BNSSG ICB Board Open Meeting

Minutes of the meeting held on 3rd July 2025 at 12.45pm held virtually via Microsoft Teams

DRAFT Minutes

Present		
Jeff Farrar	Chair of BNSSG Integrated Care Board	JF
John Cappock	Non-Executive Member – Audit	JCa
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Jaya Chakrabarti	Non-Executive Member – People	JCh
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	MK
Dr Jacob Lee	Chair of the GP Collaborative Board	JL
Alison Moon	Non-Executive Member – Primary Care	AM
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Sarah Truelove	Chief Financial Officer and Deputy Chief Executive, BNSSG ICB	ST
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Mark Cooke	Managing Director, NHSE South West	MC
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Nick Hibberd	Chief Executive Officer, Bristol City Council	NH
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JMa
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JMe
Kevin Peltonen-Messenger	Chief Executive, The Care Forum	KPM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
In attendance		
Loran Carter	Team Administrator, Corporate Services, BNSSG ICB	LC
Anne Clarke	Adults, Housing and Community Development Director, South Gloucestershire Council	AC

Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Aishah Farooq	Associate Non-Executive Member	AF
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Jo Hicks	Chief People Officer, BNSSG ICB	JH
Ruth Hughes	Chief Executive Officer, One Care	RH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Fiona Mackintosh	VCSE Alliance Representative	FM
Lucy Powell	Corporate Support Officer, BNSSG ICB *minute taker*	LP
Paul Roy	Associate Director for Research, BNSSG ICB	PR
Alison Smith	Deputy Chief Executive, Avon and Wiltshire Mental Health Partnership NHS Trust	AS
Sam Willitts	Head of Sustainability, BNSSG Integrated Care System	SWi
Beth Winn	GP, Charlotte Keel Medical Practice	BW

	Item	Action
1	**Apologies** Jeff Farrar (JF) welcomed all to the meeting. The above apologies were noted. Anne Clark (AC) was welcomed to the meeting as deputy for Dave Perry and Alison Smith (AS) was welcomed to the meeting as deputy for Dominic Hardisty.	
2	**Declarations of Interest** No new interests were declared and there were no interests pertinent to the agenda.	
3	**Minutes of the 1st May 2025 ICB Board Meeting** The minutes of the 1st May 2025 meeting were agreed as correct.	
4	**Actions arising from previous meetings and matters arising** The ICB Board reviewed the action log: **Action 95** – Deborah El-Sayed (DES) provided an update as reflected in the action log. The framework would be presented to the September ICB Board for endorsement. The action was closed. **Action 99** – Rob Hayday (RHa) outlined the expectations of staff leaving and it was agreed to close the action. All other due actions were closed.	
5	**Chief Executive Officer's Report** JF confirmed that this was Sarah Truelove's (ST) last BNSSG ICB Board meeting. JF thanked ST for her work for the ICB and thanked her for her clear communication and explanations at Board meetings. JF reminded ICB Board members to complete their annual declarations of interest forms if they had not done so already. Shane Devlin (SD) outlined the three items from the Chief Executive report: • Strategic Direction and transformation of BNSSG ICB	

- Winter Planning
- Update on Healthier Together 2040

Strategic Direction and transformation of BNSSG ICB
SD confirmed that the cluster with Gloucestershire ICB had been formally confirmed, and the national teams were working through the appointment process for Chairs and Chief Executives. The style and shape of the ICB would be based on those functions that would grow, with some functions transferred to NHS England and other local providers. SD noted that a transition process would be developed to safely transfer these functions.

Winter Planning
SD noted the core responsibilities of the ICB including vaccination uptake, admission avoidance and system coordinator to ensure a whole system approach. The ICB was expected to complete a desktop review and modelling to evaluate whether the developed plan would work during surges, staff shortages and variations of flu. The winter plan would be approved by the ICB, issued to NHS England, and tested during September 2025.

Update on Healthier Together 2040
Healthier Together 2040 (HT2040) was the ICB's work programme to understand local populations and the services which needed to be in place to help people to live longer healthier lives by 2040. HT2040 would be the blueprint for future strategic commissioning.

