Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

DRAFT

Bristol, North Somerset, South Gloucestershire CCG Governing Body meeting

Minutes of the meeting held on Tuesday 7th August at 1.30pm. Clevedon Hall, Elton Road, Clevedon, North Somerset

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Peter Brindle	Medical Director Clinical Effectiveness	PB
Jon Evans	GP Locality Representative South Gloucestershire	JE
Kevin Haggerty	GP Representative North Somerset Weston and Worle,	KH
Brian Hanratty	GP Locality Representative Bristol South	BH
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
Anne Morris	Director Nursing and Quality	AMor
Alison Moon	Independent Clinical Member Registered Nurse	AMoon
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		
Colin Bradbury	Area Director North Somerset	CB
Deborah El-Sayed	Director of Transformation	DES
Felicity Fay	GP Locality Representative South Gloucestershire	FF
David Jarrett	Area Director South Gloucestershire	DJ
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
Viv Harrison	Consultant in Public Health, Bristol Local Authority	VH
Sally Hogg	Consultant in Public Health, Bristol Local Authority	SH
In attendance		
Sarah Carr	Corporate Secretary	SC
Niall Mitchell	Head of Individual Funding Requests	NM

Jo Hartland	Head of Research and Development	JHa

	Item	Action
01	**Apologies** Jon Hayes (JH) welcomed members and members of the public to the meeting. The apologies were noted.	
02	**Declarations of interest** There were no new declarations of interest, Martin Jones (MJ) declared that he was a salaried GP at the Locality Health Centre, referred to in the report at item 6.2. This item was for information and no action to manage tis declared interest was required. Nick Kennedy noted that a declared interest relating to Babock had expired and could be removed from the register.	**SC**
3.1	**Minutes of the previous meeting and matters arising** The minutes were agreed as a correct record with the following additions and corrections: • Page 4, first paragraph, JR commented that the Healthy Weston public consultation would commence in the first quarter of 2019. • Page 5, second paragraph to read "AMoon noted the links to partners could be wide ranging…" • Page 10 Alison Moon (AMoon) noted that an action relating to IT systems was not highlighted in the action column or on the action log. Actions were collated as a single action at the end of the item minute. This applied to pages 10, 11, 12, and 13. It was agreed that individual actions would be identified and recorded on the minute and transferred to the action log. • Page 11, second paragraph to read "… helping people to understand what help they needed and the best way …" • Page 13, An action that the CCG, through the Director for Nursing and Quality, would set out with the Safeguarding Board and Serious Case Review sub group the sign off process for Serious Case Review action plans in relation to actions for health services and other associated actions would be added	**SC** **SC**
3.2	**Minutes of the Annual General Meeting of the 3rd July 2018 previous meeting and matters arising** The minutes were agreed as a correct record.	
04	**Actions arising from previous meetings** Members reviewed the action log. Action 3rd July 2018 10.1 ref 06 Lisa Manson confirmed an update on the position relating to on hold patients would be included at item 9. It was agreed to close the action. Members noted those actions that were closed and those actions that were on track for completion.	
05	**Chief Executives Report** Julia Ross (JR) provided an update on the Sustainability and Transformation Programme (STP) explaining that the Governing	

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	Body would receive bi-monthly reports on the STP. JR highlighted the following. The system's commitment to an annual system plan for 2019/20. Sarah Truelove (ST) and Lisa Manson (LM) would take this forward with colleagues. Work continued, following the STP conference of the 21st June, to develop work programmes and the Sponsoring Board had received presentations on the programmes from the Senior Responsible Officers. Work to take forward the Value Improvement Programme had begun, led by the Clinical Cabinet. The STP would commence extensive and wide ranging work to engage with local citizens; each work programme would establish a co-design process. An external organisation had been commissioned to establish a Citizens Panel. A further Healthier Together event would be organised for the final quarter of the year. The STP had submitted a bid for capital funding against the national capital fund. The bid included primary care and also included a proposal for a single patient administration system between University Hospitals Trusts Bristol (UHB) and Weston General Hospital. North Bristol Trust (NBT) had also expressed an interest in this system. The outcome of the bid was pending. The STP workforce strategy covering social care, primary care, and acute and community services had been agreed. The strategy was essential to driving transformation. The Urgent Care Strategy, approved by the Governing Body previously, had been signed off. Work progressed on the Healthy Weston programme, with a commitment to commence public consultation in the first quarter of 2019. JR informed members that the STP had been nominated and accepted on the aspirational Integrated Care System Programme. This reflected the national recognition of the progress made by the STP. JR had participated in a meeting with the University of Bristol, the University of West of England, the Student Health Service (GP practice), mental health services and Bristol City Council. The meeting focused on mental health support to students. This had been a positive meeting looking at what more could be done to support students. More on this work would be presented to the Governing Body at a later date.	

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	JH commented that it was important to note that the success of the STP was due to JR's leadership.	
6.1	**Review of NHS Funded Homeopathy Services** Niall Mitchell attended for this item (NM). Peter Brindle (PB) explained that the CCG was the only CCG in England still commissioning Homeopathy services. This factor and other reasons including the CCG's commitment to being an evidence-informed organisation and the obligation to make the best use of resources had resulted in a decision to review the commissioning approach to these services. There had been two periods of public consultation and engagement with the most recent consultation completed in the first quarter of 2018. The second consultation had looked at three options: • Option 1: Continue the homeopathy consultation service under the CCG's current 'prior approval' policy, whereby NHS funding would be granted for one outpatient appointment and up to four follow-up appointments if the patient met published CCG criteria. • Option 2: Amend the current policy to provide homeopathy in a more targeted manner. This could include restricting the eligibility criteria, reducing the number of appointments routinely funded or extending the time before people were eligible for re-referral. • Option 3: Make NHS-funded homeopathy available only in exceptional circumstances. This would require an application by a clinician to the CCG's Individual Funding Request Panel setting out why the patient was clinically exceptional compared to all other patients. The results of the consultation were set out in appendix 2 of the paper. Approximately half of the respondents lived with the CCG area. There was no statistically significant difference between the proportion of people living in the CCG area who supported Option1 or Option 3. The data from the consultation exercise, the current evidence around the effectiveness of homeopathy and a set of criteria developed to support decision making between the three options were presented to the Commissioning Executive for review, discussion and decision. The conclusion of the meeting was that a recommendation should be made to the Governing Body that Option 3 should be adopted as the commissioning approach to these services. The paper asked the Governing Body	

