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NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the Meeting Held on Tuesday 24th June 2025 9:00 – 10:30

DRAFT Minutes

Present		
Alison Moon (*Chair*)	Chair of Committee, Non-Executive Member – Primary Care	AM
Jenny Bowker	Deputy Director of Performance Delivery, Primary Care & Children's Services, BNSSG ICB	JB
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Debbie Campbell	Chief Pharmacist and Director of Medicines Optimisation, BNSSG ICB	DC
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Jeff Farrar	Chair of the BNSSG ICB	JF
Katie Handford	Models of Care Manager, BNSSG ICB	KH
Bev Haworth	Head of Primary Care, BNSSG ICB	BH
John Hopcroft	Avon Local Optical Committee	JH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	MJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Susie McMullen	Head of Contracts: Children's, Community and Primary Care, BNSSG ICB	SMc
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Dr Shaba Nabi	Chair, Avon Local Medical Committee	SN
Prof Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
George Schofield	Avon Local Dental Committee Secretary	GS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Jacci Yull	Patient & Safety Quality Lead, BNSSG ICB	JY
Apologies		
Dr Katrina Boutin	GP & GP Collaborative Board Medical Director	KB
Nikki Holmes	Head of Primary Care, Southwest, NHS England, and Improvement	NH
Hayley Richards	Non-Executive Director, Sirona	HR
Michael Richardson	Director of Nursing and Deputy CNO, BNSSG ICB	MR
In Attendance		
Sandie Cross (*minutes*)	EA to Dave Jarrett, BNSSG ICB	SLC
Tim James	Head of Strategic Estates, BNSSG ICB	TJ
Urvi Makwana	Dental Programme Manager, BNSSG ICB	UM
Sophiya Wilson	Estates Project Coordinator, BNSSG ICB	SW

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). The meeting was previously reduced to 90 minutes, to allow the accommodation of another meeting, but that meeting had subsequently been rescheduled, so, if required, AM advised the items on the agenda today could have more time than the originally allotted time slot given. AM reiterated the important role that PCC has on behalf of the ICB Board and noting the context of uncertainty and changes, AM would like to take this opportunity to thank everyone for producing excellent quality sets of papers for items on the agenda today. Apologies are noted as above.	
2	**Declarations of Interest** There were no new declarations of interest to note, and no existing declarations of interest relating to agenda items at the PCC meeting today.	
3	**Minutes of the Previous Meeting held on 22nd April 2025** The minutes from the PCC meeting on 22nd April 2025 were reviewed. Initially, Sarah Purdy (SP) mentioned she had been omitted from attendance at the last meeting, but this had been an error, and she had actually been recorded as attending the PCC in May 2025. The remaining minutes were agreed to be an accurate record of the meeting. These minutes have been approved and will be forwarded to the ICB Board for information.	
4	**Review of Action Log** The action log was reviewed: (*Please refer to the action log for full details*) ***Action 125 – Quarterly Quality Report –*** Michael Richardson was not present at the meeting today, however it was agreed to keep this action open, and for Jacci Yull (JY) to liaise with MR to provide an update – ***action to remain open***. ***Action 128 – Audit on Antibiotic Prescribing –*** Debbie Campbell (DC) updated on the antibiotic prescribing action, advising that Liz Jonas, the Antimicrobial Stewardship Lead (AMS) had picked it up and is liaising with Richard Brown (RB) and others. Agreed action to be closed, however assurance given that the Meds Management Team would provide a routine update on progress.- ***action closed.*** ***Action 129 – Dental Input & Urgent Care -*** Matthew Jerreat (MJ) reported that the link between dental and urgent care was explored but found not to be fruitful. It was agreed to close the action as it had been explored thoroughly. This action was in relation to making connections between dental care and community pharmacy first rather than with urgent care. ***– action closed.***	
5	**PC Corporate Risk Register & Emerging Risks** David Jarrett (DJ) presented the risk register, highlighting key risks and provided an update on several critical issues. The discussion encompassed various risks and actions, with a focus on dental service uptake and procurement challenges. ➢ **Risk 12419 Quality - Commissioning Hub Support:** DJ noted the proposed closure of this risk regarding commissioning hub support to the quality team, which was reviewed at PCOG. It was reported that MR would like a final review, so therefore it was agreed this would be further reviewed at the next PCOG meeting.	

