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 6th August 2019 at 1.30pm at The Vassall Centre, Gill Avenue, Downend, Bristol, BS16 2QQ

Minutes

Present		
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
Brian Hanratty	GP Locality Representative Bristol South	BH
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
Martin Jones	Medical Director Commissioning and Primary Care	MJ
Nick Kennedy	Independent Clinical Member Secondary Care Doctor	NK
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member Registered Nurse	AM
Justine Rawlings	Area Director Bristol	JRa
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
Julia Ross	Chief Executive	JR
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
Sarah Truelove	Chief Financial Officer	ST
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Apologies		
Janet Baptiste-Grant	Interim Director of Nursing and Quality	JBG
John Cappock	Lay Member Finance	JC
Felicity Fay	GP Locality Representative South Gloucestershire	FF
Christina Gray	Director of Public Health	CG
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
David Jarrett	Area Director South Gloucestershire	DJ
In attendance		
Sarah Carr	Corporate Secretary	SC

Lucy Powell	Corporate Support Officer	LP
Cecily Cook	Deputy Director of Nursing and Quality (Attending on behalf of Janet Baptiste-Grant)	CC
Sally Hogg	Public Health Consultant (Attending on behalf of Christina Gray)	SH
Debra de Silva	The Evidence Centre (For item 6.3)	DDS
Tim James	Estates Manage (For item 6.4)	TJ
Michelle Smith	Associate Director of Communications and Engagement (For item 6.5)	MS
Jenny Gibbs	Medicines Optimisation Senior Pharmacy Technician (For item 6.5)	JG
Aden Watkins	Time to Change (For item 6.5)	AW
Liz Andrews	Time to Change (For item 6.5)	LA
Tom Renhard	Independent Mental Health Network (For item 6.5)	TR
Rob Hayday	Associate Director of Corporate Services (For item 9.1)	RH

	Item	Action
1	**Apologies** The above apologies were noted.	
2	**Declarations of interest** Nick Kennedy (NK) declared a new interest as a Non-Executive on the Board of GO-OP. Kirsty Alexander (KA) declared new interests, noting that a close family member volunteered for HMP Bristol, St Peters Hospice and University Hospitals Bristol.	
3	**Minutes of the previous meeting of the 2nd July 2019** The minutes were agreed as a correct record with the following amendments: • Item 5, last paragraph, Alison Moon (AM) queried whether Non-Executives were members of the Partnership Board. Julia Ross (JR) clarified that although not members of the Board, a Non-Executive Forum was being established. JR highlighted that Non-Executives were involved in system decisions through the organisational Boards and Governing Bodies, all of which had a role in developing the system plans. • Item 6.2, last paragraph, AM noted that her comments had related directly to support for new leadership roles and the minute was amended to reflect this. • Item 7.1, paragraph 4, AM asked that the minute be amended to more accurately reflect the comments made. AM agreed to provide some wording to reflect this. • Item 7.2, AM noted there had been a discussion regarding the Looked After Children action plan. LM agreed to	**AM** **LM**

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	provide a paragraph regarding the discussion to include in the minutes. • Item 9.1, paragraph 2, it was agreed to put inverted commas around the word delivery. • The initials of those who proposed and seconded the motion to exclude the press and public were included	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 05/03/19: 9.2 – Health Inequalities item to be presented to the Commissioning Executive Committee in August and Governing Body in September. 02/04/19: 9.1 – Martin Jones informed the Committee that interest had been expressed in the independent GP posts for the Primary Care Commissioning Committee. 07/05/19: 7.1 – Service will be fully operational in September and partially operational now. This action was closed. 07/05/19: 8.2 – The updated Terms of Reference would be presented to the Governing Body in September. 02/07/19: 8.1 – It was agreed that an update would be provided in September regarding the E-Coli action plan.	**DS** **DES** **JBG**
5	**Chief Executives Report** Julia Ross (JR) confirmed that the highest scoring bidder for the community services had been announced and thanked the team for their hard work in ensuring a successful procurement. JR praised the professionalism of the incumbent organisations following the outcome and initiation of the mobilisation phase. Work was continuing to produce the Healthier Together BNSSG Long Term Plan aspirations. The well-established steering groups were leading to develop the plan, building on the work already in progress. Final plan submission would take place on the 15th November with an interim submission required on 27 September. There was a robust process and timeline in place to ensure Healthier Together remained on track to deliver. Following previous successful public engagement, there were plans for further public and patient involvement during the development of the local Long Term Plan. JR had attended the South West Chief Executive Forum explaining that the key discussions were around the urgent care challenge and development of the Long Term Plan. JR talked about her helpful and informative visit to the GEMS (Geriatric Emergency Medicine Service) service at Weston	

