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 1st of May 2018 at 1.30pm, at the Winter Gardens Pavilions, Weston College, Weston Super Mare, BS23 1AJ

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Colin Bradbury	Area Director North Somerset	CB
Deborah El-Sayed	Director of Transformation	DES
Jon Evans	GP Locality Representative South Gloucestershire	JE
Felicity Fay	GP Locality Representative South Gloucestershire	FF
Brian Hanratty	GP Locality Representative Bristol South	BH
Viv Harrison	Consultant in Public Health, Bristol Local Authority	VH
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
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member Registered Nurse	AMoon
Anne Morris	Director Nursing and Quality	AMor
Justine Rawlings	Area Director Bristol	JRa
Julia Ross	Chief Executive	JR
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
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		
Peter Brindle	Medical Director Clinical Effectiveness	PB
Kevin Haggerty	GP Representative North Somerset Weston and Worle,	KH
Peter Marriner	Lay Member Strategic Finance	PM
In attendance		
Sarah Carr	Corporate Secretary	SC
Margaret Kemp	Senior Project Manager Recommissioning	MK

Mike Pingstone	Associate Director of Procurement, NHS South, Central and West Commissioning Support Unit	MP
Jeanette George	Director of Corporate Services (Interim)	JG

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01	**Apologies** Jon Hayes (JH) welcomed members and members of the public to the meeting. The above apologies were noted.	
02	**Declarations of interest** There were no new declarations of interest.	
03	**Minutes of the previous meeting and matters arising** The minutes were agreed as a correct record with the following corrections: • Page 13, final paragraph to be amended to read "AMoon … noted that an issue identified previously was to understand the impact of the service …" • Page 18, final paragraph to be amended to clarify that Anne Morris (AMor) had been asked to confirm progress and attain assurance. An action for AMor to ensure ownership of the action plan by the CCG would be added.	**SC** **SC**
04	**Actions arising from previous meetings** • 6 March '18 item 7.4 ref 01, timescales had been added to the Primary Care Quality Development action plan presented to the Primary Care Commissioning Committee. 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, it was agreed the action was to report recovery rates in the performance report. The action remained open. • 6 April '18, item 7.1 Julia Ross (JR) would provide an update on the 3 Rs programme in her report. • 6 April '18, item 7.3, ref 01, a Mental Health Strategy was in development and would be presented to the Governing Body at its July meeting. The action was closed. • 6 April '18, item 7.4, ref 02, NHS England (NHSE) funding had been confirmed. The action was closed. • 6 April '18, item 7.4, ref 03 and 04, the issues highlighted had been included in the scope of the review which would be reported to the Governing Body in September 2018. The actions were closed. • 6 April '18, item 8.1, Contract Penalty Notices (CPNs) would be discussed at the May meeting of the Quality Committee. The action remained open. • 6 April '18, item 10, ref 01, Lisa Manson (LM) would provide Nick Kennedy (NK) with an update on the resolution of the colorectal	DES DES

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	service issues at UHB. The action remained open • 6 April '18, item 8.2 ref 01 the SCR action plan had been received by the Quality Committee which would monitor progress. It was agreed that the action plan would be reported to the Governing Body. All other actions were closed.	**AMor**
05	**Update from the Clinical Chair** JH reported that the first CCG Clinical Leads forum had taken place. Discussions had included the clinical leadership roles, ways of working and leadership development. The first Leadership Development event, supported by the Faculty of Medical Leadership had also taken place. The CCG had been visited by Stephen Powis, the NHSE Medical Director. Presentations had included the successes and challenges in the BNSSG area and the unique aspects of the local population. The meeting had been positive. Discussions had included workforce retention and development. There had been a STP sponsored Urgent Care Strategy Stakeholder meeting with a focus on activity in the urgent care setting, the patient experience of services and outcomes. JH was meeting with the Chairs of provider organisations and neighbouring CCGs to build a network of relationships to support the delivery of the STP ambitions.	
06	**Chief Executive's report** Julia Ross (JR) reported that a check point event had been held on the 19th April for the Healthy Weston Programme. Clinicians had presented the outputs of the work completed to date. The independent report 'Healthy Weston: Public Dialogue and Co-design Themes' had been published. The majority of feedback was positive and there were key elements to take forward. The next stage would involve the development of the Pre-Consultation Business Case (PCBC). There were a number of actions arising from the first phase that could be implemented as part of business as usual. Other ideas involved more substantial service redesign and the next stage would involve the publication of the PCBC. This would be ready in the Autumn of 2018. To support this Katie Norton had been appointed as Programme Director.	

