

**HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD**

**WEDNESDAY 12 FEBRUARY 2025 AT 10:00 HOURS, SYNERGY SUITE, HEALTH HOUSE, GRANGE PARK LANE, WILLERBY, HU10 6DT**

**Attendees and Apologies**

**ICB Board Members: "Ordinary Members" (Voting Members)**

**Present:**

Sue Symington (Chair) HNY ICB Chair

Councillor Jonathan Owen Local Authority Partner Member

Amanda Bloor HNY ICB Acting Chief Executive

Dr Bushra Ali Primary Care Partner Member

Dr Nigel Wells HNY ICB Executive Director of Clinical & Professional Services

Jane Hazelgrave HNY ICB Acting Deputy Chief Executive / Chief Operating Officer

Jayne Adamson HNY ICB Executive Director of People

Jonathan Lofthouse Provider Partner Member

Mark Brearley HNY ICB Interim Executive Director of Finance and Investment

Mark Chamberlain HNY ICB Non-Executive Director

Richard Gladman HNY ICB Non-Executive Director

Stuart Watson HNY ICB Non-Executive Director

**Apologies:**

Stephen Eames HNY ICB Chief Executive

Teresa Fenech HNY ICB Executive Director of Nursing & Quality

**ICB Board Members "Participants" (Non-Voting Members)**

**Present:**

Andrew Burnell Partner Participant (Community Interest Companies) – Via Teams

Anja Hazebroek HNY ICB Executive Director of Communications, Marketing & Media Relations

Councillor Michael Harrison Partner Participant (Local Authority: North Yorkshire and York)

Councillor Stanley Shreeve Partner Participant (Local Authority: N & NE Lincolnshire)

Jason Stamp Partner Participant (Voluntary, Community & Social Enterprise)

Karina Ellis HNY ICB Executive Director of Corporate Affairs

Louise Wallace Partner Participant (Public Health)

Peter Thorpe HNY ICB Executive Director of Strategy & Partnerships

Professor Charlie Jeffery Partner Participant (Further Education)

Dr Simon Stockill Primary Care Collaborative Lead

**Apologies:**

Brent Kilmurray Partner Participant (Mental Health, Learning Disabilities & Autism)

Helen Grimwood Partner Participant (Healthwatch)

Max Jones HNY ICB Chief Digital Information Officer (CDIO)

**"Observers" and Individuals Presenting Items**

Dr Deepti Alla HNY ICB Associate Non-Executive Director

Professor Dumbor Ngaage HNY ICB Associate Non-Executive Director

Paula South HNY ICB Director of Nursing and Governance

Stacey Stanton HNY ICB Primary Care Project Officer

Emma Jones HNY ICB Business Services Senior Officer (Corporate Affairs)

**BOARD GOVERNANCE**

**1. Welcome and Introductions**

 The Chair welcomed everyone to the meeting and reminded attendees that the meeting was being live-streamed.

It was noted that Paula South, Director of Nursing and Governance was in attendance, deputising for Teresa Fenech, Executive Director of Nursing and Quality. Stacey Stanton, Primary Care Project Officer was also in attendance, observing the meeting at the Chair's invitation.

The Board was reminded that the meeting was being recorded and would be shared with the public for that purpose. Artificial intelligence (AI) was assisting in the minuting.

**2. Apologies for Absence**

The Chair noted the apologies as detailed above, and it was confirmed that the meeting was quorate.

**3. Declarations of Interest**

 In relation to any item on the agenda of the meeting Board Members were reminded of the need to declare:

(i) any interests which were relevant or material to the ICB;

(ii) that nature of the interest declared (financial, professional, personal, or indirect

(iii) any changes in interest previously declared;

 No declarations of interest were noted in relation to the business of the meeting, although it was noted that there might be declarations when discussing general practice from clinicians present.

**4. Minutes of the Previous Meeting held on 8 January 2025**

 The minutes from the previous meeting held on 8 January 2025 were checked for accuracy and the Board agreed them as a true and accurate record, subject to the following amendments:

 On Page 5, a point was raised about adopting a customer service culture in healthcare to improve patient experience. The Chair emphasised the importance of this approach and suggested that the Board should hold onto this idea and explore what it might look like in practice.

 A further point was raised about recognising staff for their supreme efforts under pressure. The Board discussed various ways to recognise staff, including a "shining lights" program where staff or the public can nominate individuals for recognition. The Provider Partner Member advised of a similar initiative in NHS Humber Health Partnership, and the Partner Participant for Voluntary, Community & Social Enterprise elaborated on the importance of reward and recognition, suggesting a system-wide approach.

