Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

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Bristol, North Somerset, South Gloucestershire CCG Governing Body meeting

Minutes of the meeting held on Tuesday 3rd April 2018 at 1.30pm, at Vassall Centre, Gill Avenue, Downend, BS16 2QQ

Minutes

Present		
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Colin Bradbury	Area Director North Somerset	CB
Peter Brindle	Medical Director Clinical Effectiveness	PB
Jon Evans	GP Locality Representative South Gloucestershire	JE
Deborah El-Sayed	Director of Transformation	DES
Brian Hanratty	GP Locality Representative Bristol South	BH
Sally Hogg	Consultant Public Health Bristol City Council	SH
David Jarrett	Area Director South Gloucestershire	DJ
Martin Jones	Medical Director Commissioning and Primary Care	MJ
Nick Kennedy	Independent Clinical Member Secondary Care Doctor	NK
Lisa Manson	Director of Commissioning	LM
Peter Marriner	Lay Member Strategic Finance	PM
Alison Moon	Independent Clinical Member Registered Nurse	AM
Anne Morris	Director Nursing and Quality	AMo
Justine Rawlings	Area Director Bristol	JRa
Julia Ross	Chief Executive	JR
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Jon Hayes	Clinical Chair	initial
Kevin Haggerty	GP Representative North Somerset Weston and Worle,	KH
Racheal Kenyon	GP Representative North Somerset Woodspring	RK
In attendance		
Sarah Carr	Corporate Secretary	SC
Carole Slater	Head of Mental Health Transformation	CS
Bob Deans	Attain	BD

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01	**Apologies** John Rushforth (JRu) welcomed members of the Governing Body and members of the public present to this, the first meeting of the Bristol, North Somerset and South Gloucestershire CCG (BNSSG CCG) Governing Body. JRu explained that Jon Hayes, the Clinical Chair of the CCG, was unable to attend this meeting due to prior commitments. JRu would chair this meeting as the lay member Deputy Chair. The above apologies were noted.	
02	**Declarations of interest** There were none	
03	**Minutes of the previous meeting and matters arising** The minutes were agreed as a correct record.	
04	**Actions arising from previous meetings** • 6 March '18 item 7.2 ref 01, Information regarding the AQP Assisted Conception service was available to members of the public and primary care colleagues. The action was closed. • 6 March '18 item 7.4 ref 01, timescales were being added to the Primary Care Quality Development action plan. The action remained open. • 6 March '18 item 10.1 ref 01, South West Ambulance Service Foundation Trust (SWASFT) had been asked to provide information about the new response categories with primary care colleagues. The action was closed. • 6 March '18 item 10.1 ref 02, work to include information on areas of 'zero tolerance' in the Quality and Performance Report was ongoing. The action remained open. • 6 March '18 item 10.1 ref 03, Actions to improve IAPT performance were in progress. The action remained open. • 6 March '18 item 10.1 ref 04 Information on current Contract Performance Notices (CPNs) was included in the Quality Assurance report. The action was closed All other actions were closed.	
05	**Update from the Clinical Chair** There was no separate update for this meeting.	
06	**Chief Executive's report** Julia Ross (JR) welcomed the new Lay Governing Body Members, Sarah Talbot Williams (STW), and Peter Marriner (PM), Alison Moon (AM) the Independent Clinical Nurse member, and Jon Evans, the	

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	new GP member South Gloucestershire, to the Governing Body. A number of apologies had been received, reflecting the Easter Holidays. Sally Hogg, Public Health Consultant, was welcomed to the meeting. The three Directors of Public Health had agreed that they would be represented at the CCG Governing Body meetings by the Bristol Director of Public Health. JR reported that NHSE (NHS England) had confirmed that the Directions had been lifted from North Somerset and South Gloucestershire CCGs. BNSSG CCG was not under Directions and Financial Special Measures. JR observed that this was a testament to the actions taken across the three former CCG's during 2017-18. An event bringing together the staff of the three former CCGs had been held to celebrate the achievements for the CCGs and to launch the new organisation.	
7.1	**South Gloucestershire 3 R's Programme** Lisa Manson (LM) presented the paper. The aim of the programme was to improve rehabilitation, recovery and reablement services for adults within BNSSG CCG. The current programme had been developed for South Gloucestershire. The objective was to develop capacity and capability in the community so that people with complex needs spent less time in hospital following an acute admission. The emphasis was on maintaining people at home with the support of community beds South Gloucestershire CCG had previously consulted on the future of services at Frenchay and Thornbury. The proposals in the paper built upon this consultation. A decision had been taken in 2015 to commission community rehabilitation beds on both sites, working with Sirona. South Gloucestershire Council had made clear its intention to commission residential/nursing home beds and extra care housing facilities on the two sites. A decision had been taken in December 2017 to discontinue the Sirona led development due to procurement issues. In January 2018 Attain was appointed to support the CCG to review options for next steps. Attain worked closely with the CCG, South Gloucestershire Council, North Bristol NHS Trust (NBT) and other partners to develop a preferred option, described in the paper. LM described the current position. The implementation of the programme to date had involved improvement to existing services.	

