NHS
North Somerset
Clinical Commissioning Group

Agenda Item 12.4

Clinical Commissioning Leadership Group

Held on 22nd June 2017, Room 2, Clevedon Town Council, 44 Old Street, Clevedon, BS21 6BU

Minutes

Present: Mary Backhouse, Chair (MB) (Clinical Chair, NS CCG)
Julia Ross, (JR) (Chief Executive Officer BNSSG)
Mike Vaughton (MV) (Chief Finance Officer, NS CCG)
Debbie Campbell (DC) (Head of Medicines Management, NS CCG)
Jeanette George (JG) (Chief Operating Officer, NS CCG)
Miriam Ainsworth (MA) (Clinical Lead – Community services)
Rachael Kenyon (RK) (Clinical Lead – Planned Care)
Georgie Bigg (GB) (Chair of Healthwatch North Somerset)
Mike Jenkins (MJ) (Clinical Lead – Mental Health)
Julie Kell (JK) (Associate Director of Transformation)
Caroline Laing (CL) (Head of Quality North Somerset CCG)
Jeremy Maynard (JM) (Clinical Lead –Quality)
Kevin Haggerty (KH) (Clinical Lead - Urgent Care)

In attendance: Sonia Galley (SG) Minute Taker

By invitation: Mark Hemmings (MH) (Maternity and Children's Commissioner)

Apologies: Jacqui Chidgey-Clark (JCC) (Director of Nursing & Quality, NS CCG)
Tony Ryan (TR) (Clinical Lead – Children's and Maternity)
Jenny Norman (JN) (Head of Planning & Business Support)
Joanna Underwood (JU) (Delivery Director)
Sheila Smith (SS) (Director of People & Communities)
Jon Roberts - Standing in for Natalie Field (NF) (Director of Public Health)

Ref:		Action
1	**Welcome:** MB welcomed all to the meeting. Some of the agenda items will be presented in different orders, due to some members leaving, and guest speakers arriving.	
2	**Apologies:** Apologies noted as above. JG will be leaving the meeting at 12:00. JR and MV will be leaving the meeting at 10:25. It was also noted that CL is the delegated deputy for JCC.	
3	**Declarations of Interest:** JK declared an interest in the CAHMS paper in Item 23 for personal reasons and would not be commenting on this paper or participating in decision making.	

	All GPs present declared an interest in the Primary Care Enhanced Services Item 9. MB will hand the Chair over to JG for this item. It was agreed that GPs should be able to comment on this proposal but be excluded from decision making.	
4	**Good News Stories:** KH informed members that there are lots of positive outcomes for Primary Care in Weston. Several Workshops have been held looking at the vision with key services. Care Home work has also been very positive. Work has also been happening with four practices that have formed a company, this is for the population that is centred around the airfield development , looking at work streams that sit well with the STP, improving access across the practices.	
5	**Chair's Reflection:** MB informed members that she,, along with JR and the two Clinical Chairs from Bristol and South Gloucestershire CCGs, they went to the NHS Confederation Conference in Liverpool. It was useful to hear what is being talked about nationally, what the national issues are and to hear about the actions that are being carried out at all levels to address them. There was a lot of focus on workforce and it was evident this is a national issue and not just a BNSSG matter. ~~This is one of the areas that~~ Simon Stevens talked at the Conference about the direction that the NHS should be heading in and is about the 5 year forward view and the next steps - urgent care, mental health and, cancer are key areas of focus. These are areas that BNSSG are already concentrating on. The work that is being carried out with Control Centres and with the involvement of providers is very helpful. Internally, papers are going to the Governing Body in July showing the future Executive Structure. Interviews have started and information is being relayed to staff. MB asked for members to be sensitive with staff that they are working with who are going through organisational change and yet also have to deliver against very challenging targets and deadlines. JR added that despite the uncertainties in the NHS, all the staff remain committed, dedicated and diligent and she has felt really well supported since arriving. JR continued saying that after the appointment of the Executive Team will be work to bring together the integration of Governance processes. North Somerset will continue to have a strong local focus whilst still being part of the wider BNSSG focus. JR confirmed that the Clinical Commissioning Leadership Group will continue in North Somerset and will feed into a BNSSG Commissioning Executive Group. JR gave thanks to all of the staff.	
6	**Minutes of meeting held on 25th May 2017:** The minutes were agreed as a true record.	