 It was noted the minutes would be signed by the Chair.

 **Outcome:**

 **Board Members approved the minutes of the meeting held on** **8 January 2025 and noted the above verbal updates.**

 **Board Members recognised the importance of a customer service culture when communicating with patients and service users.**

 **Board Members recognised the importance of recognising those staff who go ‘over and above’ in respect of their roles.**

**5. Matters Arising**

The Chair led the Board discussion on the matters arising, noting all actions had been completed:

**Voice of Lived Experience Piece**: This action was completed and was to be discussed later in the meeting at Item 7.

 **Detailed Update on EPR Training**: This update was received by the Board by email.

**Kapow Suggestion**: It was acknowledged that efforts were made to encourage other organisations to use the Kapow video.

 **Board Assurance Framework**: This review was completed and was to be discussed later on the agenda, at Item 8.

 The Chair asked if there were any other matters of business for the public meeting, and there were none.

**6. Notification of Any Other Business**

Members of the Board were reminded that any proposed item to be taken under any other business must be raised and subsequently approved at least 48 hours in advance of the meeting by the Chair.

 The Chair advised that no such notifications had been received.

 **Outcome:**

 **Board Members noted that there were no items of any other business to be taken at the meeting.**

**7. Voice of the Lived Experience**

The Executive Director of Communications, Marketing and Media Relations presented the findings from the Voice of Experience survey, which gathered feedback from nearly 4,800 people, including the public, staff, and stakeholders. The survey identified three consistent priorities across all groups:

* **Access to Services**: Long waiting times and difficulties in accessing healthcare were major concerns.
* **Person-Centered Approach**: Improved communication, coordination, and integration of NHS services around the individual were highlighted.
* **Staff and Workforce**: Concerns about understaffing, staff morale, and the impact on the quality of care were noted.

 The importance of using this feedback to shape future plans and decisions was emphasised, describing it as a "handrail" for the Board's work. The survey also highlighted specific areas for improvement, such as better use of digital systems, increased focus on prevention, and addressing health inequalities.

 The Board discussed the feedback and highlighted the alignment between the public's priorities and the Board's strategic direction, emphasising the mandate to make necessary changes. The importance of compassion in healthcare and concerns about the public's perception of end-of-life care was raised, suggesting further investigation into potential misunderstandings. The Board agreed the need for a person-centered approach, sharing an example of how social prescribing significantly reduced a patient's primary care visits. The issue of controversial service reductions was raised and the need for careful consideration in the upcoming financial plans.

 The Board emphasised the importance of addressing staff morale and its impact on patient care and waiting times. The significance of community transport and the need to educate the public about the broader primary care team beyond GPs was also recognised. The need to explicitly recognise the shifts towards community care and prevention in the financial planning process was also highlighted The Board reaffirmed the priority of children's health and well-being as a key focus for prevention efforts.

 The Executive Director of People informed the Board of the ongoing work to improve staff experience and retention, with a focus on health and wellbeing.

 It was noted that the service that the public wanted was the service that the NHS wanted to give.

 The Board recognised this as an excellent report and thanks were expressed for all the contributions made.

 **Outcome:**

* **Board Members noted and discussed the key themes.**
* **The presentation and full report across the ICB and ICP would be shared.**
* **Further investigation into the public's perception of end-of-life care to understand potential misunderstandings.**
* **Explore and implement strategies to enhance person-centered care, including social prescribing and community-based solutions.**
* **Develop and implement initiatives to improve staff morale and retention, focusing on health and well-being.**
* **Address community transport issues to improve access to healthcare and support prevention efforts.**

**8. Board Assurance Framework**

The Executive Director of Corporate Affairs presented the updates to the Board Assurance Framework (BAF), highlighting significant changes, including the addition of two new financial risks. The BAF now included 12 active risks, with a focus on patient quality and safety, and financial risks split between the ICB organisation and the system.

 Concern was raised about the potential quality risks associated with shifting services to neighbourhood health. It was queried how the Board would ensure the quality of services delivered in the community. Assurance was provided that any service moved to the community would undergo due diligence and clinical planning to maintain or improve quality. It was also added that the ICB's role as a commissioner included assuring the quality and safety of any services commissioned, and this would be a key focus as the ICB develop neighbourhood health models.

