Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Board Meeting

Minutes of the meeting held on 4th September 2025 at 12.45pm held at Bristol Citadel Community Church and Family Centre, Bristol, BS6 5NL

DRAFT Minutes

Present		
Jeff Farrar	BNSSG and Gloucestershire Cluster Chair	JF
Mandy Bishop	Chief Executive Officer, North Somerset Council	MB
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
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	MK
Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JMe
Alison Moon	Non-Executive Member – Primary Care	AM
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
Matt Backler	Interim Chief Finance Officer, BNSSG ICB	MBa
Mark Cooke	Managing Director, NHSE South West	MC
Nick Hibberd	Chief Executive Officer, Bristol City Council	NH
Ruth Hughes	Chief Executive Officer, One Care	RH
Dr Jacob Lee	Chair of the GP Collaborative Board	JL
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JMa
Kevin Peltonen-Messenger	Chief Executive, The Care Forum	KPM
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
In attendance		
Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB

Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
Aishah Farooq	Associate Non-Executive Member	AF
Layla Green	Deputy Director, Safety & Quality Maternity and Neonatology, BNSSG ICB	LG
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Jo Hicks	Chief People Officer, BNSSG ICB	JH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Fiona Mackintosh	VCSE Alliance Representative	FM
Lucy Powell	Corporate Support Officer, BNSSG ICB *minute taker*	LP
Keith Robertson	Senior Performance Improvement Manager, BNSSG ICB	KR
Gemma Self	Programme Director - Healthier Together 2040, BNSSG ICB	GS
Richard Smale	Director of System Coordination, NHS England South West	RSm

	Item	Action
1	**Apologies** Jeff Farrar (JF) welcomed all to the meeting. Mandy Bishop (MB) Chief Executive for North Somerset Council was welcomed to her first BNSSG ICB Board meeting. The above apologies were noted. Richard Smale (RSm) was welcomed to the meeting as deputy for Mark Cooke.	
2	**Declarations of Interest** John Cappock (JCa) declared a new interest as Non-Executive Director and Audit Chair of Estyn, the Welsh Schools Inspectorate. There were no other new interests declared and no interests pertinent to the agenda.	
3	**Minutes of the 3rd July 2025 ICB Board Meeting** The minutes of the 3rd July 2025 meeting were agreed as correct.	
4	**Actions arising from previous meetings and matters arising** The Board reviewed the action log. **Action 101** – Rob Hayday (RHa) confirmed that the transition programme risk register would be presented to the Audit and Risk Committee on the 12th September 2025 following review by the Joint Transition Committee on the 10th September 2025. The risk register would be presented to the ICB Board in October 2025. The action was closed. All other due actions were closed.	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items from the Chief Executive report: • Strategic Direction and transformation of BNSSG ICB • ICB Annual Assessment 2024/25 • NHS Planning Framework **Strategic Direction and transformation of BNSSG ICB**	

	The ICB transition programme had started with BNSSG and Gloucestershire ICB Executive Teams working together to determine clustered working arrangements and how the new ICB would be designed. SD confirmed that the initial intention had been for the whole of the ICB to be transformed by the end of 2025/26, however it was clear that as the required redundancies would not be funded centrally, this deadline could not be achieved. The ICB was working with NHS England to reprofile funding allocation for 2026/27 to support the necessary transition processes. **ICB Annual Assessment 2024/25** The annual assessment letter had been included in the report and was positive. The letter reflected the key achievements of the ICB and highlighted areas of improvement. Achievements included strong working with the Health and Wellbeing Boards (HWBs) and Population Health Management work. **NHS Planning Framework** SD had attended a workshop yesterday regarding the Planning Framework which was a national responsibility supported by the regional teams. The planning process would be managed in two phases, laying the foundations by working with partners to understand the baseline and developing the plan. BNSSG ICB and Gloucestershire ICB planning process would be similar to support future merger. Ellen Donovan (ED) asked how the ICB plans would be developed and how any inconsistencies between the two plans would be managed. SD confirmed that Sarah Truelove, Chief Executive of Gloucestershire ICB would be leading the planning process with both plans working as one. The key to a successful plan would be the engagement of partners and the ICBs would use the Operational Delivery Groups (ODGs) for Urgent Care and Mental Health to build successful plans. JCa welcomed the ICB annual assessment which was consistent with the annual audit outcomes. Steve West (SW) noted that Committee members had been asked to flag transition related risks to the Committee Chairs who would feed these into the Joint Transition Committee risk register. SD confirmed that transition risks were also being considered and flagged through directorate risk register processes. **The ICB Board received and discussed the Chief Executive Officer's Report**	

