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NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Primary Care Committee Meeting

Minutes of the Meeting Held on Tuesday 25th November 2025 9:00 – 10:30

DRAFT Minutes

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

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1	**Welcome and Apologies** Alison Moon (AM) welcomed everyone to the Primary Care Committee (PCC). Apologies are noted as above.	
2	**Declarations of Interest** AM asked for any declarations of interest to be made. No new declarations of interest were made by any attendees.	
3	**Minutes of the Previous Meeting held on 23rd September 2025** The minutes from the PCC meeting on 23rd September 2025 were reviewed. The minutes were agreed to be an accurate record of the meeting. Richard Brown (RB) noted his title was incorrectly listed as "Avon Local Pharmaceutical Committee" and should be updated to "Chief Officer, Community Pharmacy, Avon and Wiltshire" following a merger with Swindon and Wilts. AM confirmed this would be updated. No other amendments and these minutes have been approved and will be forwarded to the ICB Board for information.	
4	**Review of Action Log** The action log was reviewed: (*Please refer to the action log for full details*)	
5	**PC Corporate Risk Register & Emerging Risks** AM invited David Jarrett (DJ) to introduce the risk register item. DJ stated there were no major changes to the overall risk register, except a slight amendment to the risk around general capacity, which is a challenge across all Committees, due to ongoing change pressures. He noted the main area for discussion was the JHoots pharmacy situation. <u>Questions</u> ➢ Ellen Donovan (ED) raised a question about the dentistry risk (PCC 60), noting an unmitigated risk score of 20, a current risk score of 20, and a target risk score of 12. She questioned whether the target was realistic, given how much was outside the Committee's control? ➢ Jenny Bowker (JB) acknowledged ED's challenge, agreeing that the risk could never be eradicated due to funding limitations and that some population groups would always lack access to NHS dentistry. She agreed to review whether the target risk score was pitched correctly, considering the committee's direct control. ➢ ED emphasised the importance of being clear about what could and could not be achieved, and the need to keep pressure on to influence improvements. **Action:** **Agreed for JB to review the risk score on Risk PCC60 and advise accordingly**. **Update on JHoots Pharmacy** DJ introduced the JHoots pharmacy risk as the main area for discussion, handing over to Nikki Holmes (NH) for an update. NH provided a detailed update on the status of JHoots and related pharmacies as set out in the slides. NH reiterated the distinction between the sites which remain open	**JB**

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	managed by Manjit Jhooty and those with suspended services managed by Charlie Jhooty. In addition, key updates for BNSSG include:- ➢ Fishponds site reopened on the 17th November under Allied pharmacy management, White Cross Road in Weston-super-Mare was due to open that day. ➢ Locking Road in Weston-super-Mare faces leasehold issues due to rent negotiations. ➢ Two Portishead sites are complicated by a third-party sale in progress before administration; discussions are ongoing between the administrator, Allied, and the third party. ➢ Market interest in Portishead sites will be considered in January 2026. ➢ NH is arranging a meeting with the local Portishead practice to clarify the situation. ➢ JB added that the situation is rapidly changing, with frequent updates. Westbury and Montpelier sites remain closed and under Charlie JHooty's ownership. Usual contractual processes will be followed for closed sites. The Portishead situation is complex, with multiple applicants and regulatory limitations. ➢ NH noted that contractual levers (breaches, minded to remove) are being used to focus attention, especially in Portishead, and that weekly meetings are ongoing with Allied and the administrator. AM asked if there was anything to escalate to the PCC or ICB Board, noting the thorough approach and reduced risk in some areas due to reopened pharmacies. NH identified Portishead as the main area of significant risk, especially regarding the medical centre lease. <u>Questions / Reflections Raised Included:</u> ➢ Matt Lenny (ML) thanked the team for their work, offered local authority support if needed, and suggested that feedback from the Health and Wellbeing Board or Scrutiny Committees could be used to support the case for action. ▪ NH welcomed the offer and confirmed Allied is working on communications with practices and patients. The Health and Wellbeing Board's view is considered in applications, and the PNA update is referenced in decision-making. ➢ RB assured the committee that the LPC is supporting pharmacies as they reopen, offering help without interfering in the process. He highlighted the impact of sustained funding cuts on JHoots viability and stressed the need for feedback to include the funding context. ➢ AM noted the joined-up approach and the need for lessons learned, recognising both local and national factors. JB emphasised the importance of monitoring resilience as Allied takes over multiple sites, developing early warning systems, and supporting Allied's ongoing management. ➢ ED praised the coordinated response, raised concerns about commercial operators' sustainability, and asked about the Portishead community's access to alternatives and the market entry application process. ▪ NH explained the regulatory process and consultation periods, and that most Portishead applications are for new pharmacies, with decisions scheduled for January and February. ➢ JB confirmed that West Hill Pharmacy has absorbed most of the Portishead workload, with resilience funding provided to support them. The local authority arranged specific support for supervised methadone patients.	