 The Board pointed out a correction was needed in the BAF, noting that the likelihood and impact scores for risk C5B should be 4 each, making the total score 16. It was also suggested that the risk score might still be too low given the financial challenges for the next year. This point was acknowledged, explaining that the medium-term financial plan considered a four to five-year horizon, hoping for improved resources and sustainability in the future.

 The need for better assurance around prevention efforts was raised, noting that there was a lack of full information about all the activities happening in this area to emphasise the importance of transparency. It was suggested that the Board should have a comprehensive overview of prevention initiatives to ensure they were effectively leading in this area. This was supported by other Board Members who emphasised the importance of focusing on prevention and addressing social determinants of health.

 **Outcome:**

 **Board Members:**

* **Discussed the updates.**
* **Noted that the Board would be reviewing Risk A1 in more detail at the private meeting of the Board.**
* **Approved the updated Board Assurance Framework (BAF).**
* **Identified any further areas of risk that may impact on the delivery of the ICB strategic objectives.**
* **Agreed to update the likelihood and impact scores for risk C5B to reflect a total score of 16.**
* **Agreed the need for a detailed overview of all prevention activities to ensure effective leadership in this area.**

**CONTEXT, PERFORMANCE AND ASSURANCE**

**9. Chief Executive Update**

 The Acting Chief Executive provided an update on several key areas:

 **Winter and Urgent Emergency Care:**

It was noted that the pressures on the health and care system had slightly eased in recent weeks compared to the challenging period over Christmas and early January 2025. Gratitude was expressed to all staff for their continued efforts.

Despite this, the system was not meeting the urgent emergency care (UEC) targets, leading to the ICB being moved into Tier One for UEC from Tier Two. This decision was based on data from Quarter 3 and the comparative position of Humber and North Yorkshire (HNY).

The need for collaboration with system partners was emphasised, including Yorkshire Ambulance Service (YAS) and East Midlands Ambulance Service (EMAS), to improve performance. An improvement plan would be developed with support from NHS England (NHSE), and national colleagues were expected to visit soon.

 **Annual Assessment Process for ICB:**

 The publication of the NHS England (NHSE) assessments for the financial year was noted, which placed the ICB in category 3, indicating the need for additional support from regional colleagues. This assessment was based on oversight framework ratings.

 **Government Mandate and Operational Planning Guidance:**

 The key priorities outlined in the government mandate and the operational planning guidance were highlighted, which included cutting waiting times, improving access to primary and emergency care, reforming the operating model, and driving efficiency and productivity.

 The importance of managing within the allocated budget was stressed and the emphasis on productivity and efficiency. The planning process was complex, with multiple pieces of guidance to integrate, and the final plans were due by the end of March 2025.

 **New NHS Operating Model:**

 The Board were updated on the expected details of the new NHS Operating Model, which included a new oversight assessment framework, a performance improvement and regulation framework, and a strategic commissioning framework. These frameworks were intended to support Integrated Care Boards (ICBs) and systems in delivering their objectives.

 **Outcome:**

 **The Board noted the update provided.**

**10. Strategic Update: Operational Planning 2025/26**

The Acting Chief Operation Officer provided a high-level briefing on the operational planning process for 2025/26, emphasising the coordination required across the system, including acute, primary, community, and mental health services. The planning aligned with the three main ambitions: cutting waiting times, improving access to primary and emergency care, and driving efficiency and productivity.

 The importance of living within the allocated budget was highlighted and the significant focus on productivity and efficiency. The finance template, received recently, included detailed requirements for collecting productivity and efficiency data.

The notable change was highlighted in the introduction of a ceiling for elective recovery funding, which was 25% less than the previous year. This funding was provided upfront, and the system must deliver Referral to Treatment (RTT) targets with this fixed amount.

 Concerns were raised about meeting RTT targets with restricted resources. The need for innovative approaches was discussed, such as clinical and clerical validation, re- engineering patient pathways, and prioritising resources effectively.

Service development funding (SDF) had been provided as a block amount, with fewer mandated requirements, except for dental and cancer services. This funding had also been reduced by £4 million.

 It was noted that the initial submission to the region was due on 26 February 2025, with the final plan submission on 27 March 2025. The process was outlined of receiving plans from providers, assessing, and validating them before submission.

 The Board emphasised the importance of collaboration among providers and the ICB team to address the challenges and ensure the plans were realistic and achievable.

