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 2nd October 2025 at 12.45pm

Microsoft Teams Meeting

DRAFT Minutes

Present		
Alison Moon	Vice-Chair BNSSG ICB and Chairing the meeting Non-Executive Member – Primary Care	AM
Jeff Farrar	BNSSG and Gloucestershire Cluster Chair	JF
Matt Backler	Interim Chief Finance Officer, BNSSG ICB	MBa
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
Dr Jacob Lee	Chair of the GP Collaborative Board	JL
Dr Joanne Medhurst	Chief Medical Officer, BNSSG ICB	JMe
Julie Sharma	Interim Chief Executive Officer, Sirona care & health	JS
Rosi Shepherd	Chief Nursing Officer, BNSSG ICB	RS
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Apologies		
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
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JMa
Maria Kane	Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust	MK
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

Hugh Evans	Executive Director: Adults and Communities, Bristol City Council	HE
Kevin Peltonen-Messenger	Chief Executive, The Care Forum	KPM
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	LP
Connor Evans	Executive PA, BNSSG ICB *minute taker*	CE
Stuart Walker	Hospital Managing Director, University Hospitals Bristol and Weston NHS Foundation Trust	SWa
Mark Hubbard	VCSE Lead, BNSSG ICB	MH
Laurance Ross	Strategic Workforce Lead, BNSSG ICB	LR
Paul Gaunt	Employment support manager, Bristol City Council	PG
Richard Smale	Director of System Coordination, NHS England South West	RSm

	Item	Action
1	**Apologies** Alison Moon (AM) would have chairing responsibilities for the meeting, as previously outlined during the closed board session and for public record. This would be held until the end of March 2026. Jane Cummings would take on the role of chair for the Gloucestershire ICB board, enabling Jeff Fararr (JF) to direct attention towards the transition of the cluster, the future status of the ICB, and the activities of the Transition Committee. AM assured board members that a formal reporting link from the Transition Committee to the board remained established and also highlighted the necessity of maintaining business continuity and achieving significant objectives within a challenging environment. JF congratulated Shane Devlin (SD) on the appointment as Chief Executive of the BNSSG and Gloucestershire Cluster. **The above apologies were noted**	
2	**Declarations of Interest** JF and SD noted potential conflicts pertaining to their roles in Gloucestershire. Both JF and SD would remove themselves from the meeting during specific items if deemed necessary by the chair.	

	There were no other new interests declared and no interests pertinent to the agenda.	
3	**Minutes of the 4th September 2025 ICB Board Meeting** The minutes of the 4th September 2025 meeting were agreed as correct.	
4	**Actions arising from previous meetings and matters arising** The Board reviewed the action log. **Action – close remaining open action**	
5	**Chief Executive Officer's Report** Shane Devlin (SD) outlined the three items from the Chief Executive report: • Change and Transition • Neighbourhood Health • Public Health <u>Change and Transition</u> SD handed over to JF to provide an update following the fist Joint Transition Committee. JF reported that the first meeting had taken place on 10th September with the next scheduled for the 3rd October. JF confirmed that the terms of reference and group membership, including representation from both Integrated Care Boards (ICBs) and relevant executive members, had been agreed. There was also external involvement from the local authority and Southwest Ambulance Trust. The group had established meeting frequency and ways of working. JF noted that substantive business would commence at the next meeting, focusing on proposals for organisational structures. JF emphasised the need for clear communication from the Transition Committee to ensure everyone was informed, especially given the positive early engagement in Gloucestershire. JF highlighted the continued statutory responsibilities of the ICBs, noting noted that, so far, progress was positive. JF asked SD to update on timescales and finances. SD provided an update, stating that both executive teams had met frequently to develop an operating framework for the new clustered organisation. They were clarifying the purpose and vision of the new entity and how both ICBs would work together, maintaining existing responsibilities while developing the new model. SD stated that resource challenges, particularly regarding voluntary and compulsory redundancies, had slowed progress. A paper on the timeline for executive consultation would be discussed at the upcoming Joint Transition Committee. SD did not expect executive consultation to begin in October and suggested it might take place towards the end of the year, with full organisational consultation unlikely before March of the following year, possibly extending into 2026–27.	

	Neighbourhood Health SD highlighted significant ongoing work on neighbourhood health, noting that the ICB, in partnership with local authorities and other stakeholders was responsible for developing new models of neighbourhood health. SD emphasised the collaborative approach to develop neighbourhoods and populations, guided by the Health and Wellbeing Board and similar bodies. SD stressed the importance of implementing suitable models to improve local population health. SD stated that the ICB and cluster would play a crucial role in this programme over the coming years. Public Health SD provided the concluding section of the Chief Executive update, focusing on assurance around joint working with regards to public health. SD emphasised the seriousness with which the organisation approached its responsibilities and noted the annual assessment by the Office of Health Improvement Disparities (OHID) regarding public health duties and partnerships. A letter summarising the outcome of the recent OHID review was included in the appendix. SD highlighted the importance of ongoing strong partnership working with public health colleagues, noting that the review identified several strengths, including robust place-based relationships, effective partnership working, and innovative commissioning. Opportunities for improvement were also noted, with a caution to maintain focus during any structural changes, such as clustering. SD invited comments and questions on the report. AM opened the floor for comments or questions on the report and expressed appreciation for the inclusion of the public health item. AM highlighted the good work being done and enquired about hidden inequalities, particularly among affluent or ageing populations. AM asked whether any identified areas for improvement required a revised approach. SD invited Joanne Medhurst (JMe) to provide insight. JMe reflected on the region's diverse geography and the presence of hidden deprivation across these localities. JMe emphasised the importance of balancing large-scale population data with local, ward-level nuance and the need to consider both quantitative and qualitative insights. JMe noted the value of input from practitioners who understood their communities and stressed that effective decision-making required integrating both data and local voices. Dave Perry (DP) underlined the importance of Directors of Public Health in the evolving health and local government structures and the need for effective collaboration.	