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	This had included investment in additional nurses, therapists and other staff in the community teams. Currently 70-80 community beds were provided through the Skylark Unit in Yate and Henderson Ward at Thornbury Hospital. These were operated by Sirona, supplemented by capacity purchased through short term contracts from local nursing homes. Delivery of services was fragmented across multiple sites and this prevented patients moving between pathways, limited access to therapy input and increased length of stay. Current capacity operated on a 'step down' model providing community support following an acute stay, with a lack of 'step up' support to prevent admission to hospital. The capacity analysis was based on the population forecast in the Joint Strategic Needs Assessment and length of stay in line with the national upper quartile length of stay. The national best practice model was that the proportion of patients supported through Pathway 1 to Pathway 2 was 70 to 30. The preferred option was to enable a greater proportion of patients to be cared for through Pathway 1 (home-based care) and achieve bedded capacity length of stay performance in the upper quartile. A rehabilitation centre of excellence at Frenchay and 6-10 'step up' beds at Thornbury would be developed; co-located at both sites with nursing home and ExtraCare housing in line with the local authority strategy. The proposal for Thornbury included the build of an Enhanced Primary and Community Care Centre. The intention for the Frenchay site was for a new build containing 40 to 50 core, NHS funded community rehabilitation beds on the vacant hospital site. This would be adjacent to the current Brain Injuries Rehabilitation Unit (BIRU), with the potential for creating a BNSSG 'Centre of Excellence' for Rehabilitation. The intention for Thornbury was for two new build schemes including an Enhanced Primary and Community Care Centre. This would be taken through the delegated Primary Care Commissioning approval process and the NHSE process. The second proposed new build was for co-located Local Authority commissioned services; including 6-10 NHS funded core beds. The proposed service model at Frenchay would allow patients to move between pathways, accessing the appropriate level of therapy in a purpose built facility. This would reduce length of stay and	

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	maximising the opportunity for patients to return to their original care setting. The centralisation of bedded capacity would support the delivery of the optimal model of care. A single core facility would encourage recruitment and retention of highly skilled and trained clinical staff. The bedded care at Thornbury provided flexibility for 'step up' care from community and primary care alongside step down care from the acute providers. The proposed approach was consistent with the national 'RightCare' model. There was an opportunity to further refine the local approach, as the re-procurement of Adult Community Health Service progressed. The overall success of the programme required a whole system commitment and collaborative approach. Funding had been secured to complete a Formal Business Case for the development of an integrated primary and community care facility in Thornbury. This would be monitored and approved through the CCG Primary Care Commissioning Committee and the appropriate NHSE approval processes. Subject to the approval of the recommendation, the CCG would formally write to South Gloucestershire Council requesting that they acted as the lead commissioner for the new build residential/ nursing home facilities. The CCG would work with the local authority to establish a programme board to oversee the programme and would continue to take forward the formal re-procurement of Adult Community Health Services. LM invited questions. Kirsty Alexander (KA) asked what the implications of the proposals were for other parts of the BNSSG system. LM explained that a paper regarding the re-procurement of Adult Community Health Services would be presented to the May Governing Body meeting. Three different community services models operated across BNSSG. There would continue to be a need for bedded hospital capacity for the BNSSG population and the proposals supported this. Brian Hanratty (BH) asked if patients from across BNSSG would be able to access the proposed centre of excellence. LM confirmed that the centre would be accessible to all BNSSG patients. It was expected that the majority of patients accessing the service would be discharged from NBT. Further work was required to fully understand patient flows. JRu asked how the proposals corresponded to the themes identified	

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	in the earlier consultation. LM explained that the proposals built on the previous consultation. JRu asked how deliverable the proposals were. JR commented that the programme had made slow progress up to the decision to halt the Sirona led development. A commitment was made at that point to be clear as to the way forward and take action. The CCG had taken the opportunity to consider the programme in the context of best practice to understand the scale and scope required. The CCG was committed to establishing the Primary and Community Care Centre at the Thornbury site. The proposals built on the previous consultation and provided a clear way forward. JR observed that the proposals took into account best practice and asked if there was confidence in the ability to achieve a 21 day length of stay for rehabilitation beds. LM explained that currently there were three models across BNSSG with different levels of reliance on beds. When the CCG position was compared to the national upper quartile for length of stay it was apparent improvement was required. The intention was to have new facilities on site for 1st April 2020 and this would begin to deliver benefits in terms of length of stay. Bob Deans commented that a reduction in length of stay would be achieved through the interface of services and the models of care as well as the bed base. Jon Evans (JE) observed that the underpinning integration of services was integral to the success of the proposals. Sarah Talbot Williams (STW) asked about future engagement plans. LM explained that future engagement would focus on the re-procurement of Adult Community Health Services and the co-design of the service specification. Martin Jones (MJ) commented on impact on other elements of the system including priorities within primary care. LM explained that a Primary Care Estates strategy would be developed for BNSSG that would be discussed at the Primary Care Commission Committee. Anne Morris (AMo) sought further assurance regarding the reduction in length of stay. LM explained that the Skylark Unit was delivering improvements. JR observed that it was important, as the re-procurement of Adult Community Health Services developed, to ensure that the service specification was appropriate and provided the opportunity to offer the right, and equitable, level of care to across BNSSG. It was important to ensure that the decisions at this point	