The GP Members of the Board noted a conflict in raising a discussion around the Local Enhanced Services (LES) review. The review was conducted with significant input and support from Local Medical Committees (LMCs), which represented practices and practitioners. This collaboration was noted as a positive aspect of the process. There were some final tweaks required, particularly around activity data and costings, to ensure the accuracy and effectiveness of the LES. The primary goal of the LES review was to level up services across the region to a higher standard, ensuring that services were consistent and of high quality across different areas. The review was expected to result in an increase in investment to achieve the desired levelling up of services, aimed at enhancing the quality and accessibility of primary care services. This discussion underscored the importance of collaboration, accurate data, and investment in improving primary care services through the LES review. This would be discussed in more detail at the private Board Meeting.

 **Outcome:**

**The Board:**

1. **Noted the full content of the 2025/26 NHS Planning guidance and priorities being set out for the next 12 months, within the context of the Government's medium to longer term direction of travel for the NHS and expected 10-year Plan later this year.**

1. **Agreed to the proposed approach and timelines for Humber and North Yorkshire, with a report to the Board on 12 March 2025 and Board sign off of Plans on 24 March 2025.**

**11. Finance Report**

 The Interim Executive Director of Finance and Investment took the paper as read, which provided a comprehensive update on the latest financial position of the Integrated Care Board (ICB).

 The significant financial challenges the ICB and Integrated Care System (ICS) faced were highlighted in the current fiscal year (2024-2025). It was noted that work was taking place with the Providers to ensure the financial position was the best it could be. In terms of capital planning and expenditure, the ICB was underspent and within the planning guidance for 2024-2026, the ICB was anticipating that these would be spent by end of March 2025.

 The need for careful management of resources was emphasised to ensure that the ICS could deliver the required services within the allocated budget. It was noted that the financial constraints were more severe this year, with reduced funding for elective recovery and service development.

 Discussion and assurance were requested regarding the spend of capital expenditure and some of the schemes were delayed for realistic reasons.

 It was suggested that it would be beneficial to work through the priorities. It was noted that there was a framework in place for making decisions.

 It was noted that the allocation was conditional based on the system delivering a breakeven position for 2024/2025.

 **Outcome:**

**The Board**

1. **Noted the Month 9 system financial position for 2024/25.**
2. **Noted the mitigating actions being pursued in year to deliver 2024/25 financial plan.**

**12. Performance Report**

 The Acting Chief Operating Officer provided the latest performance report, which included workforce metrics and other key performance indicators (KPIs).

 The Board reviewed the progress made towards meeting the targets set for these KPIs and discussed any areas where performance was lagging. Strategies for improvement were considered, with a focus on enhancing patient care and reducing wait times.

 The report highlighted some of the operational challenges faced by the ICB, including the ongoing pressures on urgent and emergency care (UEC) services. The Board discussed the steps being taken to address these challenges and improve service delivery.

 There was also a discussion on the impact of the winter season on healthcare services and the measures in place to manage increased demand during this period.

 The performance report included a section on future planning and the strategic priorities for the coming months. This included plans for service improvements, workforce development, and financial management. The Board discussed the importance of aligning these plans with the overall strategic goals of the Integrated Care Board (ICB) and ensuring that they were responsive to the needs of the local population.

 Overall, the performance report provided a comprehensive overview of the current state of the ICB's operations, highlighting both achievements and areas for improvement.

 The Board engaged in a detailed discussion on the various aspects of the report, considering the steps needed to address challenges and enhance performance in the future.

 It was noted that in relation to UEC at Hull University Teaching Hospitals NHS Trust

 (HUTHT), 14,000 more patients were being seen within 4 hours so collectively as system more patients were being seen.

 It was also noted that the Community Diagnostic Centre (CDC) at Scunthorpe becomes live this month, and the others would become live later in the year as the national team had changed the tariff which would give a loss of £4 million, therefore recruitment had been delayed until the planning round was completed due to the financial vulnerability.

 The Board were pleased with progress made in the cancer position, primary care and community care. It was also noted that the out of area in mental health was also improving.

 With regard to workforce, from a whole time equivalent (WTE) point of view the ICB continued to do well. Overall performance was 0.8% above plan. The staff levels were a large part of the planning process in terms of efficiency.