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	➢ RB reported he would attend a public meeting in Portishead to gauge community sentiment and reiterated the importance of balancing pharmacy numbers to avoid oversupply and unviable businesses. ➢ ML confirmed the local authority's support for vulnerable users and highlighted learning about pressure points and future planning. NH confirmed regular meetings with Allied will continue, focusing on operational structure and ongoing management to avoid repeating JHoots' challenges. **Action:** **DJ to provide an update at ICB Board** 9:48: Nikki Holmes left the PCC meeting. **The Primary Care Committee received and noted the PC Corporate Risk Register and Emerging Risks. The Primary Care Committee noted the update on JHoots Pharmacy.**	**DJ**
6	**PCOG Report** AM introduced the PCOG (Primary Care Operational Group) report agenda item, noting that three months' worth of reports (September, October, November 2025) were included and suggesting they be taken as read. She invited DJ to highlight any key points. DJ agreed to take the reports as read and proposed this as the standard approach for future meetings. He noted that the previous month's meeting focused heavily on the JHoots pharmacy issue, and an item scheduled for the closed session. DJ stated that the other items in the PCOG report were smaller service areas and expressed hope that the Committee had a good sense of current operations. AM acknowledged the volume of work managed by the PCOG, expressing commendation at the group's capacity and thanking DJ for the group's efforts. No questions were raised. **The Primary Care Committee formally received and noted the PCOG Report, and AM acknowledged the work of PCOG on behalf of the PCC.**	
7	**Medium Term Plan: Primary Care** AM introduced the operational plan and joint forward plan agenda item, inviting Beverley Haworth (BH) to present. BH summarised the current status: ➢ The medium-term plan has been published, and the first planning day has been held (13th November). ➢ BH reported the planning day included a stock take of current progress and looked ahead to 2026/27 and beyond, identifying risks, dependencies, and updates to the Joint Forward Plan (now called the five-year plan). ➢ Slides provided a reminder of 2025/26 objectives and performance against plan, including metrics for general practice appointments (above plan), dental activity (about 3,000 under plan), and community pharmacy consultations (significantly above plan). ➢ General practice contract variation from October is in dispute; further action pending after GPC meetings.	

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	➢ National asks for 2026/27 include: improving access, digital focus (ambient voice tech pilot underway), 90% same-day urgent care target (this additional target will be consulted on, definition of urgent will be left to practices), and additional capacity for out-of-hours/surge periods (details awaited). ➢ Community pharmacy priorities: targeted Pharmacy First approach for lower referring practices, building links with general practice, expanding emergency contraception, maximizing discharge medicine service, new HPV vaccination area, increased NHS app focus. ➢ Dental priorities: awaiting contract reforms, focus on urgent appointments. ➢ Optometry: not included in national plan but remains a local priority. ➢ Risks and dependencies include funding/contracting uncertainty, involvement in neighbourhood health work, and ensuring funding moves with activity. <u>Next steps:</u> BH advised that templates for submission had been received, with work underway on activity and workforce trajectories, draft submission due 11th December, final submission in March 2026. <u>Questions / Reflections Raised Included:</u> ➢ AM thanked BH for the report, but noted lack of detail on contracts for next year, with financial mechanism reviews ongoing and no timelines, and asked how the Committee could help mitigate this risk? ▪ BH explained ongoing regional and national conversations, but no timelines; planning continues based on local priorities until details are received, contract details unlikely to be until after April. ➢ ED praised the report and recognised the amount of work involved. ED asked whether the plan would allow for continuation or significant change, and how much was nationally driven versus local. She also asked for more detail on the targeted Pharmacy First approach. ▪ DJ responded, stating that while the operational plan must be met, the broader ambition is holistic neighbourhood health development, with general practice at the heart. ▪ BH responded, the plan includes both top-down national requirements and local objectives. 1. BNSSG is ahead in digital, offering opportunities for local impact. 2. Use of patient surveys and health insight data supports targeted improvements. 3. Some requirements are to maintain current achievements, but there is ambition to improve, especially in dental urgent access. 4. Pharmacy First targeting involves working with lower referring practices to understand and increase referrals. ➢ RB noted that government negotiations for the community pharmacy contract had not started, and any pressure the ICB could apply would be helpful. He highlighted the potential for ICBs to take on prescribing in community pharmacy, which has shown positive results locally. ➢ Susie McMullen (SMc) emphasised the risk that increased national focus on contract management and enforcement could reduce capacity for local relationship-based improvement work, which has been key to BNSSG's success. AM, on behalf of the Committee, recognised the challenges posed by contract uncertainty and the need to balance national requirements with local priorities. There was consensus on the importance of maintaining relationship-based improvement work, despite increased contract management focus. The Committee agreed to	

