Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

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Bristol, North Somerset, South Gloucestershire CCG Governing Body meeting

Minutes of the meeting held on Tuesday 2nd July 2019 at 1.30pm at Clevedon Hall, Elton Road, Clevedon, North Somerset, BS21 7RQ

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Janet Baptiste-Grant	Interim Director of Nursing and Quality	JBG
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
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
Brian Hanratty	GP Locality Representative Bristol South	BH
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
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
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member Registered Nurse	AM
Justine Rawlings	Area Director Bristol	JRa
Julia Ross	Chief Executive	JR
Sarah Truelove	Chief Financial Officer	ST
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Apologies		
Jon Evans	GP Locality Representative South Gloucestershire	JE
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
In attendance		
Sarah Carr	Corporate Secretary	SC
Lucy Powell	Corporate Support Officer	LP

Paula Clarke	Executive Director of Strategy and Transformation, University Hospitals Bristol (Item 6.4)	PC
James Bayliss	Lead Healthcare Associated Infections and Quality Manager (Item 7.3)	JB
Claire Thompson	Deputy Director of Commissioning, Planning and Performance	CT
Gemma Artz	Head of Performance Improvement (Planned Care)	GA

	Item	Action
1	**Apologies** The above apologies were noted.	
2	**Declarations of interest** It was noted that all the Governing Body GP members had an interest in item 6.2 – Primary Care Networks.	
3	**Minutes of the previous meeting of the 4th June 2019** The minutes were agreed as a correct record with the following amendments: • Item 6.1 – the minute required further clarity that the Service Development and Improvement Plan would be developed through the Healthier Together Urgent Care workstream but managed by the CCG. • Item 6.3 – the 2nd paragraph was amended to read "…withdrawal of investment in the Core 24 services." • Item 7.2 – Kirsty Alexander (KA) asked that her question regarding working groups and assurance be clarified in the minutes. It was agreed to reword this section. • Item 7.2 – it was clarified in the minute that the funding for safeguarding children arrangements would be split equally between the three accountable organisations.	**KA**
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 02/04/19 Item 9.1 01 - Martin Jones (MJ) explained that the posts had not yet been filled and work was ongoing to progress this. It was agreed to update the Governing Body in September. 07/05/19 Item 7.1 01 – Lisa Manson (LM) noted that no timeline had been received, however the CCG was aware that the equipment had been ordered. It was agreed to update the Governing Body at the next meeting.	
5	**Chief Executives Report** **Annual General Meeting** Julia Ross (JR) thanked those involved in the CCG's Annual General Meeting which was held on the 27th June, noting that 100 members of the public, partners and elected officials had	

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	attended the event. Positive feedback had been received regarding the level of engagement at the event as well as the plans for the future outlined at the meeting. **Healthier Together Partnership Board** The first meeting of the Healthier Together Partnership Board had been held, members included chairs and chief executives from Healthier Together organisations. JR highlighted that the Partnership Board had fostered a joint sense of ownership across the system and a willingness to work together on financial recovery and other system issues. **Primary Care Networks** 18 Primary Care Networks have been agreed and put forward for authorisation across BNSSG. Following the first meeting with the Primary Care Network Clinical Directors the CCG had been encouraged by the operational arrangements being put in place. The Primary Care Networks are working with the locality teams and providers and were a core building block to enable integrated out of hospital services. **Framework for the Long Term Plan** JR explained that the framework for the Long Term Plan had been published, noting that the summary would be distributed to Governing Body members. JR noted that Healthier Together was already developing most elements of the Long Term Plan. JR explained that the system was in discussion with NHS England/NHS Improvement about transformational funding to support delivery. Initial plans would be submitted on 27th September 2019 with the final plan submitted on 15th November 2019. The final plans would form part of the national implementation plan. Alison Moon (AM) asked what role the Partnership Board would have in assuring the long term plan. JR confirmed that it would have the final sign off and noted that the engagement of Non-Executive Directors and the Chairs at the Partnership Board provided an important perspective.	**JR**
6.1	**Locality Transformation Scheme 2019/20** David Jarrett (DJ) presented the paper on behalf of the three Locality Area Directors noting that much of the Locality	

