was an important that there was a place for this work to be reported and celebrated. SD expected that the review would identify the work to connect and create the architecture needed. SD highlighted the importance that Locality Partnerships were able to deliver without burdensome governance processes. It was expected that the review would identify the right levels of governance needed. DJ confirmed that the work of the Locality Partnerships had been aligned to the Health and Care Improvement Groups (HCIGs) and much of the work was reported through Community HCIG. JF noted the importance that the ICB Board was sighted on the work as it was	

	as much about valuing the work of the Locality Partnerships as it was as a reporting mechanism. **The ICB Board received the update from the Integrated Care Partnership Board**	
9	**Questions from Members of the Public** JF read out a series of questions received via email to the ICB Board and ST provided a response: What was the amount of funding provided by the ICB to a partnership with the VCSE CATCH project to set up a long term programme of support for implementing green plans and connecting to the VCSE sector? £20,000 What was the amount of funding provided by the ICB to deliver energy and green plan progress audits to identify opportunities for energy savings to enable primary care to develop business cases to work with third parties to implement plans to de-carbonise their estate, and to whom was the funding provided? £47,000 contract was awarded to Kovia Consulting Ltd What further funding does the ICB plan to provide to VCSE organisations and GP Practices to support the implementation of green plans? No commitments have been planned but funding opportunities are being explored and informed by the audit work.	
10	**Any Other Business** There was none	
	Date of Next Meeting Thursday 5th December 2024 at the Vassall Centre, Gill Avenue, Bristol, BS16 2QQ	

Lucy Powell, Corporate Support Officer October 2024