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	did not adversely impact on plans in the future. The Governing Body was being informed that the modelling had been future proofed within the context of a wider community services footprint across BNSSG. JR observed that the facilities at the Thornbury site did not meet the required standard. Staff at Thornbury Hospital did excellent work in difficult working conditions. This was an opportunity to bring health and social care closer together through combined facilities. Nick Kennedy (NK) sought assurance regarding the funding for the proposed new build. LM explained that the nursing home procurement would be led by the Local Authority. The CCG would commit to the block purchase of a number of beds for a confirmed period. JR explained that the CCG would separately commission the therapy and nursing staff; the issue for the CCG would be to specify that the building was appropriate for NHS funded and staffed beds. There was a question about the level of engagement with the Local Authority. David Jarrett (DJ) explained that the CCG had fully engaged with the Local Authority; Local Authority Officers had been involved in the steering group and, subject to full council approval, there was a commitment by the Local Authority to lead the procurement process. Sarah Truelove (ST) noted that the facilities in the proposals would offer different services and asked if patients would be able to move between the two depending on need. It was confirmed that this would be the case. JRu sought confirmation that the proposal was not driven by a reduction in costs. LM confirmed that the intention was to maintain the current budget and invest more in Pathway1. Peter Marriner (PM) noted that the date for services to go live was 2020. PM ask how reliant the project was on the completion of all elements. LM explained that Local Authority colleagues believed that a two year window would be sufficient to establish the care home element of the proposals. Land for development had been identified and progress depended upon the procurement and development process. This was an acknowledged risk, as was ensuring that there were partners for the development. PM asked if proposals had taken into account possible population growth. LM confirmed this. LM commented that there was a current issue in relating to the length of stay experienced by a group of patients. This issue needed to be resolved separately. The model assumed that providers worked optimally across the system.	

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	JR asked what the impact would be if the current length of stay issues were not addressed. LM explained that there were two elements to the transition. One element related to ensuring acute providers reduced length of stay and the second element involved ensuring that the community infrastructure worked together. This partially depended on estate. LM explained that the proposal for flexibility to commission additional beds would help mitigate this risk. JE commented that it was important to be able to plan for flexibility. LM commented that the CCG had improved its predictions regarding activity and this improvement would continue. PM asked how flexibility would be achieved through a commercially provided bed base. LM explained that the CCG and Local Authority currently spot purchased beds and the system did not work on at 100% bed occupancy. The increasing accuracy of activity predications would also contribute. JR commented that during the transition there were options to be pursued to provide flexibility. BH asked about the engagement of local practices and community providers. LM reiterated that a full engagement had been completed in 2015. A further engagement would be undertaken across BNSSG in relation to the re-procurement of Adult Community Health Services. DJ commented that the local practices had been fully engaged. KA highlighted the importance of working with patients and carers and third sector organisations in relation to prevention. JR agreed that this was important and was part of the Sustainability and Transformation Plan (STP). The team was thanked for the development of the proposal. **The Governing Body approved:** • **the preferred option to deliver a new model of care for rehabilitation, reablement and recovery services for the people of South Gloucestershire, including:** - **A centre of excellence for intensive rehabilitation in 40-50 beds co-located within a new build residential/nursing home facility at Frenchay (70-80 units in total, subject to planning permission)** - **An enhanced primary and community care hub (subject to completion of the full business case), co-located with a new build residential/ nursing home facility at Thornbury (70-80 units, subject to planning permission). This would include a**	

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	dedicated frailty unit offering a 'one-stop shop' proactive service for frail and older people to keep them as healthy and independent as possible, alongside a 6-10 bedded unit providing short term support for people to avoid or recover from hospital admission. - **Reinvestment in rehabilitation support for people in their own homes** • **Noted that the CCG would retain the option to flex the number of beds by purchasing short term additional capacity on either site** • **Noted that clinical service provision would be delivered through the reprocurement of Adult Community Health Services (separate programme)** • **Noted that he CCG would seek to partner with South Gloucestershire Council and** • **Agreed to request that the Council acted as lead commissioner for the new build residential/nursing home facilities required** JR confirmed that with this decision confirmed a letter formally requesting that the Local Authority act as the lead commissioner would be sent	**JR**
7.2	**BNSSG CCG Budget 2018-19** ST explained the context for the 2018-19 budget. The plan took into account the additional allocations announced in the 2017 Autumn Statement and the planning guidance issued in February 2018. ST highlighted the increase in allocations set out in table 1 and the expenditure budget set out in table 2. The savings programme at section seven was highlighted. To meet the £10 million deficit control total set by NHSE and increases in expenditure set out in the paper the CCG would need to deliver a £37 million (3%) savings programme. The £37m savings programme included £32m of CCG savings and £5m of "system savings" jointly developed with providers in 4 newly established "Task and Finish Groups" focused on key areas for system cost reduction: outpatients, urgent care, bed use and mental health service configuration. The savings programme at table 4 included an estimated £12.7m full year effect of 2017-18 initiatives and £24.3m of new schemes. ST explained that the budget proposal was consistent with the	