6.1	**Healthier Together 2040 – Strategic Intentions for Working Age with Long Term Conditions** Deborah El-Sayed (DES) highlighted the eight strategic commissioning intentions which had been developed through the Healthier Together 2040 (HT2040) work. The intentions had been developed through engagement with system partners and the local populations. Gemma Self (GS) was welcomed to the meeting. GS explained that HT2040 programme was designed to shift the way healthcare services were designed through a population needs approach. HT2040 had tested the approach by engaging with the working age population with multiple health needs. Evidence and engagement had identified 10 issues to address and during the system test and design process, 15 concepts had been created and trialled using the three horizons approach. The model of healthy neighbourhoods was also used to inform the approach. GS explained that the focus had been determined as working age adults who had been out of work for a year or more due to health. There was a need to look holistically at this population as not all the issues identified were health related. GS explained that good practice would be for each individual to have a health and wellbeing plan, and a health and social care integrated scheme in place to coordinate the individuals care needs as well as support them to be healthy. GS noted that this type of care with neighbourhood place level support, and access to children and family hubs would support people to live healthier lives. GS highlighted that GPs played an important role and engagement with GPs had identified a need to ensure that longer appointments were available for this population. The HT2040 approach saw physical and mental health as interlinked and the model of care included apps to help people live healthy and well and shift towards a relational way of working at neighbourhood level with personalised care. GS explained that the work had highlighted the need for healthy work places who supported staff with multiple health needs, extending occupational health to carers and embedding WorkWell and local employment standards. GS highlighted that the outputs from HT2040 would be flexed and adapted as further insight and engagement took place. The ICB would take on a trusted listener role and develop services based on public engagement, population data at ICB and neighbourhood level, and evidence. GS highlighted that the local vision had been reinforced nationally through the 10 year plan. Next steps included how to develop the work across BNSSG and take those first steps in Gloucestershire ICB, as well as the next cycle of design and	

	testing of current elements such GPs at the Deep End. Care coordination models were being reviewed and there was willingness from the system to take these models forward. GS highlighted the reorganisational change which would be a challenge to the programme and the move to a strategic commissioning focus which was aligned with the expected outcomes of HT2040. SW welcomed the work and highlighted the importance that the right populations were engaged and providing feedback. Digital poverty was a major barrier for many communities and this needed to be addressed as the ICB moved to digital solutions. SW highlighted the role of all levels of education to deliver the skills needed for people to be able to manage their own health care. GS confirmed that the HT2040 team worked with the VCSE (Voluntary, Community and Social Enterprise) Alliance to reach out to local communities. A digital task force had been developed with professional leaders and members of the public to consider how to support those without access to digital solutions. The West of England Combined Authority (WECA) was also involved in the work to support regional planning. The expectation was that services would be commissioned with providers offering universal services with tailored personal approaches to respond to local needs. Alison Moon (AM) welcomed the personalised and coordinated approach proposed and asked whether all the data what had been identified and were there any gaps. AM asked whether the ICB would receive any support to achieve the neighbourhood level aims and outcomes. GS highlighted that there was a national working group determining the shifts needed in finances however it had been identified that there was a national lack of skills and knowledge about how the work could be achieved. Work was taking place locally to review how spend aligned to patient need. SD confirmed that 6 workstreams had been identified nationally to enable the 10 year plan which included enabling resources. SD noted the importance that the ICB continued to test the work of HT2040 rather than wait for national direction. JCa welcomed the healthy workplace lines and the link with WECA and the importance of organisations working with employees to determine staff experience. JCa asked whether there was any intention for the ICB to support smaller system partners to embed occupational health models. Jaya Chakrabarti (JCh) highlighted that the links with education and employers were key to improving population health.	