 It was acknowledged that the ICB was expecting the Mental Health Collaborative to generate efficiencies across the system. There was a lot of work taking place regarding modernisation of services. Recruitment was an issue and looking at other things that could be done through technology to improve things for people for example, groups within the community. Zero out of area placements would not be achieved as certain individuals required extremely specialised services and these services were only provided in certain areas, albeit recognising that this might not be in the most appropriate place. Reference was made to the indicator which stated ‘inappropriate’ out of area placements, and it was confirmed that this was correct as it only related to certain individuals accessing these services.

 It was noted that the operating model that the ICB had across the system had not fully been implemented. The ICB was currently re-gearing the system in terms of the delivery model to get the outcome that was needed, and the Collaboratives were at the heart of the progress with delivering this.

 **Outcome:**

 **Board Members:**

1. **Noted the development of the Board performance report in terms of its content, length and presentation.**
2. **Considered and discuss the performance report, in particular, the issues highlighted in the cover sheet.**

**13. Board Committee Summary Reports**

The Chair introduced the items for escalation from the Board Committee Summary Report and the alerts for escalation were noted, specifically regarding the following:

 **Pharmaceutical Services Regulations Committee**

There were no alerts to escalate to the Board.

 There were two matters to advise / assure the Board on and this was in relation to pharmaceutical needs assessment and contracting issues.

 **Quality Committee**

There were two alerts to escalate to the Board regarding urgent and emergency care, and the intensive and assertive community mental health treatment review and City and Health Care Partnership (CHCP) action plan special review.

 The key point in relation to emergency care was important from a quality of care perspective. The Mental Health treatment review had been undertaken, and feedback would be provided to a future meeting.

 **System Quality Group**

There were no alerts to escalate to the Board.

 **Finance, Performance and Delivery Committee**

There were two alerts to escalate to the Board regarding approval of procurement recommendations and continuance of focus on delivering the 2024/25 financial plan.

 Reference was made to the high value contracts.

 **Workforce Board (Workforce Committee)**

There were no alerts to escalate to the Board.

 **Audit Committee**

 There were no alerts to escalate to the Board.

 **Clinical and Professional Committee**

 There were two alerts to escalate to the Board regarding prioritisation of resource and funding for the Women Living Well Longer programme. The prioritisation of resource was raised. Funding for the Women Living Well Longer programme would end at the end of the financial year 2024-2025. A womens health conference had taken place in North Yorkshire last year so this linked into the wider work being taken. This was an important matter to the Board and consider a sustainable way of keeping this going.

 **Remuneration Committee**

 There were no alerts to escalate to the Board.

 **Pharmaceutical Services Regulations Committee**

 There were no alerts to escalate to the Board.

 **North East Lincolnshire Joint Committee**

There was one alert to escalate to the Board regarding understanding the potential implications of the establishment of a contractual joint venture for Mental Health, Learning Disabilities and Autism.

 The Board acknowledged the key areas requiring further oversight. There was an emphasis on ensuring that Committee discussions and recommendations aligned with the Board’s strategic objectives. The Board acknowledged the importance of ongoing monitoring and follow-up on the escalated issues.

**Outcome:**

 **Board Members noted the content of the Committee Assurance and Escalation Reports.**

**OTHER MATTERS FOR THE BOARD**

**14. Governance Items Reserved to the Board**

 **Constitution and Standing Orders**

The Executive Director of Corporate Affairs presented items reserved to the Board, including the Constitution and Standing Orders.

 The Board reviewed the Constitution and Standing Orders noting that the majority of changes were requested by NHS England (NHSE) as part of their national updates to the model constitution.

 Emphasis was placed on ensuring compliance with statutory requirements and best governance practices.

 Upon approval by the Board the final version would be submitted to NHSE for their approval and would subsequently be published on the ICB’s website.

 **Outcome:**

 **Board Members**

* **Approved the proposed amendments to the ICB Constitution and Standing Orders.**
* **Noted that, following approval by the Board, the definitive version would be submitted to NHS England (NHSE) for formal sign-off.**

**15. Freedom to Speak Up Update**

The Executive Director of Clinical and Professional provided an update on the Freedom to Speak Up (FTSU) initiative, noting progress and areas for improvement. The internal audit tool had highlighted some areas of progress which was required for the ICB, and the findings were outlined.

 The initiative aimed to create a culture where staff felt safe and empowered to raise concerns about patient care, safety, and working conditions without fear of retaliation.

 The Board reaffirmed the importance of psychological safety in the workplace to enable open conversations. Emphasis was placed on ensuring all staff feel heard, particularly frontline workers experiencing high levels of stress.