7	**<u>Action Log:</u>** Action 50: This has been fed into a Quality issue. This action is closed. Actions 51, 53, 54, 55, 56, 57 and 58 are closed. Action 52: The owner of this action is changed to DC. The action is left open for JK and DC to discuss.	
8	**<u>Integrated Performance Report:</u>** CL delivered the Quality section of this report. Highlights that CL reported are: <u>UHBristol:</u> • National Early Warning Scores (NEWS) – there has been 100% compliance in acting on NEWS scores for two consecutive months. • Two Never Events have been reported. One is a Dental Never Event relating to a retained foreign object (gauze) .The second Never Event pertains to a misplaced fine bore nasogastric tube (linked with review of the X-ray). The Root Cause Analysis (RCA) investigations are underway for both cases. CL emphasised that Never Events need to be discussed across BNSSG to ensure learning is shared. <u>WAHT:</u> • Senior management team changes - in April 2017 new senior members took up some key positions.. A settling in period was recognised and now their previous experiences within acute settings have made a noted improvement to the Trust. • Performance overall in Emergency Department (ED) – a marked improvement has been seen. They have reached their trajectory on 4hr waiting times, although not with the standard last month. • CQC visit – the CQC has recognised some improvement in their services particularly in surgery and critical care, however, the Trust requires overall improvement. • The Trust has announced a temporary closure of the Emergency Department from 4th July 2017 overnight between 22:00 and 08:00 hours. • One ward was closed with Norovirus in June and this has now reopened. • There have been two Never Events. One has been completed and the other is under RCA investigation. <u>NBT:</u> • The standard and timeliness of Discharge Summaries has improved. At the IQPM last week in WAHT, they were asked to contact NBT to find out how they had achieved this so that shared practices could be used. <u>NSCP:</u> • NSCP continue to receive high FFT Response Rates and the Clevedon Hospital MIU had a 33% response rate. • The staff turnover has increased for the third month in a row. Exit interviews have been conducted but no specific themes have emerged. • Pressure ulcers remain an issue with 12 community acquired pressure ulcers reported in April 2017. One was reported as a Serious Incident.	

AWP Trust Wide:

- The CQC re-visit started on 12th June 2017. The CQC will be looking at the 136 Place of Safety units particularly in relation to the current Warning Notice.
- Callington Road, Bristol has had a temporary ward closure and all patients have been moved within the Trust.

AWP North Somerset Locality:

- Street Triage Service is to be launched in June (service provision from Thursdays to Mondays between the hours of 1500hrs and 2300hrs.
- Staff sickness absence continues to improve
- Assurance has been received around the cardiac arrest procedure following the withdrawal of the Service Level Agreement from WAHT, the locality reported that staff are compliant in Physical Emergency Response Training (PERT).

SWAST:

- Verbal assurance has been received around clinical quality indicators. The Deputy clinical Director identified that the Trust were in the process of planning to focus on 10 key areas to improve performance.
- Complaints have dropped to 28.36% and this will be monitored through the IQPMG.

Care UK NHS 111:

- It has still to be decided as to which CCG will take the "oversight" role for adult safeguarding for Care UK.

Infection Prevention and Control:

- Bristol CCG had 11 cases of Clostridium difficile Infection (CDI) reported.
- North Somerset CCG had 2 community cases reported of CDI in April and both will be undertaken by RCA.
- South Gloucester CCG had a total of 3 cases of CDI reported, these will also be undertaken by RCA.

All of the reportable infection cases are now discussed at the BNSSG HCAI group and themes are collated.

- Bristol CCG reported 2 cases of 48 hour MRSA in April. The cases have been submitted to NHSE for arbitration and the results will follow from the panel in due course.
- North Somerset CCG reported 1 case of MRSA in WAHT in April and the learning was shared at the IQPM meeting last week.
- South Glos CCG reported 2 cases of MRSA in April. Both cases have been reported to a third party and arbitration will follow.