	Jo Medhurst (JM) highlighted the point raised about the gaps in the data and noted that there was a risk the ICB over analysed data rather than acting on what the evidence was showing. Fiona Mackintosh (FM) welcomed the work and VCSE Alliance involvement. FM noted that the shift needed to be humans at the centre of their care and the outcomes delivered for people were vitally important. It was important that the softer impacts such as patient and population experience were measured. FM noted that a common barrier for organisations to connect was legislation, e.g. procurement regulation, and FM believed that there needed to be a process alongside regulation to support work with the VCSE sector. JF noted that it was important for the ICB Board to consider where the HT2040 programme would sit within the system as the ICB moved towards the strategic commissioning focus. SD believed that this work was fundamental to understanding population and changing the way the ICB commissioned services. The learning from HT2040 would underpin the design of a strategic commissioning organisation. The ICB needed to understand the measures to monitor to determine which services needed to change, as well as the outcomes which were changing, to support healthy living. There were links to HWBs and Integrated Health Organisations (IHOs). The learning from this one cohort would be applicable to other cohorts. JF asked whether Gloucestershire ICB had undertaken work similar to HT2040. SD confirmed that slightly different work had taken place which had been helpful in terms of shared learning and the programme would combine the best elements of both. DES was encouraged that the work of HT2040 had preempted the work outlined in the 10 Year Plan. There was commitment from the VCSE sector, Local Authorities, carers and the population as well as communities and front line staff. GS highlighted that there would be decisions to make around priorities and the programme was using a risk register approach to monitor those. Consideration was also needed to identify how decisions would be made in the future. **The ICB Board:** • **Approved the HT2040 Strategic Intentions for working-age adults with multiple health needs and the approach taken**	

	• **Endorsed the progression to the next design/delivery phase, including testing outcomes with communities, developing neighbourhood operating models, and aligning incentives** • **Noted the approach set out to inform Strategic Commissioning**	
6.2	**Winter Plan Approval** Keith Robertson (KR) was welcomed to the meeting. David Jarrett (DJ) explained the paper was seeking ICB Board support for the approach to the winter plan. Work on the winter plan would continue with a Board Assurance Framework to be submitted to NHS England. To develop the winter plan, work had taken place across the system and plans tested in a range of forums including the ICB Outcomes, Quality and Performance (OQP) Committee in July 2025. Five areas of focus had been identified by NHS England and the ICB needed to prepare a response against each of these areas. DJ provided assurance in each area: **System-Wide Winter Preparedness:** The ICB had received collaborative system feedback and embedded the learning from last year. A system coordination centre was in place until March 2026 and there was a suite of processes to support escalation. DJ noted that an approach had been identified for shared system risk using dynamic risk assessment. **Reducing demand and increasing access:** DJ reported the vaccination programme had been established early in BNSSG and was targeting populations less likely to participate. The system was proactively investing in surge capacity and a winter pilot had been put in place for Integrated Care at Home. **Improving Hospital Flow and Reducing Delays:** DJ highlighted improvements in ambulance handovers and the Discharge Improvement Programme which monitored the No Criteria to Reside (NCTR) trajectory. Work had taken place to align provider bed capacity with trajectory to improve flow. Surge plans would be tested through NHS England events. **Mental Health Crisis Response:** DJ highlighted that Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) were developing new mental health escalation standard operating procedures to improve length of stay. **Digital Transformation:** DJ outlined the support expected from Technology Enabled Care (TEC) and the Federated Data Platform throughout winter. DJ confirmed that the system was taking a risk assessment approach to all the focus areas and these areas would be continually reviewed through the appropriate groups. The Winter Plan had been developed with partners and system groups and tested through the Health and Care Improvement Groups	

