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MEETING:	The 36th Meeting in Public of the NHS North Lincolnshire Clinical Commissioning Group Governance Body.	NHS North Lincolnshire Clinical Commissioning Group **GOVERNING BODY PUBLIC MEETING**
MEETING DATE:	Thursday 14th December 2017	
VENUE:	Board Room, Health Place, Brigg	
TIME:	13:30 – 16:00	

PRESENT:		
NAME	**TITLE**	**SERVICE/AGENCY**
Dr Margaret Sanderson *(MS)*	NLCCG Chair	NHS North Lincolnshire CCG
Emma Latimer (EL)	Chief Officer for Interim Period	NHS North Lincolnshire CCG
Julie Warren (JW)	Turnaround Director	NHS North Lincolnshire CCG
Erika Stoddart (ES)	CCG Vice Chair/Lay Member Governance *(until 3.15 pm)*	NHS North Lincolnshire CCG
Ian Holborn *(IH)*	Chief Finance Officer	NHS North Lincolnshire CCG
Richard Young *(RBY)*	Director of Commissioning	NHS North Lincolnshire CCG
Dr Faisel Baig *(FB)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr Andrew Lee *(AL)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr Salim Modan *(SM)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr Neveen Samuel *(NS)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Dr Satpal Shekhawat *(SS)*	CCG Member/General Practitioner	NHS North Lincolnshire CCG
Janice Keilthy *(JK)*	Lay Member, Patient & Public Involvement	NHS North Lincolnshire CCG
Heather McSharry *(HMcS)*	Lay Member, Equality & Diversity	NHS North Lincolnshire CCG
Ian Reekie (IR)	CCG Lay Member, Primary Care Commissioning	NHS North Lincolnshire CCG
Penny Spring *(PS)*	Director of Public Health	North Lincolnshire Council
Chris Nield (CN)	Consultant in Public Health	North Lincolnshire Council
IN ATTENDANCE:		
Martina Skellon (MSk)	Office Manager & Note taker	NHS North Lincolnshire CCG
Mike Napier (MN)	Associate Director of Corporate Affairs	NHS Hull CCG
Chris O'Neill (CoN)	STP Programme Director for Item 9 only	NHS Hull CCG
Chloe Nicolson (CN)	Quality Manager for items 2 and 10 only	NHS North Lincolnshire CCG
John Pougher (JP)	Head of Governance for item 8 only	NHS North Lincolnshire CCG

APOLOGIES:		
NAME	**TITLE**	**SERVICE/AGENCY**
Catherine Wylie *(CW)*	Director of Risk & Quality Assurance/Nurse Member	NHS North Lincolnshire CCG
Dr Richard Shenderey *(RS)*	Secondary Care Doctor	NHS North Lincolnshire CCG
Dr Robert Jaggs-Fowler (RJF)	Director of Primary Care/Medical Director	NHS North Lincolnshire CCG

SUMMARY OF DISCUSSION	**DECISION/ ACTION (including timescale for completion or update)**	**LEAD**
1.0 WELCOME, ANNOUNCEMENTS, APOLOGIES AND QUORACY		
MS welcomed all attendees to the thirty sixth meeting 'in public' of North Lincolnshire Clinical Commissioning Group Governing Body.	**Decision: Noted**	Chair

SUMMARY OF DISCUSSION	DECISION/ ACTION (including timescale for completion or update)	LEAD
Apologies were noted, as detailed above. Lay Member, Governance advised that she would need to leave before the meeting finished. The Chair drew the members' attention to the new style agenda and advised that the strict timings for discussion items should be adhered to. This would be the last Governing Body meeting for the CFO as he would be leaving at the end of December 2017 and, on behalf of the Governing Body, the Chair thanked the CFO for his hard work over the last 18 months. The chair also welcomed EL as the new Chief Officer and JW as the Turnaround Director. It was noted that the meeting was quorate to proceed.		
2.0 PATIENT STORY		
The Quality Manager introduced the patient story. She advised that the presentation was not on the CCG's website; however the patient had provided his authority to share his story with the members of the Governing Body. The patient hoped that the following would be prioritised by local health services: • The provision of further support to carers. • The provision of further support to multi-disciplinary teams. • That the NHS procurement process would expedite care. • That local patient transport services would be reviewed. There were no comments or questions from members of the Governing Body regarding the Patient Story.	**Decision: Noted**	Chair
3.0 DECLARATION OF INTEREST		
There were no declarations of interest.	**Decision: Noted**	Chair
4.0 GIFTS & HOSPITALITYS DECLARATION		
No gifts or hospitality declarations were reported.	**Decision: Noted**	Chair
5.0 MINUTES OF THE MEETING HELD ON 12 OCTOBER 2017		
The minutes from the meeting held on 12 October 2017 were accepted as an accurate record.	**Decision: Noted**	Chair
6.0 ACTION LOG – ACTIONS UPDATE FROM 12 OCTOBER 2017		
All actions had been closed on the Action Log and there were no actions arising from the meeting held on 12 October 2017.	**Decision: Noted**	CFO
7.0 MATTERS ARISING (not covered on the agenda)		
The chair advised that IR had stood down as Vice Chair of the Governing Body and ES had agreed to take on this role. The Chair drew the members' attention to Item 3 from the minutes of the meeting on 12 October 2017 regarding minutes being circulated in draft form to members within 7 days. The Chair advised that the draft minutes should be	**Decision: Noted**	CO