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	Transformation Scheme work was outlined within the Long Term Plan priorities. DJ set out the key points of the scheme highlighting that the ambition of the programme is to enable the community to become the default setting of care for a much wider cohort of patients. This continued development would be through two existing programmes of work; frailty and locality based mental health services and the addition or urgent care services. Models of delivery were being developed aligning with frailty hubs and the adult community services procurement. KA asked whether the pathway changes could be developed in time for the winter pressures. DJ noted the clear governance route for pathway changes was through the Clinical Oversight group who would support this process to ensure readiness for winter. JR asked whether following the pathway workshop the risk profile had changed. DJ noted that there had been positive engagement and enthusiasm for pathway redesign from across the system. Rachael Kenyon (RK) gave an example of the discussions ongoing at locality level regarding urgent care and the actions primary care colleagues can take to reduce pressure in the system. Peter Brindle (PB) noted that the pathway redesign work was based on reviews of partially developed pathways or pathways developed from other CCGs. **The Governing Body noted the progress and approved the areas of focus for 2019/20.**	
6.2	**Primary Care Networks Report** MJ reminded the Governing Body of the key place the Primary Care Networks held within the long term plan and system working. Recommendations have been made for 18 Primary Care Networks; which are representative of the local population and able to deliver their needs. It was highlighted that the Local Medical Council had been a part of the assurance process and as	

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	part of this 4 Primary Care Networks had been tasked with actions which had been completed prior to recommendation. A meeting with the Primary Care Network Clinical Directors has taken place to discuss organisational development with the locality teams. AM added that the Primary Care Commissioning Committee had discussed how the Clinical Director roles would be supported in keeping their local personality and autonomous working. **The Governing Body received the report.**	
6.3	**Adult Community Health Services Procurement Update** LM explained that the update had been embargoed but would be added to the CCG website following the meeting. LM gave the background to the procurement noting that the final bidder proposals had been evaluated and the highest scoring bidder would be notified in July, this would remain confidential during the standstill period, until the end of July. During August an assurance process would take place involving NHS England and NHS Improvement with the intention for contract award and contract signature to take place at the September Governing Body meeting. **The Governing Body noted the progress and next steps.**	**LM**
6.4	**University Hospitals Bristol NHS Foundation Trust 'Embracing Change, Proud to Care – Our 2025 Vision'** Paula Clarke (PC) was welcomed to the meeting to present the strategy for the future of University Hospitals Bristol (UHB) for the next 5 years. PC set out the engagement that had taken place in order for UHB to develop the vision, including public engagement events, discussions with patients and online questionnaires. The key points of the strategy were outlined as: • To grow specialist hospital services • To work more closely with health and care partners to provide more joined up local healthcare services • To become a beacon for outstanding education and research PC provided the detail on how UHB would achieve these strategic points.	

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	FF asked whether the plan was for specialists to provide services in the community. PC explained that this would be reviewed and determined what would provide the best value to patients in terms of quality of care and patient experience. PB asked whether UHB becoming a regional centre would affect the BNSSG population needs. PC noted that this had been discussed extensively throughout the development of the vision. UHB was aware of the need to work in an integrated way with the system and considerations on delivery of care were key to the vision. JR welcomed the strategy and reflected that the ambitions for organisations may change as the Healthier Together long term plan is developed. Nick Kennedy (NK) asked how the system wide considerations are being communicated to UHB staff. PC answered that messages to staff regarding the Healthier Together programme were relayed through internal communications. NK also asked for assurance that following the merger with Weston Area Health Trust (WAHT) engagement in the Healthy Weston programme would continue. PC explained that UHB was part of the Healthy Weston process and steering groups noting that although the commissioner was leading on this work, this was a shared model and this would continue. **The Governing Body received the presentation on the UHB Vision.**	
7.1	**Learning Disabilities Mortality Review (LeDeR) Activity Data** Janet Baptiste-Grant (JBG) presented the paper noting that good progress was being made on the action plan. The CCG has received 78 LeDeR referrals since January 2018. The percentage of deaths in a hospital setting were consistent with the national average. JBG highlighted the spike in reporting for April 2019 following an awareness raising campaign in March reminding staff to report. It was noted for the CCGs population size there should be 22 reviewers, currently there were 11. Recruitment and retention has	