	(HCIGs). The ICB Board was asked to delegate Board assurance to the System Executive Group (SEG) and ED and AM as Committee Chairs. ED confirmed that updates had been presented at the OQP Committee where the winter plan had been challenged particularly around improving NCTR rates and stroke rehabilitation. ED confirmed that herself and AM would meet with DJ to test the level of detail around the focus areas to provide an additional level of assurance for the ICB Board. JF asked how the ICB would capture the experience and learning and pass this to the region if they took on the winter planning function in the future. SD explained that this was a complex area as there was distinction between having the responsibility for monitoring performance and contract management and this would need to be worked through. RSm confirmed that the Model Region was being developed, and it was likely that management of the winter plan would be in partnership between the ICB and the region. AM highlighted the significant work noting that the plan was asking people to do more and asked how much more staff could do during the pressurised atmosphere of winter and asked whether people were enthusiastic about the winter plan. KR highlighted that a more robust governance structure was in place for 2025/26 and staff recognised the need to respond quickly to emerging pressures and risks. DJ outlined that there was genuine buy in from the acute trusts, local authorities and community partners and there had been a shift in approach with providers leading these programmes for the system. DJ explained that trajectories had been determined, and rapid action would be taken when deviations were identified. Maria Kane (MK) highlighted that staff were keen to be engaged in the winter planning prior to winter but once the vaccination programmes started then the pressure would begin. MK noted that providers taking on the convening role needed to be assured that stress testing had taken place and needed clarity on the role of local authorities and South Western Ambulance Service NHS Foundation Trust (SWASFT) during surges. MK noted that public confidence was based on those key visible areas such as ambulance handovers. MK highlighted the need to consider commissioning alternatives to the emergency department as well as educating members of the public on the appropriate health service to attend. Dominic Hardisty (DH) noted that more people attended mental health services during the summer and explained that mental health and maternity were both areas where surges were throughout the year. DH noted the importance that	

	throughout the winter it was important that business as usual processes were held and gripped as they were in the summer months. **The ICB Board:** • **noted, discussed and supported the approach for the current BNSSG winter plan** • **was made aware that there was ongoing work and scheduled activities covering; providers winter plan sign off, system risk assessment and surge planning** • **delegated approval of the NHS England winter plan board assurance statement to the System Executive Group (SEG)**	
6.3	**Joint Transition Committee Terms of Reference** SD explained that the Joint Transition Committee (JTC) was a joint committee of BNSSG and Gloucestershire ICBs. RHa confirmed that the model ICB Blueprint outlined the requirement of a JTC to manage transition arrangements. In line with the Scheme of Reservation and Delegation (SoRD) both ICB Boards needed to approve the terms of refence for the JTC. The JTC would make decisions such as the design and structure of the new organisation as well as triggering consultations and receive assurance around finance. In common arrangements for the ICB Remuneration Committee were in place and Audit and Risk Committees would follow. The risk register for the transition programme had been shared with the Audit and Risk Committees. RHa outlined the membership for the JTC which included 2 Non-Executive Directors from each ICB, a partner Non-Executive Director or Executive Director for each, and the ICB Chief People Officers and Chief Finance Officers as well as the Cluster Chair and Chief Executive. The Chair of the BNSSG Independent Advisory Group on Race Equity was also invited to the Committee and Gloucestershire ICB has confirmed they were content with Tracie Jolliff attending in that role. RHa confirmed that the ToRs would remain under review and changes made if needed. JF confirmed that Jo Walker, Gloucestershire County Council Chief Executive and Raz Akbar, Non-Executive Director at SWASFT were members of the JTC filling the Partner Non-Executive and Executive Director roles. For BNSSG ICB, AM as Deputy Chair and JCa as Audit Chair were Committee members. JM highlighted that there was no specific clinical role on the Committee and asked if that was required. SD confirmed that based on the agenda, subject experts would be invited to attend the JTC from across all areas of business as specialist knowledge would be required to support decision making.	

