

## **BNSSG ICB Board Meeting**

**Minutes of the meeting held on 4<sup>th</sup> December 2025 at 12.30pm**

**The Vassall Centre (Gill Avenue, Bristol, Avon, BS16 2QQ)**

### **DRAFT Minutes**

<b>Present</b>		
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
John Cappock	Non-Executive Member – Audit	JCa
Shane Devlin	Chief Executive Officer, BNSSG ICB	SD
Jaya Chakrabarti	Non-Executive Member – People	JCh
Dominic Hardisty	Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust	DH
Jo Beer	Chief Executive Officer, Sirona care & health	JB
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
Steven West	Non-Executive Member – Finance, Estates and Digital	SW
Maria Kane	Chief Executive Officer	MK
Mandy Bishop	Chief Executive Officer, North Somerset Council	MB
<b>Apologies</b>		
John Martin	Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust	JMa
Dave Perry	Chief Executive Officer, South Gloucestershire Council	DP
Rachel Pearce	Managing Director, NHS England South West	RP
Mark Cooke	Managing Director, NHSE South West	MC
Ellen Donovan	Non-Executive Member – Quality and Performance	ED
Fiona Mackintosh	VCSE Alliance Representative	FM
Nick Hibberd	Chief Executive Officer, Bristol City Council	NH
Ruth Hughes	Chief Executive Officer, One Care	RH
Deborah El Sayed	Director of Transformation and Chief Digital Information Officer, BNSSG ICB	DES
<b>In attendance</b>		

Jen Bond	Deputy Director of Communications and Engagement, BNSSG ICB	JB
Kevin Peltonen-Messenger	Chief Executive, The Care Forum	KPM
Aishah Farooq	Associate Non-Executive Member	AF
Rob Hayday	Chief of Staff, BNSSG ICB	RHa
Jo Hicks	Chief People Officer, BNSSG ICB	JH
David Jarrett	Chief Delivery Officer, BNSSG ICB	DJ
Steve Nelson	VCSE Alliance Representative	SN
Connor Evans	Executive PA, BNSSG ICB <i>minute taker</i>	CE
Seb Habibi	Chief Transformation and Digital Officer, BNSSG ICB	SH
Kate Lavington	Head of Design, BNSSG ICB	KL
Richard Smale	Director of System Coordination, NHS England South West	RSm
Ruth Whateley	Clinical Effectiveness Programme Manager, BNSSG ICB	RW
Cheryl Simpson	Public Contributor	CS
Kaye Christopher Grant	VCSE Ambassador, Life Changing community group	KCG
Tabinda Rashid-Fadel	VCSE Ambassador, Accure Health	TRF
	<b>Item</b>	<b>Action</b>
1	<p><b>Apologies</b></p> <p>Alison Moon (AM) welcomed all to the meeting.</p> <p>Jeff Farrar (JF) thanked Deborah El-Sayed for her contributions to BNSSG ICB and wished her well for the future.</p> <p><b>The above apologies were noted</b></p>	
2	<p><b>Declarations of Interest</b></p> <p>Steve Nelson (SN) raised a Declaration of Interest in relation to the Cardiovascular item on the agenda (6.2). Tabinda Rashid-Fadel was one of SN's vice chairs.</p> <p><b>There were no other new interests declared and no interests pertinent to the agenda.</b></p>	
3	<p><b>Minutes of the 2<sup>nd</sup> October 2025 ICB Board Meeting</b></p> <p>The minutes of the 2<sup>nd</sup> October 2025 meeting were agreed as correct.</p>	
4	<p><b>Actions arising from previous meetings and matters arising</b></p> <p>The Board reviewed the action log.</p>	

	<b>All remaining open actions were closed</b>	
5	<p><b>Chief Executive Officer’s Report</b></p> <p>Shane Devlin (SD) outlined the three items from the Chief Executive report:</p> <ul style="list-style-type: none"> <li>• Strategic Direction and Transformation of BNSSG ICB</li> <li>• Winter Preparedness and focus on Vaccination</li> <li>• Celebrating Success</li> </ul> <p><u>Strategic Direction and Transformation of BNSSG ICB</u></p> <p>In November, the Transition Committee met to address key issues during a period of significant organisational change. They prioritised maintaining clinical representation and reviewed efforts to strengthen equality, diversity, and inclusion (EDI), particularly in HR processes. A new recruitment mechanism was introduced to ensure EDI was embedded throughout the organisation. The committee also discussed integrating the NHSE Board Assurance Framework for Health Inequalities and stressed the need for wider system collaboration on EDI commitments.</p> <p>A substantial portion of the meeting focused on the executive consultation and voluntary redundancy (VR) process, outlining timelines and acknowledging associated risks, especially the balance between financial and workforce impacts. Weekly HR drop-in sessions were established to support staff. The committee also addressed mandated cost reductions, ongoing uncertainties regarding accounting and audit implications, and agreed on coordinated internal audit arrangements across ICBs. Concerns were raised about retaining experienced executives, recognising the potential impact on organisational memory and morale. Overall, the meeting demonstrated a strong emphasis on clinical input, EDI, effective governance, and supporting staff through transition.</p> <p>SD noted the aim of reaching a full organisational consultation document in March 2026.</p> <p><u>Winter Preparedness and focus on Vaccination</u></p> <p>As reported to the Board in September, the Winter Plan for the year focused on key priorities identified by NHS England in their June publication, “Urgent &amp; Emergency Care Plan Preparing for Winter 2025/26.” The main areas addressed were system-wide preparedness, reducing demand and improving access, improving hospital flow and reducing delays, mental health crisis response, and digital transformation.</p> <p>Preparations included establishing an ICB-led System Control Centre for daily operational and clinical monitoring, implementing a system-wide communications plan and targeting vaccines among the population and staff through an extended vaccination programme. Investment in home-based social care capacity and the creation of an Acute Respiratory Hub in primary care were also prioritised. Efforts to improve hospital flow involved the roll-out of a timely handover process and a discharge improvement programme.</p>	

Mental health support was enhanced with new escalation procedures and a multi-disciplinary team approach for high-intensity users. Digital tools, including real-time data feeds and predictive modelling, were used to better manage system pressures.