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	Hospital. JR praised the service, noting it as an exemplar for other organisations. She was delighted to note the positivity of the staff and their commitment to the ongoing integration of services across the local community as both the Locality and new Community Services Provider comes into place.	
6.1	**Update Adult Community Health Services Procurement** Lisa Manson (LM) explained that Sirona Care and Health Community Interest Company had been announced as the highest scoring bidder in the adult community health services procurement. LM noted that following bid evaluation and score moderation, the recommendation to award Sirona Care and Health highest scoring bidder status had been formally announced on the 22nd July 2019. The CCG were currently in the due diligence phase. LM highlighted that as well as the standard due diligence checks the CCG were also undertaking additional reviews due to the length and size of the contract. It was noted that should any concerns be unable to be addressed the next highest bidder would be notified. Assurance meetings with NHS England/Improvement were continuing. The CCG would be meeting fortnightly with Sirona Care and Health and existing providers to ensure a clear and safe transition of services. The CCG would also work with the existing providers to establish viability following the procurement. In addition to standard exit arrangements, the CCG has developed a Memorandum of Understanding between the three current providers. Alison Moon (AM) thanked LM for the update and asked about the level of detail the CCG would review as part of the due diligence process. LM explained that the team were reviewing the elements of the bid that required further assurance and gave the example that the CCG had tested the financial model against staffing requirements as well as each service line. It was explained that the CCG was also triangulating the service lines and risks through a planned, structured process. Kirsty Alexander (KA) asked how the contract would be mobilised alongside current providers including Primary Care Networks and North Somerset Community Partnership. LM noted that the	

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	specification highlighted the need for the community provider to work with localities and other existing services. LM highlighted that the children's services provided by North Somerset Community Partnership were a consideration as part of the exit arrangements and there was a process in place to assess this. **The Governing Body noted the progress and next steps of the procurement process.**	
6.2	**Update IAPT Procurement** The IAPT contract has been awarded to Vita Health following assurances received from the due diligence process, the outcomes of which were outlined in the paper. Recommendations from previous users of Vita Health had been sought and were positive regarding the work undertaken and delivery of Key Performance Indicators (KPIs). It was noted that throughout the mobilisation plan was the commitment to work with local organisations, and work has begun on the handover from incumbent organisations. LM highlighted that as part of the due diligence process the CCG had received detailed financial information relating to Vita Health and the CCG has assured themselves of the provider structure and accounts. It was noted that as an additional assurance measure a deed of guarantee has been drawn up. The service would go live on the 1st September 2019, and there would be enhanced provider monitoring following this date to ensure safe transfer of services and delivery of KPIs. The Governing Body discussed the requirements for 75% of patients with a long term condition to be reviewed by the service within six weeks. Jonathan Evans (JE) noted that this was a large cohort of patients and could prove a challenge. LM highlighted that the developed service specification placed importance on accessibility, noting that patients have a range of referral routes into the service. David Soodeen (DS) suggested that there could a targeted approach for these patients through a route such as Primary Care Networks. AM asked whether there were risks to be considered. LM explained that there were no material risks to make the	

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	Governing Body aware of and noted that risks were being recognised and resolved once recognised. Sarah Talbot-Williams (STW) asked whether Vita Health had considered working with voluntary sector partners. LM confirmed that Vita Health were working with a broad range of partners including voluntary sector. JR assured the Governing Body that the due diligence process had been deep and exhaustive. She asked whether there was any feedback from the local organisations Vita Health was contacting as they mobilise their services. LM said that this was not available yet but feedback from partners and sub-contractors would be sought as the process went on. **The Governing Body noted the due diligence process undertaken, the next steps in regards to mobilisation and that the contract had been formally signed with the service to commence on the 1st September 2019.**	
6.3	**Healthy Weston Consultation Themes Review** Colin Bradbury (CB) noted that the Healthy Weston consultation had ended in June 2019 and the CCG had commissioned an independent report into the feedback received. Debra de Silva (DDS) was welcomed to the meeting to present the feedback on behalf of The Evidence Centre. DDS highlighted the extensive methods the CCG had utilised in order to gather the opinions of over 3000 local people, including events, surveys and door to door consultation. It was noted that the consultation process had received feedback from a cohort of people who were representative of the local population by sex and ethnicity. The consultation had identified priorities: • Treatment at a hospital with the best equipment, staff and safety record • Closest hospital to home • Able to receive all treatment needed at one hospital There were no differences in these priorities based on age, gender or ethnicity.	

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	It was explained that of the proposals consulted on, there was less support for the proposal relating to A&E opening hours. Alternatives had been proposed by the local residents suggesting the possibility to use hospital staff in different ways. DDS noted that organisations had also expressed opinions on the plans and explained that Weston Hospital had responded to the consultation with concerns that the lack of doctors and staff at Weston General Hospital made closing the A&E overnight the safest option. DDS outlined the general concerns of the population noting that these included the safety of travelling in an emergency, family being away from home whilst in hospital and considerations of the increasing population of North Somerset. There were also concerns around the access to primary care and community services. The consultation had also revealed that local residents were seeking assurances that the travel times cited by the CCG were correct. Positive feedback to the other developments outlined in the plans had been received, including the frailty hub, the changes to children's services, mental health crisis services and the capacity for more planned operations. John Rushforth (JRu) was encouraged by the wide variety of people that had been consulted with and asked whether there were any differences in responses for any specific groups of people. DDS noted that although the majority of the support or concern was uniform, some groups of people felt more strongly about some elements. For example, NHS staff were more supportive of the changes to A&E opening hours and people over 75 were more concerned about being in hospital away from family and friends. The Governing Body discussed the concerns regarding travel and CB highlighted the travel working group set up with the Local Authority and noted that there would be awareness campaigns around travel schemes patients were already entitled to. It was noted that the CCG was working closely with Public Health to identify the areas of population growth. The housing developments and the subsequent increase in families was	