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	proceed with planning and submissions as required, while monitoring risks and dependencies. 9:55: Ali Mundell joined the PCC. 10:00: Richard Brown left the PCC. **The Primary Care Committee noted and accepted the Medium-Term Plan for Primary Care.**	
8	**Primary Care Finance Report** Jamie Denton (JD) presented the primary care finance report, noting the papers covered the September financial position. JD summarised the various financial positions. <u>System Financial Position</u> ➢ The system is reporting a break-even position year-to-date and, in the forecast, across both the ICB and system providers. ➢ A potential financial challenge identified in September has now been quantified as a £13.9 million unmitigated risk, which includes the primary care position. This risk is not reported in the forecast but will require work to close the gap. <u>Primary Care (general practice grouping) Position</u> ➢ JD reported this is forecasting a £2.9 million underspend year-to-date. ➢ Primary medical care delegated: £1 million underspend, driven by slower population growth and differences between published allocation and population methodology caps. ➢ Core primary care services: £200,000 overspend due to planning differences and HMRC challenge, with faster-than-anticipated transition to an employed model. ➢ Medicines management: £2 million underspend, driven by lower drug costs, license expiries, successful patient switching schemes (edoxaban), and higher-than-expected rebate income (£1 million favourable balance). ➢ Some cost increases (e.g., for tesepratide) are being absorbed nationally, not locally. ➢ The medicines management position is expected to improve further as invoices are received, potentially by at least £1 million. <u>POD (Pharmacy, Optometry, Dentistry) Finance Report Position:</u> ➢ JD reported this is forecasting an £800,000 underspend, mainly driven by higher numbers of 56-day prescriptions and successful PGDs (Patient Group Directions). The Committee reviewed the financial position, noting underspends in primary care and medicines management, and a significant unmitigated system risk. Risks and mitigations were discussed, with confirmation that current approaches are consistent with previous years. <u>Questions / Reflections Raised Included:</u> ➢ ED asked for confirmation of the £13.9 million unmitigated risk and whether the team was planning to live with it or seeking opportunities to reduce it. • JD confirmed the risk and explained that the team is not being asked to deliver more from the primary care portfolio at this time; the pressure is coming from the acute financial position. Mitigating schemes are being developed, but	