	Julie Sharma (JS) supported previous comments and questioned whether the executive structure sufficiently reflected the importance of public health expertise, cautioning against losing focus due to varied language around population health. SD agreed, emphasising the need for the organisation to serve as a conduit for professional voices, especially public health, and praised the role of the Chief Medical Officer in ensuring these voices were heard. SD warned against losing this as the organisation expanded and stressed the necessity of amplifying these voices within the new ICB structure. JMe expanded on this, describing close collaboration with Directors of Public Health to clarify leadership and supporting roles, thereby avoiding duplication and working effectively within multi-disciplinary teams. JMe recommended mirroring this approach as working practices evolved. Steven West (SW) echoed the importance of collaborative working, noting the advantage of having public health functions within unitary authorities and the value of joined-up data to understand and engage communities. SW stressed the need to prepare the next generation of public health professionals for the new system architecture and commended the region's progress. SD concluded that neighbourhood health would be a standing item on future board agendas, aligning with the 10-year plan and upcoming commissioning requirements. **Action: Neighbourhood health to be a standing item at each open board meeting going forward.** **The ICB Board received and discussed the Chief Executive Officer's Report**	RHa
6.1	**Update on progress against Equality Objectives** AM clarified that the recommendations were to note the progress and discuss further strategic considerations. AM then invited JMe to present the update. JMe reminded the group that the objectives had been agreed upon in a board workshop, focusing on four specific, impactful measures. JMe emphasised the importance of specificity and granularity to drive real change rather than broad ambitions. JMe outlined that each objective was led by an executive director and handed over to colleagues for updates.	

	<u>Maternity</u> Rosi Shepherd (RS) reported on the maternity objective, highlighting the system's participation in a project with the NHS Race and Health Observatory (RHO). The focus was on reducing disproportionate preterm births among racialised Black and Brown mothers. The team had identified lower administration rates of magnesium and steroids within this group and had been working closely with the RHO. Early data from UHBW indicated positive progress, while further work on data quality was ongoing at NBT. The LMNS team was reviewing every preterm birth to identify trends and conducting qualitative work with mothers to understand barriers in treatment pathways. A celebration event was planned for November to present the findings, with an expectation of significant progress by March. <u>Ethnicity data recording</u> JMe noted that progress on ethnicity data was more mixed. Deborah El-Sayed (DES) explained that since the report was written, steps had been taken to improve data collection, including the reinstatement of the Intelligence Centre procurement. DES stressed the need for all providers to focus on data collection as a system-wide effort. DES anticipated clearer progress and a tangible plan in the next update once the Intelligence Centre was fully operational. AM queried the status and risks associated with financial implications, highlighting the importance of acting on the insights gained from data collection. DES clarified that data was being collected, with efforts focused on improving completeness rather than starting from scratch. <u>Workforce</u> Jo Hicks (JH) clarified that the update pertained to the ICB workforce, not the wider system. JH acknowledged the impact of organisational changes announced in April on delivering objectives but noted that inclusivity remained a focus. Actions such as the guaranteed interview scheme and reasonable adjustments for recruitment continued. The ICB was committed to maintaining diversity during restructuring and had reinstated the anti-racism development programme for senior leaders, set to commence in November. JCh raised concerns about maintaining workforce diversity, particularly given Bristol's diverse population, and advocated for setting minimum diversity standards. JF agreed, noting that previous organisational changes had inadvertently reduced diversity and emphasised the importance of ongoing scrutiny.	

	Cardiovascular disease JMe described the collaborative work led by the health improvement team to address hypertension management among Black, Afro-Caribbean, and Black African groups. The working group, which included substantial public representation from these communities, sought to understand underlying barriers. Insights from this work would inform commissioning principles and ensure services did not perpetuate structural inequities. Jme shared insights from qualitative research into barriers to hypertension treatment, highlighting the need for humility in service redesign and the importance of listening to lived experiences. JMe asserted that equality work should be considered business as usual rather than requiring additional funding. JF acknowledged the efforts but noted significant challenges remained, particularly around data capture and system changes. JF referenced a recent paper highlighting poor outcomes for Black and Brown populations in the southwest and advocated for stronger system-wide leadership and data-driven accountability. JF also mentioned an imminent statement in Gloucestershire on the rise of racist incidents and their impact on staff, suggesting BNSSG should consider a similar stance. Steven West (SW) put forward an opportunity for collaboration, sharing experiences from the University of the West of England's institution-wide anti-racism work. SW emphasised the value of sharing learning across organisations, particularly in workforce development. JMe confirmed that connections with the university's Race Engagement Network were already established and expressed interest in formalising collaboration. Richard Smale (RSm) commended the training initiatives and asked about the status of the Equality Impact Assessment (EQIA). JH confirmed that an EQIA was in progress and updated continuously throughout the organisational transition. SD reflected on the challenge of distinguishing between the ICB's organisational remit and its broader system influence. SD stressed that while the ICB could control certain objectives, systemic change required wider collaboration, especially with the transition to new governance structures. JF supported this view and reiterated the legal duty to promote equality and combat racism, stressing the need for clear system-wide commitment and action.	