Alison Moon (AM) asked whether the ICB has considered the impact of organisational change on winter planning and whether there was anything Committees and the Board could help to develop areas of priority. SD confirmed that the Executive leads had been asked to review their work over the next months to determine what must be done against what might have been done. The ICB would narrow down core business to include organisational plan delivery. The risk register would be assessed regularly during the transition and narrow down the focus further if elements were slipping.

Aishah Farooq (AF) noted that the report included a number of identified improvements, but urgent care was challenging and complex and asked what assurance could be given that the plan would deliver different outcomes this year. SD explained that the ICB had reviewed the key challenges such as No Criteria to Reside (NCTR), and system plans had been developed to support improvement. David Jarrett (DJ) explained that there was significant partnership working to robustly stress test the plans for areas around the system which was a different approach to last year.

	Ellen Donovan (ED) confirmed that the Outcomes, Quality and Performance (OQP) Committee would be reviewing the winter plan arrangements at a future meeting. ED asked about the confidence in moving current ICB functions to NHS England. SD explained that NHS England would be developing a regional model which would identify the moving functions as well as proposals on how to receive them. ST confirmed that the work was ongoing. Fiona Mackintosh (FM) highlighted that data collection, research and innovation were some of the functions to be moved to NHS England and believed that this would be detrimental as organisations would lose the knowledge required to provide the services needed by the local populations. SD explained that the ICB was unable to be a world class commissioned with owning research, innovation, and data collection and this would be communicated to NHS England. **The ICB Board received the update from the Chief Executive**	
6.1	**Corporate and Integrated Care System Risk Register** SD presented the item explaining that the Corporate Risk Register (CRR) outlined the risks of the ICB and the Strategic Risk Register outlined the risks of the system. The CRR was populated by the risks scoring over 15 on the individual ICB directorate risk registers. The Strategic Risk Register and the mitigations for the risks were reviewed by Chief Executives across the Integrated Care System (ICS). Rob Hayday (RHa) confirmed that the registers had been received and reviewed by the ICB Audit and Risk Committee. The ICB CRR contained 16 risks. Four risks were recommended for removal from the Register as the scores were below 15. These risks would remain on Directorate Risk Registers. Two risks had been escalated to the CRR; these related to the payment mechanisms for elective services and ADHD and Autism services. Due to the variable activity in these areas, it could impact the ICB financial position. RHa also noted a risk associated with the System Executive Group (SEG) around the impact of the NHS reform on future ICS performance. ED thanked the teams for allocating the risks on the Strategic Risk Register to ICB Board Sub-Committees and asked that the risks were presented within the papers to the Committee including the impacts and mitigations. ED noted that the winter planning paper needed to include the risks and mitigations for the OQP Committee to test and challenge. SD agreed and welcomed the testing of the actions related directly to the risks. AM noted the mitigation of the risk associated with the impact of NHS reform related to the Transition Committee. AM asked whether the mitigation relied	**ICB Execs**

	solely on the Terms of Reference for the Committee. SD confirmed that there was a separate Risk Register for the transition process developed by BNSSG ICB and Gloucestershire ICB. This register would be included as an appendix to the Risk Register in the future so that the Board members were aware of the actions taken once the Transition Committee was established. **The ICB Board:** • **received the Corporate Risk Register (CRR) and noted the details** • **Accepted the risks escalated to the CRR and approved the closure/de-escalation of risks from the CRR where indicated** • **Received the Integrated Care System Strategic Risk Register and noted the details**	**SD/ RHa**
6.2	**Integrated Care System Green Plan Refresh** ST explained that all NHS organisations needed to refresh their green plans by the end of July 2025. ST highlighted that this was area proposed for transfer to providers and explained that Sam Willitts (SWi) who worked on the Green Plan on behalf of the whole system was employed by North Bristol Trust (NBT). The approach set out in the Green Plan has been embedded into the system operational plan response. The most significant change to the plan was the separation or those elements which were in direct control of the NHS, where there was a commitment to reduce to zero carbon by 2030, and those outside of NHS control, where the timeframes for reductions were nationally driven. The Green Plan outlined the ambition for BNSSG to be leaders in this work and this was already being delivered. The plan to follow in the Autumn would outline the actions needed to deliver zero carbon for those areas within NHS control. The HT2040 programme had the most significant impact on the delivery due to the shift to preventative care and focus on being proactive in developing care models. There were plans in place for the ICB Board to undertake Carbon Literacy training. ST confirmed that as part of the capital prioritisation work, £3m had been set aside for the Green Plan Steering Group to prioritise and leverage for further investment and maximise carbon reduction. ST noted that this was an area of developing private finance initiatives and securing funding to deliver the ambitions set out in the Green Plan was a priority. ST highlighted the engagement with the Community Leadership Panel on Climate and Just Transition which had been woven into the plan. The Green Plan would be presented to partner organisation Boards for approval. Jaya Chakrabarti (JCh) asked whether the Green Plan included plans to digitise the significant amount of paper communication still used throughout the local	