During the winter, the vaccination programme progressed well, with BNSSG achieving high Covid and flu vaccine uptake—65.8% for Covid and 45% for flu among eligible populations, both exceeding regional averages. Community engagement played a key role, involving over 30 local partners to promote winter health messages and support access to resources in areas of greater health inequality. Activities included distributing informational materials, running Q&A sessions, and using trusted community media. Infection prevention and control messaging was also intensified, encouraging steps such as handwashing, ventilation, mask-wearing, and proper respiratory etiquette among both the public and staff.

Throughout the season, RSV, flu, and Covid prevalence remained relatively stable, although RSV hospitalisations in young children rose and flu levels stayed above the seasonal norm. Norovirus activity decreased but remained within expected levels. The overall approach aimed to bolster winter resilience and ensure effective support for both the public and healthcare system staff.

### Celebrating Success

SD summarised 3 key areas of success for BNSSG.

#### 1. Vanguard Project Highly Commended at the HSJ Awards

The Children and Young People’s Vanguard Project had been highly commended at the HSJ Awards on 20 November 2025 in the category for Reducing Inequalities and Improving Outcomes for Children and Young People. It had also been shortlisted for the Early Intervention and Prevention for Children, Young People and Families Award. The project, launched in 2020 and funded by NHS England South-West Health & Justice, brought together various NHS organisations, local authorities, and voluntary sector groups to identify and support high-risk children, aiming to prevent their involvement with the criminal justice system. Over 1,500 children had been supported. The recognition had highlighted the project’s trauma-informed, integrated approach and its success in reducing high-risk behaviours while improving children’s wellbeing and sense of purpose.

#### 2. “WorkWell” Wins the “Partnership Working” Award

WorkWell, a UK government pilot led by the Department for Work and Pensions and the Department of Health and Social Care, had been created to address the rise in long-term illness preventing people from working. In the BNSSG region, delivery had been managed by a partnership between the BNSSG Integrated Care Board, Bristol City Council, Job Centre Plus, and the VCSE sector, with £2,650,000 secured to support 2,550 people. By the time of reporting, WorkWell had assisted 2,000 participants with interventions such as Green Social Prescribing and wellbeing coaching, and provided

	<p>substantial funding to the VCSE sector. The initiative had won the 'Partnership Working' Award at the Southwest Integrated Care Awards, recognised for uniting partners around a shared vision and delivering tangible positive change. Additional funding had been anticipated for the coming years</p> <p>3. Local Maternity and Neonatal System (LMNS) and Race &amp; Health Observatory (RHO) Project</p> <p>The BNSSG system had been selected as one of ten nationally to participate in a project aimed at tackling inequalities in maternal and neonatal health, particularly in light of increased maternal morbidity and higher mortality rates for women and babies racialised as Black. Within BNSSG, preterm birth had been identified as a key focus due to its significant link to infant mortality, with local data revealing substantial disparities in care received by women of different racial backgrounds. The project had involved quantitative and qualitative research, including data analysis, staff surveys, and interviews with affected women. Various quality improvement projects had been implemented, such as introducing a pictorial leaflet to address knowledge gaps. As a result, the inequity gap had been greatly reduced, with all women racialised as Black receiving appropriate antenatal interventions. The project had emphasised the critical impact of racism in healthcare and the importance of anti-racist training and clinical practices, and had been recognised by the RHO, with its findings presented to the National Chief Midwife.</p> <p>Steve West (SW) addressed public confusion surrounding COVID-19 vaccinations, particularly concerning vulnerable populations and individuals aged 75 and over. SW emphasised the need to monitor spikes in COVID-19 cases that could lead to increased hospital admissions.</p> <p>AM referenced the national decision that staff outside of high-risk groups were not required to be vaccinated but noted that this remained a high-risk area on the risk register. AM asked whether it was still possible to raise concerns regarding this risk. Jo Medhurst (JM) observed that influenza posed the primary risk among the workforce.</p> <p>Jen Bond (JB) confirmed that communication efforts regarding vaccinations had been conducted both internally and externally.</p> <p>JF asked Maria Kane (MK) for UHBW's staff vaccination uptake, which MK said was in the region of 50%, higher than previous years.</p> <p>Steve Nelson (SN) acknowledged the success stories, specifically evidence of collaborative working.</p> <p><b>The ICB Board received and discussed the Chief Executive Officer's Report</b></p>	
6.1	<b>Update on Integrated Neighbourhood working arrangements</b>	

The Board received an update on developments in the Neighbourhood Health Agenda within BNSSG. This update built on previous monthly reports and reinforced that Neighbourhood Health was central to both the NHS 10 Year Plan and the "Healthier Together 2040" strategy. It was noted that, although national guidance was still awaited, partners had already agreed on the need for collaborative, locally tailored plans, and had established guiding principles for delivering national outcomes. Health and Wellbeing Boards (HWBs) were acting as partnership forums, leading area-specific plans and promoting a place-based, collaborative model.

The development process was organised into phases aligned with the Model ICB's strategic commissioning process and national expectations, particularly those of the NNIP programme. The first phase, understanding the local context and population, was reported as complete. This phase included a discovery report and extensive engagement under Healthier Together 2040, establishing a shared purpose and narrative across partners.

A dedicated session on neighbourhood health was convened by the BNSSG Integrated Care Partnership Board on 13th November, with participation from NHS, Local Authorities, voluntary organisations, and community groups. Key outcomes included the decision to rename 'Neighbourhood Health Plans' as 'Neighbourhood Wellbeing and Health Plans', adoption of a prevention-first approach, person-centred planning, and prioritisation of joint health and social care. Systemic tensions were identified, such as budget constraints and the challenge of engaging diverse communities. The importance of the VCSE sector was also highlighted.

