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 Open Meeting

## Minutes of the meeting held on 1st May 2025 at 12.45pm held virtually via Microsoft Teams

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# DRAFT Minutes

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| **Present** | | |
| Jeff Farrar | Chair of BNSSG Integrated Care Board | JF |
| John Cappock | Non-Executive Member – Audit | JCa |
| Shane Devlin | Chief Executive Officer, BNSSG ICB | SD |
| Jaya Chakrabarti | Non-Executive Member – People | JCh |
| Ellen Donovan | Non-Executive Member – Quality and Performance | ED |
| Dominic Hardisty | Chief Executive Officer, Avon and Wiltshire Mental Health Partnership NHS Trust | DH |
| Maria Kane | Joint Chief Executive Officer, NHS North Bristol Trust and University Hospitals Bristol and Weston NHS Foundation Trust | MK |
| Dr Jacob Lee | Chair of the GP Collaborative Board | JL |
| Joanne Medhurst | Chief Medical Officer, BNSSG ICB | JMe |
| Alison Moon | Non-Executive Member – Primary Care | AM |
| Dave Perry | Chief Executive Officer, South Gloucestershire Council | DP |
| Julie Sharma | Interim Chief Executive Officer, Sirona care & health | JS |
| Sarah Truelove | Chief Financial Officer and Deputy Chief Executive, BNSSG ICB | ST |
| Jo Walker | Chief Executive Officer, North Somerset Council | JW |
| Steven West | Non-Executive Member – Finance, Estates and Digital | SW |
| **Apologies** | | |
| Mark Cooke | Managing Director, NHSE South West | MC |
| Deborah El Sayed | Director of Transformation and Chief Digital Information Officer, BNSSG ICB | DES |
| Rob Hayday | Chief of Staff, BNSSG ICB | RHa |
| Nick Hibberd | Chief Executive Officer, Bristol City Council | NH |
| John Martin | Chief Executive Officer, South Western Ambulance Service NHS Foundation Trust | JMa |
| Rosi Shepherd | Chief Nursing Officer, BNSSG ICB | RS |
| **In attendance** | | |
| Jen Bond | Deputy Director of Communications and Engagement, BNSSG ICB | JB |
| Kerrie Darvill | Intelligence Centre Programme Director, BNSSG ICB | KD |

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| Eva Dietrich | Consultant Psychiatrist, Clinical Director, Avon and Wiltshire Mental Health Partnership NHS Trust | EDi |
| Aishah Farooq | Associate Non-Executive Member | AF |
| Layla Green | Patient Safety Lead – Maternity and Neonatology, BNSSG ICB | LG |
| Jo Hicks | Chief People Officer, BNSSG ICB | JH |
| Ruth Hughes | Chief Executive Officer, One Care | RH |
| David Jarrett | Chief Delivery Officer, BNSSG ICB | DJ |
| Fiona Mackintosh | VCSE Alliance Representative | FM |
| Kevin Peltonen-Messenger | Chief Executive, The Care Forum | KPM |
| Lucy Powell | Corporate Support Officer, BNSSG ICB *minute taker* | LP |
| Richard Smale | Interim Director of System Coordination, NHS England South West | RSm |
| Neil Turney | Head of Mental Health & Learning Disability & Autism, BNSSG ICB | NT |

| | Item | Action |
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| 1 | **Apologies**<br>Jeff Farrar (JF) welcomed all to the meeting. The above apologies were noted. | |
| 2 | **Declarations of Interest**<br>No new interests were declared and there were no interests pertinent to the agenda. | |
| 3 | **Minutes of the 6th March 2025 ICB Board Meeting**<br>The minutes of the 6 March 2025 meeting were agreed as correct. | |
| 4 | **Actions arising from previous meetings and matters arising**<br>The ICB Board reviewed the action log:<br>**Action 91** – Jo Hicks (JH) confirmed that cultural auditing had been discussed at the System EDI (Equality, Diversity and Inclusion) Leads Group. The action was closed.<br>**Action 95** – It was noted that there was a significant amount of work across the system relating to Digital Transformation. Deborah El-Sayed would provide an update at the next meeting.<br>All other due actions were closed. | |
| 5 | **Chief Executive Officer's Report**<br>Shane Devlin (SD) outlined the three items from the report:<br>• Preparing for Reform<br>• Voluntary, Community and Social Enterprise (VCSE) Alliance Update<br>• System Plan 2025/26<br><br>**Preparing for Reform**<br>SD explained that at the beginning of April 2025, all Trust and ICB Chief Executives and Chairs received a letter; working together in 2025/26 to lay the | |