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	discussed and it was confirmed that primary care services were being strengthened to take these additional patients into account. **The Governing Body noted the contents of the independent report as part of the decision making process for the Health Weston Programme.**	
6.4	**Healthier Together Estates Strategy** Tim James (TJ) presented this item noting that the Healthier Together Estates Strategy had received feedback from a variety of Committee and Forums and extensively consulted within primary care. The Strategy sets out the condition and capacity of CCG estate and outlines 6 key principles around the quality and utilisation of estate. TJ noted that using these principles the CCG would be able to better assess potential estates schemes. Justine Rawlings (JRa) asked whether an estates plan would be developed from the strategy. Sarah Truelove (ST) agreed that the strategy was the first step in developing a plan for estate across the system. It was also noted that as part of Healthier Together, Local Authority colleagues were involved in these conversations. **The Governing Body approved the Healthier Together Estates Strategy.**	
6.5	**Time to Change Employer** Deborah El-Sayed (DES) explained that as part of the Equality and Diversity Strategy action plan, the CCG had agreed to become a Time to Change employer. Michelle Smith (MS) highlighted that as a Time to Change employer the CCG would submit an action plan of how the organisation would change the attitude to mental health, and integrate this into processes such as HR. A Time to Change network has been established which would drive the change through Time to Change Champions. Jenny Gibbs (JG) provided some examples from the network of how the CCG could support staff with minor adjustments to help meet the demands of their jobs. AM noted her support of the pledge and asked whether these considerations would be made within the recruitment processes. DES noted that as part of the pledge the CCG would support current staff as well as new staff. Aden Watkins (AW) noted that there was a team at Time to Change who worked closely with organisations to ensure that the Time to Change message was	

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	conveyed during recruitment. ST highlighted that a working group had been developed to review how the CCG can recruit a diverse group of talent. Nick Kennedy (NK) asked how general wellbeing of staff would be addressed. JG explained stress prevention was a large part of the initiative and this would be addressed through stress management seminars amongst other ways. JRu asked if there was a way the CCG could benchmark staff wellbeing against other CCGs. JR was pleased to inform GB that BNSSG CCG was one of the first CCGs to sign up to the Time to Change pledges. Whilst staff wellbeing would primarily be monitored through the NHS national staff survey there were plans to develop a more regular approach to assess ongoing progress as part of our current national survey action plan. **The Governing Body:** • **Noted the contents of the action plan** • **Publically signed the Time to Change pledge** • **Noted that there would be a Governing Body seminar session on Time to Change in September** • **Noted that Deborah El-Sayed and David Soodeen were the Governing Body level Time to Change Champions**	
7.1	**Item deferred**	
7.2	**Patient Experience Quarter 1 Report** Cecily Cook (CC) highlighted from the paper, the numbers of and types of public contact received during quarter 1. The majority of the requests were for general information and signposting. CC noted that an internal audit had been undertaken on the CCG processes for managing and responding to patient feedback and a satisfactory rating had been achieved. The recommendations from the audit were now being implemented. JE asked how the GP related queries were analysed. Martin Jones (MJ) explained that these were reviewed by the quality and primary care teams and actions for improvement were implemented. MJ also noted that the resilience tool for practices also included patient feedback as a measure. JR clarified that the CCG only processed feedback regarding practice process, any comments regarding clinical care were directed to NHS England.	

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	AM noted that the Primary Care Commissioning Committee reviewed quarterly complaints reports from NHS England, but noted that 2018/19 quarter 4 and 2019/20 quarter 1 had not been received yet. These have been requested. JRu asked whether the 165 general enquires suggested that amendments needed to be made to the website to make the requested information more easily accessible. JR noted that it was encouraging that the public were contacting the CCG for help and it was agreed that CC would ask the team if there were any themes in the enquiries that could indicate a change to the website was required. CC highlighted the internal auditors report, noting that the key action from the audit was to ensure the management of compliments, general enquiries and complaints policy was robust and the CCG had processes in place to ensure that the customer service team received the feedback/complaints from throughout the CCG. STW asked whether the trends in feedback by area could be reviewed across previous years to make further sense of the data. It was also noted that appendix 4 needed a key for the numbers. It was agreed to review these areas for the quarter 2 update. **The Governing Body received the Quarter 1 Patient Experience Report**	**JBG** **JBG** **JBG**
7.3	**BNSSG CCG Quality Work Plan 2019/20** CC noted that the development of a Quality Strategy had been approved by the Governing Body and following workshops with patient representatives and staff feedback it was agreed to present this document as the Quality Work Plan 2019-2021. STW noted that it while it was beneficial to have the aims and actions outlined in one document, there was little reference to target dates. CC confirmed that the current action plan was work to be completed during 2019/20 and updates on progress would be provided to the Governing Body each quarter, alongside an end of year summary. LM suggested the commissioning teams work with the quality team to develop a dashboard with measurable and specific goals.	**JBG/LM**