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available to the Chair within 7 days in order to check for accuracy. However usually draft minutes were not circulated to members until the papers for the next meeting were distributed. IR, as chair of that meeting, advised that the request had come from RS. As he was not involved in CCG business on a week by week basis, he felt it was unreasonable to expect members to remember what had been discussed two months later. Other members had also expressed a view that the draft minutes should be available earlier. The CO advised that this would depend on the CCG's Standing Orders, but she thought within 14 days was reasonable. The CO also advised that the CCG's Standing Orders were currently being reviewed as part of the Governance Review. Item 10.1 Assurance Framework regarding the ACP. It was queried why the Governing Body had not received an update for some time. The CO advised that she had attended a number of meetings with Denise Hyde, Executive Director, People and Transformation at North Lincolnshire Council and with Councillor Rob Waltham, Leader of North Lincolnshire Council. Meetings would continue to take place. It was hoped that a better relationship could be forged between the two organisations and an update would be provided to members in the New Year to clarify the place based arrangements for North Lincolnshire.		
8.0 GOVERNANCE & ASSURANCE		
8.1 Strategic Risk Register The HoG advised that the Strategic Risk Register presented an overview of the key strategic risks facing the CCG. There had been some significant changes to the Register and it now more accurately reflected the CCG's strategic challenges and risks. The current Register represented an interim Risk position and the CCG's Strategic Intent and Objectives and associated risks would be reviewed in the New Year. The principles would be embedded and a road map had been produced to ensure the CCG would be risk effective. This formed part of the CCG's strategic planning. ES queried the risk scores on the Governing Body Assurance Framework as these were all either 25 or 20 which were the highest scores possible and therefore Action Plans would need to be put in place to reduce the scores, as a score of 25 was outside the risk appetite. It was noted that this work would be on-going.	**Decision: Approved**	HoG
8.2 Use of Corporate Seal There was no use of the Corporate Seal.	**Decision: Noted**	CO
8.3 Chief Officer's Update The CO advised that although she had now been appointed as the Chief Officer for NL CCG on an interim basis she would continue to be the Chief Office for Hull CCG. There were no plans to merge the two organisations. EL advised that she wished to echo the Chair's sentiments regarding the departure of the CFO. It had been a challenging time for NL CCG and the CFO had done a sterling job. The CO advised that she also wished to thank JW for her input as Turnaround Director during the time that she had been with NL CCG. The CO	**Decision: Noted**	CO