The Board was informed that the second phase, developing the Neighbourhood Health Plans, was in progress. HWBs were working towards submitting plans to DHSC by December 2025, with a likely extension to April 2026. Plans were being developed collaboratively through workshops, integrating intelligence across health, care, public health, and VCSE partners. The intention was to synthesise the three HWB plans into a single ICB Strategic Commissioning Plan by February 2026.

The third phase, refining the strategic commissioning approach, was underway. Efforts were focused on new payment structures and integrated contracts across primary care, informed by the Wellbeing and Health Plans and existing commissioned services. Challenges included organisational change within the ICB and the complexity of national guidance, as well as the need to enhance joint commissioning with local authorities.

The fourth phase involved evaluating impact and delivery through participation in NNHIP. Woodspring and South Bristol had been selected as wave 1 test sites, supported by national guidance and coaching. Both sites developed logic models and prepared for tests of change by January 2026, though they faced risks such as limited dedicated funding and the need for alignment with wider system strategies.

As part of NNHIP, sites completed a baseline assessment across six domains: agreeing neighbourhood footprints, addressing variation in general practice access, improving primary-secondary care relationships,

<p>establishing integrated teams, reducing non-elective admissions, and planning elective pathways.</p> <p>The Neighbourhood Programme Group was reported to be coordinating progress, clarifying priorities, and agreeing partner roles, to support the development of a five-year strategy and population health plan. Next steps included updating the ICB Board in February 2026, further HWB plan development, ensuring alignment with commissioning intentions, supporting test sites, and exploring the lead integrator role.</p> <p>Seb Habibi (SH) and Kate Lavington (KL) observed that the neighbourhood health concept was not new but noted a renewed interest in developing integrated care and wellbeing plans. They reported that work would continue through February to support pilot projects in Goodsprings and South Bristol, aiming to develop strategic commissioning plans.</p> <p>KL reiterated that whilst guidance was still pending, the team were framing efforts as part of the commissioning cycle, with a focus on understanding local populations and prioritising neighbourhood health to address inequality. KL stated that plans were being shaped by insights from the ICP Board, encouraging alignment, person-centred approaches, and a strong focus on reducing gaps in healthy life expectancy. The emphasis was on achieving equity of outcomes rather than solely on investment.</p> <p>Jaya Chakrabarti (JCh) queried how geographic and community plans intersected. KL acknowledged the tension between neighbourhoods and communities and cited MINT teams as an example of supporting different communities. JCh emphasised the need for flexibility in neighbourhood models, recognising that some initiatives were better implemented beyond geographic boundaries.</p> <p>Jo Medhurst (JM) highlighted the ICB's role in setting a five-year strategic environment and establishing expectations. JM also remarked that future generations were digital, raising the issue of inequalities and access. SH noted that the programme's approach to delivery addressed digital enablement and referred to a discovery phase for understanding best practice, suggesting a new integrator or bespoke platform might be needed.</p> <p>SD remarked on governance and ownership, clarifying that HWBs had a duty to bring healthcare into the conversation but would not own the neighbourhood health and wellbeing plans. SD explained the board's need to specify what it was commissioning to support and serve healthcare. SD also considered whether oversight was needed above the three HWBs to avoid power struggles and suggested allowing local decisions while aligning system-wide direction.</p> <p>JF explained that the ICP Board had held extensive conversations on these matters. JF stated that while a single definition would not be achieved, using common language would help prevent issues from being overlooked and avoid duplication.</p>	
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	<p>SN referred to SD's comments regarding the changing relationship with HWBs and queried the authority levers and commissioning requirements at different levels.</p> <p>Richard Smale (RS) expressed confidence in the progress within BNSSG.</p> <p>JM noted that relationships with local authorities and Directors of Public Health (DPHs) were developing professionally, with healthcare outcomes potentially leading to improvements in wider determinants of health.</p> <p>Jo Hicks (JH) emphasised the need for a strong, representative workforce to serve the population effectively.</p> <p>AM acknowledged that the process had evolved with each update.</p> <p>It was agreed that feedback would be shared with HWBs, with a likely submission deadline in April. Phase 3 would involve outlining strengths and next steps for neighbourhood health commissioning over the coming two years. Next actions included integrating progress into communications, supporting HWB plan development, continuing collaborative support, strengthening lead integrator roles, and providing a further update in March.</p> <p><b>The ICB Board:</b></p> <ul style="list-style-type: none"> <li>• <b>Received the update on Integrated Neighbourhood working arrangements</b></li> <li>• <b>Considered and endorsed the next steps, identifying any additional work that the programme should be taking forwards.</b></li> </ul>	
6.2	<p><b>Cardiovascular disease - commissioning recommendations for tackling inequalities in hypertension treatment in Black African and Caribbean populations</b></p> <p>The BNSSG Cardiovascular Disease (CVD) Working Group had convened from April to October 2025 with the aim of addressing inequalities in hypertension treatment among Black African and Black Caribbean patients. The target was to achieve 80% treatment success within these populations by 2029 and to narrow the gap with white populations to within three percentage points. The group's work was grounded in lived experience and the insights of Voluntary, Community, and Social Enterprise (VCSE) organisations. Members recognised that hypertension posed a significant risk for CVD and stroke, with Black communities suffering higher incidence and poorer outcomes. Barriers to treatment adherence had been identified, particularly a lack of trust and health literacy.</p> <p>A 'Dual Approach' was recommended by the group, integrating VCSE and NHS services to deliver ten specific outcomes. The group acknowledged shifting demographics within BNSSG, noting that Black communities were increasingly dispersed beyond Bristol. They emphasised the necessity for sustainable, long-term commissioning, rather than reliance on one-off funding. It was suggested that many barriers and solutions identified would</p>	

be relevant beyond hypertension care, and the group advocated for inclusion of these recommendations within broader neighbourhood health planning. The establishment of a co-creation board comprising VCSE colleagues and patients was also recommended.

The CVD Working Group operated under the Long Term Conditions Operational Delivery Group, meeting regularly and involving public contributors, VCSE ambassadors, healthcare professionals, and researchers. Quorate meetings required representation from coordinators, VCSE, general practice, and individuals of Black African or Caribbean heritage. National and local data, including CVD PREVENT and Census 2021 findings, were reviewed, showing a high prevalence of hypertension particularly among Black Caribbean populations, and demographic changes with underrepresentation in available data.