foundation for reform. The letter set out several key priorities and objectives for the coming financial year including elements of financial planning with the emphasis on transparency for the public.

The letter indicated that the existing role, functions, responsibilities and structures of ICBs needed to change with the future focus of ICBs being Strategic Commissioning. SD explained that South West ICB Chief Executives had worked with regional teams to map the future model of ICBs which included strategic commissioning, population health management, driving planning and monitoring outcomes. This work needed to be undertaken with a much reduced cost envelope with all ICBs required to deliver new organisations at a unit cost of £18.76 per head of population. BNSSG ICB currently operated on £33.00 per head of population. There was significant work nationally, regionally and across local systems to implement these changes.

**VCSE Alliance Update**

SD highlighted the significant and positive work of the system and VCSE partners which included the VCSE Alliance, Ambassadors, the brokerage scheme and developed strategy. 175 organisations had joined the framework. SD noted the importance that the ICB recognised the successful work and that this work was carried into the future model.

**System Plan 2025/26**

The system plan had been developed collectively across the system and was a compliant, breakeven plan for 2025/26. The plan was embedded in evidence using activity and was projected to achieve. The plan would not be easy to deliver. SD thanked Sarah Truelove (ST) and her team for the work in coordinating the system to develop the plan.

JF thanked SD for the update and noted that the new ICB model would be focused on strategic commissioning and health strategy. JF added that achieving the cost reduction would not be easy and the ICB was working through this.

Ellen Donovan (ED) noted that that system plan indicated a Trust workforce reduction of 2%. ED asked what the impact of this, and the 50% corporate cost reduction, would be on frontline staff. SD explained that these reductions had been included in the plan and put the system back to the workforce levels of three years ago. ST explained that the situation was complex due to system changes such as elective centres opening, and savings and efficiency requirements. Significant work had been undertaken to improve productivity for elective and outpatient pathways to deliver the performance metrics within the

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| | resource envelope. The reduction in corporate cost growth was announced after the operational plan was completed and work was ongoing to incorporate this.<br><br>Alison Moon (AM) welcomed the VCSE Alliance update and highlighted that this was an area that the ICB should be proud of. Page 8 of the operational plan outlined the savings target of 5.8% which was higher than last year and asked whether there had been consideration from national teams of the difficulty in achieving these targets whilst the ICB was undergoing reorganisation. SD explained that the system had a clear understanding of where those savings could be made and the Performance and Recovery Board would work with partners to ensure savings could be achieved. Robust processes were in place and each organisation was committed to making the savings.<br><br>Dominic Hardisty (DH) noted the extremely positive VCSE Alliance work and explained that during a recent workshop with providers and VCSE organisations, the energy had been fantastic. DH noted that the opportunity to transform services with support from VCSE organisations was significant.<br><br>Fiona Mackintosh (FM) welcomed the direction of travel for the VCSE Alliance and noted that true integration was when there was no perceivable difference between statutory and VCSE organisations. The VCSE Alliance was reviewing how much more they could do to support integration, improve health and wellbeing work and support the reductions in costs.<br><br>Steve West (SW) noted that the primary focus of ICBs was reducing health inequalities and the work with the VCSE Alliance was making a difference and this work needed to be celebrated and continued going forward. SD agreed, the ICB needed to build on all the areas of excellent work.<br><br>**The ICB Board received the update from the Chief Executive** | |
| 6.1 | **Maternity Update**<br>Layla Green (LG) was welcomed to the meeting. LG started by saying that the system should be proud of the perinatal services within BNSSG. The system was a high performing maternity system with a Good CQC rating. LG noted that 75% of systems nationally were rated as Requires Improvement or Inadequate. There was a lot of work ongoing in the BNSSG system to reduce health inequalities and this was the thread which ran through all the current workstreams.<br><br>The Maternity and Neonatal Voice Partnership (MNVP) structure replicated national guidance and the focus of 2024/25 had been developing the partnership in collaboration with acute maternity trusts and Healthwatch, via the Care Forum | |