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	The University Hospitals Bristol Trust (UHB) and Weston Area Health Trust (WAHT) partnership was ongoing. There had been a positive meeting with NHSE and NHS Improvement (NHSI) to understand the requirements to take the partnership forward and the CCG was working with the Trusts. JR gave an update on the 3Rs programme which had been discussed at the previous meeting. South Gloucestershire Council had agreed in principle to lead the procurement and a recommendation would be presented to a Full Cabinet meeting in June for approval. Land values were an important issue and the CCG was working closely with NBT and the local authority to ensure that the NHS was able to optimise income from the land. The Programme Board to oversee the process was being established. The first meeting of the Primary Care Commissioning Committee had been held with Alison Moon (AMoon) as Chair. There had been a good discussion and debate. The minutes of the Committee would be presented to the Governing Body for information; the Committee was not a committee of the Governing Body. JR had met with North Somerset Voluntary Action Network (North Somerset VANS) which proposed to set up a process to co-ordinate the voluntary section to support the interface with health and social care. JR reported that she had been invited to the launch of the UHB strategy "Embracing Change" to talk about the integrated localities. JR highlighted the Healthier Together Conference to be held on the 21st June. This major event would include clinicians, executives, Governing Body and Board members and members of the public. The aim was to review and re-energise the STP. Muir Gray would give a key note speech and there would be presentations from the STP Sponsoring Board and workgroups would review progress and look at how to drive the STP forward. AMoon asked if other stakeholders from the BNSSG system had been invited to present at the UHB strategy launch. JR explained that it was an internal event and she had been invited as joint executive lead for the STP. UHB was supportive of the CCG ambition to develop integrated localities.	
7.1	**Procurement Integrated Urgent Care Services (IUC)** Margaret Kemp (MK) and Mike Pingstone (MP) attended for this item. Deborah El-Sayed (DES) presented the paper setting out the	

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	background to the procurement and highlighting the Five Year Forward View themes related to improving the urgent care system. BNSSG had undertaken a procurement process for an Integrated Urgent Care Service that moved from a model where the 111 service helped a patient navigate a pathway to a model where consultations were completed on the phone or the patient was connected to other services if necessary. DES confirmed that the standstill period had been concluded without challenge. The contract had been formally awarded to the BrisDoc Healthcare Services Limited in partnership with Care UK (trading as Severnside Integrated Urgent Care). MP explained that the total value of the IUC service was £12.5 million per annum, with a total contract lifecycle value of £87.5 million over seven years, and a possible extension of up to an additional three years. The initial seven year period would commence from 1st April 2019. The programme was overseen by a Programme Board chaired by Deborah El-Sayed. The membership of the board included clinicians, representatives from key commissioning functions and members of the public. There had been engagement with NHSE throughout the process. NHSE had confirmed the procurement process to be followed which involved three checkpoints: pre-advert, pre-award and pre-service commencement. The checkpoints ensured independent review. The first checkpoint ensured that the specification was fit for purpose and that the procurement process was in line with regulations and best practice, the second checkpoint ensured that an approach had been adopted that would deliver a service in line with best practice. The third checkpoint focused on the contract negotiation and the mobilisation of the service. Checkpoint two had been completed and NHSE had confirmed that the CCG could progress to contract award. MP highlighted the process and timetable set out in the paper. Two bids had been submitted and these were moderated and clarified with BrisDoc scoring the highest. 29 evaluators had taken part in the scoring process and had included all the relevant specialities, stakeholders and lay representation. A number of service users and clinicians had been involved throughout the process. The positive aspects of the successful bid were set out in the paper. MP highlighted the comprehensive approach to activity planning and the detailed approach to service development planning involving other providers in the system to ensure that services were aligned. DES highlighted that the integrated urgent care service contributed to the ambition to build a fully integrated out of hospital service in partnership with providers. JH sought clarification of the 'consult and hold/continue model'. DES explained that this meant that either a	