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	to review this decision and assure its self that a robust process had been used to reach the decision. Kirsty Alexander (KA) noted that there was a complex patient population with unexplained symptoms and asked how these patients would be managed. PB explained that there were other services that patients could choose to use such as counselling services and pain clinics. It was important to endeavour to provide the time and care for patients so that they felt properly listened to. JH comment that the paper recognised that some of the potential savings that would be made by not commissioning the service would be reinvested into providing other support for patients. JR highlighted that, when considering the number of patients with medically unexplained symptoms, the number of patients accessing homeopathy services was small in comparison. Jon Evans (JE) sought clarification that the 50% of respondents to the public consultation living outside the CCG footprint were users of homeopathy services within the BNCCG area. PB explained that some of these respondents would have been practitioners or users of homeopathy. JE asked if taking these comments into account influenced the outcome of the consultation. NM explained that there had been a number of national campaigns, both for and against providing homeopathic services, as a result there had been a focus on those respondents living within the CCG area. JR noted that there was no evidence that those respondents living outside the CCG area had used homeopathy services within BNSSG. The most appropriate group to consider was local residents rather than the wider lobbying community on either side. NK observed that a blanket ban on the commissioning of homeopathic services was not recommended. NK noted that the operation of blanket bans was unlawful and a process for patients to apply for funding in exception circumstances was required. JR highlighted that the CCG was the only CCG in England that continued to commissioning homeopathy. It was important that the Governing Body considered whether there was any reason why the CCG would be different to the rest of the country. PB highlighted table three which set out the decision-support criteria. The criteria enabled the objective judgement of the three	

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	options. A three-point scale for each of the criteria was used where a score of one equalled low / negative, two equalled medium / mixed, and three equalled high / good evidence in support of a particular option. PB explained that the process did not look for evidence in support, or otherwise, of homeopathy and instead looked for evidence supporting the options under consideration. There were two areas where there were differences between Option 1 and Option 3 which included 'Consistency with good practice guidance' and 'Alternatives and opportunity costs'; these differences resulted in Option 3 scoring 15 out of a maximum of 21 and Option 1 scoring 12 out of a 21 maximum. Option 2 scored 10 out of 21 a maximum. The three options each received the same score against the first criteria 'Evidence about safety'. When considering the criteria 'Evidence about effectiveness' the Commissioning Executive had looked at the evidence for homeopathy and the view was to score Option 3 an extra point. Post meeting, this score was reviewed and external advice was taken. It was noted that the consideration was around the evidence for each option and not around the evidence of effectiveness of homeopathy. The position reached was that there were no grounds for awarding Option 3 an extra point and there was a mix of evidence for each Option. It was agreed that the score for Option 3 against this criterion would be reduced to two for this paper. Option 1 and 3 scored the same for Engagement and Consultation and all three options scored the same against the Equalities Impact Assessment criterion. The Commissioning Executive had discussed whether offering homeopathy advantaged certain patient groups, however, no evidence could be found to support this. Option 3 scored the highest against the criterion 'Consistency with good practice guidance' reflecting the Option's adherence to national guidance and the position of the CCG as the only one in England that offered the service. The other two Options both scored one point against this criterion. The Options scored the same against the Financial Considerations criterion. It was recognised that those people using the service and those who would potentially use the service in future would require alternative services. It was considered, however, that it was likely that some resource would be released by Option 3 and therefore this scored higher than the other two options against the 'Alternatives and opportunity costs;	

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	criterion. It was noted that there had been a detailed and thorough discussion at the Commissioning Executive meeting. MJ commented that there was a cohort of patients often with multiple conditions who were conventionally not supported and for whom homeopathy had been an approach. It was important to consider in the future how these patients were supported better in a more holistic approach and the kinds of services that would be best. AMoon observed that the risks identified had mitigations in place and asked if there were any concerns about risks related to Option 3. PB explained that the risks were included in the paper; for people receiving treatment mitigations were being established to enable them to complete their current course. It was important to ensure that people who might have used homeopathy in the future were supported. The paper described all the concerns and mitigations. JR commented that it was important to note that the risk assessments reflected that in other areas of the country, where the approach in Option 3 had been adopted, there had been no reported harm patients. DS observed that there was a GP practice in North Bristol that prescribed homeopathic remedies and asked if there would be an impact on this practice. PB confirmed that homeopathic treatment was not included on the CCG formulary. The prescribing of homeopathic remedies would now be discussed with the practice in line with the national guidance. Peter Marriner (PM) sought clarification as to when the CCG would stop funding homeopathic services if Option 3 was adopted. JR explained that, if adopted, the Option would be implemented immediately; patients currently received a finite about of treatments and once these were completed funding would cease. KA asked how a decision of exceptionality would be reached. It was explained that the nature of exceptionality meant that this could not be described. John Rushforth (JRu) asked if a Panel would be given guidance regarding the level of evidence required. NM explained that the Panel met monthly and received an aide memoir to help with the review of cases which included the strength of evidence. The Panel also received support from Public Health who provided guidance on evidence presented.	