E Coli cases are now reportable and the HCAI group are looking at how to manage these cases for the future.

- Bristol CCG have identified 30 cases in April. Urinary tract infections have been identified.

JR commented that this is really helpful information and advised that the CCLG should be focusing on 3 or 4 issues.

	JR asked how pressure ulcers are being reduced. CL replied that there is a BNSSG Steering Group. It is recognised that on admission to WAHT ED pressure ulcers are not always identified and recorded consistently. JR asked what the goal for pressure ulcers is and would expect zero tolerance. MB added that analysis is being carried out in North Somerset on patients who already have pressure ulcers when they attend WAHT and asked CL how this work is progressing. CL replied that this is to be carried out by Jane Jacobi (JJ) but has not yet commenced. CL commented that the community partnership is reporting Serious Incidents within care homes of grade 3 and 4 pressure ulcers. Patients are also mapped as to where they have come from when in hospital, but no trend has been identified. North Somerset Community Partnership (NSCP) has reduced their incidents and is reporting more grade two pressure ulcers. **Action 53:** JR commented that the CCLG needs to know what the critical items are, that need addressing. CL will report back to CCLG. JM confirmed that the Quality team have a risk register and are aware of the priorities. JR said that she acknowledges that the priorities are highlighted but would like to know what is being done about them and how they are being addressed. GB said that the core issues with this are that when a patient comes into contact with the services, the services are expected to monitor and report, but in domiciliary care what is available for the carers and the community to know how to prevent pressure ulcers. MA responded that NSCP issue leaflets that are in GP surgeries and GPs issue advice. It is about self-management. GB suggested that to help promote the NSCP literature through Healthwatch to information share through their links in the community and to put it on their website. Also Healthwatch has recently carried out some Carers work. JG asked for it to be noted that the CCG are about to respond on the Carers Report and will make sure that Mary Adams, who is compiling the comments, is aware of this. DC added that learning needs to happen, from Never Events. CL confirmed that the 2 dental Never Events at Weston have been challenged by the CCG, asking what policies were being used and what staff were in the theatres at the time. Somerset Surgical Services (SSS) use Weston policies and Weston staff. SSS and WAHT are undertaking the RCA jointly. JR emphasised that it needed to be clear which items were taken to which group, and not repeating what is done in various groups and taking up agenda time of groups unnecessarily. The role of each group needs to be focused on. CL gave an update on Mortality. There is a new Medical Director in post at WAHT. The Medical Director is reviewing the current processes in place and will present his	**CL**

findings at the July Quality sub group.

JM added that Weston hospital look at different data for the SHMI report and this has been difficult. The CCG look at SHMI report from Dr Foster and Weston look at a monthly CHKS report.
JR asked if they had a panel where all deaths are reviewed.
JM replied that this was not the case historically, but moving forward and new staff grade doctor has been employed who amongst other things will be looking at mortality. JM will be attending the Mortality Review Meetings when they change to a Thursday.

MV delivered the Performance section of the Integrated Performance report.
Highlights that MV reported are:
The report reflects Month 1 and shows trends from previous years. Key areas for noting are urgent care and cancer and elective waiting, particularly in Bristol.
Diagnostic standards in Bristol were missed in April and Weston have consistently achieved this.
Members have the detail supporting the analysis of areas of challenged performance which sits behind the key exception areas.
This still reflects a North Somerset perspective on performance and this will change. Going forward the performance reporting will be at BNSSG level.

MB reflected that the ongoing concern are the cancer issues asking if the CCG had the right focus to make sure that the pathways are being separated in the ways that they should be.
DC replied that in the BNSSG Working Group meeting last week there was more discussion on the cancer time pathways and making sure these were secure to meet the 62 day targets.
MB asked what the role of cancer alliance was.
DC replied that cancer alliance worked at a different level and would have the ability to influence changes to operational detail in the timeframes required.
MB added that this is a service that is not improving and asked what it was that could be done to help.
JR commented that it is a challenge for BNSSG and asked if a deep dive analysis of the flow had been carried out.
DC replied that a RCA used to be submitted for every breach but this does not happen at this level of detail anymore, we now receive a report that shows themes. The numbers from Weston that require going on a 62 day pathway are small, so each breach means approximately a 5% drop in performance. Phil Walmsley now chairs the cancer meetings on a monthly basis and a real shift will happen in not accepting repeat breaches.
KH emphasised that when a patient had been shown to have cancer, it would be unacceptable for this pathway to have delays on it. It is all about flow and understanding the hold ups. The infrequent NBT meetings do not help the situation.
MB commented that there are 2 cancer pathways that are not happening at Weston hospital, ENT and Gynae.
DC confirmed that the ENT pathway move to UHB starts in August 2017.
JM added that Weston hospital is unable to carry out the number of CT scans that are required and favour carrying out barium enemas.

