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 1st October 2019 at 1.30pm at the Winter Gardens, Royal Parade, Weston Super Mare, BS23 1AJ

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Colin Bradbury	Area Director, North Somerset	CB
Peter Brindle	Medical Director Clinical Effectiveness	PB
John Cappock	Lay Member Finance	JC
Deborah El-Sayed	Director of Transformation	DES
Jon Evans	GP Locality Representative South Gloucestershire	JE
Felicity Fay	GP Locality Representative South Gloucestershire	FF
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
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
Matthew Lenny	Director of Public Health	ML
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
Rosi Shepherd	Associate Director of Nursing	RS
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		
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Christina Gray	Director of Public Health	CG
Brian Hanratty	GP Locality Representative Bristol South	BH
In attendance		
Sarah Carr	Corporate Secretary	SC
Lucy Powell	Corporate Support Officer	LP

Dr Andrew Hollowood	Clinical Lead for Strategy, University Hospitals Bristol	AH
Rebecca Dunn	Healthy Weston Programme Director	RD
Ned Brown	Healthy Weston Project Manager	NB

	Item	Action
1	**Apologies** The above apologies were noted.	
2	**Declarations of interest** Sarah Talbot –Williams (STW) declared a new interest as Non-Executive Director at United Communities. There were no declarations of interest relevant to the agenda.	
3.1	**Minutes of the previous meeting of the 3rd September 2019** The minutes were agreed as a correct record with the following amendment: • Section 7.2, Alison Moon (AM) asked her comment on page 10 be amended to read, "the CCG **should** focus on the learnings from the reviews and implementation of actions."	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 06/08/19 7.3 – A quality work plan dashboard was being developed and would be presented to the Quality Sub Group. 03/09/19 11 - Improvements have been considered and guidelines have been developed for staff. The action was closed.	
5	**Chief Executives Report** Julia Ross (JR) reported on a busy month for the CCG including the commencement of the new IAPT service and the continuation of the adult community service mobilisation. The interim Long Term Plan was submitted on the 27th September and the Healthy Weston Decision Making Business Case was published on the 24th September. JR thanked Janet Baptiste-Grant for her work as the Director of Nursing and Quality and welcomed Rosi Shepherd to the Governing Body as Interim Associate Director of Nursing. Julie Thallon would start on the 16th October as Interim Director of Quality for the CCG. JR reported on the successful members event held in September. The Members discussed the Primary Care Strategy and the relationship between primary care, localities and community services. The Membership received presentations on the	

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	development of Primary Care Networks and Sirona care and health attended to present their adult community model of care to the membership. Elizabeth O'Mahony, Regional Director and Amanda Pritchard, NHS England/Improvement Chief Operating Officer and Deputy to Simon Stephens visited the CCG offices and Skylark ward, a community care facility in South Gloucestershire. They were impressed with the work the CCG has undertaken on primary care resilience and development and were interested in possibly replicating some of the work around the country. JR chaired the Mental Health Crisis Concordat meeting whose members were from across Avon, Somerset and Wiltshire and included the police, local authorities and other NHS organisations. The group has started a programme of work to improve the mental health of the local population and there has been a commitment by all parties to share data to support this work. JR reported on various meetings attended in September. The Joint Health and Wellbeing Board met to discuss the Long Term Plan and how community partners could help providers to better meet the needs of the population. JR and Lisa Manson (LM) attended the Specialised Commissioning Partnership Board where the joining up of commissioning pathways between the CCG and NHS England were discussed. JR met with St Peter's Hospice to discuss how to further engage the hospice in BNSSG system work and encouraged their leadership regarding end of life pathways. JR was proud to have attended the Everyday Inclusion event which had been chaired by staff from the CCG. JR thanked Sharon Woma, Aaron Barnes and Harriet Soderberg for their contribution to the event. The CCG held their second all staff event in September to celebrate the achievements of the CCG of the past 6 months. The event had provided staff with an opportunity to discuss the CCG values, the future vision of the CCG and goals for teams and individuals. JR thanked Sarah Truelove (ST) and Michelle Smith for organising the event.	