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	AM commented that concerns raised by Executives needed to be captured within the work plan actions. CC agreed and noted that as the action plan was based on the CCG priorities any concerns should be captured. It was agreed any concerns would be part of the Quality Committee agenda considerations and assurance of the Quality Work Plan would be received through the Committee. KA noted the behavioural change required by colleagues to embrace values based healthcare as outside process this can be challenging. CC agreed to review this with KA. NK asked whether the care home dashboard was ready for review. CC confirmed that data was now available and this would be presented to the Quality Committee. **The Governing Body noted the progress against the Work Plan for Quarter 1 and approved the Quality Work Plan 2019/20 with the above comments noted.**	**JGB/KA**
8.1	**BNSSG Quality and Performance Report** LM presented the key points regarding performance at month 2. Urgent care performance remained challenged and below performance targets. There were concerns regarding increased demand during weekends and evenings as well as staffing levels across the system. LM highlighted the ongoing work to address recruitment across the urgent care system as well as the single system recovery plan. It was noted that visits have been undertaken at the emergency departments and assurance has been gained regarding the quality of care despite the challenges. Elective care performance was within trajectory for open pathways across BNSSG despite 18 week standard challenges. 52 week waiting patient numbers were below trajectory and actions have been put in place to improve performance and for all 52 week waiting patients to be treated by October. Processes have been put in place to reduce the risk of patients waiting 52 weeks. Where patients have been waiting for an outpatient appointment, the CCG have offered appointments with an alternative provider.	

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	The system is working across organisations to improve cancer performance standards. At North Bristol Trust (NBT) a second robot for urology would be operational from the 1st September. Consolidation of the breast/urology services has been put in place to support Weston General Hospital. Breast/skin cancer referrals have been referred to an alternative provider to improve performance for the 2 week wait standard. AM highlighted the downward trend in A&E wait performance since May 2018 and asked for assurance regarding the BNSSG plans. LM explained that there were a wide range of actions implemented to improve flow and discharge as well as consistent advice to patients to only attend A&E in a genuine emergency. Where the actions have not produced a result, these have been stopped and new ideas implemented. LM noted that the CCG was working to understand the reasons for the decline in performance. The Governing Body discussed the merger between University Hospitals Bristol Trust (UHB) and Weston Area Health Trust (WAHT) and asked whether the new partnership would take priority over the performance issues. LM noted that from the 1st September there would be single Chair and Chief Executive of the Trusts and this would provide accountability for performance and added that performance targets would be reviewed through the due diligence process. LM assured the Governing Body that no organisation was complacent about the urgent care system and the system wanted the best care and experience for patients. STW commented on the error in reporting of the Weston 62 day referral performance percentage. It was confirmed this was a mistyping error and the CCG expected WAHT to have robust processes in place to mitigate errors. It was asked whether the CCG were reviewing the numbers of endoscopies taking place and whether these were necessary procedures. LM noted that there was a system wide piece of work around the value of endoscopies and system capacity. It was noted that the second robot for robotic treatment would be in place for those waiting for robotic treatment. It was confirmed that patients were choosing to wait for this type of treatment.	

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	The Governing Body discussed the mental health system. MJ highlighted the work ongoing in this area in primary care and LM agreed to review the need for a mental health deep dive next month. The Governing Body further discussed the urgent care system and Peter Brindle (PB) talked about the Urgent Care Design Group and the commitment to the work to improve urgent care services across the system. The key challenge was identified as the growth in demand for A&E services and how the CCG can persuade the public to utilise other more appropriate services for their health needs. CC presented the key points regarding quality at month 2: • Assurance visits have been undertaken at emergency departments and assurance has been gained regarding the quality of care despite the challenges. • 29 twelve-hour trolley breaches were identified at Weston General Hospital during May and June and harm reviews have been received which indicate no harm. • A Never Event has been recorded at UHB relating to wrong implant. The 72-hour report has been received and an assurance visit has taken place. • A Contract Performance Notice relating to Never Events at NBT has been closed following completion of actions. A Contract Performance Notice has been issued to WAHT following a Never Event relating to wrong site surgery and the CCG is waiting for actions to be completed. Following a Never Event summit in April, and action plan has been developed and shared with providers. A further summit will take place in October. • CQC visits have been undertaken at the Acute Trusts and the CCG is waiting for these to be published. The WAHT report has been published with concerns regarding A&E and Children and Adolescent Mental Health Services (CAMHS). An action plan has been developed and monitored through the WAHT sub group. • NBT have announced their proposal to reopen Cossham Hospital in November	**LM**

