# Bristol, North Somerset, South Gloucestershire CCG Governing Body meeting

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

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## Minutes

| **Present** | | |
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| Jon Hayes | Clinical Chair | JH |
| Kirsty Alexander | GP Locality Representative Bristol North and West | KA |
| Colin Bradbury | Area Director North Somerset | CB |
| Peter Brindle | Medical Director Clinical Effectiveness | PB |
| Deborah El-Sayed | Director of Transformation | DES |
| Jon Evans | GP Locality Representative South Gloucestershire | JE |
| 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 |
| Peter Marriner | Lay Member Strategic Finance | PM |
| Anne Morris | Director Nursing and Quality | AMor |
| Alison Moon | Independent Clinical Member Registered Nurse | AMoon |
| 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** | | |
| Felicity Fay | GP Locality Representative South Gloucestershire | FF |
| Kevin Haggerty | GP Representative North Somerset Weston and Worle, | KH |
| Brian Hanratty | GP Locality Representative Bristol South | BH |
| Viv Harrison | Consultant in Public Health, Bristol Local Authority | VH |
| Justine Rawlings | Area Director Bristol | JRa |
| **In attendance** | | |
| Sarah Carr | Corporate Secretary | SC |
| Carol Slater | Head of Transformation (Mental Health & Learning Disabilities) | CS |

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| Lesley Ward | GP South Bristol, Clinical Lead Urgent Care | LW |
| Laura Davey | Corporate Services Manager | LD |

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| 01 | **Apologies**<br>Jon Hayes (JH) welcomed members and members of the public to the meeting. The apologies were noted. | |
| 02 | **Declarations of interest**<br>There were no new declarations of interest and no declarations of interest related to agenda items. | |
| 03 | **Minutes of the previous meeting and matters arising**<br>The minutes were agreed as a correct record with the following corrections:<br>• Page 3, first paragraph to read "the system had recovered"<br>• Page 15, title item 12.2 to read "April 2018" | |
| 04 | **Actions arising from previous meetings**<br>Members reviewed the action log and noted the updates. All due actions were closed. GP colleagues were reminded to review their declared interests. | |
| 05 | **Update from the Clinical Chair**<br>Jon Hayes (JH) highlighted the 70th anniversary of the NHS, noting that it was a national institution to be proud of and that there was a duty to ensure that it continued. JH informed members that he would participate in a Radio Bristol interview as part of the celebrations.<br><br>JH reported he had attended a meeting of the Avon Local Medical Committee (LMC). There had been a positive reaction to the work of the CCG and an appetite for change in primary care across the BNSSG footprint. JH had also attended a meeting of the North Somerset clinical forum meeting as part of his ongoing networking across the CCG. JH had met with the Chairs of Sirona, Weston Area Health Trust (WAHT), and Avon and Wiltshire Partnership Trust (AWP) as part of the STP Healthier Together work. JH had attended the University Hospitals Trust Bristol (UHB) Board meeting. JH highlighted the patient story presented at the meeting given by a carer of a child with disabilities. The Healthcare Passports used by patients within the hospital to help them explain their needs and preferences were described. JH noted how important this was for patients. JH commented that the CCG had now moved to a single IT domain. | |
| 06 | **Chief Executive's report**<br>Julia Ross (JR) reported that the Healthier Together event held on the 21 June had been successful. Approximately 320 people had | |

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| | attended the event and positive feedback had been received. The keynote speech, delivered by Muir Gray, had focused on how value was delivered in health care. The speech had been well received. After the event JR had met with the Chief Executive Officers of partner organisations and the event had helped make a step change in to the delivery of the STP. JR highlighted the work taken forward by Sarah Truelove (ST) and other Directors of Finance in relation to planning for 2019-20 and moving towards a single system budget. The next steps, alongside taking forward the programme described at the event, were to build a clinically lead programme focused on value. It was hoped that Muir Gray and his team would work with the local system to develop this through the Clinical Cabinet, supported by the CCG.<br><br>JR had attended a national STP Leads meeting with Simon Stevens and other national leaders. Key messages included the new investment in the NHS. Simon Stevens had talked about working together across the NHS and partners to design the ten-year plan. Primary Care remained a key issue, it had been acknowledged that GPs had left the system and a new focus on primary care was needed. There had been a session on the work focused on the GMS contract and the measurement of primary care at scale and integrated care. The CCG had offered to become involved with this work. Other priorities were: Integrated care, system leadership, Mental Health and delivery of NHS Constitution Standards. JR commented that there remained concerns about performance within BNSSG. The system was able to demonstrate improvement, however, this needed to be sustainable. There had been discussion at the meeting about the coming together of NHSE and NHSI and a commitment to do better as regulators to enable systems to work better. JR highlighted that the discussion at the meeting demonstrated BNSSG CCG's alignment to national strategy and the CCG would ensure that it was part of developing the new strategy.<br><br>JR reported on the recent clinical fora meetings. There had been positive feedback about the developing ethical decision making framework. JR had asked GPs at for feedback. This was positive and it was encouraging to hear about the level of engagement with the CCG and its plans. | |