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	financial operational plan submitted to NHSE and met the national requirements to: • deliver a £10m deficit control total • provide funding for additional activity to improve A&E performance and hold waiting lists at March 2018 levels • meet the mental health minimum investment standard • plan for winter pressures • hold a contingency reserve of 0.5% Alison Moon (AM) sought confirmation that quality impact assessments were completed as part of the control centre process. ST explained that quality impact assessments were taken forward by the Quality Team as part of the control centre process and that the Executive Team would complete a deep dive. KA asked whether Child and Adolescent Mental Health services (CAMHS) were included within mental health services. This was confirmed. PM noted that there were no savings related to the CSU and asked if the CCG was getting value for money. ST explained that plans were in place to look at all services including the CSU. NK asked whether there was a risk relating to delegated primary care commissioning. ST explained that the risk had been resolved with NHSE prior to the delegation. **The Governing Body:** • **Reviewed the budget for 2018-19** • **Noted the risk assessment** • **Agreed the proposed budget**	
7.3	**BNSSG Suicide Prevention Report** Deborah El Sayed (DES) introduced Carole Slater (CS), Head of Mental Health Transformation. DES explained the paper provided an update to the paper received in February 2018. The Governing Bodies had asked for a further paper that set out the overarching approach to suicide prevention across BNSSG, reflecting the fact that the area was an outlier. The paper outlined the number of organisations contributing to suicide prevention, including the local authorities and Avon and Wiltshire Mental Health Partnership Trust (AWP). DES highlighted that to address the issue of suicide it was necessary	

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	to bring the range of plans together, build on the examples of best practice and extend these across BNSSG. DES highlighted the pre-determinants of suicide: social isolation, economic adversity, drug and alcohol misuse and recent self harm. The paper asked the Governing Body to approve a number of recommendations which reflected the ongoing work. DES highlighted the final two recommendations. The CCG did not have an amalgamation of data from across partner organisations and the public that demonstrated the impact of initiatives in place and work was to develop this. DES highlighted the local position. The age-standardised suicide rate for Bristol was 12.8 per 100,000 people, 8.7 per 100,000 people in North Somerset and in South Gloucestershire 9.2 per 100,000 people. Particular groups were at risk: males, the unemployed and social isolated and those living in the most deprived areas. There was also a high rate of suicide amongst young females. CS drew attention to the suicide prevention bid referenced in the paper which focussed around two areas. The first was the roll out of a pilot tested in Bristol to offer help and support to those in financial difficulties that were self-harming and/ or at risk of suicide in 2017 to BNSSG. The second element focused on mental health promotion for men. DES highlighted the 'Thrive' model adopted in Bristol which had a ten year programme to improve mental health and wellbeing. DES drew attention to the programme's key objectives set out in the paper. DES highlighted the need to help connect people to services, noting that feedback was that there was a lack of awareness about the range of available services. The creation of a Thrive West model was a key activity. This would be wider than the BNSSG footprint and would aim to share best practice across the region. DES note the 'suicide cluster' reported in Bristol in the 2016-17 academic year. Colleagues across the system had worked together in response. This recognised the wider range of organisations, including schools, higher and further education, which needed to be involved in suicide prevention. Attention was drawn to the new app to help people who were considering self harm or suicide; the evaluation was pending. DES commented on the evidence that there were suicide hotspots in the BNSSG footprint and highlighted the joint work with a range of organisations to reduce the number of suicides and minimise the access to means.	

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	The paper highlighted the importance of system leadership across the STP. The proposal was that the CCG provided this. The work to link to primary care was highlighted. DES explained that there was an overall target to reduce suicide rates by 10% by 2020/2. JR welcomed the paper and asked why Bristol was particularly an outlier. The ambition should be to reduce the number of suicides and asked if the reason for the higher rate in Bristol was understood to enable a targeted approach to interventions. DES explained it was believed by partner organisations that economic adversity was a key driver. Sally Hogg (SH) confirmed that this was an area of focus for the local authority alongside work targeted at the younger population. DES commented it was important to work with a range of partners to address the underlying issues. This highlighted the importance of the data collection activity. AM welcomed the report and commented that it was important to have a shared common purpose across the system and partner organisations. AM asked if there was a shared ambition for a zero suicide rate. It was noted that AWP did not share this. AM welcomed the system leadership approach and supported more benchmarking against other areas. David Soodeen (DS) supported the development of an STP Mental Health Strategy. DS commented on the role of primary care, noting that there was information about patients only seen in primary care which could be usefully collated. DS commented on the issue of social isolation, particularly in areas of deprivation, and that tackling this was a key issue that could be helped by health services. DS noted that asylum seekers and refugees were reported as having higher rates of suicide and this was not included in the report. DES welcomed these comments and noted that this group had been omitted from the report. JE commented that the tipping points for patients were not fully understood and this information could be collected through primary care. DES agreed that information needed to be collected from a wide range of sources including members of the public. BH commented that information about the range of services accessed by vulnerable people was not always available. DES explained that AWP were placing crisis records on the EMIS system. KA commented that a significant number of mental health issues originated in childhood and it was important to ensure that support and interventions recognised this. KA asked whether there was	