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	consultation was completed or the service held clinical responsibility for the patient until transfer to another service. MP confirmed that the bid was within the financial envelope and the recommendation had been approved by the Strategic Finance Committee prior to the award as part of the governance process. MP highlighted the two areas of risk identified in the paper. The formal standstill period had been completed without challenge. The procurement process had followed best practice and external legal advice had been taken. The risk of non-completion of contract was considered to be low. The procurement process had used the NHS Standard Contract as the basis for submissions to reduce this risk. MK explained that a detailed contract mobilisation plan was in place. The contract would be finalised in the summer with service commencement 1st April 2019. JR asked how the CCG would ensure that current providers and localities would be fully integrated in the mobilisation of the service. MK confirmed that Area Directors were involved in the process and that meetings were planned with the full range of providers including the mental health trust. JR welcomed the involvement of Avon and Wiltshire Mental Health Trust. JR commented that there was an opportunity to involve social care and to develop a single front door. JR commented that it was important that providers were fully involved and engaged in the mobilisation. MK confirmed that the initial meetings were to establish how to ensure that providers were fully engaged. DES commented that design meetings had taken place involving the Area Directors and looking at how of the IUC Service model linked into the design of the Integrated Care Bureau. JR commented that this was a significant transformation lever and it was important to optimise the opportunity. The Governing Body thanked the team. **The Governing Body noted that no challenges were brought during the standstill period and BrisDoc Healthcare Services Limited (Brisdoc) had therefore been formally awarded the tender to provide Integrated Urgent Care Services to the BNSSG population**	
7.2	**Options appraisal for re-procurement of Adult Community Health Services across BNSSG** LM explained that a decision in principle to undertake a re-procurement of community services had been made at the March in-common meeting of the BNSSG CCGs Governing Bodies. This was subject to further work to identify and substantial the proposals. This paper presented an appraisal of three options. The 'do nothing' option had scored low in relation to the impact and benefits to be realised across BNSSG and the option did not achieve a streamlined	

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	service offer. The second option considered was to align contract termination dates and procure each service individually with joint Lots where desired. This option would support further change but did not provide the opportunity to standardise a single procurement and its benefits which would have resulted in further costs. The option would have supported a higher reflection of local need but did not unlock benefits across the system. The third option was to align contract termination dates and proceed with a single procurement. This option allowed rapid change across the CCG, unlocked greater benefits, had the lowest procurement cost and supported greater parity across BNSSG. AMoon observed that for option three 'meeting the needs of the population' had been given an amber score and asked how the risk would be mitigated. LM commented that the development of the service specification would involve the current providers and locality GP providers to understand the local areas and the population need. Kirsty Alexander (KA) commented that social care was a vital part of an integrated community service and asked if it was likely that there would be three different social care approaches. LM explained that there would be discussions with the local authorities to identify common areas of service provision, variations in provision and to understand the local population needs. KA asked if option three presented a greater risk. LM explained that that the approach to providers would be considered as part of the service specification development. JR commented that a BNSSG wide procurement would not necessarily result in a service that did not respond to local needs. It was important that the specification was developed to describe appropriateness to localities. JR commented that under option three not all of the challenges and risks had been described. JR noted that the impact of transition to current services was a risk and it was important to consider how this transition would be managed. The paper did not describe impact on providers. The current contractual arrangements were discussed in the appendices to the paper and the service most likely to be affect was North Somerset Community Partnership. It was important that the Governing Body understood the impact of the decision. LM explained that the transition impact would be mitigated through agreeing two year settlements with providers and through a due diligence exercise to understand how	