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	NK queried the Friends and Family Test results for UHB asking why they were lower than at other Trusts. This was attributable to the high attendance numbers and long waits for treatment. NK also asked about Serious Incident assurance and CC confirmed that a serious incident report was presented to the Quality Committee for review. KA asked how workforce statistics and vacancies were monitored. ST confirmed that the Workforce Group reviewed workforce data on a regular basis noting that for the Acute Trusts the use of bank and agency staffing is a key factor. **The Governing Body received the Quality and Performance report.**	
8.2	**Finance Report** ST presented the finance report reporting that the CCG was forecasting delivery of the financial plan for the year as at Month 3. ST highlighted the underspend in Non-Contract Activity (NCA) confirming that this would be monitored as more data was received. There has been an overspend in Continuing Healthcare (CHC) of £1.2m in the first quarter due a small number of high cost individuals. A deep dive has occurred to understand the increase in costs. Out of Area Mental Health placements have also increased and this would be the focus for the next Strategic Finance Committee. It was reported that there would be no net risk regarding category M drugs due to assumed mitigation through additional national funding. JR noted that there had been a number of additional cost pressures in relation to primary care since delegation. ST explained that as this related to a national allocation issue and had been reflected in previous years, the CCG had included a mitigation of additional national funding. However, it looked as though these may not materialise. DS asked whether additional costs of annual health checks for patients with learning disabilities would be mitigated through national funding. ST agreed to follow up with NHSE and report back to the Governing Body.	**ST**

	Item	Action
	The Governing Body received the Finance report.	
9.1	**Health and Safety Policy** Rob Hayday (RH) presented the Health and Safety Policy and outlined the key aspects of the policy. JRu asked which organisation would undertake the health and safety audit and it was confirmed that this would be undertaken by UHB. JR queried the policy reference to 'occasional' home working, asking whether some members of staff had agreed more regular and routine home working arrangements with their line manager. ST agreed to look into this and check that the policy was effective in covering all eventualities. JR also noted the policy expectation that staff should not use a mobile phone, including hands free equipment, whilst driving. She queried whether the impact this might have on staff working practices had been assessed and understood – particularly where senior staff participated in conference calls or other business calls whilst travelling. AM noted that this may also apply to using satellite navigation whilst driving. It was agreed that a business impact analysis should be undertaken and for the policy to be reviewed again by the Governing Body once it was complete. RH commented on the requirements of the Highway Code and Governing Body agreed that adhering to these had to be the first principle in the policy. RH would ensure this was included in the review. **The Governing Body agreed to review the policy again subject to a business impact assessment.**	**ST** **ST**
9.2	**Records Management Policy** Sarah Carr (SC) noted that the policy had some minor amendments which were highlighted in the cover paper. SC noted that the next review date had been amended to two years unless there were any legislation changes. JH asked how staff could use secure electronic redaction and it was agreed to add this to the policy as an appendix. **The Governing Body approved the Records Management Policy with the above amendment.**	**ST**

	Item	Action
9.3	**Revised Policy on the Management of Compliments, Patient Enquiries and Complaints** CC noted that the policy had been revised following an internal audit into the management and responses to patient feedback. CC outlined the amendments to the policy. STW praised the extensive number of ways to contact the CCG. JR commented that the cover paper highlighted the role of the Chief Executive in signing responses whilst the body of the Policy identified a number of people who may sign off letters. It was important that the Policy enabled the most appropriate person to respond. **The Governing Body approved the Management of Compliments, Patient Enquiries and Complaints policy with the above amendment.**	
9.4	**Annual Audit Letter** ST presented the annual audit letter noting that this summarised the annual work of the External Auditors. ST noted the auditors had recognised the significant challenge to agree a financial plan for 2019/20 and were satisfied with the arrangements the CCG had in place. **The Governing Body received the Annual Audit Letter**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Commissioning Executive** **The Governing Body received the minutes**	
10.3	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the minutes**	
10.4	**Item deferred**	
11	**Questions from Members of the Public** There were no questions from the public	
12	**Any Other Business** There was none	
13	**Date of Next Meeting** Tuesday 3rd September 2019, 13.30pm, The Vassall Centre, Gill Avenue, Downend, Bristol, BS16 2QQ	
	Motion to Exclude Press and Public 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	

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	is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business. JH motioned and seconded by STW	

Lucy Powell, Corporate Support Officer, August 2019

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 Thursday 27th June 2019 at 7.00pm at the Bristol and Bath Science Park, Dirac Crescent, Emersons Green, Bristol BS16 7FR

Minutes

Present		
Jon Hayes	Clinical Chair	JH
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Christina Gray	Director of Public Health	CG
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
Brian Hanratty	GP Locality Representative Bristol South	BH
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
In attendance		
Sarah Carr	Corporate Secretary	SC
Charlie Kenward	GP, CCG Clinical Lead for research and effectiveness	CK