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	➢ **Risk 12925 Dental - UDA Rates Adjustment:** This risk was concerning low UDA rates. It was agreed that this risk would be closed, as the baseline has been realigned and reported through PCC. ➢ **PCC 42 - Supplementary Services Risk:** The risk associated with supplementary services was addressed. It was noted that initial analysis has shown that most practices are engaging positively with the new services, but some have yet to deliver all elements, leading to a decrease in the associated risk, to reflect the current activity levels. DJ advised the Primary Care Team are continuing to liaise with practices directly. ➢ **PCC 60 - Dentistry & Access Improvement: - scores 15** The strategy for improving access to dentistry had been presented to PCC and subsequently approved at the ICB Board. The first Dental Strategy Board meeting is scheduled for 25th June 2025, chaired by a new clinical lead for dentistry; Samantha Braddock. This was highlighted as a significant step towards improving access to dentistry. The Dental Strategy Board aims to reflect positive developments in the overall approach to dental services. The risk related to dentistry is being actively managed and would continue to offer assurance to the PCC regarding performance trends in dentistry. ➢ **PCC 62 - General Practice Collaborative Action (GPCA) Risk: - scores 20** The GPCA risk remains high, but it is expected to be reduced in future updates to reflect the progress with mitigations. The GPCA risk remains at 20 on the risk register due to timing issues but will be reduced to 16 in the next update. Residual risks remain, and efforts are ongoing to mitigate them. ➢ **DRR-CON-12425-004 - Procurement and Provider Selection Regime (PSR) Regulations: - scores 20** DJ described this complex risk in relation to PSR & procurement regulations, especially at this time of change within the ICB, and lack of capacity within the contracts team, which had been flagged previously. A dedicated group Procurement Oversight Group (POG) is focusing on managing procurement risks across the organisation. The discussion emphasised the necessity for strategic decisions to handle intensive workloads and ensure effective procurement processes. The procurement regulations and PSR are flagged as significant challenges. DJ reported there are numerous procurements, ranging from small locality-based to large non-elective patient transport. POG is developing a risk-based approach to assessing all procurements for the organisation. <u>Questions / Reflections Received</u> ➢ Shaba Nabi (SN) sought clarification on the supplementary services risk. Jenny Bowker (JB) confirmed that the majority of practices had signed up, with only a small number yet to deliver some elements; reassuring PCC that the Primary Care Team are continuing to link in with those practices. ➢ Ellen Donovan (ED) wanted clarification on action PCC62 GPCA, as there was a pre-mitigation score of 16 and post-mitigation score of 20 and asked if this was correct? JB advised there was an administrative issue, and this has since been corrected. JB reported there had been an internal ICB GPCA meeting, as JB wanted to obtain support from all the leads in the ICB, in terms of reducing the GPCA risk, which was subsequently agreed upon, so the risk will be reduced to 16.	

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	➢ ED congratulated the ICB on the setting up of the new Dental Strategy Board, but noted in terms of access to dentistry, and how BNSSG are performing now compared to a year ago, would this be fed through the Dental Board? recognising access to dentistry had been very challenging with damning statistics previously, especially regarding children's access to dentistry. ED asked would the Dental Board offer assurance to the PCC regarding the performance trends in dentistry. ➢ DJ confirmed feedback would be presented through PCC and PCOG in the same way that performance indicators have come through to the Outcomes, Quality and Performance Committee (OQPM). There is a further report on the agenda today which looks at key indicators and key trends. A further discussion took place regarding key indicators, and trends, and the requirement to cross reference that they are part of our strategies, including the dental strategy, to show explicitly where progress has been made. The importance of linking core indicators to the strategy was highlighted. The need for more detailed reports and updates on various work streams was acknowledged. Bev Haworth (BH) advised there is an appendix from the highlight report to be discussed later on the agenda to show activity over the last year. AM noted the positive news that the ICB now have a dental clinical lead and a Dental Strategy Board in place, and also recognise the challenges around the UDA rate, questioned what neighbouring ICBs are doing regarding access to dental services and how important it might be to align approaches where possible. AM raised concerns about the light focus on optometry in the annual report papers. BH acknowledged this and mentioned that more detail would follow in future highlight reports, as the Eye Care Board has been re-established, and work streams are being developed. There is a recognition of the need to focus on optometry in future planning. Conversations with NHSE colleagues are ongoing to ensure optometry is included in operational planning. John Hopcroft (JH) referenced the 10-year plan, and advised there would be a focus on optometry, which will help stimulate some of the conversations at The Eye Care Board. **The Primary Care Committee received and noted the PC Corporate Risk Register and Emerging Risks**.	
6	**PCOG Report** DJ summarised the key decisions made at the Primary Care Operational Group (PCOG) meetings in May and June 2025. DJ pulled out the key highlights within the paper. **13th May 2025 Meeting** Primary Care Dental Services at Charlotte Keel The discussion began with an update on the status of the Primary Care Dental Services at Charlotte Keel, noting UHBW have been providing services, as part of the joint working with the dental school and that this is an extra contractual service. The service is no longer accepting new referrals, and it has been agreed with UHBW that children will continue to be seen at Charlotte Keel until they reach the age of 16 as currently provided for. In this way the service will come to a natural, managed close over the next two to three years. There was a significant concern about the risk of these children not being able to find a primary care dentist after being discharged. The	

