

Strategic Health Inequalities, Prevention & Population Health Commissioning Committee

**APPROVED Minutes of the meeting held on Thursday 18th June 2026,
09.00-12.00, held via MS Teams**

Minutes

Present		
Prof Dame Jane Cummings	Committee Chair & Joint Non-Executive Director, Cluster ICB	JC
Ayesha Janjua	Joint Non-Executive Director, Cluster ICB	AJ
Alison Moon	Joint Non-Executive Director, Cluster ICB	AM
Dr Ananthakrishnan Raghuram	Chief Clinical Leadership & Delivery Officer (Medical), Cluster ICB	AR
David Jarrett	Chief Strategic Commissioning Officer, Cluster ICB	DJ
Dr Jeff Farrar	Cluster Chair, & Joint Non-Executive Director, Cluster ICB	JF
Jo Hicks	Chief Transformation, People & Organisational Development Officer, Cluster ICB	JH
Dr Jo Medhurst	Chief Population health Improvement Officer, Cluster ICB	JM
Rosi Shepherd	Chief Clinical Leadership & Delivery Officer (Nursing), Cluster ICB	RS
Siobhan Farmer	Director of Public Health, Gloucestershire County Council	SF
Apologies		
Cath Leech	Chief Finance & Corporate Services Officer	CL
Shane Devlin	Chief Executive, Cluster ICB	SD
In attendance		
Amanda Threlfal;	Public Contributor	AT
Adwoa Webber	Head of Quality & Clinical Excellence, BNSSG	AW
Julie Northcott	Deputy Director of Public Health, Bristol City Council	JN
Lucy Heard	Public Contributor	LH
Ryan Brunsdon	Corporate Governance Manager	RB
Sarah Weld	Director of Public Health, South Gloucestershire	SW
Mel Lyddon (Item 5)	Planning Manager	ML

	Item	Action
1	<u>Welcome & Apologies</u>	
1.1	JC opened the inaugural meeting of the Joint Cluster Strategic Health Inequalities, Prevention, Population Health & Commissioning (SHIPPHC) Committee and welcomed members to the meeting.	
1.2	JC confirmed that she had been asked to chair the Committee on behalf of the two ICBs and noted that this was the first meeting of the newly established Committee, bringing together	

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	colleagues from both Gloucestershire and BNSSG. The Committee's purpose to focus on strategic health inequalities, prevention, population health and commissioning was highlighted.	
1.3	Attendees were invited to introduce themselves to support the establishment of the new Committee and its membership. Key attendees included executive, non-executive, public health, clinical and public contributor representatives.	
1.4	It was noted that some members joined late or had to leave early due to clashes with other meetings. Future meeting had been mapped to prevent clashes.	
2	<u>Declarations of Interest</u>	
2.1	The Chair invited members to declare any conflicts of interest in relation to the items on the agenda. No additional declarations of interest were made. The Committee noted the register of interests previously circulated.	
3	<u>In Principle Terms of Reference</u>	
3.1	<u>Terms of Reference</u>	
3.1.1	The Committee received the draft Terms of Reference (ToR), noting that these had been approved in principle by the Joint Cluster Board, but required further development following engagement with Committee members and partners. JM provided background on the development of the ToR, explaining that the Committee had been established to address a lack of systematic oversight of health inequalities and to ensure that data, insight and commissioning decisions are aligned to reduce variation and improve outcomes. JC highlighted that the ToR remained a working document, and members were encouraged to provide feedback to support further refinement prior to resubmission to the Board for formal approval.	
3.1.2	SW queried how the Committee interfaced with other governance structures and requested clarity on its relationship with other committees to support informed feedback on the ToR. JF confirmed that the Committee formed part of a three-committee structure and was intended to focus on strategic health inequalities, prevention and population health, with other committees covering performance, finance and workforce. JM outlined that the Committee sat within the strategic commissioning cycle, specifically: • Interpreting population health data and needs • Informing commissioning decisions • Providing assurance to the Board on outcomes and impact	
3.1.3	AM emphasised the importance of establishing a clear decision-making framework, noting that the Committee would need to make difficult prioritisation and decommissioning decisions and must be supported by a robust process.	
3.1.4	DJ advised that the Committee should define and oversee a set of key outcome measures, reflecting both population-level and place-based priorities, and that a dedicated performance reporting approach would be required to support this. It was emphasised the importance of	