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	under reporting of suicide rates in the elderly population. STW noted that in addition to primary care, many charities had detailed information that would make an important contribution. Peter Brindle (PB) asked if there were opportunities within the CCG and providers to lead by example as employers. DES explained that this would be an element of the CCG's Organisational Development. PB asked how the level of ambition would be decided. DES explained that the overall target 10% reduction in the number of suicides was driven by the Five Year Forward View. DES commented this was not the end point and the ambition should be zero. There was a discussion about the balance between incremental improvements and a wider transformational approach. DES observed that the plans included both the AWP incremental approach and the Thrive model which was transformational. DES commented that the STP strategy needed to address the transformational approach and ensure that partners shared the ambition. KA asked about the data relating to method of suicide, and whether reporting had changed. DES agreed to check this data. PM observed that voluntary organisations had a significant contribution to make. **The Governing Body approved the recommendations for future priorities for the CCG in this area of work as set out in the paper**	**DES**
7.4	**BNSSG Perinatal Mental Health Service** DES explained that the Governing Bodies had asked for further detail in relation to the perinatal mental health service. The report provided an update and highlighted the action taken. CS highlighted the funding of the service set out in section six of the paper. DES invited questions. JR observed the high levels of demand for the service and asked if the reasons for this were understood. DES explained that the demand for the service was higher than anticipated, there was also a high 'do not attend rate'. The trends had been identified and an independent review of the pathways was to be completed to understand the referral process and the clinical handover. AM welcomed the paper and noted that an issue identified previously was the impact of the service on patient outcomes. AM asked if the review would focus on outcomes and asked when it would be completed. DES explained that the terms of reference for the review were in draft form and asked AM to comment on them. KA	**AM**

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	commented on the training offered asking if this was available in all areas, given the importance training played in appropriate referrals. DES that this was an issue that would be included in the pathway review. DS commented that an STP overview would be helpful. DES confirmed that the service was within the remit of the STP mental health strategy and STP maternity services. DS queried the reference to funding for commissioning of specialist community services. DES agreed to clarify this. AMo asked about the restriction of post-natal referrals to the first three months after birth and asked if this would be part of the review. It was noted that there was evidence that women developed post-natal issues beyond three months. It was agreed that the review would consider where this was an appropriate restriction. NK commented on the number of whole time equivalent posts and the additional posts under consideration. NK asked if this was the correct staff level. It was agreed that it was important that the service was sustainable and this would be considered in the review. JE commented that an educational element that ensured that skills and knowledge were passed on to other practitioners would be helpful. **The Governing Body noted the report**	**DES** **DES** **DES**
7.5	**STP Digital Overview** The paper provided an update on the development of the digital delivery plan for BNSSG. The Governing Body was being asked to consider recommendations relating to Connecting Care and the application and requirements for Local Health Care Records Exemplars (LHCRE). DES explained that the intent was to ensure that the digital objectives delivered the transformation required across the broader programme including urgent care, planned care and primary care. DES highlighted current performance against national agendas and noted that there were issues related to cyber security and Child Health Information Systems (CHIS). The Local Digital Maturity for BNSSG was given at figure two in the paper. BNSSG was slightly below the national averages and there was variation across providers. The STP Digital Strategy, 'Bridging the Gap' was developed in October 2017 with five themes. These were set out in the paper. The Strategy was agreed by the STP sponsoring board with the caveat that the approach needed to drive towards greater practical	

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	application and plans with measurable benefits. The focus now was on shaping the overarching strategy into an approach for delivery. Four guiding principles had been developed to align plans to support the population and clinicians, in terms of the delivery of care, connect services and look to the future. The four STP areas of focus and the candidate programmes were described at figure four. The Connecting Care programme had been a significant element of the digital programme in BNSSG. The ability to provide clinicians with a seamless view of patients' needs was central. The local health economy was a leader national and the Connecting Care programme contributed to this. DES explained that this lead was narrowing. There was a local, central store of information, however there it was not easily accessible by clinicians. There had been a meeting to discuss the Connecting Care Partnership future strategy attended by a range of partnership organisations. This provided the opportunity to consider whether to continue with the direction of travel. The meeting agreed that a re-procurement exercise was unlikely to deliver benefits and was not appropriate. The commitment to the programme was reaffirmed. The view was more needed to be done to use what was available to best effect. The recommendations discussed and agreed at the meeting were set out at section 4.2.1. DES highlighted the objectives that included a focus on user experience, connecting the shared records with other systems such as Patient Held Records, ensuring that data was available to all care settings, and ensuring the record was more than the existing portal, linking to other approaches to deliver key information and that there was not one approach to all forms of data. There were a number of implications, which were described at section 4.2.2. To support organisations to commit financially to the programme, a greater focus on the benefits was required describe the return on investment. DES explained the second element of the paper sought the endorsement of the application to become an LHCRE. There was an opportunity for additional funding. The national initiative aligned to the local ambitions. There were mandatory requirements, set out at section 5.2 including the requirement that organisations committed to the initiative. This had been discussed at the STP. The proposed governance structure to monitor and drive the wider digital agenda across the STP was set out at section 6.	