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	conversation highlighted the need for a well-planned transition to ensure that children do not face gaps in their dental care. Switching patients from Edoxaban to a more cost effective direct oral anticoagulant PCOG approved the proposed switch from Edoxaban to Apixaban and incentive funding. Debbie Campbell (DC) and the Medicines Management Team at the ICB had developed this in support of NHSE Commissioning Recommendations. Primary Care Estate Priorities – Utilisation and Modernisation Fund – South & Inner-City Bristol Case for Change PCOG noted progress on development of the Estate's Priorities and Pipeline, and PCOG were in support of the delegation of individual utilisation modernisation fund (MIG) to DJ for sign off, with no objections. It is recognised there is now a proposed pipeline and agreed set of priorities. Community Pharmacist Independent Prescribing Pathfinder Update PCOG agreed and approved to expand the scope of the Independent Prescribing Pathfinder Service, to provide a complete minor ailments consultation service, in line with NHSE's pilot, which expands on the seven conditions of Community Pharmacy First. Questions / Reflections Received ➢ George Schofield (GS) referenced the Primary Care Dental Services at Charlotte Keel for Children, advising this is still a big issue, and raised concerns about the transition for children, who would continue to receive care until they turned 16, and were discharged dentally fit into an already over busy and challenging dental system. DJ advised the ICB would continue to work with UHBW and practices to manage the transition over the next few years, recognising the challenges faced. JB further advised the need to continue working on the Dental Strategy and seek ways to improve access for children across the board, as well as this cohort of 16 years and over. JB advised multiple inputs are needed, which is recognised as part of the Dental Strategy. ➢ Matthew Jerreat (MJ) suggested obtaining evidence and would be happy linking in with public health and Samantha Braddock, to see what further work could be done to improve dental access, including linking in with the paediatric manage clinical network. ➢ Matt Lenny (ML) offered to support any discussions that could benefit, from a public health perspective. ➢ AM referred to an earlier comment regarding dental statistics across BNSSG, particularly children under 5 with visible tooth decay, recognising more work was clearly needed to improve this, and would expect to see some improvements in outcomes, which would provide the PCC some assurance. **10th June 2025 Meeting** ADHD Adult Review LES DJ advised this is following on from the collective action, and PCOG was in support for the LES to be updated and used for the continued monitoring of patients. In terms of mitigating actions, this is referenced in the risk register.	

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	Direct Award – Clinical Waste Proposal & Procurement Update DJ updated on the clinical waste procurement and advised this had gone through a challenging procurement process, locally and regionally. This has not gone out nationally. PCOG agreed a direct award process for clinical waste services. The contracts team are moving forward with this procurement. Anenta Ltd – Clinical Waste Management Agents 2025 Contract Award Linked to the above, PCOG approved a contract for a managing agent for clinical waste. Both awards are moving under organisational SFI which is a positive outcome. Primary Care Weight Management Service, in line with NICE TA Tirzepatide There was a funding proposal for general practice, to support the rollout of weight management drugs in general practice. This new initiative aimed to address the growing issue of weight management among patients. DJ advised the medicines optimisation team have done an excellent piece of work supporting this. The model has been agreed for a fixed term period of time, to see what take up will be and the actual costs associated with this initiative. A further update would be shared with PCC in due course. Attendees discussed the potential risks, including the possibility of general practices being overloaded with requests from patients seeking these drugs. The conversation emphasised the need for clear guidelines and support for general practices to manage the anticipated demand effectively. Questions/Reflections Raised ➢ SN congratulated the Medicines Management Team for all their work on the Weight Management Service, noting BNSSG have advanced and progressed this, compared to other areas of the Country. SN commended the good piece of collaborative working. ➢ SN reported the LMC and One Care are working together towards a unified formula for a costings model, with the ICB ratification. ➢ Sarah Purdy (SP) was seeking assurance about how this would be communicated, recognising not all patients may be eligible under the current guidance? ➢ DC confirmed – local and national communications were circulated on 23rd June 2025. Expressions of Interest have gone out to practices, and these are beginning to be returned. DC advised there are national templates for practices to use to pull information and outcomes from. The communications are advising patients to wait until their GP practice contacts them, as opposed to them contacting their practice. Dental Stabilisation It was noted that there was an offer for increased dental stabilisation for our dental practices across BNSSG, and it was reported there was more take up of this offer then first envisaged and slightly more then there was budget allocated for. PCOG agreed to focus the increase on stabilisation into IMDS 1-5. In terms of PCC's commitment to reducing inequalities, the target areas would be focused on the more deprived communities. It is noted it is positive that dental practices have taken up the offer. The conversation continued with a further discussion on the access to dental services for vulnerable patients, particularly children. Attendees expressed concerns that vulnerable patients might not be welcomed in dental practices due to the UDA system not funding their treatment. The conversation highlighted the ongoing challenge of improving access to dental services for children across the board. There was a	