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	AM reiterated JR's comments regarding the Membership event and had been encouraged by the positive reaction from the GPs regarding Sirona care and heath's community model of care.	
6.1	**NHS Long Term Plan** ST updated the Governing Body on the progress of the Long Term Plan. The interim plan had been submitted on the 27th September. ST outlined the work ongoing to finalise the plan including meetings with the regional and national team to discuss specific metrics needed to measure the deliverables outlined in the plan and an event on the 17th October for key stakeholders, including local councillors, voluntary sector representatives and the public to further develop the plans before submission on the 15th November. Jonathan Evans (JE) noted the key principles within the plan and asked whether what matters to the local population had been included within the plan. Peter Brindle (PB) explained the plan was a work in progress, with further work being done to ensure that patient relevant outcomes were at the centre of the plan, and this was closely linked with patients increasingly making properly informed choices on their care. LM explained the ambition of the Long Term Plan was to emphasise the importance of health outcomes for the population. **The Governing Body noted the progress on the Long Term Plan.**	
6.2	**Improved Access to Psychological Therapies (IAPT) Mobilisation Report** LM reported Vita Health have been running services since 1st September 2019. Staff have transitioned smoothly to Vita Health and a training programme has begun to ensure staff are qualified. There were currently 3 main hubs across BNSSG with additional sites to be mobilised. Vita Health reported no financial issues during transition and the financial monitoring undertook by the CCG throughout the mobilisation would continue. Sub contracts have been signed and are in place. Engagement work has continued and the CCG would be working with Vita Health to improve the clarity of information on their website. GP practices have received details on how to refer patients including digital referral forms. The CCG and Vita Health were holding regular	

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	contract meetings and weekly phone calls were taking place to discuss the mobilisation. Felicity Fay (FF) asked whether there were any patients who had dropped out of the service following the mobilisation and asked when the CCG would receive feedback from patients on the new service. LM noted that the patients waiting before the mobilisation were still on the waiting lists and noted that a full report on patient experience would be received before the end of 2019. JE asked whether previous providers had forwarded new patients to Vita Health. LM agreed to check and update at the next meeting. David Soodeen (DS) asked whether the sub-contracting was improving access to those who struggle to access services and asked whether these involved community services. LM noted Vita Health were developing plans on how best to engage with patients to ensure the whole population were able to access services. JR noted that the specification specifically mentioned health access inequalities and access performance would be measured. JR asked how the CCG would measure what Vita Health was delivering. LM noted this would take place through the contract monitoring process. The CCG had ensured the safe transfer of staff, patients and patient data. JE highlighted that some of the information provided to primary care had not been up to date. LM confirmed both Vita Health and the CCG had sent additional information to practices. JE also suggested the use of an app to book appointments. LM noted Vita Health would welcome such an approach as it would increase access rates. **The Governing Body noted the new IAPT service provided by Vita Health commenced on the 1st September 2019 and noted the progress made to date with the mobilisation of the new service.**	**LM**
6.3	**Adult Community Health Services Contract Mobilisation** LM informed the Governing Body Sirona care and heath were commencing mobilisation for the 1st April 2020. The focus of the mobilisation was to ensure the safe transfer of patients during the	

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	mobilisation period. The CCG would be working with Sirona care and health through a joint mobilisation group to assure mobilisation processes. Sirona care and health were meeting and working with North Somerset Community Partnership and Bristol Community Health to ensure safe transition and all system partners were regularly updated on the mobilisation. As part of the mobilisation Terms of Reference and risk registers have been developed and the Programme Board scrutinised these fortnightly. Quality Impact Assessments have been undertaken for all service transfers and a communications and engagement plan has been developed. AM noted that although the risks were managed by the Programme Board the Governing Body needed to review the risks and associated mitigations. LM noted the CCG had reviewed the risks and comments made to strengthen these. Sirona health and care were amending these for the register. The Governing Body agreed to received monthly updates on mobilisation to include risks and mitigations. **The Governing Body noted the progress made to date for mobilisation and the process in place to manage any impact of the outcome of the procurement on other incumbent providers and plans for other affected CCG contracts**	**LM**
6.4	**Healthy Weston Decision Making Business Case** JR provided the background to the Healthy Weston Programme highlighting the two years of work and explained that the business case represented the clinical consensus reached on the future of Weston Hospital. JR explained the Healthy Weston Programme gave the CCG the opportunity to improve the quality of care provided for the North Somerset population including care at the hospital. Dr Andrew Hollowood (AH), Clinical Lead for Strategy at University Hospitals Bristol (UHB), explained the hospital proposals were a small element of the Healthy Weston Programme and had been agreed by all partners across the Healthier Together System. The significant engagement undertaken was highlighted including the 2500 people who responded to the consultation. It was important to note the proposals had been significantly amended based on the consultation responses. The process of developing the proposals	