	Jacob Lee (JL) asked about opportunities to increase board and leadership diversity during upcoming restructures. JF confirmed that the reconstitution of the board presented such opportunities and affirmed the board's commitment to improvement. AM thanked all contributors for their input. AM summarised the need to maintain focus on current objectives while exploring mechanisms for broader system impact. The board anticipated further updates, particularly on data completeness, workforce diversity, and the outcomes of community engagement initiatives. **The ICB Board:** • **Noted the progress being made against the BNSSG ICB equality objectives.** • **Discussed any strategic or other considerations the ICB Board would like the work to consider**	
6.2	**WorkWell West** AM handed over to JH for the update on the WorkWell West initiative. JH welcomed Laurence Ross (LR) and Paul Gaunt (PG) to the call and shared that the paper provided was an update on a partnership approach between BNSSG and Bristol City Council for the DWP-funded WorkWell programme, which formed part of the wider "Getting Britain Working" White Paper. JH noted that this programme was linked to earlier discussions on neighbourhoods, population health, and the broader agenda to support a healthy population, including access to good employment. JH invited LR and PG to present their slides and answer questions. LR thanked JH and AM for the welcome and introduced PG, employment support manager at Bristol City Council, the main delivery partner. LR explained that WorkWell was designed to help people return to work after ill health or to remain in work and thrive. LR highlighted the strong partnership with Bristol City Council, which had enabled the programme to reach communities and neighbourhoods that would otherwise be difficult to engage. PG provided an overview of Bristol City Council's involvement, describing their wide range of employment support programmes, including multi-agency work for people with learning difficulties and efforts to reduce rough sleeping. PG emphasised the strength of their partnership and the strategic agreements. LR stated that working in partnership had enabled closer collaboration, particularly with the Connect to Work service, and greater visibility and accountability within the team. LR noted that co-location enabled operational problem-solving and local solutions. PG shared that the WorkWell funding	

	application had provided vital infrastructure, allowing delivery to target and within budget, with a one-year extension already secured and further extensions being sought to expand partnership working across the West. LR reiterated that the partnership with Bristol City Council was central to the programme's effectiveness. LR explained that, as part of their bid, they had sought to deliver provision within neighbourhoods and recruited VCSE organisations to reach underserved communities. This approach had built trust and proved highly successful, prompting plans for another round of recruitment towards the end of the year. LR referenced data showing growth and increased satisfaction scores over the past 12 months. LR described how, initially, the programme was Bristol-focused but later expanded into South Gloucestershire and North Somerset, aided by the recruitment of a health liaison officer, involvement of job centres, events delivery, and integration with treatment pathways and hospitals. The spread and density of participants increased further as VCSE organisations joined and an employer engagement officer was onboarded. LR highlighted the complexity of work and health, noting that health barriers to employment were often compounded by non-health-related factors. LR stressed the importance of collaboration among experts from Bristol City Council, VCSE sector, education providers, and combined authorities, referencing the "Get Britain Working" plan's aim to deliver 10 years of reform through collective local action. JH acknowledged the programme's progress from a standing start and noted that BNSSG had been recognised as an exemplar by the DWP national team. JH pointed out that more work was needed to broaden diversity and access, with plans underway to address this as part of the wider regional growth strategy. JMe commented on structural inequity, referencing a chart showing that the majority of participants were female and white, querying whether the commitment to diversity could be strengthened, suggesting a more intentional approach similar to other working groups, and asked whether the team reflected adequate cultural diversity. JH agreed on the need for deeper data analysis and addressing structural inequity, noting that the steering group was considering these issues for the next evaluation phase. JH confirmed that further updates would be provided as the programme progressed.	

	Ellen Donovan (ED) praised the professionalism and early results of the programme, asking for early learnings, hard measures of success, and how GP colleagues were being supported. LR stated that funding had been secured for fit note reform and that the aim was to place work and health coaches in GP practices, allowing direct referrals and better integration with primary care. LR added that pilots in Somerset were providing insight into the support GPs needed. LR also reported that safeguarding had been a major challenge, with significant mental health cases requiring robust procedures and staff support. LR described the need to balance risk and reward due to payment-by-results funding and noted that careful attention to planned growth had allowed the programme to expand and increase capacity, especially through VCSE contributions. Fiona Mackintosh (FM) representing the VCSE Alliance, expressed delight with the programme's progress and emphasised the need to feed learning into neighbourhood health plans. FM highlighted the importance of addressing core determinants of health, such as transport, and praised the cross-sector data gathering, noting the richness of data available for both the programme and the wider system. JCh shared enthusiasm for the programme and recounted an employer's concerns about applicant employability, suggesting underlying health issues might be at play. JCh asked whether employers facing shortages were being targeted and if the programme could connect with the skills agenda. JL described the programme as an exciting piece of prevention work, noting the importance of data flows. JL referenced high sick note and unemployment rates and asked how the programme would address sick note processes, integrate job centres, and follow health outcomes. JL also queried access for individuals whose first language was not English. JH confirmed that neighbourhood health learning had been integrated into ICB planning, with further work planned on wider determinants and strategic commissioning. JH noted the programme's inclusion as a case study in the "Getting the West Working" plan and highlighted its relevance for both public and private sector employers. LR responded that translation services had been provided to support access for non-English speakers and that fit note reform funding would help integrate systems further. Jo Hicks concluded by announcing plans for a seminar session on the work and health agenda later in the year, offering an opportunity for a deeper	