	DH noted the NHS England guidelines around membership of the new ICB Boards lacked partner members and asked whether there needed to a provider led group to sense check the work of the Boards. SD believed that there needed to be further consideration around providers on Board but noted that the SEG would be the forum to have those discussions. SD believed that the Board needed to be system inclusive and could mean partners in the room but not members of the Board. This needed to be explored further. ED agreed that partner representation including local authorities on ICB Boards was critical as there was so much interconnected work and highlighted the winter planning as an example. RSm noted the importance that Boards were a manageable size but contained members able to connect the links in and out of the ICB. **The ICB Board:** • **Agreed the Terms of Reference (ToR) for the Joint Transition Committee; permitting the Chair to agree any amendments which may result from the virtual review of the revised ToRs by Gloucestershire ICB Board** • **Agreed that the ICB's Scheme of Reservation and Delegation (SoRD) would be updated to reflect the role of the Committee** • **Noted that the ToRs and SoRD would be published on the ICB website as part of the Governance Handbook**	
6.4	**BNSSG response to the Maternity National Review** Layla Green (LG) was welcomed to the meeting. LG explained that a rapid independent review into maternity and neonatal services had been announced. Five immediate actions had been detailed for ICBs with responsibilities relating to maternity and neonatal care. LG outlined these and the current progress and assurance processes in place to deliver these actions. LG confirmed that the Directors of Midwifery for North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trusts (UHBW) had confirmed the 5 immediate actions were in place and the acute trust Boards had received updates. The system was taking a collaborative approach with Bristol NHS Group one of the largest providers of maternity services in the country and both CQC rated good. Both Trusts participated in quality and safety improvement programmes. The Maternity and Neonatal Voice Partnership (MNVP) was embedded in the work of both Trusts. LG outlined the immediate actions and the actions being undertaken which addressed them: **Be rigorous in tackling poor behavior where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.** LG confirmed that both Trusts had staff in culture and leadership programmes. Staff surveys took place at regular intervals and action	

	plans were developed to support staff wellbeing. LG highlighted this was the most challenging element to evidence but the multi-disciplinary working had been noted beneficial in this space. **Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.** LG highlighted the Duty of Candour and explained that all families were involved in debriefs and maternity specialist teams worked within the Trust's bereavement services. For staff concerns, the Trusts undertook regular listening events specifically for staff. LG highlighted that engagement had been identified as an area of improvement as well as ensuring that staff felt safe to raise concerns at work. **Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.** The MNVP was embedded within maternity and neonatal services and alongside regular meetings, the MNVP undertook ward walkabouts. LG confirmed work was ongoing to improve estates and community engagement. The Trusts worked closely with Black Mothers Matter and worked to improve patient accessibility and access to translation services. The Real Birth Company had been commissioned to improve antenatal education including the availability of languages. **Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.** Data continued to be used intelligently with a new maternity outcomes system being developed across NBT, UHBW and the Local Maternity and Neonatal System (LMNS). It was expected that this new system would improve data quality and support the development of new dashboards. **Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme starting in August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighborhoods, providing additional support for the women that most need it.** LG confirmed that training continued with a new cohort of staff identified for the Black Mothers Matter training. Both Trusts have been actively engaged in the	

	Race and Health Observatory learning Action Network project. Anti-discrimination, and racism training continued alongside statutory and mandatory training, and the future focus was on other protected characteristic training for staff. LG highlighted that the paper provided further assurance of the robust structured approach to safety and the work the Trusts were undertaking with women to track progress and improvement. JM welcomed the detailed report noting that adding SMART objectives would provide some realism for the objectives expected. AM welcomed the work and asked whether perinatal mental health services should be included within the report. LG confirmed that this challenge had also been raised at the System Quality Group (SQG) as AWP had not been part of the response. There was further work to do to ensure wider system partners were part of the response including AWP and Sirona. MK acknowledged the improvement work of the Trusts who were not in such a positive position just 4 years ago. MK did not expect the Trusts to be in the list of hospitals for further review. MK agreed that inclusion of perinatal mental health services was important. The VCSE sector was also an important aspect in the work to understand culturally appropriate behavior. MK highlighted that the Trusts were delivering high quality services often in poor quality estate, which needed to be improved as it did affect staff experience. **The ICB Board noted the reports including any risks, mitigating actions and responsibilities as appropriate**	
6.5	**Annual Report and Accounts** SD confirmed that the Annual Report and Accounts had been approved by the Audit and Risk Committee, and the final submitted report was presented to the ICB Board for information. JF thanked all those who contributed to the Annual Report and Accounts which outlined the achievements of the ICB in 2024/25. JF explained that BNSSG ICB was not holding an AGM this year given the impact on resources due to organisational change. Next year's annual report would be reflective of the challenges in 2025/26 and celebrate the clustering arrangements for BNSSG and Gloucestershire ICBs. JCa confirmed that the BNSSG ICB financial sustainability had been positive and the governance arrangements and the annual accounts were to a high standard. This was underpinned by the Head of Internal Audit Opinion which	