A rapid evidence scan had confirmed higher rates of hypertension and CVD risk factors among Black and South Asian people, with Black people developing hypertension earlier and experiencing greater arterial stiffness. The evidence underscored the need for intersectional and tailored approaches and highlighted the requirement for consistent funding for VCSE outreach.

Key barriers to hypertension treatment were identified as systemic mistrust, cultural and individual differences, health literacy, and the need for tailored communication. The group's commissioning recommendations included ten outcomes: increased time for support in clinical and community settings, assertive outreach to high-risk groups, improved understanding among professionals, tailored information, transfer of trust, co-produced public health messaging, improved language support, enhanced information sharing, continuity of care, and greater workforce diversity. Case studies demonstrated the effectiveness of targeted interventions and community engagement.

JM expressed pride in presenting the paper and emphasising its importance for population health and strategic commissioning. JM clarified that credit was due to Ruth Whateley (RW) and the wider group coordinated within the health improvement team. JM highlighted the selection of a specific equality objective based on data, which evolved into broader commissioning intentions through detailed exploration of population health issues, cultural humility, and community engagement.

RW reiterated that the ICB health inequalities and prevention team had set a cardiovascular disease equality objective: to improve treatment for high blood pressure in Black African and Black Caribbean populations by 2029 and reduce the treatment gap compared to the white population. RW detailed the creation of a system working group focused on people with lived experience and VCSE sector expertise. The group, diverse in heritage and professional backgrounds, met six times over six months and co-produced report with ten commissioning recommendations. RW stressed the vital role of public contributor involvement in strategic commissioning and introduced her colleagues to provide presentations to the board.

Cherly Simpson (CS), a public contributor and retired child protection social worker, described her motivation for joining the group. CS highlighted the devastating impact of hypertension on Black communities, affecting family relationships, finances, and life opportunities. CS challenged the board to act decisively, emphasising the importance of their decisions for future generations.

Kaye Christopher Grant (KCG), representing the VCSE Alliance and volunteering community sector, shared her experiences and involvement in a study examining why Black women were disproportionately affected by stroke and heart failure. KCG argued that the treatment gap was not due to lack of understanding but rooted in past negative experiences, avoidance of unwelcoming environments, and cultural attitudes towards health. KCG identified three groups: those avoiding care, those attempting lifestyle management, and those inconsistently adhering to treatment.

Tabinda Rashid-Fadel (TRF), a cardiac physiologist, presented data showing that Black communities with recorded blood pressure had the worst treatment-to-target rates in BNSSG. TRF described a community-based health check programme that delivered 93 events in 8.5 months, engaging underserved groups. Findings revealed high rates of hypertension and cardiovascular risk in young adults, underscoring the need for earlier intervention. TRF emphasised that community-based prevention worked when built on trust and genuine partnership.

Following these presentations, a discussion ensued. JM reiterated the necessity for the board to reference the paper in strategic planning documents and to use it as a framework for commissioning care. The board agreed to integrate the recommendations into operational and strategic plans, ensuring inclusive approaches to commissioning and involving diverse voices from affected communities.

AM thanked colleagues for their time and for the challenges posed to the board. JF acknowledged recent meetings at race equity groups, noting a shift towards analysing data differently. JF explained that reviewing data by race or age revealed varying perspectives, which would be crucial for future strategic commissioning.

Jaya Chakrabarti (JCh) queried the core message regarding communication, highlighting numerous barriers for the community, particularly around trust and clarity of messaging. JM emphasised the importance of engaging with people who had lived experience to uncover actionable themes beneath the surface of the data.

Steve West (SW) spoke to the heartfelt and powerful stories, stressing the importance of commissioning suitable services at appropriate times to engage with all communities. SW recognised existing barriers and advocated for partnership working, listening, and early involvement for effective engagement, noting that prevention was preferable to intervention.

Kevin Peltonen-Messenger (KPM) found the report clear but expressed frustration, underlining the necessity of challenge and the importance of

building trust through relationships. KPM reiterated that issues extended beyond trust, referencing health inequalities observed in the community sector and ongoing programmes with underserved communities, which still resulted in poorer health outcomes.

AM questioned whether the board was utilising people who understood why certain approaches might fail, advocating for listening to those who could identify barriers and facilitate successful pathways for optimal outcomes.

John Cappock (JCa) reflected on the lack of trust and health literacy, noting the significant impact of supporting people to develop good habits, and asked how the ten recommendations could be brought to life.

SD considered the ten points, suggesting that commissioning should encompass all factors contributing to success, not just pathways. SD advised a deep understanding of the population served before developing recommendations. SN shared personal experiences of family members affected by vascular dementia, noting reluctance to seek medical help unless necessary. SN described a programme that engaged effectively with community groups, simplified access to care, and checked 1,500 people in a year, demonstrating the value of trust built over time.

JM raised concerns about productivity and outcomes, questioning how to scale and support these efforts. RW discussed a small, targeted piece of work with VCSE, highlighting the invaluable input from those with experience and identifying challenges in the infrastructure around public contributor involvement. Jake Lee (JL) referred to structural inequalities, stressing that information, data, stories, and connections drove change, and that powerful conversations should be taken back to the GP Collaborative Board.

JM suggested referencing the paper in various strategic plans and frameworks and sharing it regionally and nationally with directors of public health, Sirona, and the voluntary sector. AM asked what improvements should be expected for the specific group in question and when, noting that the Operational Delivery Group would take action. AM also linked the discussion to strategic commissioning intentions.

SD intended to integrate these insights into the new commissioning system starting in April, making them a key input. JF emphasised policy decisions should be based on both evidence and narrative, recommending action for the transition committee or board to ensure community voices influenced decisions. Rosi Shepherd (RS) noted the powerful evidence from the Black Maternity Matters work and its links, including JM's reference to allostatic load. SW mentioned the health innovation network and suggested the cardiovascular strand could be supported through dissemination and spread.