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	was governed by the Clinical Services Design and Delivery Group (CSDDG) which was chaired by BNSSG system leaders. The Decision Making Business Case had been presented to the North Somerset Health Overview and Scrutiny Panel (HOSP) meeting on the 30th September. A vote was taken at the meeting to recommend to the Full Council the referral of the CCG's proposal to the Secretary of State if the points raised by the HOSP were not addressed by December 2019 and to immediately make a referral to the Secretary of State if the CCG Governing Body approved the decision. The points of clarification required by the HOSP were: • a clinical analysis of outcomes on the transfer of A&E patients to Bristol compared to the previous outcomes in Weston. Concern was expressed regarding the sample size employed in the Ambulance Audit • evidence that the recruitment of GPs to support A&E was feasible and would not undermine local primary care • evidence that sufficient and appropriate ambulances would be available • reassurance that Mental Health needs would be addressed, particularly overnight • evidence that the emerging business case for the frailty model across BNSSG fully took into account potential additional resource implications for adult social care and the voluntary sector. JR highlighted that frailty was not an aspect of the consultation and the consideration of social care funding was not appropriate for the CCG. An additional meeting of the HOSP would be convened to review the CCG's response. The HOSP would then consider whether to recommend to the Full Council, at its 7th November meeting, to refer the proposals to the Secretary of State. The CCG would work to resolve the issues with the HOSP. Rachael Kenyon (RK) asked about the implication of the referral. JR explained the HOSP would take a judgement on whether the additional information presented addresses their concerns. JR noted the length of time to implement the changes would be affected by the referral and during this time Weston Hospital would remain challenged. JR also noted that UHB were waiting	

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	on the decision before agreeing to merge clinical teams. JR noted there would also be a significant impact on staff recruitment and retention due to the potential period of uncertainty. Colin Bradbury (CB) noted the Decision Making Business Case was the culmination of a great deal of work as the Pre Consultation Business Case had been amended following consultation feedback. CB brought the Governing Body's attention to the beginning of the Decision Making Business Case which outlined the organisations involved in the development of the proposals. CB informed the Governing Body NHS England have supported the proposals which have been designed to meet the needs of the local population. The Decision Making Business Case was developed by reviewing the best service models from around the country and working with clinicians to develop an appropriate and safe way to care for the local population 24 hours a day. CB outlined the reasons for the required changes for Weston healthcare services. Following a CQC inspection, the hospital was rated inadequate overall and was therefore closed temporarily overnight. The South West Clinical Senate agreed the previous model of care was unsafe. This was partially due to the overnight removal of junior doctors from the hospital following General Medical Council intervention. CB emphasised that the proposals were not money saving schemes, and the key driver for the proposals was clinical safety and this was the key reason for changing the model of care in Weston. Following consultation it had become clear that the public understood the need for change. Martin Jones (MJ) highlighted that the proposed changes would enable Weston to provide better quality and more sustainable services in the future. He noted, however, that the hospital still faced considerable challenges. MJ thanked system partners and the public for their engagement. Rebecca Dunn (RD) outlined the proposals for Governing Body decision noting these were the key changes to the configuration of commissioned services at Weston Hospital. RD highlighted with the changes, the hospital would be able to deliver services more compliant with national clinical quality guidelines.	