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| | who host the MNVP. The MNVP was diverse and reflected the local population. There were four leads who worked with maternity providers with one lead focused on community engagement. Another lead engaged with parents on neonatal units and there was a strategic lead hosted by the ICB. The team were currently developing a strategic ambition framework focused on improving equity and reducing inequalities.<br><br>LG explained that 2025/26 was the third and final year of the Three Year Development Plan. Appendix 1 outlined the 29 objectives for ICBs and Local Maternity and Neonatal Systems (LMNS). A review of the progress of the objectives had been undertaken. The LMNS was ensuring that the green actions were embedded and sustainable. 13 objectives remained amber and red, and these were the key priorities for the year. There was a plan behind each objective and the LMNS met monthly to maintain the trajectory for these. It was expected these would all be complete by the end of year three.<br><br>LG noted that both Trusts achieved all ten safety actions associated with the Maternity Incentive Scheme for a second year. Year 7 of the scheme had been published and work has begun to ensure compliance continues. It was expected that the Trusts would achieve the actions again.<br><br>Saving Babies Lives (SBLs) outlined 69 interventions aligned to improving outcomes. Both Trusts achieved a higher compliance than last year with the system working to 100% compliance next year. One area of focus for the LMNS was reducing smoking rates and BNSSG had a fully recruited maternity team specifically for treating tobacco dependency. The system was considering taking part in the national smokefree pregnancy incentive scheme which was a financial incentive for women smoking during pregnancy.<br><br>The Equity and Equality action plan was set out in appendix 2 and the highlight report outlined all the work taking place and it was expected that a more accessible version of the work would be shared with the public. LG noted that one of the priorities was being able to review the data and see which outcomes needed to be improved and there was work ongoing with the Business Intelligence teams in the ICB and Trusts to develop a maternity dashboard. LG noted that the priority within the action plan was accessible care for all. The ICB was working with Black Mothers Matter to develop a new curriculum for antenatal education. Initial feedback of the programme from healthcare professionals and women who attended was very positive. LG showed that this was an area where working with VCSE partners made a difference to service users. There was also an EDI lead within University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) who attended early pregnancy clinic for | |

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| | refugee women to ensure that women were supported as early as possible and North Bristol Trust (NBT) created an obstetric satellite clinic in Patchway which supported women without them having to travel to the main prison. A community model has been developed for Eastwood Park Prison.<br><br>JF agreed that reviewing the data was important to understand the disparity in communities and noted the dashboard as really positive work.<br><br>Jaya Chakrabarti (JCh) asked whether there were plans to track if these women stayed smoke free after pregnancy and noted that there were VCSE organisations and technology partners in the community who could help with this work. LG explained that the system would look for support with the interventions for women and the incentive scheme would be considered as a system.<br><br>John Cappock (JCa) welcomed the reflective nature of the work and wondered whether it would be beneficial to utilise internal audit to provide triangulation and independent scrutiny. LG agreed and explained that the LMNS had discussed Internal Audit review as NBT and UHBW moved forwards as a hospital group to get independent scrutiny.<br><br>AM noted that maternity services were a high risk clinical service and it was reassuring that the services were as safe as they could be. AM supported the no complacency element but asked how the current focus and momentum continued with the changes to the ICB organisations. LG explained that the LMNS was a monthly system meeting involving health visitors, local authorities and primary care and discussions about continuing to work as a system would happen at this meeting.<br><br>ED highlighted that the action plan showed strong performance across a number of areas but noted the improvement needed in culture. LG explained that this was an area which was hard to measure but the teams were looking at working well together, and strengthening teams so that they were able to escalate concerns using a robust set of tools. There was more work to do in this area.<br><br>Julie Sharma (JS) welcomed the work and noted the join up between services including bringing health visitors into maternity services earlier which supported ensuring that women remained smokefree. JS confirmed that a significant number of health visitors had also received the Black Mothers Matter training and so there was connection between those services to carry on the work. LG agreed and explained that maternity system had achieved so much it would be detrimental if the focus shifted elsewhere. There was a commitment from all involved to maintain the focus and scrutiny to improve services. | |