The item concluded with agreement to reference the paper in strategic documents, operational plans, and neighbourhood plans. JM and others called for a commitment to act on the recommendations, ensuring that commissioning approaches were inclusive, evidence-based, and responsive to community voices. The board resolved to monitor progress and outcomes,

	<p>with operational delivery groups tasked to implement actions and report back.</p> <p>JM thanked colleagues and the wider team for their dedication and for transforming a complex issue into actionable recommendations.</p> <p><b>The ICB Board received the report on Cardiovascular disease - commissioning recommendations for tackling inequalities in hypertension treatment in Black African and Caribbean populations and discussed</b></p> <ul style="list-style-type: none"> <li>• <b>What the recommendations mean for future commissioning</b></li> <li>• <b>What the board were going to do next with these recommendations</b></li> </ul>	
6.3	<p><b>Revised Terms of Reference for Joint Transition Committee</b></p> <p>Board approval was requested for a revision to the Terms of Reference for the Joint Transition Committee, which had been set up by Gloucestershire and BNSSG ICBs to oversee organisational changes relating to clustering.</p> <p>The only amendment to the Terms of Reference concerned committee membership; one Chief Clinical Officer from the clustering ICBs was added, and it was agreed that Dr Jo Medhurst would take this role.</p> <p><b>The ICB Board approved the Revised Terms of Reference for Joint Transition Committee</b></p>	
6.4	<p><b>Joint Remuneration Committee Terms of Reference</b></p> <p>Gloucestershire and BNSSG ICBs both had Remuneration Committees, as required by the Model Constitution for ICBs. These committees were authorised by their respective Boards and operated under published terms of reference within governance handbooks. Their responsibilities included overseeing pay and conditions for executive and non-executive roles, as well as handling employment termination matters due to redundancy.</p> <p>In preparation for a merger in 2027, the two ICBs began clustering and both Remuneration Committees became involved in organisational change processes, following direction from NHSE and the Model ICB Blueprint.</p> <p>Rather than continuing with separate meetings, it was proposed to establish a Joint Remuneration Committee, pending support from each ICB Board in accordance with their Schemes of Reservation and Delegation. This joint committee formed part of the developing cluster governance arrangements mandated by the Joint Transition Committee.</p>	

	<p>Draft Terms of Reference were developed based on existing documents from both ICBs, with similar remits and scopes, though current memberships differed.</p> <p>Deputy Chairs of the ICBs and Remuneration Committee Chairs were consulted regarding proposed membership, and current membership details were provided as an annex for information.</p> <p><b>The ICB Board approved the Joint Remuneration Committee Terms of Reference</b></p>	
6.5	<p><b>Innovate Healthier Together Programme</b></p> <p>The Board received the Innovate Healthier Together (IHT) Programme Evaluation Report, which highlighted the achievements and learnings from the programme and set out proposed next steps for approval. The IHT Programme, established as a partnership between BNSSG ICB and Health Innovation West of England (HIWE), aimed to identify barriers and opportunities for innovation within BNSSG. The System Executive Group had endorsed the collaborative partnership in July 2023, operational delivery commenced in October 2023, and formal Board endorsement followed in November 2023.</p> <p>Key achievements reported included the establishment of a baseline analysis of senior leaders' attitudes towards innovation, the launch of the BNSSG Innovation Fellowship community, participation in the Health Foundation's Accelerating Innovation Systems programme, and increased awareness of innovation through showcases and communications. Thirty staff were academically accredited in innovation practice, and over 100 staff undertook innovation mindset training.</p> <p>The programme piloted a rapid adoption model for health innovation, collaborated with locality teams to assess current approaches, and embed innovation learning within the BNSSG Improvement, Innovation and Transformation Framework. Support was also provided for the early development of the Bristol NHS Group Innovation Strategy, and insights were gathered into procurement barriers.</p> <p>The evaluation noted several challenges, such as balancing innovation with operational delivery and difficulties in pulling innovation into localities focused on stability. The importance of co-production in rapid innovation adoption was emphasised, and it was recognised that culture change required significant time and sustained investment. The Innovation Fellowship was found to improve individual innovation mindsets, but its immediate impact on system-wide culture was limited. It was also acknowledged that in-year financial returns and cost-neutral adoption expectations were often unrealistic.</p> <p>External benchmarking from the Health Foundation Accelerating Innovation Systems programme reinforced key lessons, including focusing on high-</p>	