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	consensus on the need for targeted efforts to ensure that vulnerable patients receive the dental care they need. Questions/Reflections Raised ➢ GS reported increased dental stabilisation efforts were being funded by reallocating existing resources (clawback). While this approach would benefit some patients, it also meant that others might be denied access to dental services. ➢ GS discussed the fundamental issue with the basic dental contract, which was deemed not fit for purpose. There was also a discussion about the disparity in pay rates between the core contract and add-on contracts, which was seen as a significant challenge in providing equitable dental care. ➢ Jo Medhurst (JM) was seeking clarity with the dental stabilisation piece on which quintile of the indices of multiple deprivation is being focused on, as reflected in the minutes of the PCOG meeting from June 2025, advising it is normally set in quintiles. DJ advised he would find this information and advice accordingly. AM thanked DJ for the PCOG report, recognising the large amount of work which takes place. **The Primary Care Committee received and noted the PCOG Report.**	
7	**LA Planning & Steps Taken to Align Local Housing Plans with Primary Care Services** The PCC are asked to review the policy, provide feedback, and recommend the policy for similar review and feedback from the ICB Board. AM introduced Tim James (TJ) and thanked him for the high-quality comprehensive paper presented at PCC today. The paper is taken as read. This paper would also be going to the Finance Estate & Digital Committee (FED), prior to the ICB Board. TJ thanked his colleague Sophiya, who was instrumental in adapting the paper. TJ presented a slide-deck on the housing growth and planning policy and emphasising the need for a standardised approach to engage with local authorities and secure developer contributions. TJ advised that historically, the CCG and ICB did not respond individually to planning applications; it was the role of Local Authorities (LA) to seek their views. Large-scale developments in South Gloucestershire and North Somerset were consulted, but smaller developments in Bristol which collectively had a significant impact, were not adequately addressed. The need for a more proactive approach was identified, especially with each of the three LAs developing their local plans. With regard to the development of the policy, this aims to establish a standard approach to dealing with planning growth, using agreed-upon metrics for modelling planning growth. The goal is to give the ICB a stronger voice in the planning process and improve performance in securing developer contributions. Developer contributions, such as Section 106 funding or Community Infrastructure Levy (CIL) funding, are crucial for supporting local infrastructure, including health facilities. The policy discussed is a significant step, as it is not common for ICBs to have such detailed approaches to housing growth. TJ referenced the ICB have particular responsibility around estate in the funding of a general practice surgery, stating the impact on local housing growth is significant. Planning and population growth is paramount in new housing developments of 2,000	

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	homes, as an example, where there could be an additional 5,000 – 6,000 people in that area, which impacts GP list sizes by 50% in some cases. On engagement with LA, TJ reported the policy development involved significant engagement with LA, supported by NHS Property Services' national housing planning team. The local plans set out the ambitions for strategic housing growth over the next 15-20 years, driven by national housing targets. The engagement process has been challenging due to the various stages and approaches of each local authority. TJ reported the policy includes standard metrics for assessing the impact of housing on health infrastructure, such as the number of people per house and the required square meters per GP surgery per patient. The aim is to establish a coherent approach for LA to engage with the ICB and vice versa. The policy also addresses the need for developer contributions to support local infrastructure. <u>Feedback and Recommendations</u> ➢ JM welcomed the paper, which had previously been discussed in the Joint Health & Well-Being Board and the Joint Scrutiny Committee, on ways of working collaboratively. JM emphasised the importance of considering health inequalities and population health in the policy. ➢ JM advised as a strategic commissioner, with a duty to look at population health and increase outcomes and understanding for the population, felt this was not referenced in the paper, especially the work being undertaken for the 2040 project. JM suggested to link in with Viv Harrison and Nick Hassey at the ICB, to reflect this in the planning policy. ➢ JF suggested that the policy should be reviewed by the Health Inequalities Committee and that engagement with Gloucestershire's ICB approach (TJ's counterpart in Gloucestershire ICB) would be beneficial before this was presented at the ICB Board. ➢ ML highlighted the importance of clinical input in planning policy and the need for a broader mix of housing to meet population needs. ➢ JB endorsed the proactive approach and emphasised the importance of planning to avoid practice list closures. ➢ JB advised in relation to pharmacy, optometry, and dental services she was working with LA colleagues and the LPC as they, together with ICB have been working on a pharmaceutical needs assessment (PNA) which would be going out for consultation on 1st July 2025. JB suggested that TJ could look at this to consider any need and gaps in pharmacy service provision. ➢ ED congratulated TJ on the excellent policy but raised questions about the return on investment and the sustainability of the policy in the new organisational structure and asked would there be sufficient resource to carry this policy through. TJ confirmed there would be a return and advised in the past few months the ICB had potentially secured the first Section 106 agreement in Bristol circa £1.3m for the redevelopment of the Broadmead GP facility. TJ advised with regard to the transformation of the ICBs, he was unable to confirm this as we are awaiting the new structure, but was hopeful if would continue, as the ICB have brought in the NHS Policy Service to support this. ➢ SP was supportive of the comments regarding demographics, as this will inform what services are required, and how we ensure health equity. It is also important to consider the impact of housing growth on other areas, such as maternity services. ➢ ML reported there is a lot of frustration in LAs about the amount of money available to support all infrastructure. National policy is to build on a big scale but the detail on how to do that in a way that creates healthy and sustainable	