	JR responded that patients needed to be sent elsewhere to combat the large numbers attending Weston hospital and to write a formal contract notice that states this is not what is expected and that something different should be carried out; and to inform the CCG how this will be managed. If the hospital replies they cannot do this the CCG must give notice that they will inform the GPs to refer patients elsewhere, for GPs best practice care. JG asked members how the CCLG can pick this up. JM confirmed that Joanna Underwood is picking this up. MV asked if an update could be expected at the next contract meeting. JR suggested bringing Alison Moon, as the cancer lead, into the discussions. GB asked how the impact on the patient is measured. MB replied this is measured in the clinical incidents reporting. GB queried how a more effective system could be created that would also have a better outcome for the patient. JR replied that following NICE guidance would be the best practice outcome for the patient; use the incidents / cases that we know about where patients have not had a good outcome and there have been problems with the processes; patient outcomes should be measured. JM added that Weston hospital was asked to go through each patient on the pending list for cancer. At each contract meeting thereafter they have been asked to disclose what the harms were that happened to those patients on the list and no harms have been identified. GB asked how the CCG could build into the process to ensure that the provider is looking after the patient outcome as opposed to the process delivery. MB reminded members that the Patient Council is available at WAHT and they should focus on the patient outcome. JR emphasised that the Trust should be delivering the standards expected and reminded everyone that the CCG is culpable if standards are not met. 10:00 RK entered the room. JK suggested asking one of the clinical evidence and evaluation people to pull together all the best practice methods. Secondly with performance – now that there is a set trajectory for DETOC this could be on the report because last month on a positive note this was 2.5 and the national requirement is a minimum of 3.5, which means the trajectory was met last month. MB queried standard patient's measure. JK replied that this was just being set up but as yet is not a national requirement. Some good work has taken place in Weston hospital because of the new appointee, although this is heavily reliant on one individual which is not a good process. JK continued suggesting that although ward walks are carried out when problems have arisen, the follow ups to check the proposed changes have been implemented do not happen. JG asked if DTOC and Standard patients should be put into the Performance Report. **Action 54:** to consider if the DTOC and Standard Patients should be put into the Performance report. MV delivered the Finance section of the Integrated Performance report. Highlights that MV reported are:	**JK/JM**

	MV gave apologies for the incorrect cover sheet. This report is Month 2, May 2017 budget for North Somerset element of the BNSSG Financial Plan submitted earlier this month. Moving forward the BNSSG position will be reported on. Although it is month 2, it is based on contract data from month 1. It is the beginning of the year and there are no significant variances to report. In addition to savings schemes already implemented work is ongoing to develop and implement additional schemes which will support delivery of the overall savings plan. The financial forecast at Month 2 shows that we are in line with the plan. During the year the CCG will review risks to delivery of the financial plan and mitigations to these will be developed and refined and a BNSSG perspective will be used. The budget has not yet been approved by NHSE but it is not expected to change. The allocations are about £285M gross, but because of historical deficits the net resource available is about £253M, which includes a £25M accumulated deficit. Reserves are held in line with national planning guidance and will not be committed until agreed with the Regulator as per last year. Risks have been identified against savings delivery. The cash flow statement shows the reconciliation between cash drawings and the income and expenditure position of the CCG. The CCG has made cash payments at the beginning of the year to the Local Authority for Section 256 agreements and cash support to Weston hospital. This will unwind during the year and no cash issues are anticipated. The Better Payment Code – although there have been significant deficits the CCG has always delivered on the Better Payment Performance. Bills are paid on time. JK explained the absence of TR. Last year there was an over spend on the children's CHC Line. This is a budget that remains at risk. TR is at a funding meeting for several cases. JG added that these cases are low volume but very high cost. MV said that this is one reason that reserves are held to help manage this type risk. JR stated that there is a very big challenge this year for the BNSSG system; an £83M CCG savings plan to reach an aggregate control of an £8M deficit. Delivery of the savings plans is critical and work to develop new schemes is ongoing. MB confirmed that the NSCCG are very aware of this challenge. JR said that reviews need to happen to manage the CCG are against schemes set out, what more could be done and there should be a more challenging nature of schemes and asking the difficult questions. MB stated that we are almost at the end of the first quarter and asked what the position on savings is. MV replied that the control centres have been asked to produce an assessment	