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| | The Health Weston Steering Group comprising of the Chief Executives of the partner organisations and clinical lead colleagues had met. The pre-consultation business case would be prepared for the autumn. This would be signed off by the clinical senate and NHSE. The system was moving towards setting out the sustainable future of Weston General Hospital and what this would mean in terms of new services to meet the needs of the population and changes that might be required. The CCG had procured external support to help delivery to timescales. There was a commitment to starting public consultation in January 2019.<br><br>JR reported on a recent meeting with the Bristol Mayor, Marvin Rees. There had been a positive discussion regarding deliberative budgeting and the potential for the local authority and CCG to work together, overtime, to talk to the population about how to best allocate resources.<br><br>There had been positive meetings with the AHSN and CLARC and public health colleagues. There were strong partnerships in terms of innovation, evaluation and research.<br><br>JR highlighted the national Health Plus Care conference; she had been invited to speak about the CCG merger. JR was unable to attend the conference and Alison Moon (AMoon) had given the presentation on JR's behalf. There had been positive feedback.<br><br>AMoon asked if there had been reference to improvements in performance against NHS Constitution Standards by September 2018 at the national STP leaders meeting. This had been reported in the media. JR reported that this was not raised at the meeting. It was made clear at the meeting that the standards remained important and were to be delivered. | |
| 7.1 | **Mental Health Strategy Development Process**<br>Deborah El-Sayed (DES) presented the paper. Carol Slater (CS) attended for this item. DES highlighted that good mental health was one of the CCG's priorities. The ambition was that people of all ages, including children and adolescents, experienced positive mental health and were supported to live well. Current services were fragmented and this had been raised by service users. The strategy would bring together services to ensure continuity of experience across BNSSG. | |

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| | CS explained that the report provided an update on the programme of work and the focus on the development of an all age strategic framework with partners. This would underpin all aspects of mental health and wellbeing and included improving access and reducing unnecessary variation across BNSSG. The paper set out the background to the rationale for a strategy and the emphasis on lived experience and co-production. Primary care and localities would be essential to the delivery and success of the strategy. Parity of esteem was critical; in its broadest sense with physical health and parity across BNSSG. The Healthier Together event had provided an opportunity to discuss, map out, and seek views on current services and identify gaps. A 'helicopter' approach was used to collect information. CS highlighted two examples from the event, one person had commented that they had ended up at A&E with their child who was in crisis because there was no other place for them. Another person commented that pathways emphasised drugs and therapies but some people needed compassion and time.<br><br>Jonathan Evans (JE) asked if Long Term Conditions and mental health should be considered in the strategy. CS welcomed this comment. David Soodeen (DS) commented that it was mandated that there should be an IAPT service for people with Long Term Conditions and this was part of the IAPT re-procurement. JE noted work previously done within cardiology. DS commented that many Long Term Condition pathways included psychologists working in secondary care however they were not integrated with the system as a whole. AMoon highlighted the transition from child to adulthood and the need for good outcomes and welcomed the inclusion of Adverse Childhood Experiences (ACE). AMoon noted the links to partners could a wide range including, for example, housing organisations and that there were internal health partnerships to consider, for example, multi-disciplinary areas such as obstetrics. AMoon observed it was important to produce a strategy that focused on outcomes.<br><br>KA highlighted the importance of prevention and asked that the language be revised from "where possible" to "we will". Nick Kennedy (NK) commented that seeing children in inappropriate settings was a real issue. NK asked if obesity and depression would be included in the strategy. | |