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advised that as the months progressed she would be providing a performance update for Governing Body meeting and was happy to take any questions. There were no questions for the Chief Officer.		
8.4 General Data Protection Regulations (GDPR) Update HoG advised that whilst the CCG were working towards compliance with GDPR legislation, a significant amount of work still needed to be done in order to meet the 25th May 2018 deadline. A Data Protection Officer would need to be appointed. This could be a shared appointment between several CCGs but would incur a cost implication for NL CCG. JK advised that there were a lot of acronyms in the briefing paper and it would be useful to have glossary of terms for all the abbreviations being used. It was agreed that this should be provided in future. Lay Member, Governance advised that Ongo Partnership Ltd were currently working on obtaining compliance with GDPR at present and the CCG should understand that this was a laborious and lengthy process as this was a major piece of legislation. The privacy notices were key as consent would be needed for every type of use. The CO advised that it would be important for NL CCG to work with neighbouring CCGs and this would have the additional benefit of any costs being shared. HoG advised that eMBED were currently preparing a proposal for a shared post across local CCGs.	**Decision: Noted**	HoG
8.5 Review of internal structures and committees The CCG had been issued with legal directions from NHS England in August 2017. As part of this an external Governance Review had been commissioned and this had been undertaken by Jayne Brown from Strategic Solutions in October 2017. A number of recommendations had been made and the CCG had been asked to review its current committees and internal structures. The TD reported that at present, only the first level of committees which reported to the Governing Body had been reviewed. A review of the sub committees would follow. Some clarity would be required within each group regarding their responsibilities and how they reported to the Governing Body. The Strategic Intentions would need to be set and delivered to the sub committees in order for the work to be carried out. This was part of a broader process. It was proposed the new structure would be adopted from February 2018. The TD advised that she would be discussing with the Chairs of the various committees how the changes would happen and to discuss the transition period. Revised Terms of Reference had also been drafted for discussion with the Chairs. The TD drew the members' attention to the enclosed diagrams in the briefing paper which illustrated the new structure versus the current structure. As part of directions and, following the PwC report which had made a number of recommendations, one of their specific recommendations had been the formulation of Finance & Performance Group and that group had now been in operation for about six months. The main difference between the new and current structure was that the number of committees had reduced from six to five. Quality and finance needed to be placed together and this was one of the main significant changes. The Quality and Finance & Performance Groups would	**Decision: The Governing Body agreed with the proposal to implement the Governance Framework Governing Body Structures from February 2018.**	TD

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therefore merge. In order to do this a number of other sub committees would be needed which the CCG did not currently have in its structure. The prioritisation Board would be able to test some of this in the period to transition. The CO advised that this committee was also a joint committee in Hull and it was to ensure that public decisions were made in a transparent way. The Chair advised that the Lay Member, Governance had provided her with some comments before she left the meeting. With regard to finance, performance and quality being merged, she agreed with the integrated approach, as it was very disjointed to see everything in the way it was currently presented and also more difficult to make linkages. The only other change would be Engine Room which would become the Planning & Commissioning Committee which would meet monthly in future rather than fortnightly. This represented a major change regarding how the CCG would commission and deliver care. Once the clinical pathways had been agreed, these would be signed off by the Planning Committee and the Procurement Board would put the process in place. This would ensure the lines of governance were kept clear. A mixture of GPs would sit on all of the committees and this was currently being worked through. The proposed Terms of Reference would be discussed in the Private section of the Governing Board meeting. The CCGs priorities would also be shared with the Council of Members (CoM) in order to keep the GPs informed. It was queried what committee would help steer strategy and it was confirmed that the Governing Body workshop in January would address this and then a workshop with CoM would take place to ensure the strategy moved in the right direction. It was queried why the CoM meetings would become bi monthly. The Chair advised that every other month a development session or a workshop could take place, but this could be amended if need be and it was agreed that this could be discussed further at the CoM meeting in January. Lay Member, Primary Care Commissioning advised that he was fully supportive of the need to review the decision making process. However, it could be perceived that the CCG were ignoring one of the recommendations of the PwC report which was that the CCG should establish a finance committee. He queried whether it would be prudent therefore to include finance in one of these committees. Another recommendation was that finance should feature prominently on the agenda of all Governing Body meetings. However, the finance report on this agenda had been relegated to 10.1. The CO advised that the CCG should be looking at an integrated approach and a finance plan alone would not deliver savings, however this could be looked at further. The role of the Executive Team was queried and the CO advised that the Executive Team met weekly and each of the committees would be supported by an Executive Officer who would work with the Chair of that committee. The TD advised it would need to be clear what level of decision making took place at each committee in order to provide assurance.		