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| | **The ICB Board received the update, noted the report including any risks, mitigating actions and responsibilities as appropriate** | |
| 6.2 | **Systemwide Data Sharing Agreements**<br>Kerrie Darvill (KD) was welcomed to the meeting. KD explained that the Information Sharing Charter was moving from a project based way of sharing information between partner organisations to purpose based. KD highlighted the benefits expected from this change which included simplification of process and new joint ways of working. There was a newly established Information Governance Committee whose membership included Information Governance leads from across the system. The rationale for change and data sharing processes have been developed as a system and the Information Sharing Charter was ready for approval from the ICB Board. The framework would continue to be adapted to manage any new activity which needed to be reviewed as part of the charter. The system Senior Information Risk Owners (SIROs) had approved the Information Sharing Charter, although written approval was awaited from three organisations. The GP Collaborative Board (GPCB) were supportive of the changes and an assurance statement had been written by the BNSSG ICB Data Protection Officer. Emails would be sent to system Chief Executives to confirm support and wider stakeholder communications would be sent via usual routes. Following approval, the first of the Data Protection Impact Assessments (DPIAs) would be developed.<br><br>JF confirmed that there had been a discussion at the Finance, Estates and Digital (FED) Committee regarding whether the work should pause in light of the system changes however there had been support to continue.<br><br>JCh noted the future focus on strategic commissioning and asked whether data sharing was ready to be built into the procurement of services to ensure partners were contractually obliged to share data. KD noted that there would be a DPIA designed for this as part of the ongoing work.<br><br>SD explained that the ICB role of strategic commissioner would require the ICB to understand the population and design services in partnership with others. Having good information was fundamental to this and a key enabler to ensure success as an ICB in the future. SD highlighted that the work to get into this position had been culturally difficult and the team had managed this well.<br><br>ED highlighted that issues around data sharing were raised at every Outcomes, Quality and Performance (OQP) meeting and asked when would organisations be able to share data. KD explained that it was planned as a step process as DPIAs were developed but those involved with new initiatives would notice the difference as the information sharing would be quicker as system partners have | |

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| | agreed to share information as a principle. ED asked about those current processes which would benefit from data sharing now. KD noted that if those current processes fit under the purposes of the Information Sharing Charter, then data could be shared as per the Charter. Work continued to ensure that current processes aligned with the developed principles of the Charter.<br><br>SW highlighted the significant work which had gone into the Charter and the level of sign up was extremely positive. The FED Committee had discussed making the culture shifts simpler to support buy in. The FED Committee also noted that there were organisations wider than the Integrated Care System (ICS), such as universities who could provide opportunities in terms of public health and mental health and wellbeing.<br><br>Dr Jacob Lee (JL) thanked the team for their hard work and noted that having the framework and assurance was reassuring for primary care. JL thanked the team for their significant work in engaging with membership forums and practices and offered GPCB support if practices had additional questions.<br><br>**The ICB Board approved the BNSSG Information Sharing Charter and progress to date** | |
| 6.3 | **Intensive and Assertive Community Mental Health Services Review**<br>Neil Turney (NT) and Eva Dietrich (EDi) were welcomed to the meeting. David Jarrett (DJ) explained that the ICB had been mandated by NHS England to continue to provide progress on the Intensive and Assertive Community Mental Health Services Review at public Board. The review had been completed in September 2024 and progress reported to the previous ICB Board in January 2025 where it was noted that there was a discrepancy between Did Not Attend (DNA) policy and practice. In addition to the review, ICBs have been asked to consider the national guidance, the Independent Mental Health Homicide report and it was expected that the actions from this report would be incorporated into the improvement plan by the end of June 2025.<br><br>NT confirmed that a deep dive into DNA policy and practice had taken place to identify the improvements required. The audit identified a number of cases within a three month period where reason for discharge was noted as DNA. Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) reviewed the cases for those patients who matched the assertive outreach profile and found that for those patients a multi-disciplinary team (MDT) approach to discharge was taken and rapid access plans were put in place so what should have happened did. The audit found that in a small number of cases, higher vulnerability was identified which could lead to an increased risk of relapse. NT explained that the audit did not identify any patients which should not have been discharged but | |