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	current providers would remain stable going through the transition. This activity would start as soon as possible. There would be implications for the current providers in terms of recruitment and retention of staff. LM explained there was an option to consider implementation at different points. David Soodeen observed that there were community services commissioned by other commissioners and asked if these would be part of the procurement. LM explained that there would be further discussions with partners to understand what would be within the scope of the procurement. JR commented there would be a scoping process to clarify the position. DS supported the scoring matrix used and asked for further information including the criteria. LM agreed to share the criteria. JR asked colleagues whether the scoring looked correct and whether there were areas of concern related to the scoring. There were none. **The Governing Body approved option 3 to re-procure all adult Community Health Services across BNSGG singularly and simultaneously so as to realise the maximum benefits to social, clinical and financial outcomes**	**LM**
7.3	**NHSE Operational Planning Guidance 2018/19** LM explained that the paper presented the second year of the two year operational plan. The staff meeting in June would be used to set out vision and strategy for the organisation which would carry through into operational planning. The paper reflected the current position. A more accessible version of the plan would be produced that would set out the key operational plan requirements for 2018-19. LM drew attention to the financial planning context and the plan to achieve the financial target for 2018-19. The CCG had worked with providers to agree contracts within this envelope. Growth was set at the following levels for key areas: prescribing at 2.9%, Continuing Health Care at 3% and mental health at 1.5% (in line with the mental health minimum investment standard). The CCG had worked with providers to reflect actual levels of growth in emergency admissions; these had been greater than the national standard. It was noted that elective activity was lower than the national standard. The system approach for 2018-19 had been to agree to set aside 50% of emergency admissions growth funding to invest in schemes to prevent emergency admissions. This has been taken forward through the System Oversight and Delivery Group.	

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	LM highlighted the constitutional standards. The CCG would be unable to deliver RTT performance at 92% across 2018-19. The CCG, with its providers, had committed to ensure that there was no growth in the waiting list size across BNSSG. The CCG had committed to achieve the standard where no more than 1% patients wait over six weeks. The CCG was planning to meet the 62 day cancer treatment standard and achieve all other cancer standards. The CCG was working across the system to improve urgent care performance. Currently predictions were that the CCG would achieve 90% sustainability by the end of March. This would be challenging and was a priority. The CCG aimed to improve its access rates to IAPT services and to achieve 19% by the end of the year. The CCG needed to achieve 25% by the end of 2021. The CCG aimed to improve and maintain performance against the dementia standard across the CCG in 2018-19. ST clarified that the financial statement in the plan related to 2017-18 and that the figures in the plan were consistent with the Financial Plan agreed by the Governing Body at the April meeting. JR noted that a number of delivery dates had passed. As staff were appointed to roles the plan would be taken forward and refreshed, however the priorities in the plan remained appropriate. AMoon noted the Winter Plan at appendix 3 and asked if there was further information regarding the respiratory Hot clinic at NBT. Hot clinic capacity had been reduced at the Trust. There followed a discussion about Hot clinics. It was noted that Hot Clinic capacity issues could contribute to the increased referrals to the Medical Assessment Unit. It was noted that 80% of admissions related to respiratory conditions. Jon Evans (JE) commented that, in relation to Winter Planning, it would be helpful to prioritise need and place an emphasis on those services to prevent admissions. LM reported that NBT would restore capacity. It was asked whether this was the capacity available prior to the move to the Brunel building. JR noted that it was important to consider the capacity required now. LM explained that this was the first iteration of the Winter Plan and had been submitted at the end of April. The plan would be further refined. Work to understand the system regarding demand for urgent care was ongoing. DS asked about influenza targets noting that there were no targets for Primary Care. JR commented that this could be considered as part of Primary Care Commissioning.	

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	Sarah Talbot-Williams (STW) commented on the communications elements within the Winter Plan. Dividing key stakeholders and key intermediaries lost the sense of an integrated communications strategy. STW noted that using the third sector would be a way of helping with communications. STW asked about the risk log. LM explained that this would be part of the final plan. JR asked if the key messages in the Winter Plan had been tested with the public. LM explained that the messages had been tested at the national level but not locally. This would be taken forward. STW commented on the communications and engagement sections of the Operational Plan. STW asked if there would be a more digital and interactive approach? DES commented that the Transformation team would be involved in taking this forward. KA observed that Advice and Guidance services could be explored to support reducing admissions. LM explained that the contract terms agreed with the three providers included a national CQUIN regarding Advice and Guidance. There was a programme of work that would allow the expansion of Advice and Guidance where appropriate, including ensuring its effectiveness. Brian Hanratty (BH) commented on the Referral Management Service and whether this could be used as a collection point for Advice and Guidance enabling it to be shared. BH asked who to discuss possible approaches with. LM confirmed that possible approaches should be discussed with her. BH commented on pathway redesign and working with providers with the referral management service. LM agreed to discuss this outside the meeting. **The Governing Body reviewed and approved the BNSSG Operational Plan 2017-19 refreshed for 2018/19**	**LM** **LM**
8.1	**Quality Assurance Report** The paper reported on the first meeting of the CCG's Quality Committee in May chaired by AMoon. The committee had discussed: The launch of the Multi-Agency Strategy for the Management and Prevention of Pressure Injuries at the West of England Wounds Annual Conference on the 19 April. The Strategy was the culmination of 2 years work undertaken with care providers across BNSSG to develop a consistent approach to pressure injury management. A significant number of Serious Incidents related to pressure injuries. The strategy aimed to reduce the number of grade two, three and four pressure injuries. It set out clear standards and expectations for	