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	Sarah Talbot-Williams (STW) asked why the contract variation notice would be issued to the acute trust, noting that the service provider was a social enterprise. It was explained that the service was contracted through UHB. STW sought clarification of the action to publicise the decision within a month. It was explained that the decision would be publicised immediately once taken. The IFR website would be updated once the contract variation notice was served. **The Governing Body:** • **Assured itself that a robust process had been followed** • **Considered the evidence and public consultation feedback, and** • **Voted unanimously to approve the Commissioning Executive recommendation to move forward with Option 3, that NHS funded homeopathy would be available on an individual, case by case basis following approval by the Individual Funding Request Panel** • **Noted that the decision would take immediate effect, following normal contract notification periods**	
6.2	**Primary Care Quarterly Report** Lisa Manson (LM) explained that NHS England had delegated the commissioning of primary care to the CCG as of April 2018. The CCG had established a Primary Care Commissioning Committee, (PCCC) that sat alongside the Governing Body. This was the decision making body for the management of the delegated functions and the exercise of delegated powers. The Committee held meetings in public and was chaired by AMoon. A sub-committee, the Primary Care Operational Group, had been established to oversee the associated work programme. The quarterly report provided a detailed update on the primary care work programme; noting that the minutes of the Primary Care Commissioning Committee were received by the Governing Body. LM highlighted the pace of work and progress made. The key areas of work were highlighted. The Local Enhanced Service Review looked at the Local Enhanced Service payments to practices to address the different arrangements established previously across the CCGs. The conclusion of the review, and the new specifications were available on the CCG website. There had been five practice mergers in the first quarter of 2018-19. The process to review proposed practice mergers had been	

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	refined to ensure that the PCCC was assured regarding patient engagement. Work to understand the rationale relating to the temporary closures of practice lists was highlighted. LM drew attention to the procurement of General Medical Services currently provided by the Locality Health Centre under an APMS contract which ended on 31st October 2018. The procurement of Interpretation and Translation services was highlighted. Primary care estate had been included in the STP bid for capital funds for the first time. The bids were detailed in the report. A number of Minor Improvement Grants had been agreed. A new specification for Improved Access had been approved; this had been developed in conjunction with practices and localities. There had been a focus on the development of a Quality and Performance report. This included reviewing the measures to monitor, report and how best to use available data. Work continued on the GP Five Year Forward View including reviewing the monitoring and assurance to be presented to the PCCC. JE welcomed the progress made and asked if there was a task for the Locality Representatives and others to explain the responsibility regarding delegated commissioning and the decision making processes to the membership. JR noted that the work now undertaken by the CCG had been previously carried out by NHS England. JR agreed that the interface with localities and practices was important and asked GP colleagues to advise on the best way to do this without creating conflicts of interest. JE commented that clarity of communication was important, previously practices were separated from the process. It was important to help practices understand the processes and this was for the locality representatives in the locality groups. It was important to be transparent and communicate effective. DS explained that he was the area representative for Bristol on the PCCC and that he provided feedback at locality meetings on both the Governing Body and the PCCC. DS commented that it would be helpful to have a consistent message to ensure all key issues were captured. DS commented that each locality had specific interests; for example, the Bristol Inner City and East Locality was interested in the procurement of Interpretation and Translation Services and the evaluation of the bids. LM commented that members of the primary care team would welcome the opportunity	

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	to work with the localities to understand how communications could be improved, recognising that this was a relationship with practices as providers and not as commissioners. LM commented that support with the evaluation of the procurement would be welcomed. DS agreed to support this.	**LM/DS**
	JR asked if the GP Bulletin could be used better to communicate with Practices. MJ explained that there had been discussions with the communications team about the GP Bulletin and noted a Head of Communications with Primary Care would be appointed. It was recognised that the GP Bulletin needed to be a key communication mechanism with the membership. The communications team would work with the Area Directors and MJ to produce a richer publication that would include information of interest to the localities as well as key messages and address the comments made regarding consistent messages. Justine Rawlings (JRa) commented that a member of the Bristol North and West Locality had attended the PCCC and had found it a useful experience. Brian Hanratty (BH) commented that the paper was helpful in providing clarity for members. BH explained that the Bristol South forum was considering how to reset engagement to ensure consistent communications. DS asked if the paper could be shared with the fora. It was agreed that the Area Directors would share the report.	**MJ** **JRa** **CB** **DJ**
	AMoon explained that there had been four meetings of the PCCC. The initial meeting had been jointly led with NHS England and subsequent meetings had been led by the CCG. The pace, focus and work across teams was evident. The meetings had been attended by members of the public. AMoon commented that from the content of the meetings it was evident that the CCG led primary care commissioning and worked in partnership with NHSE.	
	KA asked how arrangements agreed under the previous CCGs would be managed to ensure links between the Governing Body and the PCCC. JR commented that the role of the PCCC was deliberately separate to the Governing Body and it was the role of the executive ensure the links between the two bodies. JR noted that GP representatives who attended the PCCC as observers would be able raise awareness regarding previous arrangements.	