improvements to reduce risk were identified. Although risk could never be completely eliminated, two risks were identified and mitigations developed.

NT explained that the first risk was around the improvements to be made to the current DNA policy and approach to discharge. A new discharge checklist for clinical staff would be developed and added to the electronic patient record and an MDT approach would continue to be adopted for all patients under this particular cohort. A new non engagement policy had been created to reflect the new processes. Another audit using the same methodology would be undertaken in three months.

The second risk related to identifying patients who were part of this cohort. Work was underway to progress this with a data led initiative which would develop a set of patient parameters which would flag patients who need additional support. Colleagues at AWP had discussed with Nottinghamshire the measures they had put in place, and these parameters were expected at the end of quarter 2 2025/26.

These risks and mitigations would be monitored through the appropriate oversight groups. Progress on the actions required a whole system approach between AWP, VCSE providers, primary care and community care and the improvement plan had been developed through coproduction. Once the national learning had been incorporated into the improvement plan, it was planned to undertake wider engagement with stakeholders to include families, carers and general practice.

DJ explained that at the last ICB Board meeting it was agreed that the oversight of the programme would be through the OQP Committee. The timings of the Committee meant that this had not yet happened but following a meeting with ED this would be the assurance Committee for the improvement programme moving forward. ED thanked DJ, NT and the team for all their hard work and noted that feedback from the recent meeting had been considered and areas highlighted looked into.

SW noted that previously independent mental health homicide reviews were undertaken at a regional level to ensure that learning was shared across the region and asked where these reviews were now undertaken. NT confirmed that learning from national serious incidents and reviews had been included on the action plan as this needed to be improved. In a first step to strengthen the process, ICB quality colleagues were sharing these incidents with the Service Delivery Unit and escalated into the Operational Delivery Group.

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| | Kevin Peltonen-Messenger (KPM) welcomed the comprehensive report and understood that these were some of the most vulnerable patients and asked whether late attendance was considered DNA and therefore the patient discharged. EDi explained that some patients had the capacity to choose to engage and others needed a more personalised approach to access services and therefore patients would not be discharged for a late attendance or one DNA and the audit reflected this. Before decisions about discharge were made, the team would discuss the situation with other agencies who were involved with the individual and their family. Creating a flag system for those most vulnerable patients meant that a DNA would prompt a phone call to them, their families or GP to encourage engagement appropriately.<br><br>JL supported the flagging of these individuals and formalising the informal knowledge of patients held by individual organisations such as levels of engagement. JL noted the importance that patients within this cohort were not moved to the back of a waiting list due to non attendance and suggested that there was a quick route back into provider services. EDi agreed and explained that there needed to be a rapid access plan for those patients in the assertive outreach category who have been discharged from a service as there was no other choice. That individual should not have to go through the referral process again.<br><br>JCh noted that the local data sharing plans were closely tied to this work and aggregating data would support organisations to react properly to this patient cohort. JCh asked whether the work on EDI was linked with the VCSE Alliance to reach into local communities. NT confirmed that this would likely be the case as the VCSE organisations was involved in the review and provided some of the associated services. NT agreed to discuss the links with the system data sharing agreement with DJ. EDi explained that the provider organisations, including VCSE providers, were part of the oversight group for BNSSG and so there was collaborative work in this space but there was more to do to ensure VCSE organisations had access to specialist input. The goal was to use existing resources collaboratively and learn from each other.<br><br>**The ICB Board reviewed the progress to date, the progress against areas requiring immediate attention, the next steps required by NHS England and discussed and supported the recommendations set out in the paper** | |
| 7 | **Outcomes, Quality and Performance Committee**<br>ED explained that the March OQP Committee had received reports on significant areas including, research strategy, heart failure pathway, healthcare associated infections and safeguarding. | |