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	The huge amounts of feedback from the consultation was referenced and RD outlined how the feedback had been incorporated into the plan to enhance the proposals. It was noted the close partnership working with UHB had meant Weston Hospital could safely maintain more A&E and emergency surgery activity which meant fewer people would need to travel to receive the care they needed. RD outlined the recommendations the Governing Body were being asked to approve. JR praised the enormous amount of work undertaken by the Healthy Weston Team and explained the recommendations were interdependent, they amounted to one decision on all the proposals. JR highlighted that the proposals would enable Weston Hospital to better comply with clinical standards whilst optimising the local resource. Felicity Fay (FF) was encouraged that patients had not come to harm following the temporary overnight closure of A&E and noted that with the proposed improvements for planned care, fewer people would need to travel for planned surgery. It was confirmed that of the 500 patients requiring planned surgery, the planned care model could reduce the patients required to travel to less than 100 as only those requiring the most specialist care would need to travel. JE commented on the direct admissions to the hospital overnight from a clinician. MJ noted that as part of the Weston Hospital model of care a clinical registrar would determine the appropriateness of the direct referral. South Western Ambulance Service have been heavily involved in this work. AM commented on the huge amounts of work and was pleased to see the consultation feedback had been incorporated into the Decision Making Business Case. AM was encouraged that no serious harm had occurred following the temporary overnight closure but asked whether any incidents had been reported following the overnight closure. MJ explained there was further review ongoing for all other incidents in order to identify if any further work is required to improve patient safety or experience. This piece of work was being led by the CCG.	

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	AM noted the direct referrals and agreed this should reduce the number of patients transferred to Bristol or Taunton. AM noted the clinical standards appendix and highlighted that several of the standards moved from red to amber or green following the proposed changes and asked how this had been measured and assessed. It was confirmed that a huge amount of work had been undertaken to develop the appendix. This included self-assessments undertaken by the hospital and lead clinicians, the Critical Care Network reviewed the assessments as did other specialists. The assessments were reviewed against previous self-assessments. RD noted that acute paediatrics had not been assessed previously and the assessments had been carried out by a consultant in emergency medicine and a consultant paediatrician from Weston Hospital, the assessment had been validated by the Healthy Weston CSDDG RK highlighted the high use of agency staff and the training of junior doctors and asked how the proposed changes would affect workforce. RD explained one of the key aspects of the new model of care was workforce and how to provide the benefits required to retain the workforce including providing opportunities for staff to develop and maintain skills and introducing multi-disciplinary teams to the hospital workforce. John Cappock (JC) commented on the travel schemes and asked how these would be communicated to patients. Ned Brown (NB) noted communications had been planned as part of the programme of work. Information on the travel schemes have been communicated online and within the hospital. Receptionists have been provided with training and local charities have been engaged and provided with information. John Rushforth (JRu) asked how Weston would continue to be funded and resourced in the current financial climate. It was confirmed the regional and national teams had been involved in discussions to ensure funding for Weston Hospital. It was noted the proposals were a part of the merger business case which would strengthen the financial position. FF noted that the model depended on GPs working within A&E and asked whether the Deanery had been consulted. MJ confirmed the CCG was working with the Deanery and noted nationally young GPs were	

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	looking for rotational places at hospitals and part of the hospital plans would ensure quality training at the hospital. CB noted the frailty plans would attract GPs interested in that speciality to the hospital. Nick Kennedy (NK) congratulated the CCG on the clinical approval received for the proposals. It was queried whether the digital solutions set for July 2020 would be separate to any IT requirements needed as part of the merger. It was confirmed it was a separate process, the Medway system used by UHB would be developed within Weston as part of the merger arrangements. RD confirmed the General Medical Council had been involved in the proposals and were supportive of these and confirmed the proposals would go some way to addressing their concerns. David Jarrett (DJ) asked whether the proposals for emergency surgery covered all the pathways that are currently available. It was confirmed that this was the case. LM welcomed the proposal to extend the hours of the children's services and asked whether the activity from A&E would transfer to the ward. RD confirmed that as part of the proposals children would be moved through A&E and into the Seashore Unit faster. Referrals from Primary Care would also be directed into the Unit and the shift in activity was built into the proposals. The Governing Body unanimously approved the recommendations. **The Governing Body approved the proposed clinical model.**	
	Questions from Members of the Public A member of the public praised aspects of the proposals and suggested the problems faced by Weston Hospital were due to consistent underfunding and asked for assurance that at the end of the process the hospital would not be sold to a private company. JR noted that currently the hospital was not underfunded and there were additional funds provided to the Weston healthcare system. JR assured that there were no plans to sell the hospital and the proposals agreed would not downgrade Weston Hospital to anything but a full hospital. The agreed proposals ensured that all services that can be provided	