	had improved, which was due to the hard work of Nic Saunders and the Executive Team. **The ICB Board received the Annual Report and Accounts which had been approved by the Audit and Risk Committee**	
7	**Outcomes, Performance and Quality Committee** ED confirmed that the July OQP Committee had received an update on the maternity national enquiry, the annual medicines optimisation report and a report on safeguarding. The Committee had scrutinised and challenged the winter plan and were assured by the process described by DJ. The Committee welcomed the innovative solutions which had been based on learning. ED noted that the Committee had highlighted the risk in delivering the plans during winter pressures. DJ provided a performance update noting that Referral to Treatment Time (RTT) and planned care were performing well. There were challenges in cancer particularly in the urology and gynaecology specialities but plans were in place within NBT to bring performance back to trajectory. There had been strong performance during July 2025 with good 4 hour performance and category 2 ambulance waiting times. There had been a positive NCTR reduction and strong urgent care performance across June and July 2025. AWP were improving access to Child and Adolescent Mental Health Services (CAMHS) and were on trajectory to achieve. Community waiting times for ADHD and Autism diagnosis remained challenged and DJ and Julie Sharma (JS) were engaged with the team to focus on short term work to improve waiting times. This was an example of system transformation work and would be presented to the ICB Board in the future. DJ highlighted that there had been an increase in out of area placements across the system and it was acknowledged that this was not the best way to support these patients. This was being reviewed with local authority partners at performance meetings. JM raised the national increase in Healthcare Acquired Infection rates as well as the focus on immunisation. MMR rates needed to be improved and the system was working on this. JM highlighted that a ReSPECT audit reviewing the experience of disabled people with physical or sensory impairments had been undertaken across NBT and UHBW. The report determined that ReSPECT decisions had been made based on individual and clinical input with the appropriate level of patient and next of kin engagement with capacity well	

	documented on ReSPECT forms. The outcome of the audit had been fed back to the Co-Chair of the Physical or Sensory Impairment Working Group. JM highlighted that the Trusts had managed well during the resident doctor's industrial action. A lessons learned document had been developed which included actions identified from the learning. This included actions such as support from wider system doctors. No safety incidents had been reported during this period. **The ICB Board received the update from the Outcomes, Quality and Performance Committee**	
8	**People Committee** JCh confirmed that the ICB People Committee had discussed workforce metrics noting that there were fewer leavers during quarter 1 2025/26. The Committee had received an update from the Inclusion Council and Staff Partnership Forum and supported the pay protection policy, organisational change policy and domestic abuse policy. JH provided a provider industrial action update and noted that the pay award had now been paid to staff. **The ICB Board received the update from the People Committee**	
9	**Finance, Estates and Digital Committee** SW provided an update from the Finance, Estates and Digital (FED) Committee noting that the Committee was monitoring the financial position of the ICB and the system. Current challenges in ADHD services were a risk to the breakeven position. The last Committee meeting had a digital focus and the Committee had heard the possibilities open to the ICB in the future including the connections to communities. DES highlighted GP IT as an area for consideration due to the changes to Commissioning Support Units. This was an area of urgency and an expression of interest process had started to determine which provider would provide this service. The FED Committee had received an update on the risks and indemnities associated with the transfer of the Senior Responsible Owner (SRO) role. The intention would be presented to the ICB Board next month to determine the risk appetite. DES highlighted that primary care services needed to step into a different place with providers taking the ownership of partnership arrangements and managing risk in a different way. SW noted the importance that any function transitions were smooth and learning built into future transitions. **The ICB Board received the update from the Finance, Estates and Digital Committee**	