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| | The OQP Committee had also received important updates on the stroke pathway and No Criteria To Reside (NCTR) and patient flow. The Committee had recognised that despite significant work in the area of flow, there remained challenges. The system target was 15% with the current position at 20%. Work was ongoing to fully understand the root causes of some of the issues. The Committee received an update on the challenges facing the stroke pathway which aligned with those for NCTR and work continued to address these issues. The level of discharge through the stroke pathway was lower than expected and the levels of NCTR patients was higher than expected.<br><br>The team were starting to understand the flow issues and two weaknesses had been identified. The length of stay within P2 and P3 beds was too long when compared to the national picture, a series of initiatives had been put in place to address this. There was work ongoing to introduce a new pathway 0+ which would be a step down from P1 which was hoped would improve flow. The OQP Committee was committed to robust evaluation of the schemes. ED noted that there was a lot of good work continuing and it was important this wasn't lost in the changes.<br><br>DJ highlighted that the stroke pathway update had been valuable and the ICB had embedded the programme within business as usual urgent care governance. DJ noted that the patient flow work was a multi system effort and a group of senior leads from across the system including local authorities, were working to get to a level of understanding and granularity the system has not had before. DJ explained that alongside discharge to assess the system was looking at those patients not discharged and those who should be treated in the community without entering hospital. DJ noted that one month into the new year, there were no areas of escalation to report.<br><br>**The ICB Board received the update from the Outcomes, Quality and Performance Committee** | |
| 8 | **People Committee**<br>JCh confirmed that the workforce elements of the 2025/26 Operational Plan had been submitted. The People Committee had received the specific workforce details and targets. The focus remained on meeting the rate card for medical temporary staffing and monitoring staffing numbers in line with the efficiency plan. The Committee received the 2024/25 annual report and evaluation of the GP Training Hub which showed significant success in expansion of training places and a high level of satisfaction with the training development offer to non-clinical primary care staff. Strategic workforce oversight continued to focus on one workforce activity, specifically workforce agility and the ability to work across organisational boundaries. The Committee was leading on the establishment of | |

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| | processes to support organisational change. JH noted that the People Programme Board has been supportive and was fully committed to carrying on the system work whilst the ICB People team focused on supporting ICB staff through the organisational changes.<br><br>**The ICB Board received the update from the People Committee** | |
| 9 | **Finance, Estates and Digital Committee**<br>ST confirmed that the month 12 finance report confirmed the break even year end position for the ICB and across the system. The FED Committee had recognised the challenges for 2025/26 and at its last meeting received a presentation from UHBW. The Committee received assurance from UHBW on delivery of the operational plan and the Board arrangements in place to oversee this.<br><br>ST confirmed that the accounts had been prepared and submitted to the auditors for their review. The Audit and Risk Committee would receive the auditor outcomes.<br><br>JF noted that the position the system achieved was very positive and the presentation at the FED Committee demonstrated how well the system was working in partnership. ST noted that most of the systems who achieved the break even position received national Deficit Support Funding and BNSSG was one of 10 systems which did not receive the funding and still achieved a break even position.<br><br>**The ICB Board received the update from the Finance, Estates and Digital Committee** | |
| 10 | **Primary Care Committee**<br>AM noted the Primary Care Committee (PCC) had received an excellent presentation on Pharmacy First from the Chief Executive of the Local Pharmaceutical Committee. This was a national programme with a recent third element added clinical pathway consultations where pharmacies take referrals from individuals or GP practices and treat patients. BNSSG ICB was the highest performing ICB in the country. In March 2025, 12,000 patients used the service and 75% of those did not go on elsewhere for treatment. Pharmacies expressed ambition to do more to support the system and it was noted that this would be a useful Seminar session.<br><br>AM reported that the Primary Care Operational Group (PCOG) supported a local enhanced service for teledermatology. Jo Medhurst (JM) outlined that the service was for rapid access to skin cancer diagnosis. JM noted that the service was a good example of system working to ensure that new technologies were | |