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	Kevin Haggerty (KH) commented that it would be helpful to have a Quality and Performance report focused on key areas for improvement within localities. LM agreed to investigate the development of separate locality reports enabling comparisons. NK asked if the proposed metrics covered all the areas the CCG wished to consider. LM explained that the metrics had available data sets and allowed a comparison between practices. The next stage of the process would be to identify other areas to be monitored and discuss this with practices. It was important to ensure that data could be collected and monitored consistently across the CCG. JR observed that the monitoring of quality and performance across general practice had been a key feature of discussions and there was an appetite to work with the CCG. There was a high standard of general practice across BNSSG as measured by the CQC and the Quality Outcomes Framework. The CCG wanted to understand if there were other measure that would support general practice. **The Governing Body noted the delivery of the primary care work plan through quarter one of 2018/19**	**LM/ AMor**
7	**Report on Looked After Children (LAC)** JH left the meeting at this point to attend to other business. JRu chaired the meeting for this item. Anne Morris (AMor) explained the paper provided an update on the actions put in place to meet and improve the needs of looked-after children and care leavers across BNSSG. Prior to merger each CCG had different arrangements for the strategic oversight for looked-after children. The CCG designated nurse for looked-after children had come in post on the 1st August 2018. AMor highlighted the CCG's responsibility to ensure that appropriate arrangements and resources were in place to meet the physical and mental health needs of looked-after children This included access to a designated doctor and nurse for looked-after children. The function of these roles was to provide assistance commissioners of health services to fulfil their responsibilities to improve the health of looked-after children. The NHS had a major role in ensuring the timely and effective delivery of health services to looked-after children and contributed to meeting the health needs of looked-after children in three ways: commissioning effective services, delivering through provider organisations, and	

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	through individual practitioners providing coordinated care for each child AMor commented that the recent Special Educational Needs and Disabilities inspection report for North Somerset had found that the post of designated nurse for looked-after children was vacant. AMor explained that recruitment to the post had been unsuccessful and this would be discussed with the North Somerset Community Partnership (NSCP) service manager to understand whether the post could be reconfigured. AMor noted that the current situation was not sustainable. The report provided performance information for quarter 4 from the Children's Community Health Partnership (CCHP) and NSCP. Looked-after children's services for the CCHP, which covered South Gloucestershire and Bristol, were provided by Sirona. The CCHP had reported poor performance in relation to the completion of Initial Health Assessment within 28 days. NSCP had also performed poorly against this requirement. Performance in relation to the review of health assessments was also poor across all three areas. It was noted that the Community Looked After Children (CLAN) team was dependent on receiving timely notifications of a child coming into care to enable the completion of an Initial Health Assessment within the statutory timeframe. There was evidence that notifications were not being received within this timeframe and the CCG had requested an audit of notifications over a six-month period. This would provide information for further actions to be taken forward with Local Authority colleagues. New initiatives were being piloted by the CLAN team to improve performance related to late notifications. These included holding provisional slots for initial health assessments. It was noted however that if the appropriate information was not received in time the slots could not be used. To address this the health form was now embedded within the Local Authority database. AMor drew attention to the requirement for effective channels of communication between local authorities, CCGs, NHS England and health service providers, to ensure that the health needs of looked-after children were met without delay. The relationship between the local authority and the CLAN team in Bristol had improved however, as reported, processes for sending timely	

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	notifications remained challenging. Individual social workers were responsible for notifying the CLAN team of children and young people coming into care. To date an electronic system to automatically complete this had not been identified. It was explained that in North Somerset notifications were sent to the CLAN when a child or young person was in 'pre proceedings'; however approximately only half of these cases would progress to become looked-after Children which resulted in unused slots for assessments. It was likely that adopting a similar process in Bristol and South Gloucestershire would create a greater number of unused slots given the larger numbers of children and young people involved. AMor explained that table four in the paper should have reported six cases for Bristol in quarter four and not 42. There was an agreed method for data sharing to ensure correct information was available for future reports. Table five should have read Strength and Difficultly Questionnaire (SDQ) and not SDG. AMor commented that the figures for the review of health assessments were low and reflected refusals and cancelled appointments. The figures also included looked-after children who were placed out of area. For these children and young people, the review health assessment was traditionally completed by the host local authority. It was found that this was causing delays and the Bristol CLAN team now carried review health assessments over a wider geographical area. This would increase the number of review health assessment completed. Attention was drawn to the action plan which had changed significantly since the drafting of the paper to reflect progress made. The intention was to complete all actions as quickly as possible. The CCG designated nurse for looked-after children was completing a review with providers and local authority colleagues to provide a comprehensive overview of resource implications, noting that there were workforce issues to address alongside the management of referrals. JE sought assurance that the audit of notifications would align with the planned review. AMor explained that both were required and confirmed that the audit would inform the review. DS noted that looked-after children were placed within the BNSSG area by other	

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	local authorities and voiced concerns regarding notifications for these young people. AMor agreed this was an area of concern and a national issue. It was important to work with local authority colleagues to ensure an awareness of children placed within the CCG area. LM explained that the providers had been asked to identify how many looked- after children could be seen within 28 days at notification. This would identify capacity issues and help understand potential resource issues. KA commented that this was long standing issue and previous discussions had considered shared IT. JR commented a robust, monitored plan was critical; these were very vulnerable children and young people and a timely response was important. It was important to understand the detailed issues. JR asked that an updated action plan be presented to the Governing Body after review by the Quality Committee. It was agreed that an updated action plan would be presented to the Governing Body in October**.** JR asked that this included an appropriate governance arrangement that enabled partners across health and the local authorities to hold each other to account. AMoon explained that the Quality Committee had requested the paper. The report to the Committee had raised a number of concerns and further work had been requested. The Committee had not received the plan presented to the Governing Body. AMoon explained that the Committee was concerned about the position and wished to understand the immediate actions to be taken and the medium actions required to resolve the position. AMoon highlighted concerns related to the outcomes for the children involved, and the level of sign-up by local authorities to the Child Protection Information Sharing System. 43 percent of local authorities had signed up to the system and it was not known whether the BNSSG local authorities were part of the system. It was expected that the review would cover this. The updated and revised plan would be considered by the Quality Committee. AMoon agreed that out of area looked-after children, placed within BNSSG, was a concern. It was also important to reach agreement with local authority colleagues on information sharing. JR asked that any challenge on this area was escalated to her as this was a	**AMor** **AMor** **AMor**