 The Board identified several challenges, including:

• Some staff members still felt reluctant to raise concerns, particularly in pressured environments such as emergency and urgent care.

• The need for more proactive communication and visibility of the FTSU process.

• Ensuring Freedom to Speak Up Guardians were accessible and trusted by staff across different healthcare settings.

The Board noted several next steps, including:

• Strengthening awareness campaigns to ensure all staff understand their rights and how to raise concerns.

• Reviewing the effectiveness of the current process and ensuring appropriate escalation routes for concerns.

• Tracking and reporting trends in speaking-up cases to identify systemic issues within the organisation.

• Enhancing support for staff who raise concerns, ensuring they receive protection and follow-up actions.

 The Board noted that processes around FTSU had been strengthened by the collaborative approach of teams across the Integrated Care Board (ICB), and in particular the in-house legal and regulatory services.

 Discussion took place and it was noted that FTSU was a very powerful tool. One of the concerns raised was in relation to support and protection from colleagues and if this could be built into the programme so that people could be supported and assured as part of the process.

 Concern was expressed about some of the issues noted as some of these were in relation to human resources (HR) rather than FTSU and consideration needed to be given to ensure that issues were properly addressed in the right place. A question was raised about the ICB operating a FTSU process and whether there was a consistent approach across the system. The Board learnt that while there were processes in place across the system, variation across the system existed. Consideration was to be given to how to promote FTSU and how to access it and also know when not to access it.

 It was recognised that the problems experienced in office environments previously were less prevalent now, among a workforce working increasingly flexibly across the wide geography of HNY.

 Assurance was provided about the triage process for FTSU, HR and safeguarding issues were not considered as part of this process and people were directed and supported accordingly.

 The work of the Deputy Director of Governance, Legal and Regulatory and her team was acknowledged in supporting this work.

 **Outcome:**

 **Board Members received the details regarding Whistleblowing/Freedom to Speak Up arrangements which have been received by the ICB since November 2023 and assurance that they have been managed or are being managed with appropriate process.**

**16. Board Assurance Framework Review**

The Board conducted a final review of the Board Assurance Framework (BAF) in light of discussions held throughout the meeting. The Chair asked if any additional changes or updates were required based on the meeting’s deliberations.

 No new amendments were proposed to the BAF at this stage. The Board confirmed that the key risks discussed (financial risks, patient safety, and workforce pressures) were appropriately captured in the framework.

 **Outcome:**

**Board Members noted the changes to be made to the Board Assurance Framework in the light of their discussions at the meeting.**

**17. a. Items for Information**

 The Chair drew members’ attention to the positive developments set out in the news and MP briefings and encouraged everyone to read these and were reminded that as system there were as some really fascinating, important and useful things taking place.

 **b. Questions from the public**

 Questions from members of the public were discussed and it was noted that the responses as detailed below would be responded to directly and also published on the ICB website:

 **Question 1: AI in Mental Healthcare**

 As the adoption of AI continues to shape the delivery of mental healthcare, what is the ICB’s approach to leveraging these tools to enhance outcomes, improve efficiency, and ensure equitable access to services? Additionally, if you are a third-party that is able to support the ICB's strategy and priorities, who would be the best person to contact regarding this matter in the first instance?

 **Answer from the Board:** The capabilities of AI are rapidly advancing, and in Humber and North Yorkshire ICB we are already starting to leverage AI to enhance patient outcomes and streamline operations. The integration of AI technologies is transforming the approach to healthcare delivery, bringing more precision, efficiency, and personalisation to patient care. Notably, initiatives such as predictive analytics for patient risk stratification and AI-driven diagnostic tools are showing promising impacts.

 The ICB already has an ICB AI Governance Policy (available at <https://humberandnorthyorkshire.icb.nhs.uk/documents-and-publications/operational/>) and is currently drafting its own AI Action Plan to maximise the value of AI across all HNY health and care providers including in mental health. The AI Plan would address topics such as training needs, a joint approach to AI safety, improving administrative processes using AI, improving clinical decision support, population health intelligence, links with academic and industry partners, and developing our own AI workforce skills. Additionally, for the last year the ICB has hosted an active AI Community of Practice with membership from health and care partners across the system including mental health.