10	**Primary Care Committee** AM explained that the Primary Care Committee (PCC) had held an extraordinary meeting to discuss the BNSSG ICB response to the Pharmacy Needs Assessment consultation which was led by public health and approved by the HWBs. The Committee provided feedback and noted the links between urgent care services and housing strategy. The Committee believed that improving health inequalities should be a key focus. The Committee reviewed the current provision and there were no gaps across BNSSG. The Committee had highlighted the opportunities for pharmacies and pharmacists to support the local populations. **The ICB Board received the update from the Primary Care Committee**	
11	**Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee** The Committee had considered health inequalities from the digital perspective and discussed research. Evidence had indicated that it was important that communities had an advocate for research and that this was an important step in improving research within communities. JM highlighted the nuances within digital exclusion and the assumptions that were made regarding choices around digital use. JM noted that there were tensions within communities and cultures around digital use and it was important that BNSSG ICB engaged with communities to learn how to implement any digital solutions. DES noted that the 10 year plan shift to digital solutions made this work even more significant and it was important that the FED Committee understood how decisions had been made and were aware of those nuances that had been discussed at the SHIPPH Committee. JCh noted that Ofcom had undertaken a lot of research into digital poverty which was transferable to the work being undertaken by the ICB. JM noted that the Committee had shared learning about a racial equity approach and this would be presented to the ICB Board as a development session. **The ICB Board received the update from the Strategic Health Inequalities, Prevention and Population Health Committee**	
12	**Audit and Risk Committee** JCa confirmed that at the Audit and Risk Committee in June 2025, the Committee had approved the Annual Report and Accounts as delegated by the ICB Board. It had been the final meeting of Grant Thornton as the external auditors and JCa thanked them for their work. The Committee had received an update on the Data Security and Protection Toolkit (DSPT) which at the time	

	was not compliant. However, the Committee had received an update that the final submitted DSPT had been compliant. The Committee had also received the Counter Fraud Annual Report. **The ICB Board received the update from the Audit and Risk Committee**	
13	**South West Joint Specialised Services Committee** DJ to provide an update following his attendance at the Committee.	
14	**Integrated Care Partnership** JF explained that the Gloucestershire Integrated Care Partnership (ICP) Board was its HWB and noted that ICP Boards as they were within the BNSSG model were unlikely to exist in the future but it was important that health systems were connected to local authorities. The BNSSG ICP would discuss this challenge further as would the BNSSG ICB Board. JF reminded members that although not nationally prescribed, there was scope for provider leaders to attend Boards as attendees rather than members. SD noted that this had been discussed by Chief Executives as HWB's would remain, but membership was not the same as the ICP Boards as there were no system Chairs attendance. SD highlighted the importance that those ICP connections were held elsewhere. SD highlighted that Gloucestershire ICB would prefer to remain with the HWB model. ED believed it was important to continue to have a forum for ICB and local authority partners to come together. SD noted that the ICP Board was a space to have system discussions, but HWB's would be stronger in that space. JM noted that with partners not sitting on the ICB Boards and the ICP Board ceased, there needed to be a new way to build system partnerships and have mature conversations about working together. The neighborhood approach meant that leaders needed to listen to the populations to enable the system to work the right way. JM believed that the neighbourhood structure was key to both of these elements. SW noted that the views of decision making Boards needed to be balanced and innovative to make difficult decisions in a resource challenged environment. The decisions needed to be informed and evidence based. JCh highlighted that the IHOs would develop a different system governance approach. SW noted that WECA was also part of the system although less involved in health and social care. SD confirmed the current WECA mayor was engaged in working with the system and was a cosignatory on three neighbourhood health pilots.	

	The ICB Board received the update from the Integrated Care Partnership	
15	**Questions from Members of the Public** JF read out a question received from a member of the public. "Early identification of high cholesterol and other conditions that increase the likelihood of cardiovascular disease is instrumental in taking a preventative approach and remains a key priority in the NHS Longterm Plan. The local Citizens' Panel around self-reported health status highlighted cardiovascular disease as one of the main contributing factors to disability and poor health. Familial Hypercholesterolaemia (FH) is a common genetic condition that causes high cholesterol from birth, unfortunately over 80% of people with FH are undiagnosed, leading to preventable heart attacks and premature deaths. FH is treatable and the earlier this invisible condition can be identified, the sooner it can be managed. Developing services to identify and manage FH can also support greater awareness of the risks of high cholesterol in general, encouraging more people to be tested and better understand and manage their CVD risk. **Questions:** As a person with lived experience of a late diagnosis of Familial Hypercholesterolaemia (FH) and elevated levels of Lp(a), I would like to ask the board what plans are in place locally to: • improve the detection rates of people with genetic, inherited conditions leading to high cholesterol levels • ensure equity of access to genetic and cascade testing for FH and high Lp(a) • provide personalised support to improve the number of people with high cholesterol being effectively treated with lipid lowering therapies" It was agreed that a written response would be provided and included retrospectively in the minutes. - Please find below responses to the questions raised: **Improve the detection rates of people with genetic, inherited conditions leading to high cholesterol levels** Identification/ detection rates and equity of access across the Southwest geography vary widely, but within Bristol, North Somerset and South Gloucestershire (BNSSG) it benchmarks well with detection rates, which is down to the commissioning of services to provide genetic testing in established lipid/FH services. However, recognises there is still further work to do.	