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	matter to raise with local authority chief executive colleagues. AMoon confirmed that this was an action that came out of the Quality Committee. KH commented that the number of looked-after children who had not had assessments was a concern and it was important to have more information on this in the next update. AMor commented that it was important to view the locality authority action plan alongside the CCG plan to ensure that these matched. JR agreed and commented that it was the CCG's role to facilitate this and it would be idea to have one action plan. DS observed that the out of area placement of looked-after children was a national issue and that a local solution would not address all the issues as a result. AMoon confirmed that the issue of information sharing applied across all local authorities and noted that Bristol CCG had previously raised the issue with NHS England. AMoon commented that this could be escalated again with NHS England. STW commented that there were issues that related to refugee children. JR asked that future papers clearly separated the issues. **The Governing Body noted** • **the report and the appointment of a Designated Nurse for Looked After Children** • **the actions planned to achieve recovery of performance,** • **that quarterly progress reports on the improvement trajectory and action plan will be reported to the Quality committee**	**AMor** **AMor**
8	**Finance Report** JH re-joined the meeting. Sarah Truelove (ST) drew attention to the planned deficit for 2018-19 which was £10 million. Achievement of this would release £10 million from the Commissioner Sustainability Funding bringing the overall position to breakeven. The forecast as at Month three was to deliver the plan for the year. The CCG was reporting a year to date variance of £3.9 million for hospital services. This was largely offset by the reserve position. There were significant data quality issues with aspects of the acute data and this lack of data had impacted on the position. The CCG's savings programme position had improved in month. The CCG was on track to deliver the financial duties set out in the report. Attention was drawn to the year to date variance relating to acute care and specifically non-elective	

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	admissions. It was noted that non-elective admissions were above plan and a particular issue at NBT. Critical care activity was above plan; this activity related to two long stay patients and the over performance was not likely to continue. The savings position at month three was close to plan with £6 million of savings delivered. This was encouraging and there was more to be done in relation to the forecast position, with some control centres still to complete forecasts. This delay was due data availability and would be resolved. Indications were that the position continued to improve in month four. ST drew attention to three financial risks. The non-delivery of savings continued to be a risk; this was currently showing a £10 million variance. No cheaper stock obtainable continue to be a risk. The CCG had been informed by NHSE that this would not be a recurrent issue. There were further potential issues related to this, for example potential changes in prices arising from the Brexit negotiations. The CCG would continue to discuss this with NHSE, noting this was a national issue. Urgent care demand was a new risk for month three and this was a significant concern. The CCG was working to understand and resolve this matter. LM commented on the A&E Delivery Board discussions regarding urgent care demand. The full position and impact on all aspects of urgent care was presented at the meeting. Non-elective performance was being maintained. The was bed availability across the system and length of stay was reducing however there had been an increased number of attendances, particularly in July. Providers were asked to supply data as close to real time to understand the pattern of activity. A review of procedural changes was in place to understand if there were differences in the management of patients by specialty. The August A&E Delivery Board meeting would continue to focus on the position. KA asked if locality information on performance and activity could be provided. This was agreed. DS asked about the reported activity for respiratory services which was above plan. ST confirmed that this was one of the data issues to be investigated. NK asked if the CCG was assured that critical care over performance related to two patients only. ST commented that approximately 60% of the overspend related to two patients. The	**ST**

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	issues regarding data quality were also thought to be a contributory factor. JE asked when the decision to release the £10 million Commissioner Suitability Funding would be made and whether financial pressures outside of the CCG's control, such as no cheaper stock, would be taken into consideration when determining the release of funds. ST explained that maintaining a dialogue with NHSE was important, particularly in relation to the issues of no cheaper stock obtainable. ST highlighted that the final position was one of judgement and this was part of the role of the end of year discussions. MJ noted that there was an appetite at the CCG and Governing Body to become involved in richer discussions about data to understand the position. To enable these discussions, it was important to consider how to bring together data. JR observed that BNSSG had a historically low rate of GP referral and commented that this was a factor to review and understand. It was important to focus on both non-elective and elective activity. ST commented that there had been a 2.6% increase in referrals with a plan for a 1.2% increase. There had also been a significant increase in consultant to consultant and other clinical referrals. JR asked that that this was followed up. ST commented that there were specific areas where this was high, for example dermatology. LM commented that these needed to be understood in terms of the other mitigations in place such as advice and guidance services and work to review this was ongoing. JH asked if this information would be shared and discussed at localities. JRa commented that the data had been reviewed at each locality and there was work in place with the locality executive groups to identify the key issues for each locality. The intention was to report on variations at locality and practice level. AMoon asked if the referral management service was BNSSG wide. It was explained this was not the case. MJ commented that there was plan to roll out the referral service across the CCG once a service review was completed which would be within the year. **The Governing Body noted the financial position, the key risks, issues and mitigations reported at Month 3**	**LM** **LM**
9	**Quality and Performance Report** LM explained that A&E performance had improved up to the end of May to 92.8%, despite an increase in attendances of 3.2%. The biggest improvement had made at NBT. The current position was	