	health system. SWi explained that this had not been specifically mentioned in the plan but was one of the efficiencies expected as part of the digital work. The expectation was that good practice and the benefits of digital communication would be shared throughout the system. **The ICB Board:** • **Reviewed the changes made to the Green Plan in the refresh process and noted that these met the NHS England aims** • **Noted that organisations would take the plan to individual Boards for approval and addition of any specific appendices** • **Noted that the delivery plan would be updated to reflect the outcomes and actions in the refreshed plan and committed to organisational responsibilities for delivery** • **Noted that a public facing Green Plan document would be designed to publish on the ICB and NHS England websites** • **Noted submission of refreshed Green Plan to NHS England** • **Approved the refreshed Green Plan**	
6.3	**Deepend Project Update** Paul Roy (PR), and Beth Winn (BW) were welcomed to the meeting. PR explained that the aim of the ICB research programme was to develop health and care research projects which made a difference to those who need it most. PR noted that those with the greatest need were offered the fewest research opportunities, and this needed to be reversed. PR provided some background to the ICB research team noting that the team was externally funded and worked by a set of principles which included ensuring the best use of resources and robust governance processes. The team facilitated connections across the system and local population to ensure that research was coproduced. There was a focus on consistent learning throughout the research process and ensuring that health and research teams were connected to develop evidence based research plans. PR noted the low rates of inclusion within research projects, explaining that a recent study found that 95% of research participants in BNSSG were 95% white, 65% women and mostly from affluent areas, with the average age around mid-50s. These were not the people with the greatest needs in the health system and so proactive work was needed to shift research into the areas of greatest need. PR noted that there was also underrepresentation of research in workforce with lots of opportunities for medics, fewer for nurses, and even fewer for allied health care professionals, and the Voluntary, Community and Social Enterprises (VCSEs). PR highlighted the significant investment in research but noted that	

	this was not evenly distributed across the areas of health and social care with community services receiving significantly less than the acute trusts. PR noted that research was also a way to generate income for the ICS and highlighted the joint roles between the ICB and University West of England (UWE). Developing partnerships with academia was one of the five pillars within the ICB Research Strategy which also included targeting those with the greatest need, and diversifying health and care research. There were two strands of investment for targeting those with the greatest needs, the research engagement network and training and support for researchers. BW explained that GPs at the Deepend was a project designed to support GPs working in areas of high deprivation where patients were more complex and circumstances were more challenging. This led to an increased workload for GPs who often needed to undertake a deep dive into patients to determine their wider determinants of health. The primary aim of GPs at the Deepend was to tackle health inequalities in primary care and focused on patients living in the most deprived 15% of the UK using an index of multiple deprivation. BW noted that research indicated that those individuals who have the most health needs are the least likely to access healthcare and there was a direct correlation between deprivation and lack of access to health care. BW noted that the levels of inequality between the areas of affluence in Bristol and those highlighted as the most deprived was stark, with life expectancy 15 years lower in areas of high deprivation. BW explained that often in areas of deprivation, individuals' wider social determinants made everything in their lives difficult, and it was important that their GP was someone they were able to trust would advocate for them. Workforce and research were key elements of the project. Workforce was a vital component due to increased workload and high levels of burnout associated with working in the most deprived areas. This was acknowledged and utilised as a way to improve engagement with GPs, and recruitment and retention had improved. The Training Hub funded a Health Inequalities fellowship programme which had been running for two years. Clinicians in the Deepend were funded for 8 hours a week to work on non-clinical work to reduce health inequalities. There had been tremendous success with these projects which included ways to increase cancer screening uptake and making a practice carbon neutral. These clinicians reported that diversifying their week had reduced the feeling of burnout, they felt they were better serving their population group and were dedicated to their clinical workload. Funding was also made available for 'Power up' Projects for a clinician to work on one of the social determinants that was a frustration, and these projects had resulted in a 63% reduction in patient sick	