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	communities is less clear. Important we work together to do all we can to build prevention and early intervention into how this housing is built and what communities look like including access to all social care and NHS services. Conclusion and Next Steps ➢ The policy is seen as a positive step towards aligning housing plans with primary care services, with strong support from the committee. ➢ Further engagement and refinement of the policy are needed, including considering feedback on health inequalities and broader stakeholder engagement. ➢ The policy will be reviewed and recommended for similar review and feedback from the ICB Board. PCC are fully supportive for the policy development, noting other suggested considerations before it gets to the next stage. AM thanked TJ & SW 10:00 – Matthew Jerreat left the meeting. **The Primary Care Committee noted and accepted the LA Planning & Steps taken to align Local Housing Plans with Primary Care Services.**	
8	**Primary Care Finance Report** Jamie Denton (JD) presented the primary care financial report, highlighting the financial position for 2024/2025 and the overall system financial position. ➢ The reported underspend was just over £200,000, with £26,000 from the ICB and £179,000 from providers. ➢ The general practice position showed an underspend of £3.6 million at the year-end, primarily due to the medicines management position. **Budget 2025/26** JD presented a slide deck covering three budget papers included in the pack. ➢ Significant investment in primary medical care was noted, with a resource limit of £214 million for 2025/2026. ➢ The allocation formula indicated a distance from the target of 1.44%, resulting in a funding gap of just over £3 million. ➢ The ICBs registered population has increased during 2024/25 (approximately c.1.05%) against the ONS projections, which is the basis of the forecast population for 2025/26. ➢ The delegated primary care budget included a £1.6 million deficit, mitigated through a reserve within the non-delegated primary care budget and assuming the 0.5% contingency, £1.067m, remains uncommitted. ➢ The global sum payment increased to £121.79 per head of population, an 8.26% increase compared to the previous year. ➢ The QOF payment reduced, with a £1.5 million reduction recycled into the global sum payment. ➢ The PCN network funding was confirmed at £2.6 million per PCN. ➢ Additional roles funding was allocated in full to the ICB for 2025/2026. ➢ There has been a new allocation introduced to support Advice & Guidance, based on a national fair share methodology this is assumed to be worth £1.282m.	

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	Questions/Reflections Raised ➢ SN raised concerns about the Doctors' & Dentists' Pay Review Body (DDRB), and the lack of mitigation in the global sum. JD clarified that the majority of the global sum payment increase was not recycled funds. The presentation of the budget did not include any DDRB increase for 2025/26 to the ICB budget. Non-delegated Primary Care Position Overview: ➢ The allocation for 2025/2026 was just over £33 million, including NHS 111 and out-of-hours services. ➢ The net uplift was a 2.15% increase to budgets for the current year. ➢ Primary care transformation funding was allocated at £2.1 million, with an additional £200,000 for GPIT infrastructure and resilience. ➢ The SDF funding for digital tools ceased for 2025/2026. Questions/Reflections Raised ➢ AM enquired about the funding for Local Enhanced Services (LES) JD confirmed that the budgets were set based on predicted activity levels. ➢ JB emphasised the ambition for all practices to take up LES. Medicines Management Position ➢ The inflation for medicines management was set at 1.3% for the year. ➢ Anticipated growth and product pressures were around £9.2 million. ➢ The savings plan for the current year was just over £5 million. Questions/Reflections Raised ➢ SN raised concerns about the mismatch between NHS England's predicted prevalence and reality for certain drugs. ➢ DC acknowledged the challenge of proving outcomes for new expensive drugs. Pharmacy, Optometry, and Dentistry ➢ The allocation for 2025/2026 was just over £91 million, with a net weighted growth of around 3.5%. ➢ The national guidance suggested a potential relaxation of the ring fence for dental budgets. ➢ The allocation included an investment of £2.8 million for national initiatives. Questions/Reflections Raised ➢ GS enquired about the potential relaxation of the ring fence for dental budgets. JD clarified that there was no confirmation yet, and any opportunity to utilise funding would be taken through PCOG for decision-making. **Recommendations and Conclusion** JD summarised the recommendations for the PCC, including managing within the allocation, noting the savings target for medicines management, and achieving a balanced financial plan. The committee members accepted and were in full support of the recommendations. AM thanked JD for the comprehensive presentation finance reports. 10:30 – Matt Lenny left the meeting.	