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	more challenged and there had been a number of days of significant poor performance. Commissioners were working to understand how providers responded to surges in attendances and how the wider system could support this. The position regarding 18-week elective referral to treatment times had improved by 1% to 89%. The open number of pathways had deteriorated by the end of May from the position at the 31st March. Operational Planning Guidance for 2018-19 changed the measure of elective workload. Performance against the 62-day Cancer target had been compromised by the fire at the UHB Haematology and Oncology Centre in May. Recovery of performance was expected by the end of August. Activity overall had increased. The trajectory for the reduction of the number of patients waiting over 52 weeks remained on target and would be achieved by the 31st March 2019. LM confirmed that there were 1200 on hold patients to be reviewed and that this would be completed by the 31st August. AMor drew attention to the MRSA standard. It had been previously reported that changes had been made nationally so that cases previously were apportioned to a third party were now apportioned to the CCG. AMor highlighted the reported 3 CCG apportioned cases and informed members that the reported number of cases apportioned to trusts was incorrect; there were no trust apportioned cases. There was a renewed focus on post infection reviews across the CCG. The Quality Improvement Oversight Board would review and develop system wide learning and solutions. The MRSA leaflet had been updated and there was ongoing research into the use of Clinell wipes. The CCG was looking to improve data sharing with trust colleagues to improve data accuracy, better wound infection control and improved infection control compliance. Of the three cases of MRSA apportioned to the CCG one involved an Intravenous Drug User. The CCG was reviewing the post infection reviews of the cases to understand the underlying causes. There had been no Never Events reported during the reporting period. A Never Event was reported by an acute provider in July and this was being reviewed. The Never Event related to the connection of oxygen and air; no harm had come to the patient. A full RCA and a safety learning event was planned for all partners. AMor highlighted that AWP had made significant progress related to the reporting of Serious Incidents. The Trust held twice-monthly	

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	executive lead ratification panels to review root cause analyses. The Trust was recruiting to a central patient safety team and there was increased locality based root cause analysis training for staff. DS commented that it would be helpful to see information on the rapid response team and other aspects of community services alongside data regarding A&E attendances and noted that community provision was not included in performance report. LM explained that commissioners were working to develop meaningful, consistent community data sets. Three different performance reports were received from community providers and comparable data was limited. It was agreed that contextualised data would be included in future reports. AMoon highlighted the breaches reported in relation to cystoscopy at NBT and noted that this had been discussed at the Quality Committee. It had been confirmed that Harm Reviews were being conducted and that no harm had been identified. AMor confirmed this. AMoon explained that the Quality Committee had requested that the full MRSA action plan was presented to the August Committee meeting and the 72 hour Never Event Report to be presented to the Committee. JH noted that there had been an increase in the number of Never Events reported at UHB during 2016-17. The narrative referred to guidance changes during the year, with a disproportionate impact on UHB. JH asked if the reasons for this were understood. It was explained that the particular change related to Dental Never Events and this had an impact on UHB due to the Dental Hospital services provided. A review of all Dental Never Events had been completed. There had been a visit by NHSE, NHSI and the CCG to look at practice. The subsequent report had recently been made available and further clarification was being sought from NHSE on a number of points. UHB had accepted the report and an action plan would be developed. It was agreed the Quality Committee would receive the NHSE report. JRu asked about the ambulance service report, seeking clarification of the comment that although the target was not being met formal performance management procedures could not be put in place. LM explained that this related to the Ambulance Response Programme (ARP) monitoring. SWASFT had run the	**LM** **AMor**

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	ARP as a pilot and monitoring was implemented in March 2018. The CCG was working with the Trust to develop data into a meaningful reporting format. SWASFT was one of four ambulance services nationally not meeting the targets. JR observed the two-week cancer standard had been achieved and asked if this was sustainable and for an update on the position against the 62-day standard, noting that NBT had dipped in performance. LM explained that performance against the two-week cancer standard was improving but not yet sustainable. This was partly due to the increase in referrals in recent months. There remained issues in relation to breast and dermatology services. There were issues related to urology and delays in cystoscopy that impacted on the 62-day standard and the impact of the fire continued to be felt. Weston Hospital had focused on reducing the number of patients who were waiting over 104 days. This focus had impacted on the 62-day standard. JR commented that the CCG had expected to sustainably achieve the 62-day standard from quarter three 2017-18. LM explained that the fire was the most significant issue regarding performance; UHB had committed to achieve the 85% standard by the end of August. The expectation was to be on track in quarter three. There would continue to be a deterioration during quarter two with the lowest dip expected to be reported in the performance data for July. JR commented that this was an important standard for the CCG to be on top of and it was agreed that action plan would be discussed at the Quality Committee. JR observed that the CCG planed target for dementia diagnosis was above the national target and that the CCG was not currently meeting the plan. JR asked for more information on this. LM explained that this was year two of a two-year plan aimed at achieving a higher standard across BNSSG reflecting the higher rate of dementia diagnosis in the Bristol area. The CCG was struggling to achieve this and work to review the provision of dementia services was looking at how to streamline services to support a higher rate of diagnosis across the CCG. JR asked whether the model adopted in Bristol had been rolled out across the CCG. LM confirmed that this had not yet happened. JR asked that this be taken forward. JR observed that national standards were set at a particular level and it was important for the CCG to understand why it might take a different position. JR commented	**LM** **LM**