Geeta Iyer	GP, Clinical Lead for Primary Care Development	GI

	Item	Action
1	**Chair's welcome and apologies** JH welcomed all presented to the first AGM of Bristol, North Somerset and South Gloucestershire CCG. The above apologies were noted. JH explained that each GP practice in Bristol, North Somerset and South Gloucestershire (BNSSG) was a member of the CCG. The CCG was responsible for commissioning healthcare services for the population of BNSSG. The CCG's role was to look at the populations' healthcare needs and design and improve healthcare services. The AGM was a celebration of the successes of the past 12 months and JH thanked the CCG staff for their meticulous and relentless hard work. The Governing Body members introduced themselves. JH thanked Kate Swann and Ollie Ellis for their work organising the event.	
2	**Declarations of interest** JH explained that all members of the Governing Body were required to declare interests which were recorded and published on the CCG Register of Interests. This register was published on the CCG website (https://bnssgccg.nhs.uk/about-us/how-we-manage-conflicts-of-interest/). Members were invited to declare any new interests or interests relevant to the items to be discussed. There were no declared interests that conflicted with the agenda and no new declarations were made.	
3	**Minutes of the 2017/18 AGM** The minutes were approved at the Governing Body meeting August 2018. The Governing Body received the minutes.	
4	**Annual Report and Accounts 2018/19** ST presented the Annual Report and Accounts 2018/19. Attention was drawn to the CCG's primary financial duties which had been achieved in 2018/19. These were to: • Maintain expenditure within the revenue resource limit • Maintain expenditure within the allocated cash limit • Maintain capital expenditure within the delegated limit • Ensure running costs are within the running cost resource limit • Ensure compliance with the better payment practice code In the first year of operation the CCG had a resource allocation of £1.3 billion. A historic cumulative deficit of £83 million was inherited by the CCG. The CCG achieved its primary financial duty to achieve breakeven and delivered £2.6 million of savings.	

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	The CCG achieved its duty to ensure that the running costs did not exceed its allocation. ST explained how the CCG used the money allocated to it: • 10% allocated to Community Services • 12% Primary Care • 52% Acute Hospitals • 10% Mental Health • 10% Prescriptions • 5% Continuing Healthcare • 1% Running Costs The key financial challenges highlighted included: • Increased levels of emergency care, the CCG was working with partners to understand the reasons for the increase in activity and find solutions to reverse this • Increased numbers of planned operations • lower than planned efficiency savings ST explained that there were two major accounting challenges in 2018/19: the formal constitution of the CCG and the delegation of commissioning responsibility for primary care from NHS England to the CCG. For 2019/20 the CCG would be working on the creating value to ensure: • the best possible health outcomes • resources met the needs of the whole population • the CCG spent every taxpayer pound as effectively as possible	
5	**The Year in Review** JH noted that alongside members of the public there were colleagues from partner organisations including providers and Local Authority colleagues at the meeting. A short video clip reflecting on the CCG's achievements in 2018/19 was shown. The work to ensure the future of high quality health services for the population of Weston was highlighted. The level of public engagement and the debate and feedback from patients and service users had been significant. JH drew attention to the CCG website which detailed the activity undertaken and in progress, and highlighted the stakeholder newsletter. Members of the public were encouraged to sign up to receiving this.	

	Item	Action
6	**Our Vision and Priorities for the Future** JH introduced JR, Chief Executive, explaining that JR had driven the CCG forward, successfully steering it through the organisational change over the past year. JR set out the CCG vision and priorities for 2019/20, explaining that the CCG served a diverse population of approximately one million people. Approximately 10% of the population were from Black and Minority Ethnic backgrounds across the whole of BNSSG. This rose to 16% in Bristol. Each of the areas within the CCG had specific issues with inner city, rural and urban populations. There were significant pockets of deprivation and there was a life expectancy gap of 15 years between the most and least deprived areas. The CCG's focus was on how to best meet the needs of population and to achieve this CCG worked with members of the public and the providers of services. JR highlighted the Healthier Together Partnership which included providers, colleagues from the Local Authorities and increasingly the voluntary sector to ensure the best benefit from the resources that the CCG had stewardship for. The CCG vision was to achieve "healthy, fulfilled lives for everyone who lived in BNSSG". JR noted that this task was both simple and complex. This would be achieved through putting people at the heart of what the CCG did; understanding what people wanted, their needs and aspirations. The CCG would work with members of the public, staff, provider organisations, local councillors and the voluntary sector to shape services. The CCG wanted to ensure that the best value was achieved for every pound spent. This meant understanding what outcomes people wanted from services and ensuring that the resources available to the CCG were allocated to properly represent the priorities and needs of the population. There was a challenge between where and how funding was spent; this was a difficult balance however the CCG was striving to improve the position. Finally, the CCG wanted to ensure the best efficiency to get the best value. JR observed that the CCG did not always get this right. JR shared a patient story where there had been failings in service provision. The CCG had worked with provider colleagues to improve the position as a result.	

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	JR highlighted four key areas for the CCG in its commissioning role that would be described further at the meeting: • Value-based healthcare: how the CCG would work with people to use resources to shape and delivery the right care and services for the population • Primary Care Strategy: GPs were at the heart of the health care system. The patient registered lists held by GPs enabled services to be planned and be proactive to help keep people well and independent and respond quickly • Community Model of care: the CCG had focused on developing a new model of care that worked with people to ensure they were supported in the community working will all service providers • working better with people: what did it really mean to work with the public and how could people help the CCG and become involved.	
7	**Creating better Value in Healthcare** CK, local GP and CCG Clinical Lead for research and effectiveness, explained that value based healthcare was an approach to planning and the delivery of healthcare that focused on getting the best outcomes for the population and making the best use of resources. Value based health care focused on three key areas: • outcomes that mattered to people. This meant moving away from a traditional outcomes approach to people-based outcomes such as spending time with family, and being pain free. • high quality, efficient care for people. This involved looking at where people were not getting access to high value interventions that they would benefit from. • dividing up resources to ensure the best outcome from all the resources available. This approach was needed because the CCG population, in line with the national trend, was getting older and health needs were getting more complicated. Healthcare had improved with innovations however new treatments could be costly. Available resources had not kept pace with demand, including staffing levels. Value based healthcare was an approach to tackling these issues.	