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	The Primary Care Committee noted and accepted the summary financial plan, the key risks and noting the position.	
9	**General Practice, Performance, Contracts & Quality Updates** **Primary Care Services Highlight Report** JB initiated the discussion by acknowledging the excellent work done by BH and the team on the primary care highlight report. The report sets out key deliverables and next steps. BH provided an overview of the primary care highlight report, noting the collaboration with business intelligence colleagues to develop the report using Power BI. The report includes core measures such as GP appointments, dental activity, and Pharmacy 1st referrals. It also contains focus measures and a focus summary, with a tracker in the appendix showing year-on-year and month-by-month metrics. Katie Handford (KH) shared slides on the general practice element of the report, highlighting the following points: ➢ The overall number of GP appointments was slightly lower than the previous year. ➢ The percentage of appointments seen within two weeks decreased slightly, this pattern was also seen across the Southwest. ➢ Telephone appointments remained around 30%, while face-to-face appointments were around 62%. ➢ Capacity and access improvement planning for 2025-2026 is underway. ➢ The NHS app usage remained consistent, with an increase in patients receiving notifications and messages through the app. ➢ Support for practices continues through the access, resilience, and quality teams. <u>Community Pharmacy First Highlights</u> ➢ BH reported that the ICB is the highest performing in the country, averaging over 3,013 referrals a month from various sources. Those referrals are from GPs, self-referrals and from 111 service. ➢ The community pharmacy independent prescriber pilot has two out of three sites live, aiming to manage more conditions locally. ➢ There is ongoing work to increase hypertension case finding, such as working with the comms team for Community Pharmacy (CP) to attend some outreach events. ➢ Roll out the contraception service to enable resupply and initiation of oral contraception prescriptions using CP PCN leads. ➢ Expand PGDs e.g. Infected eczema ➢ New Medicines Supply service plus for hypertension – Pilot to increase medicines adherence in areas where patients are not reaching BP targets. <u>Eye Care Highlights</u> John Hopcroft (JH) provided highlights regarding the eye care element of the report. ➢ JH discussed the Eye Care Delivery Board's focus is on evaluating the macular pilot, reviewing local enhanced services, and standardising pathways across the ICB. ➢ The post-op cataract pathway is also being reviewed. <u>Dental Care Highlights</u> Urvi Makwana (UM) provided updates on dental care:	

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	➢ UDA delivery was 79% in February 2025. ➢ 36% of adults were seen by an NHS dentist, higher than the Southwest regional rate of 30%. ➢ 54.3% of children in BNSSG were seen by an NHS dentist, compared to the regional rate of 48.8%. ➢ Urgent dental care activity targeted 19,076 appointments, with 3,782 delivered in April (83% performance). ➢ Expressions of interest for urgent care have reached 28, with a geographical spread analysis underway. ➢ Stabilisation efforts include additional investment and contract variations for 17 practices. ➢ The supervised toothbrushing program has been extended to all schools in IMDS 1-6, with a recent grant for local authorities to focus on IMDS 1 and 2. ➢ The referral management electronic system is on track for delivery by January 2026. <u>Questions/Reflections Raised</u> ➢ ED raised questions about the dental care numbers, noting discrepancies between different sections of the report. ➢ ED emphasised the importance of highlighting dental care challenges and ensuring the board is creative within the rules to improve outcomes. ➢ JB acknowledged potential technical discrepancies in data and highlighted the challenge of increasing dental practice contract delivery without seeing new patients. The budget constraints for urgent care dental delivery were also discussed. ➢ AM emphasised the importance of focusing on outcomes and learning from high-performing areas. ➢ AM asked if the highlight reports helped the team in a day-to-day basis, or was it generated just to inform the PCC members of outcomes. BH advised it was a 50/50 response, because the highlight report is good for the primary care team to remain focused on key areas. ➢ It was suggested attaching the highlight report to the board report for public focus and monitoring progress against the strategy. BH confirmed that the highlight reports are helpful for team focus and monitoring progress. An offer for offline conversations with AM and ED was appreciated. BH to facilitate the meeting. **Action – for BH to arrange a meeting with herself, KH, AM & ED to help support and further evolve the Primary Care Highlight Report**. **Quarter 4 Quality Safety Report** AM welcomed Jacci Yull (JY) to provide an update on the Q4 Quality Safety Report, as MR was not at the meeting today. Due to time restraints, JY was asked if there were any urgent matters that needed immediate attention. JY advised there was not, and pulled out key points and themes included in the report. ➢ The report included themes that had been consistent over time, along with mitigations and a medication section provided by the Medicines Management team. ➢ There were no new or different issues from what the committee had previously seen.	