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| | utilised to improve services for patients. Healthcare assistants were able to take pictures of skin queries to send to clinicians and around 60 – 70% of these are closed through clinical review which allowed clinical dermatologists to focus on diagnosed skin cancers. JF noted the system working and asked the ICB Board to consider how this system coordination role was replicated in the future.<br><br>AM reported that the PCC had received an update on the new GP Contract. Investment into Primary Care, focus on advice and guidance and improved connectivity between primary and secondary care was noted as elements of the contract. A new patient charter would be developed which would set out the standards that patients should expect from GP Practices. The Local Medical Committee view was that there needed to be more and national negotiations continued. The PCC had also received details of the new Pharmacy contract which DJ confirmed had negated the risk of collective action. The PCC had also received an update on the national programme to increase primary dental care under an urgent setting. The Committee received good assurance on the systems and processes in place to provide 19,000 extra urgent dental appointments for the 1st June 2025.<br><br>JCh asked when the ICB would focus on optometry. DJ confirmed that the ICB recognised that this was the last service to review in depth and this would be undertaken in alignment with the future changes. The work plan outlines engagement in opportunities in community ophthalmology and the ICB has a good relationship with the Local Optical Committee. RHu noted the huge appetite from the Local Optometry Committee in terms of the community urgent eye pathway.<br><br>**The ICB Board received the update from the Primary Care Committee** | |
| 11 | **Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee**<br>JF noted the enthusiasm within the SHIPPH Committee. There had been two substantive items at the last meeting, the impact of the changes to the ICB and the 2040 Healthier Together Strategy which Gemma Self presented. The Committee were reminded that strategic commissioning and reducing health inequality were critical elements outlined in the new ICB functions and this gave more relevance to the 2040 strategy. JM highlighted that the SHIPPH Committee was more diverse than the other Committees, with half of the members non-public sector who provided insightful check and challenge. JF noted that the Committee members had highlighted the health centric focus of Healthier Together 2040 and opened up the discussion to different perspectives and lens. ST welcomed this approach noting that making the necessary shifts required | |

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| | being open to feedback and adapting existing and longstanding processes. All of the feedback from the Committee would be considered in the next steps.<br><br>FM noted the close working relationship between Gemma Self and the VCSE Alliance and the value of the SHIPPH and the work which happened at the Committee. The VCSE members of the Committee were equal members and in the space every voice counted. FM noted the importance of such spaces particularly as the focus in the future would be population health.<br><br>Dave Perry (DP) noted that Healthier Together 2040 was the most important strategic work the system was undertaking and was designed to test the process using small cohorts of the population and learn from this. DP noted that challenge was an important part of this to build into the learning and into future service design.<br><br>**The ICB Board received the update from the Strategic Health Inequalities, Prevention and Population Health Committee** | |
| 12 | **Audit and Risk Committee**<br>JCa confirmed the Audit and Risk Committee had received positive internal audit reports and Head of Internal Audit Opinion. The ICB has continued with the processes instigated by Nic Saunders last year and there has been good ICB engagement with the internal auditors. JCa thanked the Executive Team for their work.<br><br>The ICB had reprocured the contracts for both internal audit and external audit services. RSM had been awarded the internal audit contract with KPMG awarded the external audit contract. Both contracts were effective from this year.<br><br>The risk management framework had been reviewed by the Committee in March and April. The Committee requested that the scrutiny of risk at Committees and alignment with agenda setting was considered as part of the Framework. This has been resolved and the ICB Board was asked to approve the risk management framework.<br><br>**The ICB Board approved the Risk Management Framework**<br><br>JCa reported that the Audit and Risk Committee had also reviewed the refreshed Counter Fraud Policy and Security Policy. The Board was asked to approve these policies.<br><br>**The ICB Board approved the Counter Fraud Policy and Security Policy** | |