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| | Peter Brindle (PB) asked how would it be known when parity of esteem was being achieved. CS commented that measures demonstrating this were challenging; parity of investment in terms of funding and resources was one measure. Being able to demonstrate that people were being treated as a 'whole' rather than 'codes' would also be an indicator. DS commented that reducing the gap for morbidity and mortality would also be an indicator. JR commented that it would be helpful to have measures that demonstrated parity**.** Martin Jones (MJ) observed that patients were good at articulating the position. DES commented that it was important that the strategy reduced the fragmentation of services and it was important to start shaping Key Performance Indicators to measure integration.<br><br>AMor commented on ACE and public health issues such as obesity, noting that there had been studies on these areas conducted in America that could be helpful. Sarah Talbot-Williams (STW) welcomed the focus on lived experience and the proposal to widen the range of partners. Lisa Manson (LM) commented that work was underway in relation to children being seen in crisis in A&E. Work was focused on investment in CAMHS and how this could be used both to prevent and support patients in crisis. Peter Marriner (PM) commented it would be helpful to describe what success would look like and how it would be monitored. DES explained that the draft strategy would come back to the Governing Body in Winter 2018. It was agreed to incorporate the Governing Body's comments in the Strategy.<br><br>**The Governing Body noted the report and provided feedback as requested** | **DES** |
| 7.2 | **Update on the Development of Locality Commissioning Groups and Locality Provider Groups within BNSSG CCG**<br>David Jarrett (DJ) explained that the locality commissioning leadership groups were well established. A key development was the establishment of the area meetings which brought together a range of stakeholders to discuss locality plans. The membership fora had been established across BNSSG to ensure a consistent approach. A schedule had been developed for the full BNSSG membership forum (planned for two per year) and the next event would be held on 11th September. | |

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| | Six provider localities had been formally established with Memoranda of Understanding developed as part of Phase One of the Locality Transformation Scheme (LTS). Phase Two of the LTS was now being completed. The locality provider groups had been asked to deliver a service model against the specification for improved access for GP and Primary Care services in each locality. Submissions were received at the end of June; these would be reviewed and the intention was that the new service model would be implemented from October 2018. JH sought clarification of the reference in the paper to the agreement of the phase two plans for access meant agreed with commissioners and not agreed within the locality. DJ confirmed this.<br><br>The second element of Phase Two was the development of priorities through the locality provider fora bringing together key locality providers including community service providers and local authority providers. These fora identified initial priorities and ways of working at a locality level. The priorities had been submitted. The intention was to present the priorities to the Integrated Care Steering Group. The development of Phase Three and the provider alliance would be through the STP. The CCG continued to work with the provider groups. The paper summarised the release of funds through the LTS. DJ commented the positive development of the locality provider groups.<br><br>Colin Bradbury (CB) highlighted the importance of matrix working arrangements across the wider organisation to the development of the locality commissioning groups. JE commented that it would be helpful to look at sharing learning across the localities and ensure the dissemination of good practice. JE observed it would be helpful to align discussions at membership meetings in relation to the on-going procurements. JE commented that feedback from the South Gloucestershire membership was that they found it helpful to have 'across table discussions'.<br><br>PM sought clarification of the funding. It was confirmed that it was per head of population within each locality. JH commented that it was important to have boundaries between providers and commissioners. JR noted that there had been discussions regarding the role of the locality commissioning groups signing off the provider localities plans. It was appropriate the route was through the Commissioning Executive. Racheal Kenyon (RK) | |

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| | asked if the ethical decision making framework would be used as part of the decision making process. JR confirmed that this would underpin all the CCG's decision making.<br><br>STW asked for further information regarding the appropriate and proportionate involvement and engagement of patients and the public in the development of the locality model and implementation plans. DJ explained that the engagement process had not be clarified and was a work in process. It was noted that each locality was developing engagement fora however these did not currently constitute an engagement plan.<br><br>**The Governing Body noted:**<br>• **the progress made to date in developing locality commissioning groups and locality provider groups**<br>• **progress made to date through Phase 1 and Phase 2 of the Locality Transformation Scheme**<br>• **Supported the continued development of Phase 3 the Locality Transformation through the Sustainability and Transformation Plan (STP) Integrated Steering Group** | **DJ/CB/ JRa** |
| 7.3 | **STP Urgent Care Strategy**<br>Lesley Ward (LW) was welcomed to the meeting. DES explained that the development of an Urgent Care Strategy had been endorsed in September 2017. The strategy was an evolving document and would continue to be refined.<br><br>There had been a rigorous development process which included public engagement. There had been support from the Finance and Business Intelligence teams to complete benchmarking and financial modelling. Key findings had been tested across the system through a series of sessions with colleagues from Urgent and Emergency Care services across BNSSG. There had been a focus on key drivers and on population groups to ensure a responsive Urgent Care system for the future. There were four key themes in the strategy; Integration, Targeted Prevention, Simplification, and Consistency across the system and clinical assessment. The core tenet of the strategy was to bring organisations together to address key issues. DES highlighted the key enablers including workforce and digital technologies. The overarching expenditure challenge was in the region of £325 million; currently Urgent Care costs were approximately a quarter | |