<p>impact priorities, scaling proven solutions, adopting a problem-first approach, forging strategic partnerships, engaging staff and communities early, and using data and commissioning as drivers for change.</p> <p>The NHS Strategic Commissioning Framework, published in October 2025, reaffirmed the essential role of ICBs in promoting and commissioning innovation, with expectations to scan for new developments, adapt services, and collaborate with Health Innovation Networks.</p> <p>The Board agreed to continue the HT Innovation Fellowship with HIWE’s support, to extend the offer to Gloucestershire and other partners, and to establish a new System Innovation Collaborative to accelerate the discovery, adoption, and spread of innovation. The Collaborative would build partnerships, share learnings, and embed innovation in strategic commissioning and service planning.</p> <p>SH presented the conclusion of the IHT programme and Health Innovation West England’s key findings from their interviews and analysis. The Board was asked to note these findings and consider recommendations for next steps, particularly regarding continued support for innovation during organisational changes and the evolving role of the Board as a strategic commissioner.</p> <p>SD, co-chair of the innovation programme, commented on initial disappointment at not achieving all ambitions within the year but acknowledged substantial progress and advocated extending collaborative efforts for a further couple of years. SD stressed the importance of system-wide innovation beyond individual organisations and recommended ongoing review and expansion of the collaborative approach to involve more partners.</p> <p>SW, chair of the Health Innovation Network (HIN), explained that HINs operated as a national network of 15, enabling successful innovations—such as atrial fibrillation detection and magnesium sulphate use in premature births—to be scaled nationally. SW highlighted the fellowship as a mechanism for supporting local innovation across provider organisations, industry, and academia. In closing, SW reflected on the need to focus on enablers of innovation across organisations rather than just barriers, suggesting that identifying and modelling successful examples could help sustain progress.</p> <p>MK emphasised the difficulties of navigating the fragmented landscape of research, development, improvement, and innovation, advocating for a coordinated local and regional approach to avoid duplication and maximise impact. MK supported efforts to unify various agencies under a single architecture and offered to help coordinate these efforts from the ICB perspective.</p> <p><b>Action: Coordinate baseline of what is out there and develop on it.</b></p> <p>The Board unanimously agreed to receive the evaluation report and support the proposed next steps, including maintaining the fellowship and establishing a collaborative approach going forward.</p>	<p style="text-align: right;"><b>SH/MK</b></p>
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	<p><b>The ICB Board:</b></p> <ul style="list-style-type: none"> <li>• <b>Received the IHT Evaluation Report.</b></li> <li>• <b>Supported the proposed next steps</b></li> </ul>	
7	<p><b>Outcomes, Performance and Quality Committee</b></p> <p>The committee meeting addressed several key points regarding quality, performance, and system challenges. Ellen Donovan (ED) had sent apologies but highlighted the critical importance of the winter plan and the scrutiny it received from the committee.</p> <p>The next meeting was scheduled for 11/10/2026, with the agenda expected to focus on quality outcomes and performance reports. RS noted a gap in paperwork, as the quality report and minutes had not been uploaded, and agreed to resolve this with Rob Hayday (RH). RS confirmed that the winter plan had been strongly scrutinised, passed through both the system quality group and HCP for validation and assured the board that there were no new quality or safety risks, although infection prevention control and MRSA remained areas of high focus.</p> <p>The prevent policy had been approved and endorsed by the committee but the uploaded version was not finalised so board approval was deferred until the correct version was available.</p> <p>Dave Jarrett (DJ) commented on the performance report, observing sustained strong results from RTT diagnostics, cancer and mental health standards. DJ flagged the national flu peak occurring earlier than usual and emphasised the ongoing need to promote the vaccination programme. DJ also raised concerns about being off-plan regarding reducing numbers of patients with no criteria to reside in acute and community settings, stressing that progress was contingent on partner support and senior leadership, particularly around reducing P3 length of stay.</p> <p>Jo Beer (JB) shared an initial assessment of the issue, noting that a third of such patients fell under Sirona's P1 and P2 categories, with P3s belonging to local authorities. JB suggested that better integration and collaboration among senior leaders could address many 'own goals' in the current system. JB reported that the community hospital's average length of stay was 31 days, aiming to reduce it to 28 days to manage demand, and planned point prevalence audits with medical leads and local authority colleagues to optimise patient pathways. JB also mentioned the lack of admission criteria, which led to inefficiencies and unnecessary long-term care placements.</p> <p>MK welcomed JB's fresh perspective and called for renewed efforts to standardise assessment models, risk thresholds, and resource use, believing that sufficient resources existed but were misallocated. MK described efforts to engage with national improvement programmes like 'Getting it Right First Time' (GIRFT) and noted ongoing collaboration to improve community sector outcomes.</p>	

	<p>Richard Smale (RS) referenced issues encountered by CICs and other non-traditional NHS partners, suggesting the need for better system integration and recognition.</p> <p>JB noted that addressing the no criteria to reside problem was not solely Sirona's issue but required more effective relationship-building and collaborative problem-solving across the system. JB emphasised the value of maintaining momentum and ensuring solutions were brought back to the board before becoming mired in data.</p> <p><b>The ICB Board received the update from the Outcomes, Quality and Performance Committee</b></p>	
8	<p><b>People Committee</b></p> <p>JCh provided an update</p> <p>The ICS People Committee convened last week, as referenced in the minutes already available for previous ICB and ICS meetings. Members reviewed workforce monitoring data and discussed ongoing issues affecting staff, including turnover and sickness absence rates. The total staff numbers remained above plan, with turnover at 10.7%, down 2% from the previous year. Sickness absence in October was 5.2%, unchanged from last year. The committee continued to monitor temporary staffing, which was 5.9% over plan, considering the impacts of industrial action and winter pressures.</p> <p>The strategic workforce team, commissioned by the committee, had held a round table with system partners to develop an integrated workforce development framework. This framework aimed to prepare both current and future workforce, emphasising readiness and adaptability under the 'one workforce' initiative. The importance of good employment practices and their effect on population health was highlighted. The committee planned to have a systemwide framework guiding workforce development by the end of the financial year.</p> <p>The committee received a report on violence and aggression towards staff, noting its emotive nature. It was revealed that over 20% of BNSSG NHS staff had experienced harassment, bullying or abuse from patients or the public, with disproportionate impact on staff racialised as black or brown and those with disabilities. All providers were implementing support activities such as trauma-informed care, deescalation training, risk assessments, visible leadership, anti-racism initiatives, and other evidence-based interventions. The committee committed to ongoing monitoring and planned a follow-up on staff survey results in February 2026.</p> <p>Committee members commented on the complexity of tracking repeat offenders and flagged the lack of a clear systemwide picture regarding identification and monitoring across different parts of the system. Uncertainties remained about how incidents were tracked, recorded, or prosecuted, and how patient confidentiality affected information sharing. It</p>	