	collective discussion. AM thanked all contributors, acknowledged the strong interest and support for the programme, and looked forward to the next update. **The ICB Board: commented and discussed the WorkWell impact to date and the integration of Work and Health**	
6.3	**VCSE Vision and Developments** DES informed the Board that Mark Hubbard (MH) would be presenting and highlighted the key role MH played in the development of the paper. DES emphasised that the main purpose of the discussion was to seek the Board's support for taking forward the proposed next steps, as outlined in the paper, and then handed over to MH for the presentation. MH recalled the previous appearance with FM the prior summer, when the initial paper was presented, and acknowledged the ongoing strong support from the Board. MH reported significant progress in the development of the VCSE alliance, which was now regularly engaging with over 270 diverse organisations across the system footprint. MH described the alliance's network of 150 ambassadors, who brought diversity of thought and community expertise to system planning, delivery groups, and committees. MH highlighted the success of the VCSE alliance, especially the co-designed VCSE brokerage programme, which had enabled 16 VCSE organisations to receive small awards to deliver neighbourhood-level work under the WorkWell Programme. Notably, 60% of these awards went to organisations with no prior NHS transactions, thereby extending engagement into previously unreached parts of the VCSE sector. MH outlined the new VCSE vision and framework for action, describing the vision as one where health creation and equity would be rooted in trusted, inclusive partnerships, with VCSE organisations valued as co-creators of a healthier, fairer future at the core of system activities. MH noted this was the first time such a vision had been established in the system and explained that five goals had been set, focusing on culture, planning, decision-making, delivery, and learning and innovation. MH pointed out that, up until now, the public sector might have viewed the VCSE as a homogeneous group focused solely on delivery, but the new goals articulated the diverse roles of VCSE organisations throughout the commissioning cycle and strategic planning. MH explained that under each goal, a set of potential actions had been identified to advance involvement, integration, and alignment. These actions had been sense-checked and formed a flexible portfolio, intended to adapt to the changing environment. MH stated that the new BNSSG strategic VCSE	

	group would be tasked with prioritising these actions for maximum impact, especially in light of the Healthier Together 2040 neighbourhood health initiative, the shift to communities, strategic commissioning, and the 10-year health plan. MH concluded by stating that the Board was being asked to endorse the vision and support the establishment of a new BNSSG strategic VCSE group. MH chose not to use slides, opting instead for a verbal introduction, and invited discussion. AM thanked MH, commending him for the verbal update and opening the floor for comments. SD expressed appreciation for the work done within BNSSG, particularly through the alliance. SD emphasised the importance of recognising the VCSE sector not just as a provider of services but also as a source of thought leadership within the new clustered organisation, noting that the vision and goals would help embed this value from the outset. SD encouraged the Board to commit to the vision and goals as a strong foundation for future development. JF fully supported the paper, echoing SD's comments, and shared observations from the Gloucestershire AGM, noting the strong and well-established connection between the voluntary sector and the health system. JF highlighted the importance of linking up community and hospital care and agreed that the proposed vision and principles were a sensible way forward. SW also endorsed the approach, reflecting on the progress made since initial discussions three years prior in Weston-Super-Mare about engaging with the sector. SW recognised both the power and potential of the sector and noted that the decision to be bold with procurement and funding had paid off. SW urged continued development as the Board moved into the next phase. JCh, drawing on previous experience running a social enterprise, voiced strong enthusiasm for advancing the VCSE agenda and emphasised the need to support VCSE organisations to scale, grow, and achieve greater stability. FM, representing the VCSE, praised the co-design and collaborative approach MH had taken. FM described the work as an exciting milestone, given the collective journey of the ICB Board, the system, and the VCSE alliance. FM acknowledged the ongoing work but noted significant progress, particularly with neighbourhood plans, the 10-year health plan, and the shift to strategic commissioning. FM welcomed SD's comments regarding thought leadership, highlighting the insight and intelligence the VCSE sector could contribute to shaping the future. **The ICB Board:**	