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| | of this, the strategy gave a position to deliver savings of approximately £23 million. The strategy was ambitious and savings would be reinvested. Lesley Ward (LW) commented that the strategy was being taken forward and aspects were currently being implemented. DES highlighted the Plan on a Page which showed how the strategy connected to on-going projects.<br><br>DES explained the governance process to date. The next steps were highlighted and included referencing frailty specifically as part of the cohort of patients described as having 'multi-morbidity' and strengthening the payment mechanisms section to include potential new contractual frameworks. More detail non-medical supporting interventions such as community pharmacy would be added to the strategy. DES drew attention to the finance and resource implications, explaining that the work now became part of control centre activity.<br><br>STW asked why hospital at home had not been included. DES explained that this was covered in a different strategy and that there were a number of different strategies that needed to fit together. STW commented that the engagement undertaken to date was unlikely to have reached specific patient groups such as the homeless. STW noted that within the findings there was no breakdown by groups and asked how it would be ensured that there was engagement with groups. DES explained that this was the starting point for the delivery of the strategy and that there would be a targeted engagement process. One of the considerations of the Patient and Public Involvement Forum was ensuring that representation of these groups was reflected in its membership and formal governance as well as ensuring that continued collaboration was more encompassing. The strategy included the creation of alternative ways of engagement including a collaboration platform.<br><br>JH asked if the strategy would be presented to the governing bodies of the STP partner organisations for approval. It was confirmed that the strategy had been received by the Sponsoring Board and the STP executive group. Each organisation would take the documents through their internal governance processes. The STP group of Chief Executives had signed off the strategy. | |

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| | DS asked whether the figures for the number of urgent care contacts within primary care and the spend per annum on primary care were correct. DS asked if a comparison across practices was available. DES commented that a comparison had not be completed across practices. The information was aggregated data. DES commented that a review of data to understand referral routes would be helpful and it would be helpful to have measures for primary care to understand consistency. JH noted that this was an important point to take through the Primary Care Commissioning Committee. There were performance standards applied to 'out of hours' primary care services, and this was an opportunity to consider metrics for primary care in-hours. DES added that it would be helpful to understand outcomes to help understand efficacy and appropriateness of referrals. This could be reported back to GPs. MJ commented that patients and outcomes could be followed through the urgent care system as a whole, however, there was no measure for patients seen as urgent care patients solely within primary care. KA commented that self-care needed to be threaded through out services. DES agreed that the communications aspect was important; the messages to people about how to use the urgent care system were important.<br><br>PB commented that frailty was not a subset of multi-morbidity. The issue was whether to focus on frailty or multi-morbidity. DES agreed that the language needed to be refined. JE asked if there was confidence that Connecting for Care would be a IT sufficient enabler with the anticipated time lines. DES confirmed that Connecting for Care was an important enabler. There was a broader IT strategy across organisations to create interoperability between organisations. JE highlighted it was important to keep sight of progress.<br><br>AMoon noted the reference to harm as a result of pressure and commented that patients on outlying wards had less good outcomes and this should be included in the description. AMoon asked if there was confidence that information about patients held by 111 was shared with ED when patients were referred, noting a recent coroner's report that had found that the IT systems did not talk to each other. DES commented that this did not happen however it was technically possible. It was important to ensure that this improved and it was part of the IUC/CAS work to build clinical protocols and the flow of information. DES noted that there was a | **MJ/ AMor** |

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|  | programme of work involving the ambulance services and urgent care system and this was helping to advise and shape the national ambulance service digital strategy and the connection to the urgent care system. There was the possibility of support from the centre regarding the licences required to create the interoperability between IUC/CAS' and Trusts. Locally this work was going forward.<br><br>AMoon asked if the strategy included helping people understand what help they needed and the most way to access that help. DES explained that this was covered in the simplification theme; it was important to simplify the offer and explain this to people. JR commented that systems needed to change and not public behaviour. Changing systems to enable people to do things differently was important and this was why simplification was key. It was agreed to take forward the comments made by the Governing Body.<br><br>**The Governing Body reviewed, commented on and endorsed the STP Urgent Care Strategy for BNSSG** | <br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>**DES** |
| 8.1 | **Development Plan for the Quality Strategy**<br>AMor explained the overall aims of the strategy which were set out in the paper and drew attention to the key priorities explaining that these were not in a priority order. The paper was a developmental plan that had been discussed at the Quality Committee. The Committee had challenged the ambition and priorities and these would be revised. The plan would be further reviewed by the Committee.<br><br>DS commented that measuring quality in primary care needed to be included in the strategy. It was noted that there was a system to share feedback from primary care however secondary care clinicians could also provide helpful feedback. DS asked how local CQUINs related to the strategy; noting it was important that these were aligned. AMor welcomed the comments about engagement with a broad range of clinicians and agreed that the local CQUINs needed to be part of the strategy. JR commented that primary care quality would be a focus for the CCG with its responsibilities for delegated commissioning. There needed to be a focus on the whole provider system as there were challenges across providers. |  |