	Item	Action
	One objective was to identify low value interventions and do fewer of these and identify areas where more high value activity could be done. Key-hole surgery for knee pain was a treatment where there was previously been a high level of activity and was costly. The patient reported outcomes for the procedure were low however, and this activity had now reduced allowing resources to be directed towards other high value treatments such as hip replacements which had better patient reported outcomes. CK explained that people from the most deprived areas were three and half times more likely to be admitted to hospital for conditions such as diabetes or asthma, which could be managed in the community. There was an opportunity to focus on interventions in the community that would prevent complications and more expensive hospital treatment. Value base healthcare approaches were summarised as moving from asking questions such as "what's the matter with you" to "what matters to you". This required cultural and system change; one way to achieve these was to have real shared decision making between patients, their families and clinicians. This would require the right information in the right format. Clinicians needed to hear what mattered to patients. CK explained work was underway to develop ways to collect information about which outcomes matter to people. The approach was embedded into priority programmes such as the mental health strategy. CK encouraged members of the public to become involved.	
8	**Primary Care Strategy** GI, local GP and Clinical Lead for Primary Care Development, explained that primary care covered a range of services including GP surgeries, community pharmacies, dental services, optometry, and walk in services. There were services that provided a vital link with primary care such as community services and the integrated urgent care service that looked after people outside of core GP hours. It was explained that 90% of patient contacts took place in primary care. The existing primary care strategy was written in 2016 and there had been significant changes since then. The Healthier Together Partnership was in place with system wide strategies designed to move more care into the community and improve services. The	

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	CCG was working to procure a single provider of community services across the CCG footprint. The national context for primary care had changed; there was a new GP contract that drew practices together into Primary Care Networks to delivery care to patients. The revised strategy would look at health inequalities in BNSSG, identifying the health and care needs of the population to allow the design and delivery of the right services to improve health outcomes for the population and improve the quality of care. The CCG had ongoing engagement with members of the public and was using this to inform the strategy. There were four priority areas that overlapped and enabled each other: • Developing the workforce; • Infrastructure; • Quality and resilience Next steps included continuing with patient, public and stakeholder engagement. The detailed delivery of the strategy would begin after it was approved in October. Members of the public would be able to share their views and opinions with the CCG through the Get Involved section of the CCG website. This was an opportunity co-design, as one system, personalised, seamless and consistent primary care to the population.	
9	**Community Model of Care** JRa explained that the community model of care sat within a wider context. It was part of a wider system which included general hospital care and regional centres of excellence. It was supported by a number of infrastructure programmes and projects within Healthier Together. Integrated community localities were a cornerstone of the overall system of care. There six localities across BNSSG that supported the diverse population. The CCG was working together to delivery more joined up care with the ambition to support people within their communities. To achieve this the localities were working with a wide range of organisations and disciplines. The CCG wanted to support people to be healthy, well and independent at home. The CCG also wanted to ensure that when people had urgent care needs, these could be met as close to the patient's home as possible. There would be occasions when people needed to have	

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	care elsewhere and it was important that they were able to get this as soon as possible and could access these services. It was important that when patients returned home they were expected so that services could support them. There followed a short video that described how the CCG was developing the community model of care to support patients, families and carers.	
10	**Working Better with You** JR hoped that those present had heard how the CCG had a strong vision that it would bring to fruition through working with Healthier Together, patients, the public and local authority colleagues. The CCG wanted to hear about the needs and aspirations of individuals. The CCG wanted to work with people to ensure that they were being referred to services that met their needs. The CCG wanted to hear what services were like for patients and to ensure that it heard from a representative sample of its population. The CCG had set up a Citizens Panel to ensure a fully representative sample of the population that could share its views and insights to help the CCG understand what the whole population wanted and needed. The CCG was determined to ensure that it acted on the information shared by members of the public and worked to improve things. The CCG was aware that there some services that did not meet the needs of people. The Citizens Panel had told the CCG that 13% of people in the area regretted having a previous procedure. The CCG needed to understand what was important to people, to talk to them about the benefits and risks of treatments to allow patients to make informed, shared decisions. This approach would work for patients and for services, allowing funds to be spent in the best way. Value and what it meant to people was key. The CCG wanted to move from “what’s the matter with you” to “what matters to you”.	
11	**Questions from Members of the Public** JH thanked the speakers for their presentations. Questions were invited from the members of the public. A member of the public commented that they remembered ‘the first version of community care’ which appeared to fail because the resources were not in place and asked what scrutiny would	