	• **Endorsed the BNSSG VCSE Vision & Framework for Action (as fulfilment of the ICB Board's decision to co-design a new Healthier Together VCSE Integration Strategy).** • **Supported the establishment of VCSE governance: the new BNSSG Strategic VCSE Group.**	
6.4	**Corporate Risk Register and ICS Strategic Risk Register** AM invited SD to introduce the item. SD provided some background, explaining that the corporate risk register was developed from within the organisation and took inputs from across the system. SD clarified the distinction between the corporate and strategic risk registers, noting that while they were connected, they remained separate. SD explained that risks scoring over 15 could be escalated to either register, and the System Executive Group served as the forum to discuss and assess these risks and their mitigations. SD mentioned that there had been changes to the corporate risk register this month, highlighted in the document, and invited Rob Hayday (RHa) to discuss these changes, as well as the strategic risk register. Rob Hayday thanked SD and began by addressing the corporate risk register. RHa noted that although the format had changed in response to earlier board requests, making it less spreadsheet-oriented and more accessible, members would be familiar with the content. The register now included a summary broken down by directorate, with risk titles and further details on subsequent pages. RHa summarised that all risks scoring 15 or above at a point in time were included, and three risks—funded care budget, clinical safety risk management for digital systems, and elective variable activity had been reduced in score and were recommended for removal. These were highlighted in the summary table. RHa also mentioned two risks that were new or had increased in score: the Oliver McGowan mandatory training and the impact of NHS reforms on ICB performance. RHa explained there was always a delay in producing the register due to the need for internal risk harvesting and review by the Audit and Risk Committee. RHa acknowledged feedback regarding document headings and noted expected improvements in future iterations. AM thanked RHa and opened the floor for comments and questions. JCa expressed concerns regarding the Oliver McGowan risk, urging system partners to prioritise and fast-track compliance with the mandatory training, given the importance and the background of the case. JCa emphasised the need in getting as many people as possible compliant quickly and highlighted the region's responsibility to ensure full compliance, referencing the tragic circumstances involving Oliver and the family.	

	AM thanked JCa and handed over to SD for further comment. SD acknowledged the strength of the ICB's Oliver McGowan training team, particularly their use of trainers with lived experience. SD noted the challenge as the organisation transitioned to a system-wide approach, questioning whether the system was ready to maintain the training's momentum. SD highlighted the reputational risk if the system failed to deliver and confirmed the government's view of the training's importance. SD called attention to the need for robust plans across the system and invited JH to provide some perspective. JH confirmed that the risk had been escalated to ensure board visibility, particularly as the ICB was one of a few to employ lived experience trainers, which had benefited the system. JH explained that, while the People Committee was focusing on the issue and working with partners, progress was not as rapid as required. With ICB funding for the initiative ending on 1 April, there was concern about sustaining and building on the progress made. JH reiterated the need for senior leadership to support and maintain momentum in this area. AM asked JH to specify the action required from system leaders. JH repeated an appeal, previously made to the ICS People Committee, for leaders to query their teams and remove any barriers to progress, whether related to governance, finance, or organisational change. JH emphasised that, although there was general willingness, delays were arising from system and organisational processes, and these should not prevent timely action, as time was running out. AM summarised that leaders should return to their organisations and address these issues. JCh suggested expanding the ask to identify where blockages were perceived, so support and action could be targeted appropriately. AM thanked JCh and invited further comments from ED, who asked for clarity on follow-up procedures and how the issue would be prioritised to ensure sustainability when the ICB stepped back. ED queried how to maintain focus and avoid the initiative collapsing after the transition. Stuart Walker (SWa) agreed to discuss the issue further with JH and assured the group that the matter was not lost in governance, but some clarification was required. SWa provided assurance on behalf of the group that the importance of the issue was fully recognised, especially for the region, and suggested detailed discussions could take place outside the meeting.	

	AM thanked SWa and returned to JH for final remarks. JH expressed appreciation for SWa's input. JH outlined that plans were in place with local teams, with October and November as key times for organisational responses. JH asked board leaders to continue supporting the removal of identified blockages, stressing the need for senior leadership involvement to maintain momentum and ensure critical decisions were made. AM thanked JH and invited final questions or comments on the corporate risk register, the new risk around ICB performance, or the strategic risk register. AM then asked if there were any objections to removing the risks recommended for removal. No objections were raised, and full approval was recorded. AM thanked RH and SD for their work and suggested a short comfort break before resuming the meeting. • **Action: Where applicable, all board members to return to their organisations and actively remove any barriers hindering progress on Oliver McGowan mandatory training, as well as to identify and communicate the nature of any system blockages.** • **Action: Jo Hicks and Stuart Walker to discuss follow-up procedures offline and ensure ongoing assurance and prioritisation of the Oliver McGowan training risk.** . **The ICB Board received the Corporate Risk Register and ICS Strategic Risk Register**	All JH/SWa
7	**Outcomes, Performance and Quality Committee** ED confirmed that there had been no meeting since the last update, and therefore, there was no committee update to report at this meeting. ED reiterated that at the previous board meeting, responsibility for assurance of the winter plan had been delegated to the System Executive Group (SEG), due to the timing of the Outcomes Quality and Performance Committee. The committee had not yet reviewed the developed winter plan. As a result, AM and ED were tasked to check and challenge the plan, which they completed on Monday. This was followed by a session at SEG, where the plan was discussed in detail. ED reported that they found the plan to be well-constructed and data-driven, but noted some risks regarding its delivery. ED reiterated these points for the minutes. David Jarrett (DJ) stated that, following a lengthy discussion at the last board meeting regarding the winter plan, the action to oversee it had been delegated to SEG, along with the submission of the Board Assurance Statement. DJ	