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| | KA asked if the strategy should consider value alongside safety and patient experience. JR agreed it would be helpful to refer to the three strands of quality, clinical effectiveness, safety and patient experience, and that value was an element of clinical effectiveness.<br><br>AMoon commented that the Quality Committee had supported the plan and had asked for further work on the ambitions and the ambition relating to Health Care Acquired Infections was highlighted as an example. The ambition was to be in line with other CCGs in the south west. The Committee's challenge was to be the best CCG. Another area considered was whether there was other information the CCG wished to capture, for example always events identifying best practice. DS commented that it was important to have ambitions set within a context. AMor noted that there had been a robust discussion about aspirations and the links to other strategies. MJ commented that it was important to develop appropriate benchmarking. It was agreed to take forward the comments of the Governing Body in the development of the strategy.<br><br>**The Governing Body approved the plan for the development of the Quality Strategy** | **AMor** |
| 8.2 | **Briefing on the Bristol Serious Case Review (SCR) 'Becky' and the implications for the CCG**<br>(AMor) explained that the paper provided an update on the SCR action plan. The Domestic Homicide Review (DHR) was to be completed by the Home Office. The Bristol Safeguarding Board action plan had 28 actions. The Health sub group had reviewed the health related actions and deemed them to be green with one exception that related to Connecting for Care. AMor noted that health had a role to play in all of the actions and monitoring of the entire action plan was through the Safeguarding Children's Board Serious Case Review sub group and the main board received regular updates. The outstanding actions, detailed in the appendix would be challenged at the next safeguarding board. There would be a process to gain assurance regarding completed actions and the implementation of on-going actions. This would be achieved through the quality and performance meetings with providers, the safeguarding governance group and the Quality Committee. | |

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| | MJ asked how the CCG would be assured that everything possible had been done. This related to IT systems and also what information was presented and when and whether it had been share appropriately. The action plan addressed some of these concerns. AMor commented that it was important to review these issues as part of the serious case review. Some of the actions had been implemented and it was important to gain on-going assurance.<br><br>JR voiced concerns about the action plan and highlighted that a number of actions were classed as green although this was not matched in the body of the report. JR observed that this was a very serious SCR and one where the lessons must be learnt. JR commented it was not clear how the CCG was managing the action plan and she had discussed this with AMor. JR explained that Louise Lawton, the Chair of the Bristol Safeguarding Adult Board had asked the CCG to meet with her. JR noted that the issues were connected and were about how the CCG was assured that the provider was improving quality. JR commented that this was a matter that required a forensic approach from the CCG. JR noted that some of the actions for the CCG were not entirely within the remit of the CCG. The CCG knew that there was more to do in terms of mental health and safeguarding and how the Governing Body was assured that actions were in place. AMor commented that this SCR had shown that there was a need for an overarching piece of work regarding management of SCRs and action plans so that assurance was available. JR noted that it was for the CCG to help safeguarding leads understand the healthcare system. JR commented on the action regarding sufficient school nursing and the assurance which was described as a specification had been set out for the provider. JR commented that this was not an assurance and that the assurances needed to be stronger.<br><br>PM noted that a number of actions were outstanding and asked why there had been slippage and whether new dates were being agreed. AMor explained that this would be clarified when the draft action plan was reviewed at the subgroup. JH asked that this information was reported back to the Governing Body. AMor agreed and commented that she wished to bring back to the Governing Body a paper regarding the approach to managing SCR action plans and gaining assurance. JR commented that the paper was not explicitly clear regarding the actions where the CCG | **AMor** |

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| | was accountable and this needed to be explained further with the actions taken to address these. There was a further, wider system plan that the CCG had a role in.<br><br>AMoon observed that there were recommendations for all agencies in the action plan and recommendations that applied to all practitioners. A key issue was the signing off of agreed recommendations by the Safeguarding Board. MJ commented that the Safeguarding Board needed to champion what was expected of people and how it expected partners to react and work together regarding information sharing and behaviours. AMoon noted that this discussion could be held at the core partner meetings. AMor commented that there needed to be more appropriate challenge at the Board and the new arrangements would help this.<br><br>**The Governing Body received the briefing** | |
| 9.1 | **Finance Report**<br>ST presented the Finance Report explaining that there were a number of data quality challenges arising from issues with providers. As result an approach had been adopted for the savings plans that took the risk assessed positions at a point in time and showed the profiled position for savings delivery. This approach showed a slippage of approximately £700,000. It was explained that the majority of this fell within medicines optimisation. Month 1 prescribing data was now available and this indicated that the CCG was on plan and the position had improved by approximately £500,000. ST explained that the CCG was on plan to deliver the agreed £10 million deficit target.<br><br>ST drew attention to the financial duties set out in the report and reported that the CCG was on track to deliver these. ST highlighted the financial allocation set out in the report. There had been no in-year changes to this allocation to date. The financial position and provider analysis was set out. It was explained that a more detailed picture of the relationship between activity and finance would be shown in future iterations. ST drew attention to the financial risks. The most significant risk at the time of writing the report had been the non-delivery of savings. The risk assessed position had shown a £13 million gap with a 50% likelihood of the risk materialising. This position had improved and ST noted there was more to be done to reduce the gap further. | |