	statement of delivery. This will be compared with contract performance position and then reflected in reporting . JR commented that at Month 1 the CCG is tracking just below plan. As leaders there is a need to be on top of 'what, why, when, how' to make the CCG as good as it possibly can be. JG expressed concern that schemes that are working really well, like Map of Medicine (MoM), might be lost along the way. JR confirmed that MoM is well accepted across all 3 of the CCGs. RK added that Clinical Fellows are looking at MoM and another option across BNSSG. Sufficient local clinical involvement has been challenging because of time pressures. The CCLG discussed the Clinical Commissioning Group's latest performance delivery as at May 2017 for Quality, Finance and Performance standards and reviewed mitigating actions for those areas of exception.	
9	**<u>Primary Care Enhanced Services:</u>** MB handed over the Chairing of this section to JG. MV reported that in March an original paper was brought to the CCLG requesting a 3 month extension of the 3 enhanced services that are still commissioned and this recognised that there was still a wider review to be completed. Since then there has been limited analysis of the cost - benefits of these services and which is inconclusive. The nursing home scheme in particular is difficult to assess although has positive feedback. The recommendation is to extend to the end of this financial year and retain the 3 month notice period. Going forward there must be a clear evidence base for investment decisions. MJ informed members that a few months ago there had been a discussion about care homes and what interventions could be put in place to save funds. It would be helpful if every patient in a care home under this LES had a unique code to show a Treatment Escalation Plan (TEP) form is in place with a decision about end of life wishes. RK commented that most of these deaths occur in nursing/residential homes and not hospital. MB emphasised that we had to work with the homes to make sure that during the out of hours period to ensure that they use the most appropriate service for specific clinical situations.. **Action 55:** DC agreed that the EMIS codes needed more work and clarity. Also there is a sentence in this paper to request that TEPs go into the enhanced services and other minor adjustments are needed. JG confirmed that there is a piece of work in the BNSSG Turnaround programme to consider end-of-life pathways. The CCLG approved the temporary continuation of the Diabetes – Insulin Initiation, Minor Injuries and Nursing Home Local Enhanced Services pending work across BNSSG on evaluation and harmonisation or future commissioning/decommissioning. The CCLG approved changes to the service specification of the Nursing Home Enhanced Service to include the completion of Treatment Escalation Plans (TEPs) and to	**DC**

	rationalise reporting procedures. **Action 56:** The service to Clevedon needs to be considered when reviewing the care home LES across BNSSG 10:30 MV and JR left the room.	**DC**
10	**<u>Gluten Free Paper for Final Decision:</u>** MB took back the Chair from JG. DC explained that permission was previously given by CCLG to go out to consultation. An extensive consultation took place with over 400 responses received. These have been collated and are in one of the appendices to this paper. The key points raised in the consultation were: (as listed on Page 3 of the report) • Affordability of products • Availability of products, particularly in rural areas • Assurance of product quality and nutritional value • Support for adherence to a gluten free diet to prevent long term complications • Support for vulnerable patient groups • Assessment of the impact of any restriction on prescribing Page 4 of the report shows the key points and the ways that they have been dealt with. MB emphasised that the Comms side to this for the GP practices and to the public is very important. South Gloucestershire CCG is making their decision about this next week and if the NSCCG could be aligned to this it will make future decisions easier. Bristol CCG is waiting for the results of the national consultation. GB queried the affordability point and the GP's discretion and asked if this will go out in the Comms information. It will need writing in a way that is appropriate whilst getting the message across. There is a balance between arming the public with enough information, whilst remembering that the CCG is in a position to say yes or no. GB asked what would happen about coeliac patients because they need a special diet. KH replied that Gluten free products are far more accessible today and there are other products that can be eaten such as potatoes and rice. The Comms must make the public aware of this and the education material and support available. The CCLG discussed the report and approved the proposal to remove gluten free products from the formulary for patients over the age of 18 years and to allow a limited formulary of gluten free products to be prescribed for patients under the age of 18 years. It was noted that there is a national consultation, which would be referred back to CCLG for further consideration should the national decision be different. MB suggested that a 4th point should be made for a clear Comms plan including	