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	all care providers to prevent manage and detect pressure injuries. An update on MRSA and the increase in cases reported across BNSSG had been received. There had been a significant rise in the number of cases reported in Intravenous Drug Users. A task and finish group had been re-established as part of the Healthcare Associated Infection (HCAI) Group. This had linked to the Elizabeth Blackwell Institute study. The research study had not been published however information had been received describing the risk factors for this cohort. Short and long term actions had been developed and the task and finish group met monthly to implement these actions. New post infection review guidance from NHSI had removed the requirement for UHB and WAHT to undertake formal post infection reviews. It was noted there could be an impact on the whole system approach to tackling MRSA bacteraemia. The CCG was in discussion with NHSE regarding the proposed change. The Quality Committee had received the first draft of the action plan following the Serious Case Review reported at the previous Governing Body meeting. Improved timelines had been added to the action plan. The Quality Committee would continue to oversee the action plan alongside the BNSSG Safeguarding Governance Group with oversight from the Director of Nursing and Quality. It was noted the action plan would be returned to the Governing Body. A paper outlining the approach to ensure that quality metrics for AWP supported the early identification of issues was received. The CCG received monthly quality metrics and a risk profile was in development. The CCG was working with AWP and NHSE and NHSI to create a dashboard to enable oversight and early identification of issues. The committee received the Internal Audit Reports for the three former CCGs' CHC services alongside action plans in response to the audits findings. The committee would receive an update on the action plan at its June meeting. JH observed that Kate Rush had given a presentation to the NHSE Medical Director relating to MRSA and Intravenous Drug Users. There was the potential to work with NHSE regarding MRSA screening and treatment in custodial settings. AMor explained that the task and finish group were looking at a number of approaches. AMoon commented that the committee had strong membership and it	

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	would be an effective assurance committee on behalf of the Governing Body. The committee was keen to focus on outcomes and outputs rather than on processes. BH asked if there was assurance that there was effective management of MRSA within primary care. AMor commented that post infection review processes were in place involving general practice. MJ commented that the majority of patients would have had contact with healthcare at some point; he noted that standard processes to routinely swab or test at risk groups were not in place in primary care. It was agreed that this would be considered further. JR observed the level of involvement of the local authority was important, noting this was a partnership issue. AMor commented that the local authority and public health were members of the group. JR asked if there was a clear role for the local authority and public health to address the issue. AMoon noted that it had been asked at the Committee whether this was recognised as a shared priority. NK asked about the change in the reporting requirements for MRSA. AMor 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. AMoon observed that this had been discussed at the previous Governing Body meeting. There were a number of cases where there had been no contact with health services and a key issue was to identify agencies that had been involved to understand how to address such cases. There was a need to take the learning from these cases and translate it into actions. **The Governing Body noted the work undertaken, the assurances received and the actions agreed**	**AMor**
9.1	**BNSSG CCGs' Financial Report at Month 12** ST presented the position as at month 12 explaining that the CCG had delivered the financial position as reported over the last quarter. The position had improved from the forecast £35 million deficit at month 11 to a deficit position of £28 million at month 12. This was due to national changes including the release of headroom of 0.5% and the return of Category M drugs savings. This position had been reported in the draft annual accounts submitted on the 23rd April. The three sets of accounts were being audited and the outcome would be reported to the Audit, Governance and Risk Committee on the 24th May. ST thanked the finance team for delivering three sets	