	days and 55% reduction in pain. These projects included yoga for anxiety and reducing childhood obesity through movement. BW noted the importance of education and explained that research showed that exposing GPs to deprivation early in their training made them more likely to continue serving those populations. There was now a Deepend student selection at Bristol University where students could work in deprived areas and receive specific training in areas such as domestic violence and drug use, cultural competency and caring for refugees or asylum seekers. GPs at the Deepend also convened face to face events to boost morale and share ideas with clinicians and community members and discuss advocacy and research opportunities. BW noted that there was significant research happening, but it was not covering the areas that those populations in the most deprived areas needed or wanted answering. Working with community groups and the local populations gave insight into the areas which mattered to them, which allowed for quality improvement projects to be developed. BW highlighted the importance of feedback to those groups to outlined the impact of their engagement which emphasised the value of their contributions. BW noted that research directly affected policy and so being included in research projects was important. GPs at the Deepend aimed to improve representation in these projects and ensure that the ideas from GPs were able to be developed into research projects. BW outlined the successful research programmes including the project to improve menopause care for the women in South Bristol and supporting the founders of Black Mothers Matter to run and publish their own research projects. BW highlighted again the importance of engaging with the local population to understand what mattered to them and aligning research appropriately. There had been success in improving representation with 7 practices now participating in studies and this had been achieved through funding of the time of clinicians to do the work. The Deepend project had shown that with support and funding, research was possible and effective within these communities. JF asked what the key message and ask was for the ICB Board. BW highlighted that the project had been running for two years and had incredible success in building relationships, project implementation and the improvement in recruitment and retention. The ambition was for the Deepend approach to be built into the work of the system as a key way to support recruitment and retention, and research particularly in utilising the relationships GPs had with their patients to increase research participation. BW noted the project had	

	delivered a lot on a relatively small budget and therefore asked for GPs at the Deepend to be considered as a mainstream funding opportunity in the future. JF noted the strong research approach in BNSSG and asked for an example where research had affected policy and changed the way business was undertaken in BNSSG. BW noted examples of national research projects which had not considered the views of communities who were either affected by the conditions or needed the resources that were being consulted on. BW highlighted that the GPs at the Deepend approach would have included those communities to ensure more meaningful engagement. JF highlighted that the Board believed that policies should be based on evidence. The Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee would support gaining the perspectives of different groups as part of this approach. JCh noted the challenging timescales often involved in research projects and asked whether GPs at the Deepend was working with VCSE colleagues to explore the links between the research taking place and the communities being supported. BW confirmed this was a large part of the work and the team was reviewing the funding already available and using this as appropriately as possible. BW confirmed that much of the advocacy work had been around making GPs and primary care clinicians aware of existing services to appropriately signpost patients. PR noted the long timescales associated with the research and explained that BNSSG ICB was the first ICB to have an embedded health system impact accelerator unit which was dedicated to turning research evidence into practical steps to embed into practice. PR gave an example of a project to support patients from South Asian populations with dementia. Resources and toolkits was added to Remedy and Ardens within four months. PR also noted the resources dedicated to working with the VCSE sector as part of the research engagement network. Co-developed contracts suitable for the voluntary sector had been developed and were now being used across the country. There was also working ongoing to recognise the unpaid work of VCSE organisations involved in research and the intention was to pay for this at appropriate rates, rather than exploit the goodwill of people who care for their communities. SW noted that ICBs were established to reduce health inequalities and welcomed the approach taken which proved that targeted and focused work could take place with small amounts of funding. SW noted that there were various parts of the system looking at similar approaches including the Primary Healthcare Research Hub and the Health and Innovation Network for the West	