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| | **The ICB Board received the update from the Audit & Risk Committee** | |
| 13 | **South West Joint Specialised Services Committee**<br>No meetings held yet. | |
| 14 | **BNSSG Integrated Care Partnership Updates**<br>JF explained that the Integrated Care Partnership (ICP) Board had been updated on the proposed changes to the ICB functions. JF highlighted that the ICP Board was made up of different system partners and the discussions were less operationally focused. The ICP Board discussed the Healthier Together 2040 Strategy and All Age Mental Health Strategy. The ICP Board was having strategic discussions around the opportunities to work collectively for localities. The ICP Board received updates from the Health and Wellbeing Boards, Locality Partnerships and from the ICB. The feedback from the ICP Board was positive and the ICP Board noted the importance that the work of the ICB was not lost during the changes.<br><br>JM added that the strategic lens of the ICP Board needed to be considered by ICB staff when presenting items to ensure that the focus was right for the ICP Board. JM noted that the ICP Board may be the fixed point for organisational memory during the changes but noted that permanency needed to be considered. JF noted that the NHS reform may result in different ICB footprints and therefore the ICP Board may also change, so it was important to link with Health and Wellbeing Boards. This consideration was added as an action.<br><br>JL noted the huge amount of work taking place outside the formal health governance structure and asked how the ICB Board could be sighted on this. JL noted that demonstration of this good work would give the ICB Board more confidence to invest time and resources into the community.<br><br>FM noted that the ICP Board could be more strategic and asked how the system remained grounded in local communities. FM explained that VCSE Alliance representatives were involved with locality programme Boards but asked how these linked to the ICB and ICP Boards and Health and Wellbeing Boards. JF noted that these were the considerations that needed to be taken into the wider discussions about NHS Reform. There would be unintended consequences for the wider system following the changes to ICBs. SD explained that the answer was to develop a healthy neighbourhood plan incorporating neighbourhood health and wellbeing services. The ICB would develop plans for this approach and these would outline the connections between the ICB, ICP and the local populations.<br><br>**The ICB Board received the update from the Integrated Care Partnership** | **JM** |
| 15 | **Questions from Members of the Public** | |

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| | A question had been received from a member of the public:<br><br>“According to the Healthier Together's news update in March and April both of which emphasised the need for the ICB to make 50% cuts "in running costs" and the intention to review existing programmes, I am asking how does the board think this can be achieved without jeopardising the delivery of services and its overall health strategy?”<br><br>JF noted that the changes had been covered in the Chief Executives report item but asked SD to comment further. SD confirmed that the new model of ICBs was focused on strategic commissioning and health strategy. This would be balanced with the cost reduction which would not be easy. The South West region was working through how the ICBs could undertake those functions within the allotted cost envelope.<br><br>A member of the public noted:<br><br>“I sat through the whole meeting and as I have been an observer now of the CCG and ICB for a number of years, I have a reasonable understanding of the functions of the members of the Board. But this would not be the case for the majority of viewers of the recording of the meeting.<br><br>On the video of the meeting the space available after the speakers name is very limited and in virtually all cases filled with " Bristol North Somerset and South Gloucestershire" infact the longest insertion only gets to the second "E" in Somerset, South Gloucestershire is not mentioned at all. I would suggest that someone alters the text after the members name, to indicate their job title and if there is enough space add BNSSG, so that the public have some idea as to where their money is going.”<br><br>JF provided a written response following the meeting: “I have asked our communications team to look into how we might address this. Some options might be that I ask people to introduce themselves at the start or ask them to introduce themselves as they enter the discussion. It might be challenging to amend on screen names as these are set in Microsoft teams by each organisation, but I’ll wait to see what communication team advise.” | |
| 16 | **Any Other Business**<br>There was none. | |
| | **Date of Next Meeting**<br>Thursday 3rd July 2025, virtual meeting on MS Teams | |

**Lucy Powell, Corporate Support Officer, May 2025**