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	from Weston Hospital safely would be. AH noted that the merger with UHB would have a positive impact on the number of services that could be delivered from Weston. It was asked where someone would be transferred following an emergency call due to something such as chest pain. CB explained that the paramedics were trained to assess risk and would convey patients to the most appropriate care setting and this may be a direct referral from the paramedic into Weston Hospital if that is the safest and most appropriate place to be treated. It was also asked how people could return home following transfer to a hospital outside of Weston. CB explained transport schemes exist for patients who need transport home and the Healthy Weston Team have put plans in place to support people to return home as soon as possible. Another member of the public praised the Healthy Weston Team for their work but asked why social prescribing and residential care were not included within the proposals. Kevin Haggerty (KH) highlighted the huge ambition of the Healthy Weston Programme and explained that the greatest clinical risk was the hospital and this was the priority but there were other programmes of work. The work on community care was outlined including the work ongoing at Care Homes within North Somerset. It was confirmed the CCG was focused on social prescribing and were working in a structured and systematic way to develop this for the future. A member of the public explained that she had suffered from strokes and was concerned for her life if the hospital was closed overnight. MJ explained the CCG needed to ensure people were seen at the right time and in the right setting and noted the good quality of care provided by paramedics, night and day, who would transfer patients to the most appropriate place for their care needs. The expanding population of Weston was commented on alongside questions regarding capacity. CB noted that the proposals were designed to reduce length of stay in hospital and get people treated within the community quicker. A member of the public commented that it felt that the Governing Body members were making decisions that did not affect them. JR noted that the Governing Body was making decisions to improve the healthcare of people in BNSSG and the CCG would	

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	ensure that the population received the best quality of care and that patients have the best health outcomes. A member of the public asked whether the merger with UHB was dependent on the critical care proposals. CB noted changes needed to occur to provide safe and high quality services at Weston Hospital and if the merger wasn't going ahead these changes would still need to made. However, the merger supports the changes and makes the hospital more sustainable. It was noted the critical care changes would still have been achieved without the merger but would have been more challenging. It was noted UHB and Weston Area Health Trust already have close working relationship. A member of public referenced patients with lifelong conditions for whom quick treatment was essential and noted that under the proposals people could be calling ambulances unnecessarily. Jon Hayes (JH) highlighted that paramedics were clinicians who could make the decision to directly refer to Weston Hospital if appropriate. The Governing Body thanked the members of public for their insightful questions and thanked everyone for attending this meeting.	
6.5	**Item deferred**	
7.1	**Healthcare Acquired Infections Report Quarter 1** Rosi Shepherd (RS) noted the CCG were focused on reducing instances of MRSA and E Coli. A South West regional event has been arranged for October to further discuss this. DS asked how the CCG reviews instances of MRSA with particular groups of patients such as homeless people. RS noted this was being monitored and the CCG was working with public health to support members of our population more susceptible to Healthcare Acquired Infections and the CCG was reviewing how the homeless health service can help reduce infection. AM explained this issue was often discussed at the Quality Committee and noted there were suggestions that the pathway was reviewed due to the lack of improvement in performance. Intravenous drug users were highlighted as another cohort of patients that could benefit from such a review. FF asked whether	

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	the work undertaken by the Bristol Drugs Project would be started in South Gloucestershire and North Somerset. MJ confirmed this was predominantly a Bristol issue. **The Governing Body noted the quarter 1 position for healthcare associated infections and the associated action being undertaken.**	
7.2	**Serious Incident Report Quarter 1** RS highlighted the reduction in the backlog of open serious incidents and noted that as part of the actions for 2019/20 a never event summit had been arranged to share learning and actions across the acute providers. Pressure injuries remained a highly reported incident although there has been a reduction reported incidents. The CCG was reviewing whether this was a reduction in incidents or a reduction in reporting and this would be discussed with the providers. JR referenced the deep dives mentioned in the report and noted the action plans from these deep dives needed to be presented to the Governing Body for review. JR also highlighted the system wide serious incident panel and welcomed this as an idea to develop and arrange. RS assured the Governing Body that following the cancer incidents deep dive an action plan had been developed and agreed to check whether harm reviews had been undertaken for patients 100 days after to the incident to ensure no subsequent harm. NK noted the Acute Trust incidents and highlighted the incidents relating to the sub optimal care of deteriorating patients and suggested that learning for these specific issues could be gathered through the system wide serious incident panel. **The Governing Body noted the contents of the report.**	**RS**
8.1	**BNSSG Quality and Performance Report** LM outlined the key points in relation to performance: • 4 hour performance for the BNSSG Trust A&E 4 hour performance was 77.7% which was below the national average of 78.9%. A single BNSSG recovery plan has been developed with input from all partners across the urgent care system.	