	of England and believed there was an opportunity to join up all the work and share resources. Fiona Mackintosh (FM) highlighted that VCSE organisations received very little research funding but there was a wealth of knowledge and reach within the VCSE alliance organisations and it was important to maximise these assets within the communities. FM noted that there were individuals not registered with GPs who did not trust healthcare organisations, but worked with VCSE organisations, so it was important those links were made. FM noted that many patients did not consider themselves living in high deprivation or hard to reach and highlighted that language was important. BW agreed and noted that underserved was more appropriate terminology to describe these populations and agreed that the local services had a responsibility to engage with populations. PR noted the ambition to work more closely with the VCSE alliance and highlighted the ongoing work with VCSE organisations which included research support services for ideas, contracts, and governance. AM noted that the focus was on Bristol but highlighted that there were areas of deprivation in North Somerset and South Gloucestershire as well and asked whether the approach could be replicated across the whole of BNSSG. AM agreed with the comments made about trust and relationships and noted that there were a number of primary care clinicians including allied health professionals, pharmacists, optometrists, and dentists who have those trusted relationships with individuals, so it was important that this work was also linked across primary care. AM asked what were the principles which could be replicated for the people living in the more affluent areas of BNSSG. BW agreed and noted that there could be mistrust of GPs anywhere within BNSSG, and therefore GPs were attending health events at religious buildings and community events to undertake health checks and be visible and talk to people to gain that trust. BW highlighted work taking place to support voluntary sector organisations in contacting GPs with concerns about individuals. The GPs would then contact individuals to perhaps remove some of the anxiety involved in booking appointments. BW agreed that community hubs including all areas of primary care were important across BNSSG. There were 3 surgeries in Weston involved in GPs at the Deepend but no South Gloucestershire areas had been below the deprivation index utilised but BW acknowledged that there were pockets of deprivation throughout BNSSG which the Deepend approach could support. SD believed that research and innovation needed to be at the heart of strategic commissioning and part of the future ICB function. The ICB was unable to commission services for the local population without resource for research and engagement. SD noted that the NHS 10 Year Plan focused on neighbourhood	

	health systems and the learning from the GPs at the Deepend programme was vital to creating health systems that improved people's lives through improving their health and these programmes needed to be maintained and replicated in the future. **The ICB Board noted the continued support for the Deepend through research and considered the ways the Deepend can be enhanced to benefit the patients with the greatest needs and staff serving them**	
7	**Outcomes, Quality and Performance Committee** ED gave an update from the OQP Committee noting that the June Committee had received updates on women's health, national medicine shortages and GP collective action. The Committee had received a quality report with a focus on paediatric audiology and the quarter 4 safeguarding report. The ICB safeguarding team were working system wide to build relationships and develop a comprehensive work plan. The report outlined the themes and trends relating to safeguarding and identified the work plan risks and mitigations. The OQP Committee had been informed that C. Diff cases had risen nationally and BNSSG mirrored this trend. The system was working on a project with regional NHS England colleagues to understand the drivers. MRSA was also a concern as BNSSG was seeing higher than national average cases. This was an area of focused action. The Committee had seen increased performance on elective and cancer care. Urgent Care performance was also good and category two ambulance call outs were only slightly off target. 4 hour A&E performance was above trajectory. NCTR and patient flow continued to be a challenge, and all the Trusts were above the national target of 15% NCTR. This was a difficult position looking ahead to winter. Initiatives for winter had been discussed at the Committee and there had been helpful challenge and support at the meeting which had resulted in an action for the ICB to meet with the Chair of Quality at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) to discuss opportunities. ED reported that work continued on NBT community beds and highlighted this was an area for the OQP Committee to review. ED asked what would be different this winter, and did the system fully understand the drivers behind the concerns. DJ noted that the system had enhanced the scrutiny and governance of the delivery of the plans this year and there was more granularity within the plans and trajectories. There were clear length of stay and NCTR trajectories set, and these would be held to account through a refocused executive meeting which	