<p>was noted that some offenders might not appear on an advanced DBS check, and framing meaningful questions that could lead to actionable insights was challenging.</p> <p>Members discussed the risk posed by violent patients, especially in situations where clinicians visited homes without adequate information. They identified a need for a formalised process for sharing information between providers to protect staff, suggesting a central repository for such data, which did not currently exist.</p> <p>RS noted conversations with Sue Monk (Deputy Chief Nursing Officer at Sirona), regarding paused work on challenging patients in the community and the 'red card' process, stressing the importance of boundaries for workforce protection and a coordinated approach, mindful of organisational capacity constraints.</p> <p>SD commented on the balance between data protection and the duty to share information for staff and patient safety, advocating for systemwide collaboration. SW echoed the sentiment, highlighting the risk aversion in some interpretations of data protection and the liability for employers sending staff into risky situations.</p> <p>JF, drawing on his policing background, was surprised that there was not already a national system for warning markers and emphasised the need for multi-agency involvement, including police, ambulance, and fire services. Dominic Hardisty (DH) suggested that security management specialists from different providers and the police could offer valuable insights, noting that more action might already be happening than discussed.</p> <p>The committee agreed on the urgency of developing a set of metrics to identify and flag repeat offenders, track actions taken, and ensure staff protection. There was discussion about the potential for such issues to appear on DBS checks, and the need for consequences for perpetrators.</p> <p>JM raised concerns about staff safety, particularly for district nurses, and suggested taking staff out of uniform in certain areas due to risks such as vandalism. JM emphasised the need for urgent action and clear communication to staff regarding ongoing work. RS advised learning lessons from other systems and involving staff associations for practical insights, cautioning against overcomplicating the process.</p> <p>The committee concluded on the need for a strategic, multi-agency escalation process, joint decision-making on care provision, and a systemwide approach to information sharing and workforce protection.</p> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>• Circulate the staff perspective paper to board members for review.</li> <li>• Draft and sign off an ICB board statement outlining expectations for information sharing and staff protection.</li> </ul>	<p><b>JCH/JH</b></p>
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	<b>The ICB Board received the update from the People Committee</b>	
9	<p><b>Finance, Estates and Digital Committee</b></p> <p>SW presented the finance, estates, and digital report, taking the papers as read. SW flagged key issues, noting that the Integrated Care Board (ICB) and provider organisations were required to break even. Current financial signals indicated the ICB was on track to do so, though risks remained, particularly a projected £10.3 million risk linked to strikes and transition impacts. Mitigation efforts were ongoing, and a deep dive from UHBW was planned for January to better understand the situation.</p> <p>SW highlighted the significant pressures faced in achieving break-even, stressing the importance of doing so to access good behaviour funding. SW mentioned ongoing work on forward plans, noting substantial pressures and active collaboration with the region, Gloucestershire, and BNSSG to align final plans. Both sides were working to achieve break-even positions to unlock additional funds post-April.</p> <p>On the IT side, SW reported positive progress in mitigating risks and successfully passing activity to acute providers. Regarding estates, there was little new activity to report.</p> <p>Matt Backler (MBa) added that achieving system break-even this year would grant access to £13 million in both revenue and capital next year. MBa acknowledged concerns regarding the financial gap, emphasising the effort required by all organisations, while remaining cautiously optimistic. MBa noted that a draft plan submission was due on 17/12/2025, projecting a £48 million deficit, with expectations to reduce this to zero in the final version. A 5% efficiency target had been set, and ongoing recovery plans were being factored in.</p> <p>The board reflected on broader challenges, with remarks highlighting that annual savings requirements were substantial, limiting flexibility to shift funding towards areas of greater need. The persistent struggle to maintain financial stability meant prioritisation was difficult, and unexpected costs, such as increased ADHD diagnosis expenses, added further strain.</p> <p>DH raised a question about the future regime, noting that post-financial year, providers would be held directly accountable by NHS England, increasing risks and potentially reducing transparency.</p> <p>MK expressed concerns about the achievability of ongoing 5% savings, suggesting that only substantial, multi-year initiatives could provide the needed flexibility. MK referenced the 10-year plan as recognising these issues but acknowledged the lack of a current mechanism to address them.</p> <p>Further discussion emphasised the importance of collective action over individual organisational accountability. Participants agreed that system-wide collaboration was essential for achieving significant transformation and financial sustainability, even without a shared control total.</p> <p>SM briefly commented on the NHS's strategic leadership role as described in the region's blueprint, suggesting there was an opportunity for improved</p>	

	<p>relationships and dialogue alongside ongoing performance management. RS expressed optimism about creating a space for such conversations.</p> <p><b>The ICB Board received the update from the Finance, Estates and Digital Committee</b></p>	
10	<p><b>Primary Care Committee</b></p> <p>AM provided an update.</p> <p>The committee maintained a risk-based approach, with the risk register reviewed up front. Three main issues were highlighted, but there was nothing requiring escalation to the board. The medium-term plan had already been discussed, with a focus on primary care in its broadest sense. Uncertainty remained regarding future contracts, but the committee was assured that the team’s work was progressing well, particularly regarding the first and final submissions scheduled for December and March respectively.</p> <p>A planning day had been held to consider performance against the four key objectives of the operating plan for primary care. The committee noted that GP appointments, dental activity, and the Pharmacy First initiative were all exceeding targets, while urgent dental activity remained under plan but showed signs of improvement. A deep dive into Pharmacy First revealed that the BNSSG was the national leader in performance, with pharmacies now able to manage seven additional conditions and 91% of surgeries referring patients. In quarter two, there had been an average of 11,200 referrals, with 1,900 coming from urgent care. 80% of referrals were resolved within Pharmacy First, relieving pressure on other parts of the system. Over 100,000 referrals had been made by GPs in the last 12 months, indicating many patients were being appropriately signposted.</p> <p>The committee also began to examine quality and safety in pharmacy, optometry, and dental services, which had recently been delegated. A community pharmacy assurance framework was in place and completed for the local area, but work continued to understand quality and safety improvements in optometry and dentistry. The primary care highlight report was noted as useful for board members.</p> <p>DJ observed that discussions with the Secretary of State and the BMA regarding the GP contract were ongoing, with national attention focused on online consultations. Locally, 99% of practices had implemented online consultations, reflecting significant effort. DJ also noted progress in improving and increasing access to dentistry, particularly in urgent care and UDA, after years of challenges.</p> <p>KPM contributed that, in the last quarter, there had been exactly 301 pieces of feedback regarding primary care and pharmacies, 129 of which were positive. A report released in June showed that 60% of respondents would recommend the Pharmacy First programme to others. The committee expressed interest in understanding the views of the remaining 40% and requested further feedback.</p>	