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	• Waiting list sizes for planned care increased again in July with performance for the BNSSG population worse than trajectory for the first time. • Patients waiting over 52 weeks have dropped from 22 to 17 which was more than the trajectory of 7. This was driven by waits at North Bristol Trust (NBT). A revised trajectory has been developed for 0 waits by quarter 4 19/20. • Cancer 2 week wait performance continues to be a challenge with the CCG failing the 93% national standard. This was driven by underperformance at NBT due to breaches in the skin speciality following increased demand. • A&E attendances, outpatient activity and planned admissions were above plan. Non-elective activity was reported as below plan. DJ highlighted the issues at NBT related to cancer 2 week wait performance and asked whether this was a seasonal increase in activity. LM explained there had been an improvement following the summer however the issue was driven by increased out of area activity and this activity was being reviewed. It was confirmed Teledermatology had been rolled out across BNSSG but it was noted that 2 week wait patients would have been referred directly into NBT. JR reported that this had been discussed with NBT in terms of referrals requiring clinician input. DS outlined the system for referrals used in primary care and RK noted the referral template available on the EMIS system. AM noted the merger between UHB and Weston Area Health Trust (WAHT) and asked whether this would reduce the focus on performance issues. LM explained the shared Chair and Chief Executive were in place to provide assurance and both would be responsible for decreased performance. A Managing Director and Chief Operating Officer for WAHT have been appointed to provide additional management resource. RS outlined the key messages for Quality: • NHS 111 service provided by Care UK had been rated outstanding following a recent CQC inspection and NBT received a good rating following their inspection.	

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	• NBT Never Event Contract Performance Notice would be closed • The CCG continues its ongoing assurance programme regarding quality and assurance visits at WAHT. **The Governing Body received the Quality and Performance report.**	
8.2	**Finance Report** JR presented the finance report highlighting the key points: • The CCG have received acknowledgement from NHS England of the £12m deficit control total. • Some significant risks were emerging particularly an overspend in the adult Continuing Healthcare budget. • The significant financial pressures had been discussed by the Strategic Finance Committee and Sarah Truelove was reporting the risks to NHS England/Improvement. There was a large amount of work required to recover the financial position. It was noted that not all the pressures were local and some were nationally driven. JC highlighted the increase in independent sector contract activity and explained the Strategic Finance Committee had discussed this in depth. JC highlighted how close the end of year was and emphasised that little time remained mitigate these risks. JRu noted the need to focus on the immediate issues and also the medium term issues such as system planning and working with Local Authority colleagues. JR highlighted there were a number of financial challenges shared with the Local Authorities. NK asked whether the risks to the financial position could have been predicted. LM noted that the level of growth in independent sector activity would not have been predicted. Growth had been expected but not at the level reported. The Governing Body discussed the increase in CHC spend and it was noted the reasons for this had not yet been investigated. Further information would be presented at the next Governing Body meeting. **The Governing Body received the Finance report.**	**ST**