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	➢ There were 170 reports from general practice regarding secondary care in the last quarter. ➢ DC advised that the themes were similar across different areas, and a new system-wide patient safety leads group had been formed . AM highlighted the disparity in reporting between general practice and secondary care, noting that general practice reports more about secondary care. JM discussed the need for infrastructural changes in the primary care-secondary care interface to ensure impactful work. DC suggested including more information about the evolving governance process in the next report. The importance of continuing to track trends and addressing issues such as insulin-related incidents was emphasised. AM stressed the importance of not just collecting data but understanding the implications and actions taken as a result , noting the focus should be on the "so what" question, ensuring that the data leads to meaningful actions and assurance. **Conclusion** The discussion concluded with an agreement to bring the quality aspect further up the agenda in the next meeting. AM thanked JY for her contributions. **The Primary Care Committee received and discussed the Q4 Quality Safety Report & the Primary Care Services Highlight Report**	
10	**Key Messages for the ICB Board** AM advised she would create some key messages for the ICB Board, recognising there were some key areas that were discussed at the Committee today.	
11	**Primary Care Operational Group (PCOG) Minutes 13th May & 10th June 2025** **The Primary Care Committee received the PCOG minutes for information.**	
12	**Any Other Business** ➢ JF provided an update on the clustering with Gloucestershire ICB, explaining the appointment process for the new chair and chief executive, and the establishment of a Transition Committee to manage the process.	
	Date of Next Meeting Tuesday 23rd September 2025 9:00–11:00am, held via MS Teams	

BNSSG ICB Extraordinary "Open Session" Primary Care Committee Meeting

Minutes of the Meeting Held on Monday 21st July 2025

DRAFT Minutes

Present		
Alison Moon (*Chair*)	Chair of Committee, Non-Executive Member – Primary Care	AM
Richard Brown	Chief Officer, Avon Local Pharmaceutical Committee	RB
Ellen Donovan	Independent Non-Executive Member, BNSSG ICB	ED
Katie Handford	Models of Care Manager, BNSSG ICB	KH
Bev Haworth	Head of Primary Care, BNSSG ICB	BH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Rebecca Kemp	Managing Director, Avon LMC	RK
Susie McMullen	Head of Contracts: Children's, Community and Primary Care, BNSSG ICB	SMc
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JM
Prof Sarah Purdy	Partner Non-Executive Member, North Bristol NHS Trust	SP
Hayley Richards	Non-Executive Director, Sirona	HR
Michael Richardson	Director of Nursing and Deputy CNO, BNSSG ICB	MR
Apologies		
Dr Katrina Boutin	GP & GP Collaborative Board Medical Director	KB
Jenny Bowker	Deputy Director of Performance Delivery, Primary Care and Children's Services, BNSSG ICB	JB
Debbie Campbell	Chief Pharmacist and Director of Medicines Optimisation, BNSSG ICB	DC
Jeff Farrar	Chair of the BNSSG ICB	JF
Nikki Holmes	Head of Primary Care, Southwest, NHS England, and Improvement	NH
Jamie Denton	Head of Finance, Primary, Community & Non-Acute Services, BNSSG ICB	JD
John Hopcroft	Avon Local Optical Committee	JH
Matthew Jerreat	Clinical Chair of the Southwest Local Dental Network	MJ
Matt Lenny	Director of Public Health, North Somerset Council	ML
Dr Shaba Nabi	Chair, Avon Local Medical Committee	SN
George Schofield	Avon Local Dental Committee Secretary	GS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
In Attendance		
Sandie Cross (*minutes*)	EA to Dave Jarrett, BNSSG ICB	SLC
Samuel Hayward	Consultant in Public Health, NSC	SH
Tim James	Head of Strategic Estates, BNSSG ICB	TJ
Sophiya Wilson	Estates Project Coordinator, BNSSG ICB	SW