If you are a third party that can support the ICB's strategy and priorities, you are invited to contact our Chief Digital and Information Officer at hnyicb.digital@nhs.net

 **Question 2: Cognitive Rehabilitation for dementia**

The financial cost of dementia care to the state and individuals is well known: <https://www.alzheimers.org.uk/blog/how-much-does-dementia-care-cost> and expected to increase exponentially in the coming years. It is therefore important we identify and implement cost effective approaches to dementia care which have a strong evidence base.

A relatively recent dementia specific approach, known as Cognitive Rehabilitation (CR), recommended in the NICE guidelines <https://www.nice.org.uk/guidance/ng97/chapter/recommendations#cognitive-rehabilitation> has been shown in large, randomised control trials to make significant savings to care costs by delaying transition to residential care facilities by six months. CR is mainly used to maximise the functionality of people with dementia in relation to specific (SMART) goals which they find important: <https://sites.google.com/exeter.ac.uk/great-cr/cognitive-rehabilitation>. There is also an ongoing international debate about the rights of people with dementia to have access to reablement services (CR is a reablement service) as those of us without dementia often do: <https://www.alzint.org/news-events/events/adi-hosting-who-rehabilitation->and-dementia-global-national-and-personal-perspectives/.

 Our organisations initial exploration into potential financial savings gained from the implementation of CR demonstrates that there are potential savings to both Social Care and self-funding individuals:

 Potential savings to Social Care

 In York, the standard rate or allowance (the maximum York’s Local Authority pays for a residential dementia care home place) for people with dementia without savings is £755 per week, which equates to £19,630 per person over a six-month period. If we start to scale this figure up, it is possible to start seeing significant savings to Social Care. For example, £19,630 x 100 people = £1,963,000 (minus the cost of delivering CR and domiciliary care costs, as people with dementia delaying transition into care would potentially require domiciliary care over that 6-month delay).

 Potential savings to self-funding individuals

 The average residential dementia care home in the UK currently costs £1205 per week: <https://www.carehome.co.uk/advice/care-home-fees-and-costs-how-much-do-you-> pay),which equates to £31,330 per person over a six-month period. These residential care costs minus the costs of delivering CR and domiciliary care costs as mentioned above, have the potential to make significant savings to self-funding individuals.

 Our organisation (<https://www.partnersindementia.org/>) can provide further information and detail about the research evidence for this approach to dementia care.

 Is this something the ICB Board would consider investigating further, and if so, how, and when could this happen?

 **Answer from the Board:** Following consultation with colleagues across the ICB we can confirm that cognitive rehabilitation is currently offered via some of our VCSE organisations but there is significant variation across HNY. Additionally, we are co- applicants on a bid with Queen Mary University London who are looking at York and North Yorkshire as potential pilot sites for a rehabilitation intervention.

 All of the memory assessment services offer cognitive stimulation therapy and work around individual goal setting either directly or with third sector partners.

 As an ICB we are collaborating with academic institutions and other partners to explore the use of cognitive rehabilitation.

 We would welcome the opportunity to discuss with other partner agencies about initiatives/interventions that would benefit our population, and this work would be led by the Mental Health, Learning Disability and Autism (MHLDA) Collaborative, Dementia Steering Group would contact the individual who has raised the question.

 **Outcome:**

 **Board Members received the questions listed in Appendix A and noted that the responses provided to the meeting would subsequently be sent in writing to the enquirer.**

**18. Any Other Business**

 There were no items of Any Other Business.

**19. Closing Remarks of Meeting**

The Chair thanked everyone for their participation and contributions.

**20. Date and Time of Next Meeting**

The next meeting would be held on Wednesday 12 March 2025.

**21. Exclusion of the Press and the Public**

 The ICB Board resolved that representative of the press and other members of the public be excluded from the remainder of the meeting due to the confidential nature of the business to be transacted.

**Humber & North Yorkshire Integrated Care Board: Matters Arising Action Log (Part A)**

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| --- | --- | --- | --- | --- | --- |
| Date Raised | Action Reference | Item No. and Action | Owner | Due Date | Progress / Status |
| 12/02/2025 | **01-0225** | **Item 8 – Board Assurance Framework**Update the likelihood and impact scores for risk C5B to reflect a total score of 16.  | **Karina** **Ellis** | **March** | **COMPLETED** |
| 12/02/2025 | **02-0225** | **Item 14 - Constitution and Standing Orders**The definitive version would be submitted to NHS England (NHSE) for formal sign-off. | **Karina****Ellis** | **March** | **COMPLETED** |