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	of accounts during a particularly challenging time. The Governing Body as a whole expressed thanks to the team. JR added that that all staff had worked hard to achieve the position and thanked staff. DS asked how the change in the Bristol final position was achieved. ST explained that the change in position was set out in the appendix, and included the release of headroom and adjustments relating to Category M drugs. **The Governing Body:** • **Noted the financial position reported at month 12 and** • **Delegated to the Audit Committee the final sign-off of the Annual Report and Accounts so as to meet the NHS submission timetable**	
10	**Quality and Performance Report** LM highlighted the following areas of performance. There had been a further reduction of 2% in February in performance at a population level against the A&E standard. Urgent care remained a priority as highlighted in the 2018-19 Winter Plan. A system diagnostic approach had been used to understand the additional actions needed to support urgent care across the system. The CCG was achieving 89% against the national RTT standard of 92%, in line with the planned trajectory for 2017-18. There had been an improvement in the number of patients waiting for 52 weeks and over. This was a 'zero tolerance' target for the CCG and there was a risk that the CCG would not achieve the zero target. It was explained that there was the potential for an increase in patients waiting over 52 weeks arising from the reported cohort of patients 'on hold' at UHB. The issue underpinning the 'on hold' patients at UHB had been identified. There was a smaller cohort of patients in the same category reported at NBT. The CCG was working with the Trust to ensure that these patients were treated appropriate and identify data errors. Performance against cancer standards had improved in February. Performance in January had been affected by elective cancellations. There had been an improvement in performance against the mental health four week referral to assessment target for South Gloucestershire and deterioration in performance in North Somerset. The expectation was that as the Primary Care Liaison Service (PCLS) was rolled out the position would improve.	

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	AMor highlighted the reported Never Events. A further Never Event had been reported by UHB in March related to a lens replacement. A Contract Penalty Notice (CPN) was in place with a remedial action plan. A planned review visit to the UHB dental theatres had been jointly undertaken by the CCG and NHSI. The final report was expected; it was understood that it found that there were potential distractions in the area where staff worked which might have an impact. AMor drew attention to the improved VTE performance reported at WAHT. The Trust had achieved the 95% standard and was ahead of trajectory. There had been discussions with the Trust regarding the CPN in place and it was anticipated that the CPN could be removed. AMor reported that the CCG participated in the UHB Harm Review Panel relating to the 'on hold' patients. The CCG would also participate in the NBT Harm Review Panel. JE noted the positive performance reported in relation to elective care at WAHT and asked if there were actions that could be replicated across other Trusts. LM commented that Weston had strong performance against the 18 week target. There were issues in relation to performance against cancer standards which were being addressed. LM agreed that there were lessons that could be shared across all providers and noted the support provided to WAHT from the Emergency Care Intensive Support Team (ECIST). NK asked if the overnight closure of the A&E department had an impact on performance. It was noted that this was unlikely to have had a significant impact given the small numbers involved. Rachael Kenyon (RK) commented that the WAHT Director of Operations was to be congratulated on the improved VTE position. AMoon asked if there had been a spike in the number of consultant lead follow ups, noting that performance had been above plan. LM explained that there was a focus to reduce the number of consultant led follow ups in 2018-19, in line with the national standard. It was explained that an optimistic plan had been set for 2017-18 and that a more realistic, challenging plan was in place for 2018-19. ST noted that the spike related to the reporting approach which showed the number of working days. BH asked how the CCG rated nationally in relation to the 111 target, noting the 5% target for calls referred to ED. BH asked if this target was achievable. LM commented that the position would be tracked	

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	against the national position. DS asked about ambulance handover delays and the report that these were not applicable to WAHT. LM explained that the CCG had worked with providers to resolve issues relating to hand over delays. There was an agreed protocol at Weston in relation to hand-overs and access issues were less significant. A geo-fencing protocol was being developed and rolled out at NBT to resolve issues. It was agreed that the report should show the position at WAHT as green. DS observed that CCG position for patients waiting over 52 weeks was better that the reported position for the three Trusts. It was confirmed that the provider position included specialised commissioning and out of area patients. DS asked if those patients waiting over 52 weeks attributable to specialised commissioning were related to a specific speciality. LM explained that spinal surgery was a specific issue for NBT and UHB issues related to areas of children's specialised commissioning. LM agreed to provide DS with further information. LM commented that reporting in relation to specialised commissioning would be considered going forward. JR commented that a zero tolerance to 52 week waits was important and should be followed through into the Operational Plan. JR commented that there should be a zero tolerance to 12 hour trolley waits. LM agreed to reflect this in the Winter Plan. DS commented that reported performance against the IAPT target did not reflect the increase in referrals to the service. LM explained that the most significant increase in referrals was in Bristol, at 8%. There had not been a corresponding increase in North Somerset and South Gloucestershire. The CCG was working with AWP to map resources to areas of need and ensure that the right services were in place. These issues were routinely discussed with AWP at BNSSG level and at the wider commissioning level. This was to ensure learning was shared across commissioners to support flexibility. AWP was focused on these issues and on supporting its staff. JR commented on performance relating to MRSA, noting that 49% of cases related to Intravenous Drug Users. It was important to focus on the remaining 51% and to understand who these patients were and address the issues. It was important to ensure that actions to address MRSA were balanced. JR sought clarity regarding the reporting of performance against cancer standards, observing it was reported that performance was improving whilst it was also reported	**LM** **LM** **LM**