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	place-based plans, noting that each place would have its own priorities and outcomes, and that the Committee should provide oversight and assurance across these. JF reinforced the importance of a strong evidence base, particularly where commissioning decisions may have political or resource implications.	
3. 1.5	SW proposed that the ToR should explicitly reference the strategic commissioning cycle, to clarify where the Committee sits within the wider system. Members identified potential core deliverables for the Committee, including: • Integrated Health Needs Assessment • Outcomes Framework • Strategic commissioning priorities • Neighbourhood health programme Concerns were raised regarding whether the proposed frequency of meetings would be sufficient to deliver the scope of work.	
3. 1.6	JF advised that Committee membership should be reviewed to ensure that partner involvement added value to both the ICB and wider system. RS suggested that membership should include representation from programmes such as Health Inclusion Networks and Black Maternity Matters, to strengthen the Committee's focus on race equity and structural inequalities.	
3. 1.7	LH highlighted that public contributors were not explicitly referenced within the ToR and expressed concern that this could undermine the intention for co-production. JC acknowledged this omission and confirmed that the ToR would be updated to ensure that public contributors are formally recognised and embedded within the Committee structure.	
3. 1.8	RS recommended that the ToR explicitly reflect an all-age approach, including a stronger emphasis on early years and women's health.	
3. 1.9	Jo Hicks highlighted the need to ensure workforce considerations are explicitly referenced within the ToR, particularly in relation to inequalities and organisational responsibilities	
3. 1.10	JM concluded the discussion by emphasising that the Committee and its ToR were developmental, noting that the operating model will evolve over time and require a "test and learn" approach. Members acknowledged the current organisational context and agreed that a degree of flexibility and iteration would be required as the Committee matures.	
	<u>Actions</u> JM to revise the Terms of Reference to reflect Committee feedback, including: • Clarification of role within the strategic commissioning cycle • Inclusion of public contributors and co-production principles • Strengthened references to inequalities, workforce and all-age approach JM to consider inclusion of a strategic commissioning cycle diagram within the ToR. Executive leads to develop a decision-making and prioritisation framework to support the Committee's work. Committee membership to be reviewed, including consideration of partner, VCSE and programme representation. Members to provide further written feedback on the ToR outside of the meeting.	JM JM Execs JM All

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	<i><u>RECCOMENDATION:</u> The Committee noted the Terms of Reference</i>	
3.2	<u>Public Contributor Feedback</u>	
3.2.1	The Committee received a paper summarising feedback from public contributors, including reflections on previous committee arrangements and considerations for the future design of SHIPPHC. It had been developed following engagement with public contributors and aimed to capture both positive experiences and areas for improvement, particularly in relation to co-production and involvement JM acknowledged that previous arrangements had not consistently embedded public contributors within formal structures and confirmed that the paper was intended to highlight this gap and inform future improvements.	
3.2.2	LH emphasised the value of having public contributors within the Committee, noting that their role was to: • Refocus discussions on the impact on people and communities • Ground decision-making beyond data and modelling • Ensure a co-production approach to population health improvement LH also highlighted the importance of maintaining a strong sense of place, expressing concern that this could be diluted within a larger, cluster-wide committee AT reinforced the importance of public contributor involvement, noting that contributors bring valuable lived experience and insight, and should be used meaningfully.	
3.2.3	JM reflected that engagement with public contributors had not been fully utilised between meetings and acknowledged the need for a more systematic and intentional approach to working with communities. It was proposed that both Committee members and the wider system should consider their role in engaging directly with communities, using public contributors and Voluntary, Community Sector Enterprise (VCSE) networks to gather insight and embed this as part of a structured approach	
3.2.4	AT noted that public contributors were willing to support the system further and emphasised the importance of Clear communication of priorities and outcomes and opportunities to contribute more regularly, beyond quarterly meetings	
3.2.5	The Committee agreed that public contributors play a critical role in shaping discussion, challenging assumptions, and improving outcomes, and that future arrangements should reflect this. JC & JM thanked LH & AT for their feedback and acknowledged that public contributor involvement had not been sufficiently formalised and there was a clear opportunity to embed their role within the Terms of Reference and Committee design.	
	<i><u>RECCOMENDATION:</u> The Committee noted the Public Contributor Feedback</i>	
4	<u>Staff Structure</u>	