	confirmed that the Board Assurance Statement had been submitted by the ICB Board, but with a caveat that further work was required around delivery and assurance within the acute provider board, with this work ongoing over the coming weeks. AM acknowledged this and handed over to RS. RS added that there would be a review after the quality and equality impact assessment was completed, to ensure the governance loop was closed, and that feedback would be provided to the committee. These would take place at the system level. RS explained that there were two key meetings: the System Quality Group and the Health and Care Professional Executive. These meetings enabled system leaders to oversee decision-making, pathway changes, and risk management. A joint meeting of these two groups would be used to review the quality and equality impact assessment of the winter plan, ensuring comprehensive health and care leadership oversight. RS thanked AM and took the quality report as read, noting that it referred mostly to quarter one data, as there had not been a recent quality committee meeting to review more up-to-date information. RS explained that the governance route was for items to come to committee before being presented to the board. RS went on to highlight a strong focus on infection prevention and control, particularly concerning TB, measles, and MRSA. RS acknowledged good performance and joint working in infection control but noted ongoing challenges with MRSA and TB in certain population groups. RS mentioned that the draft LeDeR annual report had been completed later than usual, in line with the national picture, and requested the board's permission to take the report through the Outcomes, Quality and Performance Committee later in the month, and to delegate sign-off for publication to the committee. RS reassured the board that the report would be brought back as part of a future committee update but was keen to publish before the end of the calendar year to avoid delays. AM confirmed this was a specific request and asked if any board members objected to delegating responsibility for the sign-off of the LeDeR annual report. There were no objections, and AM confirmed agreement. RS concluded with two positive notes. RS reported that survey results for trainees in the system were good, indicating that new healthcare professionals were having positive learning experiences, particularly junior doctors. Additionally, RS highlighted work arising from both COVID and the LeDeR programme around 'Respect', ensuring that people's wishes at end of life were respected, especially for those with learning disabilities. This work had produced positive outcomes. AM thanked RS and turned to DJ regarding the performance report. DJ stated that, as with the quality report, the performance report was somewhat dated due to the lack of a recent committee meeting. DJ noted there had been no significant changes in trends since last month, with strong performance against	

	most operational plan standards, but ongoing challenges in areas such as out-of-area placements, mental health, and CYP access. DJ highlighted strong urgent care performance over the summer, with Cat 2 and handover delays remaining well-managed through September but cautioned that as the system moved out of summer, there would be increasing challenges around four-hour performance and patient flow, reinforcing the importance of the winter plan's delivery. ED closed by noting that the next meeting was scheduled for 22 October, in two weeks' time, and that many of the topics discussed would be revisited then. ED thanked everyone for their contributions. **The ICB Board received the update from the Outcomes, Quality and Performance Committee**	
8	**People Committee** JCh reported that bimonthly meetings for the ICB People Committees had continued in order to support organisational change. Several policies had recently been updated and aligned with Gloucestershire ICB, including the pay protection policy and the organisational change policy. JCh also stated that BNSSG had adopted a formal domestic abuse policy, which previously had been managed through the freedom to speak up process and other staff support mechanisms. JCh stated that the ICS People Committee had met the previous week, and although the minutes were not yet available, the meeting had strongly focused on supporting staff, particularly in relation to violence and aggression, with a continued emphasis on anti-racism. JCh acknowledged that the group had already discussed anti-racism earlier in the day and recognised the need for organisations and the system to increase support, especially during the migration period. JCh emphasised the importance of maintaining momentum in this area as the body transitioned to a strategic commissioning organisation. JCh further noted that the committee had received a report and presentation on the Healthier Together 2040 strategic intentions, discussing strategic workforce elements and the required response. JCh continued by stating that the committee had tasked the strategic workforce team within the ICB to collaborate with the System People Programme Board, to consider implications for workforce planning in the coming year and for the medium-term plan. AM thanked JCh for the update.	

	The ICB Board received the update from the People Committee	
9	**Finance, Estates and Digital Committee** SW pointed out several aspects relating to the financial position. SW noted that the ICB was continuing to track towards delivering a break-even financial position, but significant risks remained within the system, particularly among the acute providers NBT and UHBW. These providers were not tracking as expected, and it was anticipated that considerable effort would be required to recover their positions. ED asked for clarification, to which SW responded by highlighting increased demand, efficiency challenges, and technical accounting issues. SW stated that recovery plans were in development and that risks were being monitored, triangulated, and mitigated. SW emphasised the considerable financial pressure on the system and the need to remain vigilant. SW noted that the committee was focused on delivering for the ICB while also considering the transition position to ensure future readiness. Approvals and recommendations for procurement were being reviewed, with signalling to the Transition Board regarding areas requiring further work on new contracts. The committee had undertaken a deep dive into digital developments in primary care, aiming to pilot technology to enhance efficiency. SW also referenced a report on health inequalities, noting that the committee had agreed to closely consider the impact of financial decisions on reducing health inequalities and to reallocate resources where necessary. SW informed the attendees that planning for the following year was underway, with efforts being made to work in partnership with Gloucestershire. SW stressed the importance of data in the ICB's future form and outlined ongoing work to ensure digital and data requirements were integrated as the ICB transitioned. Risks across the system were being managed and mitigated, and an update would be provided at the next board meeting regarding both financial progress and data transition. SW concluded that, although the system was under pressure, the committee was actively addressing the issues. AM thanked SW and invited Matt Backler (MBa) to comment on the Finance Report and to take questions. MBa highlighted two main financial pressures: the ADHD and autism space, and section 117. MBa explained that mitigations were in place for these risks and that the organisation expected to deliver a modest surplus, with ongoing work to maintain the system's financial position. Trusts were submitting recovery plans to the Performance and Recovery Board at the start of October, in line with the internal exploration framework, and a system recovery plan was being developed in parallel. AM then asked DES if there were any points to raise from a digital perspective. DES amplified SW's earlier comments, noting that the system was moving towards a digital-by-default model for supporting people where appropriate.	