	producing a leaflet. DC confirmed that this would be part of all the supporting materials that would be made available MA suggested that the under 18s should be educated in the use of other foods. DC replied that this should come from paediatricians and dieticians. **Action 57: Chair's action reference agreeing a decision with MV as Chief Finance Officer.**	**MB/MV**
11	**<u>CAMHS Transformation Funding:</u>** 11:00 Mark Hemmings (MH) joined the meeting. MH presented the paper and noted that additional funding had been received in the CCG's baseline for the last two years to spend on children's transformation. JK informed members that she will not be able to take part in the decision making for personal reasons. MH noted that a multi-agency group has been set-up to comprehensively review the whole pathway from when a person just needs a little bit of help up to when a person needs an inpatient bed. So this is not just about specialist CAMHS. Key outcomes being considered include: • Promoting resilience, prevention and early intervention • Improving access to effective support – a system without tiers • Care for the most vulnerable • Accountability and transparency • Developing the workforce Half of the referrals received by the Specialist CAMHS team last year did not require specialist care and it has become clear that there is not enough early help services.. In January 2017 specialist CAMHS had 94 referrals, in February 2017 there were 104 and in March 2017 there were 160. The Autism ASD pathway waiting time from referral to treatment is about 56 weeks. In specialist CAMHS initial assessments do happen within the 18 weeks pathway, but the follow up appointments are many weeks later. The crisis intervention team is not available 24/7, just a 09:00 to 17:00 service is offered. If an immediate response is required by CAMHS during 09:00 to 17:00 then any clinic appointments on that day are cancelled and the team go and deal with the crisis. WAHT have reported that they have staffing issues in this team and that this has an adverse effct on the resilience of the team at times. 1 in 10, 5 to 16 year old children will have a diagnosable mental health issue around conduct, anxiety, ADHD and depression; 50% of all mental health disorders emerge	

	before the age of 14; 75% of mental health issues emerge before the age of 25. This shows the benefit of putting help in at an early stage. Nationally there has been additional investment given to CCGs for people in crisis with eating disorders, increasing access and perinatal and infant mental health. In 2015/16 after producing the Transformation Plan, £420K was received part way through the year in November/December. A lot of the investment has been in staff. Around £156K of this has been spent. The CCG has been able to retain the shortfall. In 2016/17 £456K was received of which only £196K was invested which meant that the plan that had been created could not be implemented. The crisis intervention team was in the plan and this had to be cancelled. For 2017/18 £456K is expected plus an 18% uplift which will be around £538K of which £152K is committed. Benchmarked nationally there are 6.6 full time equivalent posts short, which is 22 employed out of 28 people. MB asked if this was an inability to recruit or is it down to resources. MH replied it was down to resources. KH asked what happened to the money that was not spent in previous years. MH replied that this has stayed within the CCG. It is a statutory requirement that all monies that are not ring fenced have to go into the CCG against the deficit. MB clarified that the decision was taken after looking at the Outstanding rating of services following Ofsted inspection and the CQC report at WAHT which also reported that CAMHS services were of good quality. 11:15 MV entered the room. MV requested a review of the financial assessment because the CCG has not received any notice of financial allocation. A full analysis of funding flows and the investment required is required and MV is happy to be involved with this. DC asked if the increase in the population has been allowed for in the calculations. MH replied that it had and they were aware that the children's population was going to increase by 14%. **Action 58:** MH to write to Katheryn Pugh, Programme Lead for Children's Mental Health at NHSE, to identify when funds can be expected by the CCG. The Clinical Commissioning Leadership Group approved the CAMHS Transformation Funding paper requesting permission to access additional investment to the CAMHS Transformation funding allocated to NSCCG and implement local initiatives within the BNSSG CAMHS Transformation Plan, if confirmation of funding was received. There was a recognition that investment would need to be prioritised if not all the funds are received.	**MH**
12	**BNSSG Operational Plan:**	