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	there be to ensure that the vision for community care would become a reality. LM, Director of Commissioning, explained that the delivery of all of the CCG's contracts were monitored against the specifications for services. The community services specifications were detailed and the bids for the contract were evaluated against these to ensure that they could be met and delivered. Once the new provider started the delivery of services would be monitored against the specifications and the CCG would work with the provider and partners to address any potential issues. The CCG had worked through the specifications to ensure that services were affordable, for both staffing and locations. The CCG was assured that the investment in community services would support the delivery of the services for the whole population. A member of the public asked why the merger of the Bristol, South Gloucestershire and North Somerset CCGs had not included Bath and North East Somerset and whether there were plans to join the local hospitals together. JH explained the Bath and North East Somerset CCG was merging with the Swindon and Wiltshire CCGs. JR explained that North Bristol Trust, University Hospitals Bristol Trust and Weston Area Health Trust were part of the Healthier Together partnership along with the community service providers, the mental health service, GPs and ambulance service and the three local authorities. There was a determination to work together. A member of the public asked about the Healthy Weston plan which required the recruitment of GPs to implement the proposals. It was asked, given the national wide shortage of GPs and problems with recruitment, could the CCG provide a guarantee that there would be sufficient numbers of GPs to provide the required cover and, if not, what were the alternatives. MJ, Medical Director Primary Care and GP in Weston, explained that, as a GP, he was excited by the proposed changes. These were being developed to meet the needs of the local population and attract GPs to the area. The proposals would bring practices and staff from different disciplines together. GPs were	

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	commenting that they were able to improve patient access, and patients were being seen faster. A member of the public asked what was being done to improve the parity of esteem between mental health and physical health in BNSSG. It was commented noted that people with lived experience of mental health problems were involved in the contract monitoring process and asked if something similar would be adopted for the new community services contract. DES, Director of Transformation, commented that the parity of esteem between mental health and physical health was a key part of the mental health strategy and was a thread through community services and the primary care strategy. The CCG was exploring the Equally Well Charter and looking to work with all of its partners to ensure that these were embedded in services. LM explained that the model for included people with lived experience had not been replicated across other services. The Community Service procurement had included a patient reference panel and a patient representative had sat on the programme board. The CCG needed to understand how to best use patient involvement and the valuable time offered by people to support the CCG. A member of the public asked why, for people with autism, it took so long to get diagnosis appointments and then get reports back. The questioner highlighted his personal experience which involved a wait of 15 months for confirmation of diagnosis noting the impact on his life. It was asked what the CCG could do to improve the situation. LM explained that it was clear there was unequal access to autism diagnosis, follow up and support across BNSSG. The CCG was working to design services so that people with autism were assessed and given a diagnosis as quickly as possible. Reducing waiting times was a priority for the CCG. The member of the public was invited to become involved in the CCG's work relating to autism. A member of the public asked how the CCG was progressing integration with social services.	

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	JR explained that there were early discussions going forward. Social care was working with the CCG through the locality structures. In some areas of BNSSG social care teams were organising themselves to work alongside integrated localities. People who used services did not see the difference between health and social care and integration was important. It was a challenge due to differences in resources and funding, cultural differences between the two areas, and governance arrangements. The CCG was determined to work with local authority partners to achieve greater integration through the integrated localities. A member of the public commented that he frequently attended meetings of the CCG and often was the only member of the public present. He commented that the CCG had an identity issue; its name was unwieldly. He asked if the name could be changed to create a new identity. JH commented that this was a point well made. The CCG served the population of Bristol, North Somerset and South Gloucestershire, however the name was unwieldy and the CCG communications team would look at what could be done. A member of the public commented that they were disappointed as they had attended the meeting to hear about dementia and Alzheimer's disease however there had been no mention. The ward for people in crisis with memory problems at Callington Rd had been closed and people now had to go to Weston. This service was staffed often with temporary staff. An example of a patient who was moved to Northampton due to the lack of beds locally was given. It was asked how elderly carers were expected to cope. JH noted that whilst there had been no presentation on dementia at the AGM, it was a significant issue and part of the CCG's work. JR commented that the CCG understood that its balance of spend on mental health was lower than it wanted it to be. The Citizens Panel members had been asked how they would apportion £100 against services; the response was that 50% would be allocated to mental health. The CCG had a good dementia service in Bristol and investment was being made to ensure this was replicated across the system.	

	Item	Action
	LM explained that the closure of the ward at Callington Rd in 2017 was not something that the CCG or Avon and Wiltshire Partnership Trust had wanted to happen. The CCG was working to ensure that there was a strong workforce in Weston to provide the optimum care of patients with dementia. There would be engagement with patients, carers and members of the public regarding the provision of beds for dementia patients; the CCG wanted to know the views of people and also understand how it could better provide support in the community. A member of the public commented that what matter to people was that the NHS continued to be free at the point of use. Recently Warrington and Halton Hospitals Trust had issued a price list for treatments previously funded by the NHS. The public protect resulted in a pause in the scheme. It was asked if any hospitals in the area had similar plans to issue a price list. JR confirmed there were no such plans and there was no expectation that that there would be such plans within BNSSG. NHS services were paid for by the CCG and there was no intention, either now or in the future to publish a price list for services. JH thanked all those present for their support. JH highlighted that the CCG Governing Body met monthly in public and these meetings were advertised on the CCG website and were held across the area. The CCG would be delighted to have members of the public attend these meetings and welcomed feedback on this meeting and future events and consultations.	

Sarah Carr, Corporate Secretary, July 2019