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	that performance against the 62 day standard remained compromised. LM explained that the CCG had moved from a position poor performance against the 62 day standard to a point, at the end of quarter three, where the standard was being achieved at BNSSG level by the two main providers. At the start of quarter four there was a dip in performance and there were potential issues for quarter four as a whole. The 62 day standard was broadly sustainable across providers and this would be built on in 2018-19. JR asked if the Governing Body could be assured that there was a sustainable position, noting the ambition was to have reliable, sustainable performance against the standard regardless of circumstances. LM responded that work taken forward in 2017-18 had matched capacity to demand and there was now more confidence regarding sustainability. JR highlighted the Never Events reported at UHB, noting that there were CPNs in place. JR asked if there were further actions that the CCG could take and asked how much the CCG knew about the clinical harm involved and the impact on patients. JR noted that a number of the Never Events related to wrong tooth extractions. AMor explained that UHB had carried out an internal review and had taken actions to address the issues identified; the review visit was organised following further Never Events and the report was expected. NK commented there had been a helpful discussion at the Quality Committee meeting relating to Never Events. AMoon commented that despite the implementation and review of action plans Never Events continued to be reported. AMoon commented that the CCG had linked with a Trust outside of BNSSG which had been the subject of an independent review regarding Never Events. The learning to date was that a greater focus was required on human factors. AMor commented that culture was important. RK noted that the Medical Protection Society had recently focused on human factors. JR commented that it was important to focus on Never Events. JR commented on the on-hold patients reported at UHB and commented that progress (not moving quickly enough) and asked when the work would be concluded. LM would review this and report back. JR asked if urgent care should be included in the provider dashboard. It was confirmed that this was an omission that would be rectified	**LM** **LM**

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	The Governing Body noted the performance position of the CCG and key providers, including the risks, mitigating actions and responsibilities	
11.1	**Item deferred**	
11.2	**Governing Body Committees' Terms of Reference** Jeanette George attended for this item. ST explained draft terms of reference had been received by the Governing Bodies at their in-common meeting. These draft terms of reference had been discussed by committees. The terms of reference for three of the Governing Body committees were presented for approval at this meeting. The remaining terms of reference would be presented to the Governing Body for approval in June. ST explained that the terms of reference had taken into account the CCG Constitution, the CCG clinical leadership model, the roles of the clinical and lay members, feedback from NHS E and other stakeholders and the feedback from Internal Auditors. AMoon commented that there had been a good discussion at the Quality Committee regarding the terms of reference that had resulted in a number of amendments to the membership. It had been agreed that the clinical leads for children and adult safeguarding would be invited to attend as appropriate as would all clinical leads. The clinical lead for quality had agreed to liaise with colleagues. STW noted that PPI was highlighted in the merged terms of reference but not in the next item, 11.3. The Governing Body thanked Jeanette George for her support and for her support over her career in the NHS, noting that JG retired at the end of May. **The Governing Body reviewed and approved terms of reference for the:** • **Commissioning Executive** • **Quality Committee** • **Strategic Finance Committee**	
11.3	**Locality Governance Arrangements** Justine Rawlings presented this item on behalf of the three area directors. The paper set out the locality leadership model, in line with the Constitution. The model described how the CCG would engage with, and be accountable to, the CCG membership. JRa highlighted that there were a different number of localities in each area and the	