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	that it was important to ensure that effort was put into diagnosis, and treatment and support. LM would provide further information on the setting of the plan and the aspiration behind it. The review of dementia services was part of the work related to the Mental Strategy. Currently services were fragmented and there was work to complete to streamline services. BH commented that the work in Bristol focused on diagnosis and management in general practice with Dementia Navigators. There had been a significant educational element. The aim was to avoid referring patients to specialist dementia services. DS commented that he was a lead for NHSE on Mental Health and that NHSE was considering raising the percentage target. DS observed that when considering the demographics across BNSSG, although Bristol had a bigger population there were more people who would potentially have dementia in South Gloucestershire and North Somerset and implementing the Bristol model across BNSSG would potentially increase diagnosis rates significantly. DS highlighted the social medicine aspect of the Dementia Navigator model. JE commented that the Dementia Advisors, from the Alzheimer's Society, in South Gloucestershire had a similar role. JE highlighted that it was important to ensure that diagnosis of dementia in primary care was supported by a range of services. It was important that CT scan referrals from primary care were accepted and it was important to re-energise education regarding diagnosis and provide resources. It was noted that there were radiology issues relating to NBT. LM commented that it was important to standardise the service across BNSSG and this issue would be review. MJ drew attention to the improve figures for Delayed Transfers of Care (DToCs) reported by AWP. LM noted that the number of out of area placements was in single figures and length of stay had reduced. **The Governing Body noted the performance position of the CCG and key providers, including the risks, mitigating actions and responsibilities**	**LM**
10.1	**Research and Development (R&D) Annual Report and update** PB introduced the paper explaining that the Research and Development team had worked across the three CCGs for a number of years. PB commented that this was an area where the	

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	CCG stood out in terms of performance regarding research activity and how income from this was used to support an evidence and evaluation service. The papers explained the activities undertaken in the past year and how the Research and Evidence team were seeking input from the Governing Body on how it should continue to grow, develop and impact on all the functions of the CCG. Jo Hartland (JHa) drew attention to the update paper which showed how the team worked with academic colleagues at Bristol University, University of the West of England and others to ensure that colleagues looked at NHS focused issues which were developed into co-research ideas in conjunction with NHS colleagues. The overarching aim of the strategy was to support research informed practice and practice informed research. The strategy was described in the document and this demonstrated the range of partners involved. The type of work undertaken was described in the paper, including evaluations undertaken and research funded by national bodies that had arisen directly from work with commissioners. JHa highlighted the plans for the future which included: • Consolidating and expanding the position of the service in the heart of the CCG's work • Expanding the training offered to colleagues • Whilst recognising that some research activity was based on relatively long time scales, encouraging swift turnaround and fast response to issues • Work to support the delivery of the 8 objectives identified by the Executive Team. JHa explained that the team was working with the new clinical effectiveness team and would work as one in the future. KA asked if asked if the team would support the development of the primary care localities. JHa welcomed the suggestion and explained that the team would be working with locality colleagues to get research recruitment on to the agenda. DS asked if the team provided support to procurements and to potential procurements. JHa explained that the team had worked to become more involved across the range of activities and the relocation of the team alongside other CCG teams would support this. The team could support with the design of evaluation and	

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	have an input into all aspects of procurement including service specifications. DS commented that the work undertaken in relation drug users and hepatitis had a link to health inequalities. AMoon explained that the Quality Committee had received the report. The Committee had discussed the dashboard for clinical trials which was 'red'. The Committee had noted that it was not as easy for primary care to link to clinical research networks. AMoon asked how the public health core offer would work in future. PB explained that a new BNSSG core public health offer had been agreed. This was being reviewed in the light of consultations undertaken by Bristol City Council. Significant cuts were being made to the service and key members of staff had also been lost in the North Somerset service. It was clear that the local authorities would not be able to resource the core offer in line with previous commitments. The CCG was working closely with the Directors of Public Health and consultants to review the offer to ensure a focus on matters that were important to the CCG. There was a potential risk as posts supporting research and evidence reviews within the Bristol Public Health team were likely to be lost alongside the Health Economics post. JR asked that the CCG make representation to Bristol City Council on this matter. There was an expectation, when public health services moved to local authorities, that appropriate support to CCGs would be provided. PB explained that he had raised this with the local authority and their position was this was an internal consultation. JR asked that PB to write formally to the Local Authority to express the CCG's concerns and request that they took due regard of the concerns when making their decisions. JRu asked if the CCG was able to access research that would assist activities such as public and patient participation and organisation development. PB confirmed that the service would be able to help across the full range of activities undertaken by the CCG. JRa commented that in terms of the integrated localities there was an opportunity to develop the evidence base as the work progressed. JR commented that how evidence and research supported innovation as well evaluation was important. PM asked how the CCG obtained advice on emerging technologies. It was explained that this fell within the remit of Deborah El-Sayed. PB commented that it was important to have a rigorous approach to	**PB**

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	understand how new ideas would deliver. JR asked that the Annual Report introduction be amended to highlight that the team was part of the CCG. **The Governing Body:** • **commented on the paper** • **supported the future activities described** • **confirmed support to reinforce the messages and support the work promoting the importance of evidence and evaluation across all CCG work, and** • **approved the publication of the Research and Evaluation Annual report with the above amendment**	**PB**
10.2	**Policy for the Sponsorship of Activities by, and Joint Working with, the Pharmaceutical Industry** PB explained that the policy had been developed by the Medicines Optimisation team with support from the corporate team. The policy had been updated to reflect an obligation for employees who were involved with pharmaceutical companies to have their details entered on to the Disclosures UK Database. The policy also reflected CCG's Gifts and Hospitality policy and Managing Conflicts of Interest policy. JE asked if the obligation to disclose information involved information before 2016. It was explained it did not. STW noted that there was a typographical error on page 10. This would be corrected. STW asked how much money the CCG received from sponsorship. It was agreed to investigate this however it was understood that the CCG did not receive any sponsorship currently. ST confirmed there were regular checks of the information. PM asked if the policy should refer to software and similar innovations and whether this should be clarified at page seven, section four. JR asked that the final paragraph of the introduction should make explicit reference to clinical leaders and also consideration needed to be given as to whether the CCG members were covered by the policy, noting although it would not extend to members as policy it would be good practice for members. JR sought clarification of the statement on page seven that "The CCG expects all commissioned provider organisations to ensure that their employees allow disclosure". It was explained that this was a	**PB** **PB/ST** **PB** **PB** **PB**