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4.1	The Committee received a presentation from JM on the proposed Population Health and Intelligence staffing structure, noting that the structure had recently been shared with staff following consultation. The three core components of the structure: • Data and analytics • Population health improvement • Strategy, insights and engagement It was noted that the structure was currently subject to recruitment and the organisational change processes, with posts expected to be filled over the coming months.	
4.2	Members acknowledged the scale of organisational change and the importance of ensuring appropriate capacity and capability within the new structure and alignment to the Committee's strategic objectives.	
4.3	AJ emphasised the importance of workforce development and training and noted the need to support staff in new roles, particularly in relation to strategic commissioning. JM confirmed that this would be supported through the organisational development programme and national training opportunities.	
	<i>RECCOMENDATION: The Committee noted the staff structure presentation.</i>	
5	<u>NHSE Health Inequalities Statement Requirement 2025</u>	
5.1	AW introduced the item and outlined that the Health Inequalities Statement was a statutory requirement for NHS organisations to publish data on inequalities and demonstrate actions being taken in response. It was noted that recent changes to NHSE guidance had: • Updated the indicators and reporting requirements • Increased flexibility for systems to determine locally relevant population groups • Required organisations to demonstrate actions taken in response to identified inequalities	
5.2	AW advised that while both systems had produced high-quality data and reports, there had been limited progress in translating this into systematic action and impact. Members noted that the data continued to show persistent inequalities, particularly relating to deprivation and ethnicity, and did not present new findings beyond those already understood. JM emphasised that the key issue for the Committee was to move from insight to action and to align discussion with the Committee's overall purpose.	
5.3	ML emphasised that, while the data and reporting were well established, the priority was determining how the system responds, highlighting the opportunity presented by the cluster arrangements to shape a more integrated approach to tackling health inequalities and embedding these within commissioning and decision-making processes.	
5.4	AW raised the importance of clarifying how health inequalities were addressed across all committees, noting the risk that responsibility could sit solely with this Committee rather than being embedded system wide. SF reflected on the Gloucestershire approach and highlighted that inequalities had previously been treated as everyone's business, supported through system-wide frameworks and accountability mechanisms. AJ suggested that each committee should articulate how it addresses health inequalities, ensuring the agenda is embedded across governance structures. Action: JM to discuss with Execs to clarify how health inequalities are embedded across all committees, including expectations and accountability	JM