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	been discussed at the LeDeR steering group and the number of reviewers available would be discussed at the next Director of Nursing and Quality meeting. It was reported that the majority of the cases that have been reviewed were deemed to have had good or excellent care. Where recommendations have been made following reviews, these have been added to the action plan. Felicity Fay (FF) queried why trained reviewers did not always become active reviewers. JBG speculated that this may be due to the review process being more time intensive than expected and JR confirmed that the LeDeR model was being revised nationally. JBG informed the Governing Body that 2 BNSSG reviewers were dedicated reviewers. AM noted that the governance around the reviews was robust and despite focus on process initially the steering group was now focused on the learning from the reviews. AM gave an example of associated factors between reviews and confirmed that the group were asking questions regarding these similar qualities. JR queried the quality assurance process for reviews given the majority of the reviews had positive outcomes. AM assured the Governing Body that the steering group tested and challenged a sample of the reviews. Christina Gray (CG) asked who undertook the review for patients out of area and it was confirmed that these were undertaken in the area where the patient died. CG asked whether learning would be taken into account within the BNSSG action plan. The Governing Body agreed that the actions should be incorporated into the BNSSG action plan and JGB agreed to check this was the case. AM pointed out that LeDeR reviews are only carried out if the patient was registered with a GP. Colin Bradbury (CB) queried, following the reporting spike in April, whether the levels of reporting were accurate. JBG clarified that the increase in reporting during April were attributed to deaths which had occurred earlier in the year but not reported. It was asked whether the team could confirm that this was the case and provide some clarity around the data.	**JBG** **JBG**

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	Kevin Haggerty (KH) asked how primary care were involved in the notification process. JBG suggested that the team investigate this further. **The Governing Body received the report.**	**JBG**
7.2	**Quarter 4 Safeguarding reports** **Safeguarding Children Report** JBG noted the reduction in number of clinicians with safeguarding children training at level 3 within primary care at quarter 4 and noted that 500 training spaces were available across BNSSG. Provider compliance for level 2 safeguarding children training had increased across the Acute providers but had not reached the target of 90% of staff trained. JBG outlined concerns related to the compliance levels for level 3 training for Sirona which has declined from quarter 2 to quarter 4. Sirona believe this was due to a manual reporting issue and that the levels will improve as a new online training system was used. JBG informed the Governing Body that as part of a joint safeguarding arrangements, thematic joint reviews would be undertaken across the system with South Gloucestershire's review already taken place. STW asked for clarification regarding the level 2 training at Sirona. JBG explained that once the level 3 training was monitored through the training system the training rates would show higher. It was noted that the CCG would be undertaking a visit to Sirona to review the training data. STW asked whether the CCG were assured by the action plan in place and JBG explained that a revised action plan had not been received. The Governing Body discussed the training needs for Primary Care and the difficulty in finding the time for clinical staff to attend the training, Jon Hayes (JH) suggested the idea of training invitations to be extended to nearby practice teams. Social Care referrals were discussed and RK outlined the difficulties GPs face when referring into Social Care. JBG agreed to raise this issue with the Local Authorities.	**JBG**

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	JR noted the differences in CAMHS across the three local authorities and asked how the CCG assures that important issues, such as CAMHS, would be discussed at the Safeguarding Children Boards. JBG noted that the new safeguarding children arrangements were the CCGs opportunity to be involved in agenda setting. JBG noted that currently the agenda was driven by pertinent issues and gave the example of knife crime. It was confirmed that the CCG contributed to agenda decisions. CG noted that the new safeguarding children arrangements for Bristol would be driven by a newly developed dashboard through which significant issues would be highlighted. **Safeguarding Adult Report** JBG gave the details of the training levels for staff at the CCG noting that this was falling short of the Safeguarding Adults training requirements. The numbers of staff PREVENT and WRAP trained were also falling short of the target percentage. JBG noted that work was ongoing with the organisational development team to develop an establishment list to ensure staff roles are captured correctly and approached to undertake the training. It was noted that all clinical staff, including those at general practice, would be required to undertake level 3 safeguarding adults training and JBG acknowledged the challenge this would provide. It was reported that three domestic homicide reviews have now been published with implications and actions for the health system following two of the reviews. It was confirmed that actions are reviewed by the CCG and implemented if required. JR requested that an action plan be submitted to the Governing Body regarding the adult safeguarding training within the CCG. JBG confirmed that the action plan had been submitted to internal audit and agreed to circulate this to the Governing Body. John Cappock (JC) suggested that the CCG review the consistency of approach for the safeguarding training noting that this appeared to be undertaken and monitored differently across the NHS. JR asked JBG to discuss this further with Directors of Nursing to ensure the systems and processes are joined up particularly around training and reporting.	**JBG** **JBG**