	Work is on-going across BNSSG to detect and increase the diagnosis of patients with FH. In 2022 a proactive piece of work took place with general practitioners, in collaboration with local specialists on detecting familial hypercholesterolaemia amongst their patients who had had a high cholesterol level. Clinicians have worked together to produce local and national information on the management of hyperlipidaemia, including management and referral of potential familial hypercholesterolaemia (FH) to support detection and management. In addition, most of our practices are signed up to offer NHS health checks which calls people from age 40 (younger if from a minority ethnic background) and each decade thereafter until 70 (unless on a disease register by then) which would pick up elevated cholesterol levels. We promote shared decision making between patient and clinician to enable better understanding of potential interventions, management, and implications for the person and their families where applicable. **ensure equity of access to genetic and cascade testing for FH and high Lp(a)** There is equitable access to genetic testing to exclude FH as per the national genomic test directory criteria in the BNSSG area, with an established adult FH family screening service across BNSSG since 2014, based at University Hospital's Bristol and Weston (UHBW). Access will usually be via a referral to the lipid clinic, and the specific criteria is clearly outlined in the lipid guidelines bundle. If an individual is a family member of a known FH index, they have access to cascade testing on referral to lipid or FH specific Nurse led clinic. With regards to lipoprotein there is proactive process to screen at risk patient groups for elevated levels, as well as, providing support for GP-led ad hoc screening of family members of index patients with very high levels. The service offers Lipoprotein (a) (Lp(a)) testing for individuals with hyperlipidaemia. For Index cases with known high Lp(a), Lp (a) testing is recommended for their immediate 1st degree relatives via primary care. If those relatives are also being seen in the FH clinic for FH cascade screening, they will be offered Lp (a) testing alongside FH cascade screening. Regarding Access to cascade screening for local relatives of a genetically confirmed Index (identified in UBHW lipid/FH clinic) has an agreed pathway such that the cascade relatives are provided with a letter giving the FH service contact details to which they can self-refer. Referral of cascade relatives in the BNSSG area for cascade testing does not require a GP referral. Paediatric (<	

	16 years old) relatives are referred to the UHBW paediatric clinic for screening by the FH service as part of the family cascade screening process, with parental agreement. Although this works well, there are some pitfalls when relatives live outside area or GP practice cannot support. More work is being done nationally/locally to link genetic testing databases. **provide personalised support to improve the number of people with high cholesterol being effectively treated with lipid lowering therapies** BNSSG as a system have proactively completed work at patient level to ensure patients are maximised on lipid therapy and have shown significant improvements in those patients to target that includes patients with FH. BNSSG do have a local pathway for clinicians to follow that aligns to national guidance – BNSSG lipid guidelines on the diagnosis and management of lipid disorders The BNSSG ICB Medicines Optimisation team conducted a review of lipid lowering therapy for secondary prevention in patients at risk of CVD to ensure prescribing aligns with BNSSG guidance and best practice. This was undertaken in 23/24 and 24/25 as part of a prescribing quality scheme. Part of the project involved further investigation for possible familial hypercholesterolemia if sufficiently high historical cholesterol levels were observed. The results showed that 37% of patients had their treatment intensified. The ICB continue to have a focus on cardiovascular disease that includes those treated on lipid therapy and has seen improvements in those to target over recent years. Regional & ICS Insights | CVDPREVENT	
16	**Any Other Business** There was none	
	Date of Next Meeting Thursday 2nd October 2025	

Lucy Powell, Corporate Support Officer, September 2025