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| | ST highlighted the risk related to ‘no cheaper stock obtainable’. ST noted that this was an issue arising in 2017-18. NHSE had informed the CCG that this was a non-recurrent issue that would not carry over into 2018-19. The CCG was finding that stocks were becoming available at a higher price which created a challenge. The CCG was monitoring the position and continued to analyse the data and raise the issue with NHSE. ST highlighted the mitigations in place and the CCG was reporting no net risk.<br><br>NK asked if the method used to calculate the risk values and percentage likelihood were standard accounting practices. ST explained that the intent was to provide an indication of the degree of concern regarding each issue and the potential likelihood at that point in time of the risk materialising. There was a discussion about the methodology. JRu commented that the percentage likelihood was not a statistical judgement but was a structured judgement of the current position. ST explained that it was intended to give visibility to the Governing Body. As the positions changed over time it would provide clarity regarding the context.<br><br>DS asked about the risk relating to the historic issue of payment for sexual health testing and whether this related to a specific test. ST commented that this related to two tests over several years. The CCG was confident that the position could be defended as the issue had not been raised previously. It was agreed to provide DS with more detailed information. DS asked about the ‘no cheaper stock obtainable’ risk. DS asked if the mitigation would be provided by NHSE. ST clarified that the mitigation was not provided by NHSE and that NHSE had been clear with the CCG when it set out its plans that ‘no cheaper stock obtainable’ should not be considered a recurrent issue. ST explained that it was not being recognised as a risk to the CCG and information was being passed to NHSE seeking clarity about the position and the mitigation. ST would continue to raise this with the local team to resolve the position. JE commented on the total commissioning budget and asked if growth was shown in the budget. ST explained that growth was included when the plan was set, the intention in the report was to provide a record of new allocations received in-year.<br><br>**The Governing Body noted the financial position, the key risks, issues and mitigations reported at Month 2** | **ST** |

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| 10 | **Quality and Performance Report**<br>LM explained that the issues relating to data quality and validation referred to in the finance report had impacted on the performance report. LM drew attention to A&E performance which had improved by 5% between March and April. There had been a 7% increase in performance at NBT. There had been a significant reduction in the number of long stay patients; weekly focus meetings were held to review all patients with a length of stay of over 21 days to understand how their discharge could be supported to further support flow within the Trust. Both NBT and UHB had taken actions to improve flow and the benefits of these actions were evident. There had been improvements in the fluctuations in attendance. This was changing in terms of the numbers of patients presenting and there was an indication that there had been an increase in the numbers of 'minors' attendances; this highlighted the importance of the Urgent Care Strategy and monitoring patient information.<br><br>LM highlighted that planned care performance was sustained at 88%, in line with the commissioned plan and the trajectory for the referral to treatment milestones. The number of patients waiting over 52 weeks had reduced. Commissioners were actively reviewing these cases and asking patients if they wished to move to an alternative provider. LM reported that patients had expressed a preference to remain with existing consultants.<br><br>LM reported that the CCG expected to achieve the 62-day Cancer Standard in May. A dip in performance was expected for June and July as a result of the fire at the UHB Haematology and Oncology Centre. Full recovery was expected by August.<br><br>KA commented on the reported increase in elective activity. LM explained that the data needed validation and this would be followed up. KA asked if it would be possible to access 'real time' data. LM explained that the timing of data did not allow for validation. The Commissioning Executive received recent data however this was not validated and did not always align with the validated data submitted nationally. Given the public nature of the report it was important that data was recognised by all parties.<br><br>JR asked about the reported deterioration in performance against diagnostic standards and highlighted the reported increase in the |  |