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	requirement of the NHS Standard Contract. JR asked that this be made explicit in the policy as the CCG could not extend its policy to include providers. JR highlighted page ten, section 5.8 and the reference that "…the clinical lead may decline or decide to refer the representative to the deputy director …" and asked if this should read "should refer.." Section 5.9 also include a statement that "staff may wish to refer to the CCG Individual Funding Request Commissioning Policies…". JR asked that the use of the word 'may' in the sections and others be reconsidered. JR asked that the section be reviewed to ensure that the IFR policies were the correct place to refer staff to. JR asked why item 8 included the statement that "Commissioners should not proactively seek out such schemes [primary care rebate schemes]" PB agreed to review this. JR asked that section 8.3 set out the CCG's governance arrangements to approve primary care rebate schemes to included approval by the Commissioning Executive or other appropriate governance structure and publication on the CCG website. DS commented could be used by members. PB confirmed that the CCG was in the process of offering the policy template to all members. There was a discussion about the potential for sponsoring of locality events and it was noted that it was important to have clear parameters. AMoon commented that guidance was that primary care rebate schemes had to be initiated by pharmaceutical companies. JR clarified that it was not for the CCG to initiate schemes however if there were opportunities the CCG should consider these. NK asked if the CCG had experience of joint working with the pharmaceutical industry. It was explained that there were examples of this kind of working which had been productive. **The Governing Body agreed that the policy would be revised and re-presented for approval to a subsequent meeting**	**PB** **PB** **PB** **PB**
10.3	**Business Continuity Policy** LM presented the policy that set out the process to follow in the event of business continuity event. The policy defined the command and control structure required and supported the CCG by identifying priority services with a focus on clinical services such	

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	as Continuing Health Care. Each Directorate would have a Business Continuity Plan enabling the CCG to maintain business critical functions in the event of an incident. JR asked that communications be added as a priority services. JR asked what the timeframe for the development of Directorate Business Continuity Plans was. It was agreed to aim for plans to be completed for the end of September. STW sought clarification of the communications strategy section. LM explained that the intent was there would be an organisation wide strategy, noting that business continuity measures were often triggered by a major incident. There would be a bespoke communications strategy for each incident. AMoon asked if exercises would be linked to risk scenarios. LM explained that the CCG would undertake internal exercises to develop the internal response to the risk scenarios and would participate in other organisations' exercises. The CCG would work with partners to develop wider exercises. MJ sought clarification of the requirements for the primary care directorate. It was confirmed that the requirement was to develop plans for the directorate and not wider primary care. LM commented that there was further work to complete to understand the responsibility for the wider primary care system. PM asked if there would be an incident committee to manage a response and if there would be templates to use in the event of a loss of IT. LM explained that the CCG had a Director on Call rota supported by managers on call and business continuity would be managed through this process. There were also templates for the management of incidents. It was agreed that this would be referenced in the policy. **The Governing Body approved the Business Continuity Policy with aspiration that Directorate Business Continuity Plans would be in place by the end of September**	**LM** **All** **LM**
10.4	**Information Governance Compliance, Data Security and Protection Toolkit and Information Governance Polices** ST explained that the Governing Body had requested an action plan to improve performance against the Information Governance Toolkit. The toolkit had been replaced by the Data Security and Protection Toolkit. The previous Toolkit had different levels of compliance; under the new Toolkit an organisation would be compliant if it met all mandatory requirements. The Toolkit included both mandatory and non-mandatory elements and the	

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	work plan aimed to ensure that the CCG was compliant across both sets of elements. The change in focus in the Toolkit was reflected in the work plan. The papers included the refreshed Information Governance Policy and the Confidentiality and Security of Information Policy which had been updated to reflect the revised Data Protection Act 2018. PM asked about the monitoring of progress and asked if an October submission would be too early given the requirement relating to Information Governance training. ST explained that the ambition was to ensure that all Information Governance training was completed by the end of quarter three. **The Governing Body noted the Information Governance Compliance and the Data Security and Protection Toolkit Briefing and approved:** • **The Information Governance Policy** • **The Confidentiality and Security of Information Policy**	
11.1	**Minutes of the Quality Committee May and June 2018** AMoon commented on the June minutes, noting that the Committee had focused on the Looked After Children paper and the Serious Case Review. **The Governing Body received and noted the minutes**	
11.2	**Minutes of the Commissioning Executive June 2018** **The Governing Body received and noted the minutes**	
11.3	**Minutes of the Strategic Finance Committee June 2018** PM gave a verbal update on the July meeting. The Committee had reviewed the financial position and the progress reported in relation to the savings plan. The Committee reviewed progress across Control Centres. The Committee had received an update on the Adult Community Services Procurement. **The Governing Body received and noted the minutes**	
11.4	**Minutes of the Primary Care Commissioning Committee May 2018** It was noted that the June minutes had been deferred, awaiting further update by NHSE. AMoon commented that it was important to receive timely updates to minutes.	

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11.5	**Minutes of the Patient and Public Engagement Forum May 2018** STW that the Forum met bi-monthly. The Forum was in a developmental stage and STW was working with the Area Directors and Deborah El-Sayed looking at how the Forum worked with the Area Fora. Staff were developing a full calendar of activities and establishing the underpinning communications.	
12	**Questions from the Public** There were none.	
15	**Motion to Exclude Press and Public** JH proposed a motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business. JRu seconded the motion	
14	**Date of next meeting: Tuesday 4th September, the Vassall Centre, Fishponds, Bristol**	

Sarah Carr
Corporate Secretary
August 2018