	reported into the SEG and Performance and Recovery Board. DJ noted that delivery of the plans were key for winter as well as the overall operational plan. Rosi Shepherd (RS) highlighted that the increase in Healthcare Acquired Infections (HCAI) were being reviewed with the region. MRSA had been an issue within BNSSG for a long time and related to the homeless populations. The ICB was working closely with public health colleagues to tackle this. It was noted that the BNSSG LeDeR Framework had been reviewed and recommended by the OQP Committee for ICB Board approval. **The ICB Board approved the BNSSG LeDeR Framework to be published** **The ICB Board received the update from the Outcomes, Quality and Performance Committee**	
8	**People Committee** JCh reported that the meetings of the ICB People Committee had been focused on the ICB reorganisation programme but continued to discuss business as usual. The ICB People Committee would meet bi-monthly and support the Remuneration Committee and approve any people related decisions. JCh noted the ongoing and constructive engagement with the Staff Partnership Forum and Inclusion Council in regard to operational change. The Union Recognition Agreement has been developed to formally acknowledge the role of the Unions in representing employee interests during the period of change. As part of the ongoing work to align policies with Gloucestershire ICB, the BNSSG ICB policies regarding Pay Protection and Ring Fencing were updated. The ICS People Committee did not meet in May 2025, but performance updates and organisational priorities were shared by partners and circulated to Committee members. The next ICS People Committee would focus on system wide workforce risks and the quarter 1 performance metrics. The Terms of Reference for the ICS People Committee had been updated, and these were attached for ICB Board approval. RHa noted that once approved, he would ensure they were included in the BNSSG ICB's published Governance Handbook. **The ICB Board approved the revised ICS People Committee Terms of Reference** **The ICB Board received the update from the People Committee**	**RHa**
9	**Finance, Estates and Digital Committee**	

	SW explained that the Finance, Estates and Digital (FED) Committee was focused on reviewing the early financial projections against trajectories and ensuring that these remained on track. The Committee planned to continue the deep dive programme into specific organisational saving plans so that concerns can be addressed by the system. The Committee noted that the ongoing reorganisational changes could present challenges in maintaining focus on the delivery of savings plans. This would be monitored by the FED Committee. The FED Committee held in June had undertaken a deep dive into Continuing Healthcare which was an area of identified risk. The FED Committee had also reviewed the capital requirements across the system. Additional funding had been secured, and the system was taking a risk-based approach to estate investments. The FED Committee would continue to monitor capital expenditure to ensure it was utilised. The system was working to understand the housing growth in BNSSG, and development had started on how to interface and influence developers to ensure appropriate investment in population health needs during the design and delivery stages. A strategy was being developed to ensure that ICB input was consistent. The Committee also discussed cyber security threats and how to respond to national threats as a system. Work continued across the system as well as in individual organisations. ST explained that the system was £1.7m in deficit at month 2 which was driven by slippage on UHBW saving schemes in month 1, UHBW delivered on their savings plan for month 2. The Performance and Recovery Board reviewed the slippage and there were robust monitoring processes in place to ensure that the position was recovered over the rest of the year. ST highlighted that the BNSSG ICB Procurement Policy had been reviewed by the FED Committee and recommended to the ICB Board for approval. **The ICB Board approved the BNSSG ICB Procurement Policy** DES confirmed that the ICB was working on a Cyber Strategy and there was a seminar session planned for November 2025 to review the ICB Board responsibilities around cyber security and data security. Julie Sharma (JS) asked whether the ADHD and autism financial risk related to adults or children's services. ST explained that this related to adult services and the new entrants into the market for these services. There were no national tariffs or standards in this area, so the ICB was working with the national team to	

	understand this. ST highlighted that this was an opportunity for the ICB to influence national policy. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
10	**Primary Care Committee** AM highlighted that despite the significant personal and organisational uncertainty the Primary Care Committee (PCC) continued to receive excellent papers and verbal updates. AM noted the importance that Committees assisted the prioritisation processes needed to support the ICB during this time. The Committee reviewed the register of risks related to primary care which included risks the Committee was familiar with such as the commissioning hub and dental activity units. The PCC discussed the Dental Strategy. There there had been some progress, but more work was needed. AM reported that around 46% of children and a higher percentage of adults in BNSSG were not accessing NHS dentistry services and there were high levels of visible tooth decay in the under 5's and high oral cancer rates. The PCC were aligning the inputs and intent of the strategy against the outcomes and performance and believed that dental was a significant risk for the system. This needed to be recognised at ICB Board level. AM highlighted the link between high levels of deprivation and access and noted that dental was an area where health inequalities needed to be reduced. AM explained that the PCC had received clear and high-quality financial reports which confirmed a positive 2024/25 year end position. New highlight reports had also been received regarding the general practice Access Improvement Plan and Pharmacy First. BNSSG performance for Pharmacy First was number one nationally which was a significant achievement. The focus for the Committee was now optometry and the continued work against the Dental Strategy. DJ noted that the new highlight reports replicated the format of those reports for quality and performance meetings and supported tracking the key trends and core metrics. This would support the ICB and PCC to review the outcomes were as intended. DJ noted the one of the key Operational Plan standards was to increase access to urgent dental appointments by 19,000. Expressions of interest applications had been received from across the six localities for over 19,000 appointments. The ICB had used the Cambridge Morbidity index to prioritise appointments for those areas of greatest need but additional urgent dental care would be available across every locality. **The ICB Board received the update from the Primary Care Committee**	