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	CG suggested that vulnerability and domestic abuse could be addressed at locality level. JR noted that as the localities become more embedded and as the locality provider boards are developed this would encourage shared responsibility. **The Governing Body received the Safeguarding Children Report and the Safeguarding Adults Report.**	
7.3	**Healthcare Associated Infection (HCAI) Report** James Bayliss (JB) was welcomed to the meeting and presented the report. JBG noted that MRSA was the biggest challenge faced by BNSSG CCG in terms of HCAI despite a reduction in cases within the current year. JB noted that following analysis themes between the cohort of patients developing MRSA were emerging and it was highlighted that the CCG reviews lapses in care which may result in increased cases of MRSA. The plan was to develop a single Root Cause Analysis tool for all providers. It was reported that the CCG was significantly below the maximum threshold of C Diff cases set by NHS England of no more than 309 cases, with the CCG reporting 103 cases in 2018/19. It was highlighted that the target for 2019/20 had been lowered to 201 cases. JB noted that there was no mandated threshold for E Coli cases however the CCG ambition target had been set at 485 cases. The CCG had reported over 700 cases locally. JB noted that E Coli was a significant challenge both locally and nationally. The catheter passport had been implemented from April 2019 and the quality team have approached the Academic Health Science Network for support in streamlining the process, the quality team have also contacted local CCGs to review alignment. Antibiotics prescribing has reduced in the BNSSG area across all providers and all contracted providers except two achieved the national CQUIN regarding flu vaccinations last year. FF asked for further information about the implementation of the catheter passports. JB confirmed that these had been circulated to providers in April 2019 and the providers are currently within	

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	the rollout and training stages with assurance audits to take place in August. A local CQUIN has been developed for catheters of which part was the roll out of the passports and timely removal of catheters. FF asked whether the issue had been discussed with primary care and JB confirmed that despite the majority of the conversations taking place with the Acute Trusts and Community providers, discussions had been held at the practice nurse steering group and JB agreed to provide an update regarding other communication with primary care. AM noted that flu vaccination rates were regularly discussed at the Quality Committee particularly around the date at which these are available for use. JB noted that the flu planning group have discussed the date that the vaccines could be ordered and delivered. JR noted that the percentage of serious incidents regarding Healthcare Associated Infections seemed low. JBG explained that there may be a high number of incidents rather than serious incidents. A serious incident would contribute serious harm or lapse in care. JR noted the risks and mitigations section and noted out E Coli has the largest challenge and asked how this was being addressed. JB noted that there are elements of actions and that the next step would be a E Coli task and finish group to review other work by CCGs and other providers. **The Governing Body received the Healthcare Associated Infections report and noted the actions for 2019/20.**	**JBG** **JBG**
8.1	**BNSSG Quality and Performance Report** JBG gave the key points from the Quality report: • North Somerset Community Partnership reported an increase in level 2 pressure ulcers in the last two months and a deep dive will be undertaken to identify any actions needed. • Avon and Wiltshire Mental Health Partnership (AWP) have reported a backlog on serious incidence reporting and Root Cause Analysis. The CCG is working to support and progress these serious incidents to closure.	