	Item	Action
1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Extraordinary "Open Session" of the Primary Care Committee (PCC). AM welcomed Samuel Hayward (SH) to the meeting, and reported the main agenda item today was to discuss the Pharmaceutical Needs Assessment (PNA). AM asked for clarification on the purpose of the paper, and why it was brought to the Committee, and asked who the Executive Sponsor was. DJ confirmed the PNA is approved by Health and Wellbeing Boards, and the Committee's role is to engage in the consultation. Hayley Richards was welcomed to the PCC. Apologies are noted as above.	
2	**Declarations of Interest** There were no new declarations of interest to note, and no existing declarations of interest relating to agenda items at the PCC meeting today.	
3	**Pharmaceutical Needs Assessments (PNA)** SH introduced himself as the chair of the PNA process for BNSSG and presented the PNA, explaining its purpose, the collaborative approach taken this time, and the key findings. SH outlined the statutory responsibility of Health & Wellbeing Boards, to produce a PNA every 3 years. He highlighted that there were no identified gaps in current provision or future directories, and the PNA is essential for making decisions on new pharmacies or services. SH explained that the PNA covers all three areas (Bristol, North Somerset, and South Gloucestershire) and is the responsibility of the Health and Well-Being Boards, delegated to the directors of public health. SH explained the following elements of the PNA: ➢ This round (2025–2028) was developed collaboratively across BNSSG, rather than individually by each local authority. It is noted the PNA is a statement of need for pharmaceutical services, not a traditional needs assessment. ➢ The PNA is used by the Integrated Care Board (ICB) for commissioning decisions and must be robust to withstand legal challenges. ➢ The assessment covers current provision, gaps, demography, choice, and cross-border services. ➢ The steering group included public health, ICB medicines optimization, Healthwatch, Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC), and the Southwest Collaborative Commissioning Hub. ➢ Localities for the PNA are defined specifically for this process and differ from NHS localities. ➢ Draft PNAs are available on council websites for statutory consultees to review and respond. ➢ Statutory consultees include LPC, LMC, dispensing contractors, NHS Trusts, Healthwatch, and others. <u>Consultation and Engagement:</u> SH emphasised the importance of the consultation process and the need for responses from statutory consultees. He provided links to the draught PNA documents and the survey for responses. The Committee discussed the importance of engaging with the consultation and the strategic use of the PNA.	

	Item	Action
	Richard Brown (RB) explained the PNA is crucial for market entry decisions for community pharmacy and is now more relevant to the ICB since pharmacy contract delegation. The PNA is a binary document identifying current provision and any gaps; no gaps were found in this round. <u>Questions/Reflections Raised Included</u> ➢ Joanne Medhurst (JM) noted the PNA is now a fixed question in regional public health assurance and suggested Debbie Campbell (DC) (medicines team) should coordinate the ICB response. There are community concerns about whether the PNA adequately describes need, especially regarding health inequalities. ➢ JM suggested that she will take executive leadership on the response, working with DC and the primary care team if gaps or inequities are identified. It was agreed that DC should coordinate the ICB's response to the PNA consultation, considering the health inequalities lens and the strategic commissioning intentions. AM agreed, noting the importance of linking the PNA to the housing strategy and urgent care strategy. ➢ Tim James (TJ) raised the importance of understanding and aligning the PNA with the housing growth policy, noting that the ICB is developing its own housing growth policy and often negotiates with developers around Section 106 funding for healthcare provision, including pharmacy space. He highlighted the challenge of aligning the PNA's three-year cycle with the longer timescales of housing development and Section 106 negotiations, emphasising the need to avoid missed opportunities for future provision. SH acknowledged that while the PNA considers housing growth, its methodology and three-year cycle may not fully capture long-term risks or opportunities associated with future developments, and any identified risks are described in the report. ➢ Michael Richardson (MR) asked if the PNA process identified any future risks to provision? SH responded that the methodology does not allow for detailed risk identification beyond what is in the report. ➢ HR highlighted the need to consider the future changes in out-of-hospital care and community services, and asked if Sirona, as a community provider, was a statutory consultee and questioned how the PNA would support future out-of-hospital and community care shifts. AM summarised that the Committee's role is to engage in the consultation, executive sponsorship noted. She emphasised the importance of making connections to strategic commissioning intentions and ensuring a coordinated response to the PNA consultation. **Actions Identified** **1. Confirm ICB executive sponsorship for PNA response.** **2. Coordinate ICB response to PNA consultation (with health inequalities lens)** **3. Ensure links between PNA, housing growth, and Section 106 planning.** **4. Clarify Sirona's role as a statutory consultee in the PNA process.** **5. Committee members to review draft PNA and provide feedback as needed.** AM concluded the meeting, thanking SH for his presentation and the Committee for their contributions.	**JM** **DC** **TJ & SH** **SH** **All Members**