	DES stated that digital and data considerations were integral to the planning round, with the Digital Delivery Board focused on ensuring these were included. Deborah referenced the briefing from Shane regarding neighbourhoods, emphasising that without appropriate technology, neighbourhoods would not function effectively, and integrated care required robust digital systems. DES cautioned that the system must remain focused on digital developments to avoid falling behind and anticipated difficult decisions regarding future investment in data and digital. JS requested that future papers clarify whether references to ADHD and autism related to children or adults, as both groups faced significant but distinct challenges. JS expressed concern that ambiguity could obscure the nature of the issues. AM acknowledged JS's point, and SW confirmed that the challenges affected both children and adults. JS agreed, noting that while both groups faced challenges, the solutions might differ. **The ICB Board received the update from the Finance, Estates and Digital Committee**	
10	**Primary Care Committee** AM began by expressing gratitude to the Primary Care Committee and highlighted an issue to escalate to the board regarding Jhoots pharmacy provision in the South, specifically within BNSSG, which had attracted considerable media attention and affected people and patients. AM noted that the committee felt confident about the collaborative approach taken by ICB colleagues and partners, especially emphasising the strong relationships within the primary care committee. AM reminded the board of the primary care access objectives for the year, which included: appointments in general practice, the percentage of appointments within two hours of request, units of dental activity delivered, and the number of Pharmacy First consultations. AM stressed the importance of these objectives in ensuring patient flow and appropriate system usage. AM reported that GP access appointments were higher and the percentage of people seen within two weeks was above the Southwest average. Units of dental activity were increasing and on track, which meant more people were gaining access to dental care. AM also noted that BNSSG was the highest performing ICB in Pharmacy First consultations nationally, with an average of 11,800 community pharmacy first referrals, which was alleviating demand elsewhere in the system. AM mentioned a fourth objective around eye care, explaining that progress had been slower, but the Eye Care Delivery Board was now operational and expected to provide outputs and outcomes in the coming	

	year. AM concluded by reiterating the committee's focus on achieving the primary care access objectives and invited DJ to comment. DJ briefly commented on the previous report, highlighting the national focus on access to urgent dental appointments alongside UDA appointments. DJ noted that delivery against urgent care access standards was slightly below target but reported that full commissioning for urgent care access had now been achieved, with improvements anticipated in the coming months. DJ then addressed the challenges with Jhoots pharmacy, stating that these were national, regional, and local issues involving the provider's difficulties in sustaining a comprehensive service, leading to temporary closures and stock shortages in several branches, including the closure of a branch in Portishead. DJ reported that the provider was receiving national and regional attention and that the ICB continued to work with the provider and affected general practices to manage the situation. DJ identified ongoing patient safety and service risks due to pharmacy closures, which placed significant strain on surrounding practices. The ICB was working with public health teams, general practices, and other pharmacies to manage the impact, while NHS England's commissioning team was using contractual mechanisms to support and challenge the provider. DJ assured the board that mitigating actions, such as additional provision and support from other pharmacies, were being implemented to maintain safe access to medication and that the issue would continue to be escalated through the primary care committee. AM acknowledged DJ's update and noted for the minutes that RS, who had left the meeting, wanted to highlight progress in the percentage of people able to see their preferred healthcare professional in general practice. ED reiterated the depth and concern of the discussion regarding the Jhoots situation at the committee. ED questioned whether the ICB possessed the necessary skills and capability to address significant contractual and operational issues. ED reported that DJ had provided assurance to the committee that the situation was under control and had been escalated to a regional level. ED added that lessons learned from this situation would inform future contracting decisions and expressed support for the work done and the quality of the committee's discussion. **The ICB Board received the update from the Primary Care Committee**	
11	**Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee** JF confirmed that the papers and minutes had been circulated, enabling attendees to review the details. JF reported that the committee had discussed three substantive topics: one relating to alcohol and drugs, the second concerning smoke-free initiatives within BNSSG, and the third focusing on	

	healthy weight, which was scheduled to be launched on Monday in Stoke Gifford. JF emphasised that the conversations had been rich and had reinforced the importance of these areas as central pillars in commissioning services, particularly those aimed at tackling health inequalities and supporting population health. JF noted that the committee was generating outcomes that differed from those typically produced by other committees and suggested that JMe might be able to provide further detail on the outcomes listed in the circulated minutes. AM thanked JF and asked if JMe wished to comment. JMe acknowledged the quality, breadth, and depth of the committee's discussions and the valuable insights generated. AM thanked JF and JMe and invited any further comments or questions but none were raised. **The ICB Board received the update from the Strategic Health Inequalities, Prevention and Population Health Committee**	
12	**Audit and Risk Committee** JCa reported that the committee had met on 12 September and the minutes from that meeting were not yet available. JCa noted that the Transition Committee risks had now been incorporated into the risk register scrutiny work overseen by the Audit and Risk Committee, becoming an integral part of their processes. JCa highlighted that there was one final internal audit report this period, which related to funded care following the introduction of the Care Insurance Panel last year to oversee all-age commissioning. JCa summarised that the audit outcome was satisfactory and provided a good basis, with helpful recommendations from the internal auditors to further enhance effectiveness. The audit was generally satisfactory overall. JCa also drew attention to the internal audits progress report, which is reviewed at each meeting. The feedback was that, despite the challenges faced by SD and the executive team, the report was particularly positive, noting that it was one of the best reports they had seen, with 21 actions closed, no extensions requested, and nothing outstanding for implementation. JCa concluded by thanking everyone involved, describing the outcome as very positive and expressing appreciation for their efforts.	