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	ST noted and welcomed the proposed Finance and Benefits Group and asked who would sit on this. DES explained that this would include Directors of Finance and their nominated deputies; it would be led by the CCG. The group would require business intelligence capability. The group would replace the current finance board. JR commented that it was important to be able to describe the clinical benefits. ST observed that the involvement of clinicians was essential. AM highlighted the importance of sharing information across agencies. AM asked if the CHIS had a sufficiently high profile. DSE explained that this had been risk rated in terms of performance and would be part of the digital priorities. AM noted that it was important to resolve this issue quickly. DS and JE commented on the importance of connecting the STP work streams with the digital plan and ensure key areas of work had appropriate digital support. DES agreed that this was important to drive forward transformation. As part of the move to the new office there would be a model community in technology terms that would allow access to systems. Justine Rawlings commented on the involvement of patients and the public. DES explained that the wider conversation would be part of the Patient and Public Engagement agenda. JR commented that these would be useful elements for the digital strategy which was a different discussion. **The Governing Body considered, discussed and endorsed the proposed approach for the STP wide Digital delivery plan. The Governing Body approved:** • **Section 4.1 – Recommendations on Connecting Care** • **Section 5.2- Mandatory requirements to the Local Health and Care Records Exemplar**	
8.1	**Quality Assurance Report** The Quality Committee had discussed the following issues at its March 2018 meeting. The Care Home Support Team Project evaluation was discussed. The team was established as a pilot in 2014 in response to closed care home beds. The team had provided training and supported the introduction of new initiatives and a network of clinical fora. The project had ended and the evaluation's recommendations would be presented to the May Committee	

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	meeting. A summary of Contract Penalty Notices (CPN) was discussed. Work was on going to develop an aligned reporting template which would be presented to the Quality Committee on a quarterly basis. The Committee had reviewed the acute providers' risk registers. The format of these risk registers differed across organisations. It was noted that the risk registers were discussed at the Quality Sub Group. The Committee agreed that it would receive an overview paper on the high level risks, emerging risks, actions and time scales. An update on the implementation of the Datix Risk Management System across the CCG was discussed. This would provide a new reporting tool, accessed via a web link, for GPs. This would allow the identification of themes affecting quality or safety of patient care. The system would be used to manage PALS and Complaints records and would be rolled out to include a risk management module. AM commented on the CPN's noting that a number related to issues internal to organisations whilst others were system based. AM asked that the Quality Committee explored this. JR commented on the number of CPN's in place. It was agreed that the Quality Committee would review this in greater depth. NK observed that the CCG Risk Register included system wide risks and asked if it was shared with providers and should providers be involved in the Quality Committee. AMo commented that providers were not currently involved in discussing commissioning risks. JE commented on the number of overdue complaints reported by NBT, noting that this was a long standing issue. AMo explained that the report did not reflect the work currently underway to improve the position and that the key issue was to reach a sustainable position. **The Governing Body noted the work undertaken, the assurances received and the actions agreed**	**AMo**
8.2	**Briefing on the Bristol Serious Case Review (SCR) 'Becky' and the implications for the CCG** AMo set out the background to the SCR which explored the learning for all agencies involved in the care of Becky Watts. The briefing focused on the specific learning for the CCG as commissioner of the health services that supported Becky and her family. The CCG action plan was at appendix 1. The report identified five key themes	

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	which were highlighted in the report. These themes applied across all of the agencies involved. Findings two and three had specific relevance to health services. Finding two related to inconsistencies within agencies and between agencies in relation to recording, analysis, planning, coordination and review which made joint working less effective. It was noted that issues related to the Child Health Information System had been discussed under item 7.4. AWP, the provider of the CAMHS service had implemented electronic records which would contribute to addressing this issue. Finding three concerned the Hospital Education Service (HES) which often worked alone in providing services to children. There was a lack of coordination between the HES and other agencies with the HES unaware of how to refer to other services. Actions had been taken forward by AWP to allocate a primary mental health worker to link to the HES ensuring co-ordination. AMo explained that the Bristol Safeguarding Children Board (BSCB) had established an action plan for multi-agency learning that would be monitored by the BSCB Quality Sub Group. The Governing Body was asked to delegate the monitoring of the CCG action plan to the CCG Safeguarding Governance Group and the Quality Committee. JRu observed that the CCG action plan had completion dates for all actions as May 2018 and that the actions were either partially complete or incomplete. JR sought assurance that the actions would be completed by the target dates. AMo explained that the actions would be reviewed in depth at the CCG Safeguarding Governance Group and the Quality Committee before their completion was confirmed and noted that it was a historic case. JR asked how the historic nature of the case reflected on the actions. AMo explained that some actions were already completed for example electronic patient records implementation. AM asked if the findings four and five in the SCR were relevant to health services. AMo explained that the findings were relevant to all the agencies involved and that the finding relating to the wider family was being taken forward. AM welcomed this. JRu voiced concern that the actions would not be completed to timescales. JR emphasised the importance that the CCG managed the actions and asked that AM confirmed progress with the team and attained assurance relating to the completion dates.	**AMo**