	<p>Questions were raised about whether Pharmacy First was placing additional pressure on pharmacies. It was clarified that the standard contract for community pharmacies, rather than Pharmacy First itself, was the main source of pressure. Pharmacy First was considered beneficial for pharmacies, providing extra income when certain activity thresholds were met. JL echoed this, noting that Pharmacy First brought extra income, with practices receiving additional payments for meeting monthly targets, and that practices welcomed the initiative. The impact appeared to be greatest at the general practice ‘front door’, although it also helped urgent and emergency care.</p> <p>The committee discussed the importance of supporting resilience in pharmacy, optometry, and dentistry, noting that while general practice had an established resilience programme, more work was needed in other areas. Neighbouring pharmacies had supported each other during recent challenges, but this had placed extra strain on them. The committee concluded that resilience remained a key challenge across care services.</p> <p><b>The ICB Board received the update from the Primary Care Committee</b></p>	
11	<p><b>Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee</b></p> <p>The Strategic Health Inequalities Prevention and Population Health Committee reported on its recent activities. The minutes from the meeting held on 7th October had been circulated, highlighting issues escalated to the board, such as cardiovascular disease in the African Caribbean community. The board had also received updates regarding healthy weight, smokefree BNSSG, and responses to alcohol and drug use, which were expected to be similarly affected. The committee had progressed well, focusing on three or four key areas since its inception, and this approach had been notably successful. Further developments were anticipated, with another meeting scheduled for Tuesday. At this stage, no additional updates were provided.</p> <p><b>The ICB Board received the update from the Strategic Health Inequalities, Prevention and Population Health Committee</b></p>	
12	<p><b>Audit and Risk Committee</b></p> <p>JCa provided an update.</p> <p>The minutes discussed were from the September 25 meeting, and the group was scheduled to meet again the following week. It was confirmed that the team had been managing the audit tracker effectively, which was appreciated, and all credit was given to colleagues involved. Maintaining this performance was highlighted as important for meeting annual internal audit recommendations within the required timescales, positioning the team well for a positive head of internal audit opinion, a standard consistently achieved in BNSSG.</p>	

	<p>The only internal audit report addressed funded care, providing reasonable assurance, and as the organisation transitioned to a greater commissioning focus, it was noted that the starting position was strong with many good practices in place for further development. The internal audit plan was reviewed at each meeting, remained flexible, and continued to offer good coverage, including capacity for transition work, which was set to be delivered by year end in partnership with the Gloucestershire ICB internal auditors.</p> <p>Some concerns about completion of Oliver McGowan training across the system were raised in relation to the corporate risk register, but these were addressed through the action tracker at the start of the meeting. Finally, the new ISFE2 finance system had been monitored through audit, and a recent report indicated that its go-live had proceeded well.</p> <p>No further comments or questions were raised for John and the audit risk committee.</p> <p><b>The ICB Board received the update from the Audit and Risk Committee</b></p>	
13	<p><b>South West Joint Specialised Services Committee</b></p> <p>Nothing to escalate to board.</p> <p><b>The ICB Board received the update from the South West Joint Specialised Services Committee</b></p>	
14	<p><b>Integrated Care Partnership</b></p> <p>JF provided an update. The last meeting was a seminar session on neighbourhoods and was a good, helpful, discussion. There was a keenness for HWBs chairs to come together as a collective.</p> <p><b>The ICB Board received the update from the Integrated Care Partnership</b></p>	
15	<p><b>Questions from Members of the Public</b></p> <p>In terms of public questions, AM noted that one written question had been submitted.</p> <p>The discussion began with Barbara Harris recounting her initial understanding on the progression of the Frenchay project, which subsequently did not materialise. Barbara explained that she had asked Sarah Truelove to keep her informed. DJ had sent Barbara a letter, indicating that the Frenchay project was stalled.</p> <p>Barbara reflected on her past involvement in public projects since 2004, noting that after 21 years, she was still pursuing improvements due to incomplete reconfiguration of services. Barbara described the situation as dire, with numerous building projects underway but only experiencing losses,</p>	

	<p>such as the amalgamation of Emerson’s Green GP surgery. She expressed frustration at what she felt were repeated halts to progress, citing five false starts and the hospital being handicapped by a PFI arrangement, which drained resources and required profits to be handed over to venture capitalists.</p> <p>Barbara highlighted that, through Grock AI, it had been established that 22% to 33% of beds at Southmead were occupied by bed blockers, who had nowhere to go. Barbara criticised the movement to place care in the community, stating that for many elderly people, especially those without relatives, this resulted in elderly individuals caring for one another. She described this as difficult and noted that deprivation among the elderly was often overlooked. She commented on the lack of neighbourly support, particularly from younger people preoccupied with their own responsibilities.</p> <p>Barbara called for action, suggesting that Wes Street and Sir Jim Mackey be invited to witness the particular challenges faced locally. Barbara referred to past development projects such as Emerson's Green, expressing disappointment that new arrivals received nothing, despite critical incidents occurring without improvements in provision. She insisted that practical steps were needed, highlighting the negative impact of the PFI and expressing a lack of confidence in MPs, who she felt did not engage with these issues.</p> <p><b>Action: SD would address Barbara’s comments on PFI, community care, and elderly deprivation, noting he held a different perspective.</b></p> <p>The conversation then turned briefly to staff safety, with Barbara asking about tracking staff locations and the provision of rape alarms, also noting that police had means of communication when in difficulty. Barbara remarked it would be ideal if staff were appreciated and treated well, recognising that this was not always possible given the circumstances of patients’ illness and desperation.</p> <p>Before concluding, JF thanked Barbara for her passionate contributions and acknowledged the validity of her points. JF explained that the board had to make difficult choices based on available evidence and financial constraints, promising ongoing communication and updates. JF mentioned that the board had made investments in South Gloucestershire that year but emphasised the limitations of their budget. JF expressed gratitude for Barbara’s continued involvement and suggested that inviting Jim Mackey and Wes Street could highlight positive developments, even if it might not be the complete solution.</p>	SD
16	<p><b>Any Other Business</b> There was none</p>	
	<p><b>Date of Next Meeting</b> ICB Board: 5<sup>th</sup> March 2026</p>	