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| | number of patients waiting over six weeks for echocardiography and non-obstetric ultrasound. LM explained there had been specific issues related to capacity in cardiology; there was an action plan to increase capacity and it was expected that the position would improve. JE commented on bed occupancy noting that the Urgent Care Strategy referred to a bed occupancy of 85% which would help to free up the system. JE commented that bed occupancy at NBT was reported at 98% and asked when the CCG would intervene if the trajectory was not being followed. LM explained that there was a programme of work in place to reduce bed occupancy across the system to *95%*. A key indicator was the monitoring of patients with a length of stay over 21 days; this was being change to monitoring a length of stay of over 14 days. The specialist nature of some of the hospitals meant that some patients would have a length of stay in excess of 14 days. These instances were broken down into patients who were medically fit for discharge.<br><br>NK asked if there was further information on the referral for spinal surgery. LM explained that the waiting lists at the two tertiary units, NBT and University Hospitals Trust Plymouth, had been closed for a number of years. These were now reopened resulting in an increase in referrals. There were programmes of work as part of the musculoskeletal service to ensure that patients received optimal treatment. There would be a south west review of spinal surgery. JE commented on multiple facet joint injections which were available via exceptional funding and the potential impact of this. NK asked if the issue related to neuro-surgical spinal surgery or spinal surgery. LM explained that Plymouth had a department jointly staff between neuro surgeons and orthopaedic surgeons; this was not as clearly set out in Bristol. LM noted that there were a number of patients who had been previously operated on by specific consultants and wished to continue their treatment with these consultants. NBT undertook clinical reviews of these patients and offered alternative options however this often meant changing consultant. NK asked if the problems arose from a specific lack of capacity. LM explained lack of capacity likely applied to both neuro surgeons and orthopaedic surgeons and this was one of the reasons for a full review. There was had been a previous review and both providers had been incentivised through CQUINs to implement a spinal network. | |

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| | DS drew attention to mental health monitoring which was now reported at a BNSSG level. DS highlighted that this level of reporting could mask issues at a locality level particularly in relation to Delayed Transfers of Care (DToCs) noting that levels in Bristol had been historically higher. LM explained that monitoring was carried out at a local authority level and followed up at the monthly meetings with the Trust. This level of detailed had been aggregated for this report. LM explained that there had been concerted efforts to reduce DToCs across the AWP footprint and there had been a significant reduction in the number of Out of Area placements. LM agreed to share the monthly monitoring reports with DS.<br><br>KA asked if the number of patients waiting for adult ADHD assessment included young people in transition to adult services. DS commented that the figure would include young people and there should not be an 18 month waiting list. DS explained that at transition CAMHS services should make an early referral for transition to adult services. LM confirmed that this would be picked up and a recovery plan implemented.<br><br>JH asked who would be responsible for ensuring that all GP practices across BNSSG had access to the ICE (Integrated Clinical Environment) referral system for diagnostics. MJ commented that there was work underway to resolve this. Licence costs were an issue to be resolved. RK commented that there were aspects of ICE that impacted on patient choice. LM agreed to explore this further.<br><br>AMor highlighted that HCAI data was now reported for one CCG. Post infection reviews continued to be undertaken for all cases of MRSA. A whole system approach for reviewing HCAI cases was in development. The quality team was involved in the Harm Review Panels following the fire at the Haematology and Oncology Centre. UHB had participated in a NHSI led focus group regarding Never Events. The outcomes of this focus group were being incorporated into the Trust's action plan. The outcome of the NHSI led visit to the Dental Hospital was pending. NBT expected a CQC visit in July focused on emergency and urgent care. The CQC had completed site inspections at South West Ambulance Service Trust and the unannounced visits would be completed soon. | **LM**<br><br>**LM**<br><br>**LM** |

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| | AMor drew attention to complaints handling which had been an issue for providers. The quality team had led a meeting of acute providers and agreed a standardised approach to improve complaints handing and management. NBT should reach their target at the end of August. A learning network for complaints across BNSSG had been agreed. The issues previously reported regarding NBT's ED discharge summaries would be resolved as the patient administration system came back on-line. The quality team was reviewing compliance with Serious Incident reporting time frames at AWP. There would be a further update at the next Governing Body meeting.<br><br>JR queried the UHB Never Events commenting that there had been nine events this year. JR asked whether these were reporting issues. AMor explained that the Never Events were genuine events. AMor commented that the human factors approach and the learning from events were important. JR asked when there would be progress on reducing the number of Never Events occurring. It was noted that the majority of the Never Events reported related to Dental services. The NHSI visit to the Dental Hospital reviewed processes and procedures and it was important to use the report, when available, to ensure that the actions and action plan were appropriate. ST sked if the type of Never Event could be presented in future reports. This was agreed. JR commented that it was important to demonstrate action and provide assurance that issues were being resolved. AMor explained that the CCG had participated in the NHSI visit and that the actions noted by the CCG would be used to inform the action and provide assurance. JR observed that the role of the commissioner was important.<br><br>[Post meeting note: The Never Events reported at the meeting in this report relate to 2017-18, there have been no further Never Events reported by UHB in 2018-19.]<br><br>JR asked when issues relating to on-hold patients would be resolved and assurances would be available. LM agreed to confirm the timeframe. JR asked what the timescale for the completion of the investigation into the fire at the Haematology and Oncology Centre was. LM explained that there was an ongoing Fire Service investigation and the completion date for this to be confirmed. UHB was conducting its own internal investigation alongside the | **AMor**<br><br>**AMor**<br><br>**LM** |