11	**Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee** JF explained that the SHIPPH Committee had discussed how the organisational change proposals would affect the way the ICB approached health inequalities. The Committee had received the research report, and the Committee members had challenged how to improve support for people to undertake research in the community. The Committee had discussed developing research methodology in a collaborative way to support those individuals undertaking the projects. JF noted the importance that the ICB considered what were the changes and outputs expected from the research to reduce health inequalities and how this evidence was incorporated into strategic decision making across the ICB Board and Sub-Committees. JF noted the similar work taking place in the wider system and how this could be joined up to support the local populations. FM agreed and asked how the system could invest in communities to develop them to be researchers and noted that there needed to be transparency across the system on the research projects taking place for that join up to happen. JF noted that the 10 Year Plan outlined plans to embed the way NHS organisations moved from analogue to digital solutions. DES noted that a core area of focus was digital inclusion which was one of the reasons why people experienced health inequalities. DES highlighted that this applied to many of the social determinants for health such as applying for jobs and accessing basic services. Digital inclusion was a key element of the 10-Year Plan and strategic commissioning in the future to ensure that the ICB was commissioning for accessibility and supporting both staff and service users. DES noted that once the ICB had reviewed the 10 Year Plan then a paper would be presented to the Board outlining the actions to support this work. **The ICB Board received the update from the Strategic Health Inequalities, Prevention and Population Health Committee**	
12	**Audit and Risk Committee** John Cappock (JCa) noted that the June Audit and Risk Committee meeting had been the final meeting with Grant Thornton as the external auditors. JCa thanked Grant Thornton for their services. The focus of the Committee meeting had been approving the annual report and annual accounts for 2024/25 and receiving the external audit opinion. SD had been present as accountable officer to hear the reflections of the external auditors. Before approving the annual report and accounts 204/25, Committee members had met with the Auditors in private, and during the meeting, had the opportunity to challenge the ICB Executive Officers. The Audit and Risk	

	Committee had been happy to approve the annual report and accounts on behalf of the ICB Board. JCa noted that the year-end process had been efficient, and this was due to the collaborative working. The annual report displayed much for the ICB to be proud of and contained an excellent head of internal audit opinion and a good annual counter fraud report. The Audit and Risk Committee continued to review the internal audit plan which met current needs but there was flexibility available if required. The Data Security and Protection Toolkit (DSPT), which was a mandated process through internal audit, had been reviewed at the June meeting. JCa reported that at that point the ICB was close, but not quite compliant with the required standards. The ICB had now met the standards which positioned the ICB well as it moved towards the focus on strategic commissioning. **The ICB Board received the update from the Audit and Risk Committee**	
13	**South West Joint Specialised Services Committee** ST confirmed that the first meeting had taken place post delegation of services. There were considerations for the ICB around how the risks related to specialised commissioning were added to the ICB risk registers. ST reported that work continued on the development of a five year plan for specialised services which would be presented to the ICB Board in the future. **The ICB Board received the update from the South West Joint Specialised Service Committee**	
14	**BNSSG Integrated Care Partnership Updates** JF confirmed that Jenna Mo Harris was currently Chair of the Integrated Care Partnership (ICP) Board. The ICP Board played an important role in reviewing the wider way services were delivered and the conversation at the last meeting had been about the future of the ICP Board. It was expected that the 10 year Plan would outline potential changes in this area and there was work to do with the Chairs of the local Health and Wellbeing being Board to review this. **The ICB Board received the update from the Integrated Care Partnership**	
15	**Questions from Members of the Public** There were no questions from the public	
16	**Any Other Business** There was no other business	
	Date of Next Meeting Thursday 4th September 2025,	

Lucy Powell, Corporate Support Officer, July 2025