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	• Quality concerns have been raised with an organisation running multiple care homes across BNSSG. Visits would be undertaken to the homes concerned. The Governing Body welcomed Claire Thompson (CT) and Gemma Artz (GA) to the meeting for the performance report. CT gave the key points from the performance report for month 1: • 4 hour performance has deteriorated with quarter 1 performance below trajectory despite improved performance showing at month 3. Work is ongoing to identify the cause of the dip in performance. • For month 1, waiting list sizes and planned admissions are above trajectory, and 52 week waits are achieving trajectory. • 62 day referral treatment time was at 85%, however 2 week wait performance did not reach the 93% national standard. • Non elective activity was currently under plan and this could be attributed to the growth added to the contracts for 2019/20. FF noted the low numbers of GP referrals, and zero length of stay performance and asked what the primary care streaming pilot at NBT involved. CT confirmed that the CCG had a low baseline for GP referrals due to the referral management service. DJ noted the continued roll out of the referral management service. CT explained that a report and audit had been undertaken on the zero length of stay coding for NBT and this would also be undertaken for UHB and Weston. CT explained that GP streaming was part of a national drive to have GPs at the front door of A&E who can redirect to Primary Care. **52 week waits** GA explained that a Contract Performance Notice had been in place at NBT for 2018/19 noting that the waits were related to Musculoskeletal surgery. Some waiting lists have been closed ensuring there was capacity in the system and work would continue to redevelop the orthopaedics pathway. It was noted that	

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	UHB were on trajectory until further long waiters were discovered, these patients had now been treated. JH asked whether the complex knee long waiters were impacting on simple knee operation waiting times. GA confirmed that that these were not affected. FF asked whether there was enough capacity for a single orthopaedic pathway. GA noted that capacity and demand modelling has taken place and with independent sector organisations included, there was capacity in the system. AM asked whether the Acute Trusts had been challenged on their timelines. CT noted that the CCG did challenge however the availability of practitioners and patient choice were the reasons for some of the delays. JR asked what assurance the CCG could have that UHB would not find any further long waiters. LM explained that IST and NHS Improvement had visited the Trust and assured the processes in place. LM confirmed that patients waiting over 35 weeks were reviewed weekly and it was agreed that the Commissioning Executive Committee would be updated regularly. **Cancer Performance** GA highlighted that 62-day performance was better than national average but not yet at the 85% target. The challenge for this target locally was Urology and the complexity of the pathway as well as the increase in demand. An action plan for urology has been developed and NBT have invested in robots and consultant time to increase performance by Autumn. Work continues locally with the Trusts and the Cancer Alliance. JR asked whether there was a single system plan for improving cancer performance.GA noted that for the improvement plans there are both STP level plans and organisational plans as well as review on a regional level. CB asked about the low performance percentages at Weston Area Health Trust due to the low numbers of cases presented. GA noted that this had been a long term issue for Weston and it was noted that once NBT take on the additional pathways the numbers would decrease further but there would be further support from NBT and UHB with the more complex pathways.	**LM**

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	Urgent Care CT noted that growth had increased beyond expected for 2018/19. The system had undertaken a deep dive into this growth and the deep dive provided the detail behind the potential drivers of the growth. CT noted that additional activity within the system was driving A&E attendances up by 41 patients a day. It was noted that adult attendances were high at NBT and Weston whereas Children attendances were higher at UHB. It was also recognised that both ambulance conveyances and walk in arrivals had increased. Following analysis there was found to be no correlation to housing development, coding changes or ease of access to Primary Care but there were some potential correlation to 111 calls and healthcare professionals directing to A&E as well as the effective emergency pathways at NBT drawing attendances. CT noted that further diagnostics are taking place using the Emergency Care Data Set to understand the sources of growth in activity. Brian Hanratty (BH) asked whether the attendances at A&E were increased in the evening. CT confirmed that this was the case and noted that this had always been the case but had become exacerbated recently. NK asked about the influx of paramedics and noted the short retention period of these posts. CT reported that the CCG had discussed rotational posts with SWASFT. AM highlighted the need to understand behaviours to understand why people attend where they do. CT explained that the CCG planned to engage with members of the public to understand these behaviours to inform commissioning decisions. **The Governing Body received the Quality and Performance report and the deep dives into 52 week waits, cancer performance and urgent care activity growth.**	