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	The Governing Body received the update on the 'Becky' Serious Case Review and to reviewed, commented on and approved the CCG action plan. The Governing Body delegated the monitoring of the action plan to the BNSSG CCG Safeguarding Governance Group and the Quality Committee with oversight from the Director of Nursing and Quality as Executive Lead for Safeguarding	
9.1	**BNSSG CCGs' Financial Report at Month 11** ST presented the summary position as at month 11. The forecast outturn position was a deficit of £35 million for 2017-18. ST explained that there would be a small change to this position as it had been confirmed that the CCG would retain the Category M savings. ST invited questions. JRu highlighted that whilst the position was a deficit, the position had improved and this was a significant achievement. JR agreed with this comment. DS asked if the issues with no-cheaper stock available drugs would continue in 2018-19. ST explained that the CCG had been assured that this issue would be resolved for 2018-19. The CCG had flagged this as a potential risk in the operational plan for 2018-19. **The Governing Body noted:** • **the financial position, the key risks, issues and mitigations.** • **the BNSSG forecast outturn deficit of £35.0m for 2017/18 and that this includes previously reported net risks.** • **the requirement of the external auditors to write to the secretary of state for health of the likely breach by each CCG to spend more than its revenue resource limit**	
10	**Quality and Performance Report** LM highlighted the following areas of performance. A&E performance was not being delivered at the national standard of 95%. BNSSG performance against the standard was 80% and had been sustained in January. 18 week elective referral to treatment times were being delivered at 89.27%, in line with the CCG plan of 89.3%. There had been a further small reduction in the number of patients waiting over 52 weeks. The plan for zero waits would be achieved by University Hospital Bristol (UHB) and Weston Area	

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	Health Trust (WAHT). NBT would not achieve the standard due to compromised elective capacity and a revised trajectory had been agreed. Work was ongoing to understand the issues underpinning performance against the Mental Health referral to assessment 4 week wait target. The position reported in South Gloucestershire had improved. There was deterioration in the position reported for North Somerset. It was important to ensure that there was a consistent service across BNSSG. David Jarrett (DJ) asked how community provider performance would be reported. LM explained that community provider performance information was now available; the three services had different metrics. Work was underway to incorporate this information into the report. AM observed that representatives from BNSSG commissioners and acute providers had visited Gloucestershire Hospitals Foundation NHS Trust to review urgent care arrangements. AM asked what the learning from the visit was. LM commented that the visit had been constructive. The Trust had achieved the 4 hours target despite high bed occupancy. The Trust had a single assessment and discharge process. LM described the process. AM asked if there were issues related to emergency readmission within 30 days. LM explained that the rate of readmissions were not an issue however it was important to understand whether patients were readmitted due to problems in discharge. JR noted that the CCG had set a level of zero tolerance in relation to patients waiting over 52 weeks and asked about the compromised position at NBT? LM explained that during January and February capacity had been compromised which had reduced the ability to take forward elective activity. KA noted that there had been national media reports regarding the continuation of winter pressures and asked about the local position. LM explained that there had been an overall growth in admissions and it was important to understand the reasons for this. Areas for attention included shortening length of stay and avoiding admission. It was noted that UHB had implement a Clinical Review process that looked at clinical pathways. NBT were working to review and change the internal culture. KA commented on the increase in activity	

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	experienced by BrisDoc over the Easter period. LM commented that the CCG need to improve its predictor to support planning. DS asked if reports would include SWASFT performance against the new performance standards. LM confirmed that this performance would be reported. NK asked whether issues previously reported in relation to colorectal services reported at UHB had been resolved. LM confirmed this had been resolved and agreed to share this information directly with NK. AMo drew attention to the reporting of 12 hour trolley breaches at NBT. It was explained that the reporting process had changed and that the Trust had now resolved its reporting issues. UHB and WAHT were taking further action to resolve the position. Concerns had related to the receipt of 14 day harm review reports. AMo highlighted concerns regarding MRSA bacteraemia and a patient cohort. The MRSA Task and Finish Group had reviewed the action plan completed in 2015 to ensure that all actions remained in place. A patient focus group was being established to review actions appropriate for the patient group. JR sought confirmation that the patient cohort concerned was Intravenous Drugs Users and asked how the patient focus group would operate. AMo explained that the group consisted of experts in the area including Bristol Drugs Project. Key concerns related to wound care. It was reported that there would be a visit in April to WAHT by NHS Improvement regarding the norovirus concerns at the Trust. Colin Bradbury sought clarification of the issues relating to 12 hour trolley waits and it was explained that the reporting process had changed and there had been no change to targets. AMo explained that the reporting requirements for MRSA had changed for 2018-19 with the removal of the third party category. This would lead to an increase in the number of CCG attributed cases. AM observed that this highlighted the need for a system wide response to MRSA. AMo agreed that the focus needed to be across the whole system, noting that some cases had no health links. **The Governing Body noted the performance position of the CCG and key providers, including the risks, mitigating actions and responsibilities**	**LM**
11.1	**BNSSG CCG Constitution**	