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	underspends cannot be used to expand services until financial balance is assured. • AM noted that the risks and mitigations feel similar to previous years, with in-year management. • JD agreed, noting typical risk management approaches and mentioning a handful of section 96 applications (areas of concern), none of high value or major concern. He referenced an issue with global sum payments for care homes, which is being worked through and accounted for in the position. **The Primary Care Committee agreed to note the financial reports and continue monitoring financial risks and developments.**	
9	**General Practice, Performance, Contracts & Quality Updates** **Primary Care Services Highlight Report** Katie Handford (KH) introduced the primary care reports section, stating: ➢ The General Practice Access Recovery Report and the self-assessment for primary secondary care interface work, were attached to the meeting papers. ➢ She noted that, following a previous request, more output was included this time, specifically attaching the self-assessment for detail. ➢ KH clarified she was not planning to go through the reports in detail and would take them as read. ➢ She referenced the Primary Care Highlight Report and reminded the committee that a deep dive on a rotational basis had been agreed. For this meeting, the deep dive focused on community pharmacy. KH then handed over to Ali Mundell (AMu) to present the community pharmacy deep dive. AMu summarised the community pharmacy report: ➢ Pharmacy First supports GP practices, aiming to move over 30 million appointments nationally per year. ➢ BNSSG has 23 national and 3 local PGDs for minor ailments, with additional services for contraception and hypertension case finding. ➢ BNSSG remains the highest performing ICB in the country per 100,000 patients for Pharmacy First. ➢ In September, 91% of surgeries referred more than 20 patients/month, 83% more than 40, and 40% more than 125. ➢ Average of over 11,000 referrals/month to community pharmacy; 69% from GPs, 26% self-referral, 5% from 111. ➢ 100,000 referrals from GP practices in the last 12 months; 80% completed by community pharmacists. ➢ Ongoing work to expand PGDs, support lower-referring practices, and improve 111 referral scripts. ➢ Emergency contraception and hypertension services are expanding, with positive trends in uptake. ➢ Independent Prescribing Pathfinder (since April): 3 sites, 972 consultations (April–September), 99% patient satisfaction, 31% outside GP hours, 65% walk-in, 24% GP referral, 8% UTC/minor injuries. <u>Next Steps</u> AMu reported that there is NHSE funding until December 2025, with a potential extension to March 2026, point-of-care lipid testing pilot, and increasing independent prescribers.	

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	AM thanked AMu, noting the impact and innovation, and acknowledged RB's support and the collaborate approach. SMc echoed the praise, highlighting the breadth of work and support provided. ED was impressed by the highest performing ICB in the country for Pharmacy First, and suggested the ICB Board should be made more aware. AM and BH confirmed this is regularly reported to the ICB Board. **Patient Safety Quality Report** Vicki Court (VC) summarised the report, taking it as read, and provided context with the arrangements of delegation of POD services on behalf of the ICB, is managed by the Southwest Collaborative Commissiong Hub (SWCCH). Quality monitoring including complaints is managed by the hub and quarterly quality reports are shared with the ICB. The quality of these reports is not optimal with key information missing. Due to this limited oversight via the hub the ICB is at risk of not fulfilling its function on quality POD services. Key concerns are: ➢ The quality of reports from the hub is not optimal, with missing "so what" analysis and limited oversight, especially for community dental and optometry services. ➢ The ICB meds optimisation team have good engagement with community Pharmacy this is not via the hub, but dental and optometry lack sufficient data and oversight. ➢ Some progress: a quality visit to a dental practice with members of the SW CCH, and ongoing work with the medicines optimisation team to address concerns. ➢ The ICB is seeking to improve information flow from the hub and explore alternative data sources (e.g., Trustpilot) for patient experience. ➢ The report concludes that assurance on dental and optometry quality is limited, and further work is needed. <u>Questions/ Reflections Raised Included:</u> ➢ AM noted the lack of assurance for dental and optometry, questioned how responsibilities were previously discharged, and emphasised the need for improvement. ➢ Rosi Shepherd (RS) proposed using the Quality Management System (QMS) process for a gap analysis, clarifying roles and responsibilities, and prioritising future work. She cautioned against overpromising during the change process. ▪ VC agreed, suggesting alternative approaches to gather patient experience data. ➢ AM confirmed an action to capture this approach and reiterated the need for realistic planning and reporting to the ICB Board that assurance is currently limited, but work is in progress. **Action:** **Agreed for VC and RS to use the QMS process for a gap analysis of quality oversight in POD services, clarify roles, and prioritise future work, reporting progress to the PCC and ICB Board.** **The Primary Care Committee:** **1. Noted the Primary Care Highlight Report, Access Recovery Report, and the deep dive on community pharmacy, recognising BNSSG's national leadership in Pharmacy First**	**VC/RS**

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	2. Noted the Patient Safety Quality Report for POD services, acknowledging the current lack of assurance for dental and optometry and the need for further work.	
10	**Key Messages for the ICB Board** AM summarised the key messages for the ICB Board, identifying the main topics as JHoots pharmacy situation, the medium-term plan, Pharmacy First performance, and the POD quality assurance gaps in the report. Throughout the meeting, several recommendations and key messages for escalation to the ICB Board were discussed.	
11	**Primary Care Operational Group (PCOG) Minutes 14th Oct & 11th Nov 2025** **The Primary Care Committee received the PCOG minutes for information.**	
12	**Any Other Business**	
	Date of Next Meeting The next meeting will be held via MS Teams in February 2027.	