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8.2	**Finance Report** Sarah Truelove (ST) presented the finance report highlighting the risks and mitigations section of the report and the considerable risk within the system regarding the financial recovery plan. It was reported that the Partnership Board had supported the development of the schemes within the plan. ST highlighted a risk related to increased activity within Continuing Healthcare and noted that a deep dive had been arranged with the team to identify any actions required. DJ highlighted that the existing savings plans from 2018/19 needed to be delivered alongside the new financial plan and ST noted that these continued to be outlined in the finance report. **The Governing Body received the Finance report.**	
9.1	**Risk Management Framework** Sarah Carr (SC) outlined the revisions to the risk management framework, noting the requirement for Executive Directors to sign off risks was highlighted within the framework. It was confirmed that there was a risk appetite statement included within the framework and this would be developed throughout the year. AM noted that as part of the structure document, the word delivery needed to be included for the Primary Care Commissioning Committee. **The Governing Body approved the Risk Management Framework with the above amendment.**	**ST**
9.2	**Corporate Risk Register and Governing Body Assurance Framework** SC reminded the Governing Body that the Corporate Risk Register and the Governing Body Assurance Framework would be presented to the Governing Body each quarter. It was reported that 8 new risks had been added to the register, and noted that the descriptions would be refined and amended. The Governing Body were asked to agree the removal of risks identified for closure and these would be moved to directorate risk registers to be monitored by the directorate teams. **The Governing Body approved the Corporate Risk register and Governing Body Assurance Framework.**	

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9.3	**Freedom to Speak Up Policy** The Freedom to Speak Up policy had been developed to support a culture of openness and to help staff to raise concerns. It was noted that this was only one of many ways that staff could raise concerns. NK felt that there was no clear first line of approach for staff to raise concerns. ST explained that it was up to the member of staff how and who they raise concerns with. BH asked whether it was appropriate for the membership to use this policy for raising issues. JR suggested that there would be a different mechanism for practice members to raise any concerns and ST agreed to look into this and update the Governing Body. STW noted that the Patient and Public Involvement Forum had members from other organisations which were specifically not covered by the policy but also included within the scope of the policy through the inclusion of staff from Sub-Committees. It was agreed to add a sentence to clarify the position. **The Governing Body approved the Freedom to Speak Up Policy.**	**ST** **ST**
9.4	**Fraud and Bribery Policy** ST presented the updated Fraud and Bribery policy to the Governing Body noting that the policy had been reviewed by the Audit, Governance and Risk Committee. **The Governing Body approved the Fraud and Bribery Policy.**	
9.5	**Healthier Together Partnership Board Terms of Reference** JR presented the final terms of reference for the Partnership Board, it had been agreed that the terms of reference would be reviewed if required as the Partnership Board matures. JR noted that the long term plan would be signed off by the Partnership Board following delegation from the individual Boards. There had been a significant discussion at the Partnership Board around Primary Care engagement and it had been agreed that the CCG would lead a discussion with locality leads as to whether a locality representative should attend. It had also been agreed to review the clinical leadership across the STP and how this could be better embedded across BNSSG.	

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	The Governing Body approved the Terms of Reference for the Partnership Board.	
9.6	**Primary Care Commissioning Report** **The Governing Body received the Primary Care Commissioning Report**	
10.1	**Minutes of the Quality Committee** AM highlighted the maternity item noting that the presentation had been very useful and the dashboard included in the papers had been positive. **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** **The Governing Body received the minutes**	
10.4	**Minutes of Primary Care Commissioning Committee** **The Governing Body received the minutes**	
10.5	**Minutes of the Healthier Together Sponsorship Board** **The Governing Body received the minutes**	
10.6	**Minutes of the Patient and Public Involvement Forum** STW highlighted the report outlining the work of the forum and noted the positive session held on the Primary Care Strategy. **The Governing Body received the minutes**	
10.7	**Minutes of the Audit, Governance and Risk Committee** **The Governing Body received the minutes**	
11	**Questions from Members of the Public** Mr Blethstowe asked why the CCG did not appear to measure cancer performance targets or activity for the entire pathway. JR answered that the CCG reviewed measures for a small part of the pathway as mandated by the NHS Constitution and national metrics. The CCG would like to understand the whole pathway and in the future the values work will start to evaluate the metrics across the whole pathway. PB noted that there is work ongoing around supporting people with cancer involving clear discussions regarding benefits and disadvantages of any treatments before decisions are made.	
12	**Any Other Business** There was no other business	
13	**Date of Next Meeting** Tuesday 6th August 2019, 13.30pm, The Vassall Centre, Gill Avenue, Downend, Bristol, BS16 2QQ	

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

Lucy Powell, Corporate Support Officer, July 2019