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| | external investigation. Further information on the investigation would be presented once available. JR noted the reference to control room triage and the comment that the funding proposal also required resolution. JR highlighted the ongoing work regarding section 136 that included street and control room triage and asked whether this had been taken into account. This was confirmed.<br><br>PM commented on Never Events and reporting times noting it was helpful to have sight of when the Never Events occurred. It was agreed that this level of detail would be received by the Quality Committee and the Committee would provide assurance to the Governing Body.<br><br>AMoon noted that after the Grenfell fire providers were asked to provide assurance regarding cladding. AMoon asked if this had been completed. This was confirmed. NK commented that organisation culture could be a contributing factor and asked how assurance could be provided regarding culture. It was agreed that the Quality Committee would explore this.<br><br>**The Governing Body noted:**<br>• **The performance position of the CCG and key providers, including the risks, mitigating actions and responsibilities**<br>• **The incomplete activity performance report due to technical issues with the submission of provider data from North Bristol Trust** | **LM**<br><br>**AMor**<br><br>**AMor** |
| 11.1 | **Risk Management Framework and Risk Appetite**<br>ST explained the Framework described the arrangements in place to managing risk. ST highlighted the roles and responsibilities set out in the Framework. The risk scoring matrix was set out the framework. Risk management was being aligned across the CCG. ST explained that the template for the Corporate Risk Register and Directorate Risk Register would be amended so that the columns for current controls and assurances would be amended to read 'mitigating actions' and 'progress on actions' in line with the PMO approach. AMoon asked about the role the Governing Body subcommittees in reviewing the relevant sections of the Corporate Risk Register. It was confirmed that this was included at section 16 of the Framework and would be made explicit in the framework. PM asked that the date of entry onto the register be included in the register templates. | **ST** |

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| | **The Governing Body approved, with the above amendments:**<br>• **the Risk Management Framework, including the risk appetite statement and limits, and proposed templates for risk registers**<br>• **the review of the suite of documents by the Audit, Governance and Risk Committee** | |
| 11.2 | **Governing Body Assurance Framework (GBAF)**<br>ST explained that the GBAF was based on the June Governing Body seminar. There had been further iterations of the GBAF and it was presented to the Governing Body for approval. The GBAF was a live document and would be presented to the Governing Body quarterly. The executive team would review risks monthly and the GBAF would be presented to the relevant committees or to the executive team meeting as appropriate.<br><br>**The Governing Body approved the Governing Body Assurance framework and specifically the:**<br>- **Principal objectives**<br>- **Principal risks**<br>- **Controls**<br>- **The sources of assurances**<br>- **Mitigating actions in place to address gaps in control and assurances** | |
| 11.3 | **Records Management and Freedom of Information and Subject Access Request Policies**<br>Sarah Carr (SC) informed members that the policies had been developed in line with the Data Protection Act. The policies were part of a suite focused on Information Governance and an overarching policy would be presented to the Governing Body in August. The policies had been through the internal quality assurance process. Equality Impact Screening Assessments had been completed for each policy and implementation plans were in place. JR asked if the CCG was required to provide detailed information on contracts. It was agreed to confirm this. JR asked about information provided by other organisations section in the Freedom of Information Policy and asked that the section clarify that this applied where the CCG held information.<br><br>**The Governing Body approved, subject to the above amendments:** | **ST**<br><br>**ST** |

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| | • **Records Management Policy**<br>• **Freedom of Freedom of Information and Subject Access Requests Policy** | |
| 12.1 | **Minutes of the Quality Committee May 2018**<br>It was explained that the minutes were deferred. | |
| 12.2 | **Minutes of the Commissioning Executive May 2018**<br>**The Governing Body received and noted the minutes** | |
| 12.3 | **Minutes of the Strategic Finance Committee May 2018**<br>PM gave a verbal update on the June meeting the Committee which had reviewed the financial position. The Committee received reports on Urgent and Community Care programmes. The Committee received the Control Centre work schedule. There had been detailed discussions of these issues. PM explained that risk and the GBAF would be added as standing items to the agenda for monitoring.<br><br>**The Governing Body received and noted the minutes** | |
| 12.4 | **Minutes of the Primary Care Commissioning Committee May 2018**<br>It was explained that the minutes were deferred. | |
| 13 | **Questions from the Public**<br>There were none. | |
| 14 | **Date of next meeting: Tuesday 7th August 2018, Clevedon Hall, Clevedon** | |

**Sarah Carr**
**Corporate Secretary**
**25 June 2018**