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	Area Leadership Group was an important co-ordination group. There was area representation on the CCG Commissioning Executive Group. The terms of reference would be amended to reflect the reporting requirements set out in the CCG Constitution. KA asked a number of questions: whether the Commissioning Locality Leadership Terms of Reference should include a description of the appointment of members, whether the chairing arrangements needed to be described, whether the chairing of the Commissioning Forum could be delegated to others to support development. DS noted the Commissioning Area Leadership Group reference to the appointment of Governing Body members was incorrect. It was agreed to make these amendments. There was a discussion about nurse membership of the Locality Leadership Groups. JR commented that a decision had been taken that nurses would be represented through other fora. It was explained that a Practice Nurse Network was being established. It was clarified that the terms of reference did not require practice nurse representation as members; however practice nurses could attend Locality Leadership Groups if this was appropriate. GPs as members of the CCG were required to be members of the Locality Leadership Groups. KA commented that there were many clinical professions who would contribute to discussions and suggested a wider multi-disciplinary network. JR commented that it was important to have multi-disciplinary involvement in developing services and designing pathways and there would be opportunities to engage with this work. It was important to have professional networks, a Practice Nurse's network was being established and it would be helpful to consider if this should include other professions. Viv Harrison (VH) noted that the Area Leadership Groups and Locality Leadership Groups referred to local authority representatives. VH commented it would be helpful to clarify if representation was from public health or social care. JR agreed and commented it was important to understand the local authority role and ensure that there was representation at the appropriate group. JR noted that it was important to clarify that the whole membership would meet twice yearly and this should be shown on the diagram as an overarching membership. JRa agreed that the above suggested amendments would be made and the Terms of reference would be	**JRa** **JRa** **JRa**

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	circulated. JR asked if the terms of reference had been reviewed by the groups. It was confirmed that the LLG had reviewed the Terms of reference **The Governing Body reviewed and approved the terms of reference and ways of working for localities subject to the amendments agreed**	
11.4	**Report on the preparedness for General Data Protection Regulations (GDPR)** ST explained that the paper provided a briefing on the GDPR which came into effect on the 25th May. A revised set of Information Governance Policies would be presented to the Governing Body once the Data Protection Bill was ratified. ST reflected on the work undertaken in relation to the Information Governance Toolkit which contributed to the CCG's preparedness. The key focus for 2018-19 would be ensuring Information Asset Owners understood their responsibilities. An Information Governance Group would be established to assist this. It was explained that the CCGs had reported positive Information Governance Toolkit ratings and this would be built on. JRu asked if the IG Toolkit would be changed to reflect the requirements of the GDPR. This was confirmed. AMoon asked if the role of Data Protection Officer had been nominated. ST explained that this role was under consideration. JR asked if there was an ambition to improve the IG Toolkit scores. ST confirmed this. It was noted that the scores were at level two. JR asked if there was an understanding of the actions required to improve the scores. JR observed that it was important that the Governing Body was sighted on Information Governance and the organisations compliance with regulations. ST commented once the requirements of the revised IG Toolkit were clear a work plan would be developed and presented to the Governing Body. MJ confirmed that the plan would include trajectories. **The Governing Body noted the report**	**ST**
12.1	**Minutes of the Quality Committee March 2018l** **The Governing Body received and noted the minutes**	
12.2	**Minutes of the BNNSG Commissioning Executive Mach 2018** DS asked about the DVT pathway. LM confirmed that work on the pathway had been taken forward to align the pathway between primary and secondary care. The pathway would be presented to the Commissioning Executive for sign off and action would then be taken	

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	to contractualise the pathway. This was part of the planned care savings schemes and an important streamlining of the pathway for patients. **The Governing Body received and noted the minutes**	
12.3	**Minutes of the BNSSG Joint Strategic Finance Committee March 2018** KA sought clarification that the CCG would be responsible for primary care budget setting from April 2019. This was confirmed. **The Governing Body received and noted the minutes**	
12.4	**BNSSG Healthier Together Sponsoring Board** **The Governing Body received and noted the minutes**	
13	**Questions from the Public** There were none	
	Date of next meeting: Tuesday 5th June 13.30 Vassall Centre, Gill Avenue, Downend, BS16 2QQ	

Sarah Carr
Corporate Secretary
10 May 2018