	JG delivered this report. This plan was approved by the Executive Team yesterday. The operational plan has been completely reviewed and revised with a clear focus on delivery. With regard to Julia's challenge and what the CCLG might want to think about whilst this is being discussed the CCLG might wish to think about whether the priorities of the people of North Somerset are reflected in this plan and whether the plan gives confidence that the CCGs together will be able to deliver the plan. The work of the Control Centres as part of the Turnaround Programme has been embedded within the Operational Plan. The CCLG may also wish to consider how best to share the Operational Plan with the membership and get them involved. MV commented that it is a very ambitious savings target, but that it needs to be. All of the plans are reasonable and sensible but delivery is the issue. MV said that it is worth reflecting on the good and quick work that the Control Centres have done to turn this around. JK commented that some items repeat themselves in the plan, and gave the example of frailty and queried why there were two separate programmes for frailty. MB added that it needed to make sure that frailty also covered mental health and addiction issues. CL suggested that the key messages within the operational plan needed to be reflected in the information on the CCG's website. Information in the Operational Plan is different to the Quality information already on the website. JG suggested that the alignment could be carried out after this plan had been approved by the Governing Body. DC asked why MoM on page 50 was not part of the work programme. DC assumed that it has been put on the enabling programme and stated that she disagreed with this. **Action 59:** to feedback this comment to Jenny Norman. MB informed the members that the Joint Strategic Needs Assessment (JSNA) for North Somerset states that North Somerset's challenges are an aging population, a population that is growing in size and mental health and addiction issues. The operational plan needs to show how these issues are being addressed for North Somerset people. JG asked how the members wanted to share this with the membership, perhaps Clinical Leaders could discuss this in their seminar. MB asked that when the document was complete, would it go onto the public website. JG confirmed that it would go on the website. JG asked that if members had any further thoughts or question about the plan, that they let her have them by the next Monday. The Clinical Commissioning Leadership Group received and discussed the BNSSG Operational Plan.	**JG**

13	**<u>Update on Weston ED Implementation Plan:</u>** This item has been moved into the Closed session.	
14	**<u>Turnaround Steering Group Minutes:</u>** a. 17th May 2017 b. 26th May 2017 System Financial Recovery Plan Highlight Reports: (New title for Turnaround Steering Group) c. 2nd June 2017 The CCLG received and noted the minutes.	
15	**<u>People and Communities Board Minutes:</u>** 30th January 2017 The CCLG received and noted the minutes.	
16	**<u>BNSSG Drug & Therapeutic Committee Minutes:</u>** a. 5th April 2017 b. 17th May 2017 The CCLG received and noted the minutes.	
17	**<u>BNSSG Clinical Pathways Advisory Group (CPAG) Minutes:</u>** 8th June 2017 The CCLG received and noted the minutes.	
18	**<u>GP Forum Minutes:</u>** 12th April 2017 The CCLG received and noted the minutes.	
19	**<u>A&E Delivery Board Minutes:</u>** 22nd May 2017 The CCLG received and noted the minutes.	
20	**<u>Primary Care Working Group Minutes:</u>** a. 26th January 2017 b. 30th March 2017 c. 27th April 2017 The CCLG received and noted the minutes.	
21	**<u>BNSSG Strategic Informatics Group (SIG) Minutes:</u>** 17th May 2017 The CCLG received and noted the minutes.	
22	**<u>BNSSG Joint Formulary Minutes:</u>** a. 12th April 2017 b. 16th May 2017 The CCLG received and noted the minutes.	
23	**<u>Weston Primary Care Transformation Programme Board Minutes:</u>** 4th May 2017 The CCLG received and noted the minutes.	
	No further business was discussed.	