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9.1	**Patient and Public Involvement Forum Terms of Reference** Deborah El Sayed (DES) presented the Patient and Public Involvement Forum (PPIF) Terms of Reference to the Governing Body noting the Terms of Reference had been amended following discussions at the June Governing Body. These amendments included: • Identifying "anchor" partner organisations • Establishing a core membership of the PPIF • Setting minimum attendance levels before the meetings can effectively proceed JR highlighted the section on the responsibilities of the Forum and noted concerns with the use of the word 'ownership' in terms of the Patient and Public Involvement Strategy. It was suggested that the Forum provide assurance on the Patient and Public Involvement Strategy. JR explained the whole organisation was responsible for ensuring patients and the public were engaged. It was agreed to amend the wording. JR cited the section related to reviewing policies and noted that the reference to 'national policies' needed to be amended to read 'local policies' and also asked that it was clarified that the local policies would be reviewed to ensure they reflect national policies. JR asked whether the 'anchor' organisations would be decided by the voluntary sector or by the membership of the PPIF. JR highlighted the importance of the voluntary sector approving the 'anchor' organisations and ensuring all organisations were assured the proposed 'anchor' organisation for their expert area would be representative of their views. It was agreed to consider how best to progress this. JR noted the section that highlighted senior managers from key areas were encouraged to attend and suggested that these posts be added as members to the Forum to ensure attendance. KH noted the time pressure for clinical leads to attend these meetings. It was confirmed that to ensure consistency of discussion the membership now included clinical leads, however	**DES** **DES** **DES** **DES**

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	the clinical leads were not included within the core membership required for a quorum. JR noted that some clinicians would be more interested in joining the Forum than others and RK reflected that the perspective of primary care and therefore the perspective of patients should be consistently represented at the PPIF. It was agreed to add clinical leads to the quorum. DES agreed to review the Terms of Reference in light of the comments above and present to the Governing Body for approval in the future. **The Governing Body reviewed the Terms of Reference and agreed some amendments.**	**DES**
9.2	**Governing Body Assurance Framework and Corporate Risk Register** Sarah Carr reported this was the quarterly review of the Governing Body Risk Register and Assurance Framework which were reviewed monthly by the sub-committees and quarterly by the Primary Care Commissioning Committee and the Audit, Governance and Risk Committee. JRu noted that a deep dive into the finance directorate risk register had taken place at the Audit, Governance and Risk Committee and the risk descriptions had been challenged as requiring more detail. The risk leads were working on ensuring the descriptions were accurate and detailed. It was reported amendments had been made to the Governing Body Assurance Framework to reflect the successful engagement of the Healthy Weston Programme. **The Governing Body reviewed and commented on the Corporate Risk Register and Governing Body Assurance Framework.**	
9.3	**Confidentiality and Security of Information Policy** **The Governing Body approved the policy.**	
9.4	**Personal Security Policy** **The Governing Body approved the policy.**	

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9.5	**Receipt of Petition** JH reported a petition had been presented to the Primary Care Commissioning Committee as below: "We the undersigned are concerned about the decision to close the Bishopston Medical Practice on 30 September. The five alternative practices being suggested are Horfield, Monks Park, Fallodon Way, Gloucester Road and Montpelier. However, there may not be room at these surgeries and this could leave many residents without access to a truly local GP service. The loss of Nevil Road surgery could particularly affect elderly residents and those with limited mobility and transport. It may also put increasing pressure on the other GP surgeries in Horfield, Montpelier and Ashley Down. We call on Bristol, North Somerset and South Gloucestershire CCG and NHS England to take all necessary steps to enable existing patients to retain permanent access to a local GP surgery." LM explained the CCG had reviewed the concerns raised by patients following engagement particularly regarding any potential impact on travel. The practices have assured resilience in order to accommodate the additional patients and have identified whether any additional estate or financial support would be required.	
10.1	**Minutes of the Quality Committee** AM highlighted the Committee had reviewed 3 key areas of assurance rather than the whole range of issues usually discussed. **The Governing Body received the minutes**	
10.2	**Minutes of the Commissioning Executive** **The Governing Body received the minutes**	
10.3	**Minutes of the Strategic Finance Committee** JC noted the Committee had reviewed the position and the significant risks to the year-end position. **The Governing Body received the minutes**	
10.4	**Minutes of the Patient and Public Involvement Forum** STW highlighted the update on the work of the patient and public involvement teams provided with the minutes. **The Governing Body received the minutes**	
12	**Any Other Business** None	
13	**Date of Next Meeting**	

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	Tuesday 5th November 2019, the Vassall Centre, Downend, Bristol, BS16 2QQ	

Lucy Powell, Corporate Support Officer, October 2019