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5.5	Members discussed the need to embed a health inequalities lens across all decision-making, including: • Use of disaggregated data • Routine consideration within performance and quality reporting • Integration into commissioning and investment decisions AM highlighted the importance of asking consistent, structured questions at Board and Committee level to ensure inequalities are systematically considered in all decisions.	
5.6	Members discussed the balance between addressing a wide range of inequalities and focusing on a small number of priority areas to maximise impacts & JC supported a targeted approach, focusing on a limited number of priorities informed by data and evidence. AJ noted the importance of developing a transparent prioritisation framework, ensuring clarity on how decisions were made and communicated to the public.	
	<u>RECCOMENDATION:</u> The Committee noted the NHSE Health Inequalities Statement Requirement 2025	
6	<u>Committee Workplan</u>	
6.1	The Committee received a draft forward workplan for the SHIPPHC Committee. This had been developed based on existing committee plans and known statutory and strategic requirements. JM advised that the workplan represented an initial iteration and would require further refinement as the Committee's role and priorities develop.	
6.2	Members were invited to review the workplan and provide additional comments outside of the meeting, including identification of any gaps or items requiring inclusion. SW highlighted a potential gap in relation to screening and immunisation and noted the need for further clarify on how these areas align with wider system responsibilities.	
6.3	RB confirmed that through the Committee Hub function, he would support ongoing coordination and updating of the forward plan, including capturing items arising from other committees and organisational activity.	
	<u>RECCOMENDATION:</u> The Committee noted that the workplan would remain dynamic, reflecting the evolving nature of the Committee and wider organisational changes.	
7	<u>New NHSE Guidance: Strengthening Public Health Expertise withing ICB's</u>	
7.1	JM introduced the item and highlighted that the guidance set out expectations regarding the role of Directors of Public Health (DPHs) and the provision of public health advice to the NHS.	
7.2	SW advised that both systems already had well-established public health arrangements, and that the cluster was in a strong position relative to national expectations. SW outlined that work was underway across the four local authority areas and the ICB to: • Develop a shared approach to public health advice • Align work programmes • Support delivery of the Integrated Health Needs Assessment	
7.3	SF confirmed that Gloucestershire had historically operated a closely aligned public health and ICB model and welcomed the opportunity to work more collaboratively across the cluster.	

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	Discussion took place regarding DPH representation at Committee level, with members noting the importance of ensuring appropriate place-based input and expertise. Action: JM confirmed that further work would be undertaken with the four DPHs to develop a clear, shared approach, including consideration of representation and governance arrangements.	JM
	<i>RECCOMENDATION: The Committee noted that while arrangements were already broadly aligned with national guidance, further work is required to provide formal assurance on how public health expertise will be embedded within the cluster operating model.</i>	
8	<u>Reflection on Today's Meeting</u>	
8.1	JC invited members to provide reflections on the inaugural meeting of the SHIPPHC Committee, noting the importance of capturing learning to inform future meetings.	
8.2	AJ reflected that the agenda and structure of the meeting were appropriate, highlighting that papers were well-prepared and the inclusion of questions within papers supported meaningful discussion and engagement. AJ also emphasised the value of public contributor input, noting that contributions helped to refocus discussions on population impact and lived experience	
8.3	AM agreed that the meeting provided a strong starting point, noting that members are now aligned in understanding the Committee's purpose and direction. Am then highlighted that the next phase would require the Committee to move from a broad shared purpose to clear prioritisation and focus, acknowledging that this will require further work and careful consideration.	
8.4	JF reflected positively on the level of engagement and enthusiasm and noted that the Committee built on significant prior work across both systems and provided an important mechanism for Board-level accountability on health inequalities.	
8.5	JF also raised consideration of the format of future meetings, noting the benefits of both virtual and face-to-face approaches and suggesting further discussion across Committee Chairs. SW highlighted the importance of relationship-building, suggesting that some face-to-face engagement may be beneficial, particularly for shared learning and development.	
8.6	Members noted the importance of continuing to operate effectively within a context of organisational change and uncertainty, while maintaining momentum on the Committee's priorities.	
8.7	JC reflected that the meeting had successfully: - Established a shared understanding of purpose - Enabled constructive challenge and discussion - Provided a strong foundation for future work JC suggested that future meetings could include developmental elements, such as learning sessions or showcasing impact, alongside formal Committee business. Members supported the inclusion of a formal reflection item in future agendas to support continuous improvement of Committee effectiveness. Action: RB to include as a standing item going forward.	
9	<u>Any other Business</u>	

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9.1	There were no items of any other business.	
	Date of next meeting: Wednesday 23rd September, 14.00-17.00 via MS Teams	

Add author's name: Ryan Brunsdon via Co-Pilot
Written 25th June 2026