	AM thanked JCa for the update and asked if there were any observations or questions. There were no comments or questions. **The ICB Board received the update from the Audit and Risk Committee**	
13	**South West Joint Specialised Services Committee** SD and JD noted that there was not a new update from the South West Joint Specialised Services Committee as they had only met once. **The ICB Board received the update from the South West Joint Specialised Services Committee**	
14	**Integrated Care Partnership** AM invited JF to provide an update on the Integrated Care Partnership (ICP). JF thanked AM and asked for committee or board members' views regarding the transition, noting that Gloucestershire health and Well-Being Board continued as their integrated care partnership, unchanged unless legislation stated otherwise. JF explained that in BNSSG, the ICP chair rotated among local authority health and hell-being board chairs. JF highlighted the value of ICPs and discussed with SD the future of these partnerships, expressing concerns about losing a forum that brought together system chairs if the ICP ceased to exist. JF also mentioned potential changes in ICB membership and partner participation, which could affect non-executive level forums. JF stated that proposals would be developed and brought back, but stressed the need to ensure a collective space for senior leaders—chairs, elected members, and executives to collaborate across the system. JF invited SD to contribute, as discussions had previously taken place between them. SD responded, acknowledging that the ICP had been created with a clear focus on developing system strategy and enabling delivery by other system parts. SD noted that, by statute, the ICP was a subcommittee of the board and referenced its limited mention in the 2022 Act, which only stipulated that each ICB system should have an ICP. SD saw an opportunity to consider the most appropriate structure for engagement at different levels, questioning whether strong health and well-being boards were sufficient or if a new, larger ICP for the cluster was necessary. SD suggested that a series of conversations were required to ensure both political and officer voices were included, especially as the system grew to cover multiple local authority areas. SD clarified that ICPs were never intended as governance architecture but rather to drive collective system working. Emphasising the need for a lean ICP that encouraged broad participation and suggested beginning discussions with local authorities, health and well-being boards, and existing ICP members to define its future role. SD argued that the function of bringing decision makers together should be preserved, even if the title or structure changed.	

	AM asked SD where these discussions would take place. SD replied that there was no natural venue for such conversations, so space would need to be created—possibly through workshops or by using existing networks like the VCSE alliance and health and well-being boards. FM, representing the VCSE alliance commented that the ICP was the only space that brought together localities, health and well-being boards, acute VCSE, and others. FM expressed concern that moving towards neighbourhood health might lead to siloed working and loss of a system-wide perspective. FM stressed the importance of maintaining a space for thought leadership and strategic thinking, warning that, without it, the system risked losing direction. FM also suggested there could be synergy between the strategic discussions and the development of future ICP structures. AM agreed and handed over to JMe who reflected on previous conversations about the relationship between the executive, the provider landscape, and non-executive leadership. JMe argued for making time to consider the evolving roles of neighbourhoods, ensuring that their voices were integrated, and avoiding fragmented approaches to quality. JMe raised concerns about the patient voice, referencing changes to Healthwatch and the need for stronger representation from patient participation groups across the system. JF was supportive of creating a space for these discussions, asking chief executives and organisational representatives to consider the issue further. JF explained that reporting from the ICP to chairs had been important, but not all chairs attended ICP meetings. JF felt that, although ICPs were initially intended to set strategy, in BNSSG their value had extended further. JF cautioned that this added value could be lost quickly if a replacement space was not established, appealing for careful thought to ensure leaders felt informed and engaged. Kevin Peltonen-Messenger (KPM) agreed that a space was needed to support community-level delivery and suggested that locality partnership boards and collectives could contribute to shaping what comes next. While agreeing with JF that meetings should be purposeful, KPM emphasised the need for agility and responsiveness to both healthcare and broader community experiences. KPM underlined the importance of maintaining independent patient voices, especially for vulnerable and excluded groups, and suggested that quality boards could help shape the future of ICPs. JL explained that collaborative leadership at a senior level was crucial, highlighting the role of provider groups. JL stated that the ICB had acted as a convenor within the ICP and argued for a culture of change where providers worked closely together. JL believed senior leaders needed opportunities for	

	open, challenging discussions among themselves, free from oversight or scrutiny, to determine how best to steer their organisations and deliver for patients. JL saw this as an important aspect to consider moving forward. AM thanked JL. SD stated the discussion had sparked thoughts about establishing a ninth work programme focused on ICP engagement architecture, in addition to the eight current ICB programmes. SD warned against forming an ICB without considering the broader strategic changes underway, noting that the ICP would remain until legislative change. **The ICB Board received the update from the Integrated Care Partnership**	
15	**Questions from Members of the Public** In terms of public questions, AM noted that there was one from 'Amy' regarding AWP's care for her partner, specifically about early access to a care coordinator and structured clinical management. Amy was already in contact with AWP and the relevant support teams, who would assist her further; the board did not need to take direct action. The next formal Open Board meeting was on December 4th, with a seminar scheduled for November 6th. AM thanked the board for their contributions and engagement.	
16	**Any Other Business** There was none	
	Date of Next Meeting ICB Board: 4 December 2025	

Connor Evans, Executive PA, November 2025