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	ST explained that the CCG Constitution was presented to the Governing Body for information. The Constitution had been agreed with NHSE and signed by member practices. **The Governing Body noted the CCG's constitution which had been agreed by NHS England and its member practices**	
11.2	**BNSSG Sustainability and Transformation Partnership (STP) Accountability** JR explained that the paper had been developed by Robert Woolley and provided clarity for partner boards and governing bodies regarding accountability and authority relating to Healthier Together, the BNSSG STP. The paper did not consider the wider question of STP accountability to the wider population. Governing bodies and boards retained authority. JR highlighted that work would begin to develop a shared framework for accountability. NK drew attention to the statement in section four of the paper regarding further non-executive involvement was "…neither practical nor necessary at the current time" and asked for information about the Chairs' Reference Group. JR explained that this group consisted of the all the Chairs of each partner organisation. This group would review the governance framework and this group provided the non-executive oversight at this point. JR explained that there would be a STP event in June which would involve executive and non-executive members of governing bodies and boards and other key members of staff including clinical leaders. This event would provide an opportunity to review the STP and engage with a wider group. **The Governing Body noted the report**	
11.3	**BNSSG HR Policies** ST explained that there were a number of policies that needed to be adopted by the CCG. These were contractual policies and had been reviewed through the CCG Joint Consultative Council and the CCG Policy Review Group. STW commented on the Equality Impact Screening which confirmed that the policies would impact on staff but did not explain 'How'. ST agreed to seek further information from colleagues. **The Governing Body approved the BNSSG CCG Disciplinary**	**ST**

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	Policy and the BNSSG CCG Grievance Policy	
11.4	**BNSSG CCG Detailed Financial Policies (DFP) and Core Corporate Policies** ST explained that the draft DFP had been discussed at the BNSSG CCGs' Audit Committee meetings and had been amended following this discussion to reflect the CCG Audit Panel requirements. ST highlighted the BNSSG policies that would rolled over from the CCGs and be reviewed during 2018. **The Governing Body:** • **Noted the review undertaken by the finance team in the preparation of BNSSG CCG detailed financial policies** • **Noted the process of compliance and approval with the CCG's scheme of delegation** • **Agreed the recommendation of the Audit, Governance and Risk committee to adopt the detailed financial policies for BNSSG with amendments following the committees review** • **Noted the policies rolled forward to be reviewed in 2018**	
12.1	**Minutes of BNSSG CCG Audit, Governance and Risk Committees in common meeting** **The Governing Body received and noted the minutes**	
12.2	**Minutes of BNSSG Joint Quality Committee** **The Governing Body received and noted the minutes**	
12.3	**Minutes of the BNNSG Commissioning Executive** **The Governing Body received and noted the minutes**	
12.4	**Minutes of the BNSSG Joint Strategic Finance Committee** **The Governing Body received and noted the minutes**	
12.5	**BNSSG Healthier Together Sponsoring Board** **The Governing Body received and noted the minutes**	
13	**Questions from the Public** Councillor Toby Savage, Deputy Leader of SGC and former Chair of SGC's Health Scrutiny read out the following statement: "Thank you to Governing Body members for holding your meeting today and considering the future of the Thornbury and Frenchay sites and how they need to serve the health needs of the South Glos	

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	population. There is an awful lot of history associated with this issue as has been acknowledged by Board members today and I can speak from personal experience having Chaired the Health Scrutiny Committee for 2 years from 2015-2017. I welcome the Chief Executive's comments: "let's stop going round in circles and get on and deliver". Amen to that. What is set out in the report is an exciting opportunity to genuinely integrate health and social care – and in Thornbury's case to go that one step further and have enhanced GP services/primary care as a key feature of the plans too. Having as many services under one roof as possible maximises the opportunity to ensure that patients are getting the right care for them to maximise their independence. On average length of stay, some would say it is a herculean aspiration around this based on what we're currently achieving and so I'm pleased to see that the flexible spot purchasing on the Frenchay and Thornbury sites remains part of the plan in case assumptions don't prove to be accurate. I'm pleased to hear today and read in the report that there isn't a crude budget saving associated with this project as that had been a concern expressed by residents that saving money was a motivating factor and so the assurances around that are really helpful, including the additional investment into caring for people in their own homes through Pathway 1. Re. Section 7 on Risk in the report - the most important question I have is to what extent North Bristol Trust are on board with the commissioning intentions of both the CCG and local authority and the associated land take necessary to deliver these health and social care facilities on each site? To date they haven't been able to give the unequivocal assurance that they are supportive of the extra care and nursing provision aspects – only the CCG's rehabilitation aspects. Assurances around what pressure the CCG is bringing to bear on NBT would be appreciated given that the report gives this area the highest risk rating. In summary, the report is a welcome step in bringing this sorry and long-running saga to an end and working together across the NHS and local government to get in place the 21st century health and social care services and facilities that our residents deserve. Let's get on with it." LM explained that NBT were members of the Programme Steering Group alongside colleagues from the local authority and had made a commitment to make the land available. The procurement process	

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	would be led by the local authority and the value of the land and purchase price would be part of this process. It was important as a system to reach a solution that allowed patients to move smoothly along the pathway and this was in the interests of NBT. JR commented that the key issue would be the land value and now the decision was made the detailed discussion could progress.	
	Date of next meeting: Tuesday 1st May 13.30 The Winter Gardens Pavilions, 2 Royal Parade, Weston Super Mare BS23 1AJ	

Sarah Carr
Corporate Secretary
Add date