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The Chair advised that RS was not able to attend today's meeting but had asked her to pose the following question "Is the clinical commissioning group board referred to on page 5, the Governing Body or something else?" The Chair confirmed that it was the Governing Body. SM queried whether meeting monthly was enough for the Planning & Commissioning Committee. The CO advised that there were a number of clinical leads within the CCG and specific work would be done outside the planning meeting. It was suggested the meetings could be made longer instead and it was acknowledged that this could also be reviewed if necessary. The TD advised that it was proposed that the new structure would run for a couple of months from February 2018 and then be re-assessed from April 2018 to see if there were any gaps/duplication and if so, it could be reviewed. The purpose was to develop good practice and to build a yearly internal audit into the work plan. **The Governing Body agreed with the proposal to implement the Governance Framework Governing Body Structures from February 2018.** **8.6 External Governance Review Recommendations** The Governing Body were asked to: • Approve the Governance Review action plan development • Approve the interim steps undertaken • Agree the frequency of reporting against the actions as quarterly • Note the work that had been completed. The TD advised that following the review carried out by Jayne Brown, from Strategic Solutions, the recommendations had been shared with the Governing Body at a workshop and left with the organisation to implement. Meetings and workshops had taken place to look at the levels of risk and to identify whether any additional support would be needed to develop and embed the Organisation & Development plan for the Board and inform NHS England of progress. There had been some issues around capacity and capability. Staff appraisals and development had not occurred consistently across the organisation and objectives had not been set. It would be important to ensure the CCG provided support to ensure the workforce had the right skills. The TD advised that one criticism had been the delay NHS England had taken to issue directions and, explained that as a result, NHS England would be reviewing their processes and procedures and this would form part of their on-going work. The role of the clinical leads was queried and the CO advised that the CCG would be looking at all the clinical lead roles and their objectives in order to identify how they would fit into the organisation going forward and to provide clarity about the CCG's expectations and how support could be provided. The CCG would need to demonstrate to NHS England the steps that were being	**The Governing Body agreed to the recommendations outlined in the briefing paper.**	

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taken and an action plan was being developed. The proposal was to report back quarterly. **The Governing Body agreed to the recommendations outlined in the briefing paper.** **8.7 Draft Improvement Plan** The Governing Body were recommended to note and approve the following: • Approve the submission of an improvement Plan to NHS England in January 2018. • Approve the format of the Improvement Plan • Agree the quarterly reporting against the plan Following the issuing of Directions in August 2017, NLCCG were required to submit an Improvement Plan in response to the three key areas of leadership, financial performance and recovery, and governance. The CFO advised that the plan should have been submitted in October 2017. However, given the recent change in Accountable Officer, it was proposed to submit the plan with month 8 data in January 2018. A key point was that NHS England and the CO and the CFO met on a monthly basis and these meetings would continue. It was noted that a considerable amount of work had already been undertaken especially with regard to Continuing Health Care (CHC) and prescribing. As soon as the Improvement Plan had been signed off by NHS England this would be brought back to the public section of the Governing Body. As the CFO would be leaving the CCG after Christmas it was queried whether a handover would be taking place as a significant amount of actions were for the CFO to complete. The CO advised that the CFO at Hull CCG had been meeting with the CFO at NL CCG on a regular basis. **The Governing Body agreed to the recommendations outlined in the briefing paper.**	**The Governing Body agreed to the recommendations outlined in the briefing paper.**	
9.0 STRATEGY		
9.1 Humber Coast & Vale Sustainability Transformation Plan Update – Chris O'Neill A presentation was given to the Governing Body members. The CO advised that the CCG should be holding the demand in the acute hospital and investing in the out of hospital services. Ultimately, this was about good planning and delivery and once work had commenced around the place based plan this could be facilitated. It was suggested that there were two keys to success. Firstly ensuring the finances were in place and secondly working together with other organisations to achieve the desired results. It was also suggested that a digital vision exercise should also be undertaken.	**Decision: Noted**	STP PD

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9.2 Humber Acute Service Review The TD advised that a meeting had taken place yesterday afternoon. This had been Chaired by Moira Dumma, Director Yorkshire & Humber, NHS England. All regions had been represented as well as Northern Lincolnshire & Goole NHS Foundation Trust (NLaG), Health Education England and the colleges. A review had taken place around a number of specialties and concerns had been raised particularly in relation to workforce vacancies (specialists and nurses) at Hull & East Yorkshire Hospitals (HEY) and NLaG which had affected services and made them unsafe. Haematology had been the latest service to move to Hull on safety grounds. The review had also looked at quality and value for money. The fragile services identified had included ENT, urology and haematology. However, other services such as maternity services had also been identified by the Care Quality Commission (CQC) as being unsafe and not fit for purpose. In addition, some services were costing above the tariff. The Directors of Strategy and Planning at both HEY and NLaG had worked with the specialist clinical leads to develop a heat map in order to identify if services had the required workforce to operate safely. At the meeting yesterday it had been agreed that this work should continue in order to develop appropriate pathways. The Governing Body agreed this needed to be done in parallel in the community. A plan was being developed to review the different specialties and develop options, the results of which would then be shared with the Overview & Scrutiny Committee and the public. NS queried whether the discussions about haematology included oncology (ward 18 chemotherapy patients) as this was not clear. DoC advised that only a very small proportion of patients had been affected and further discussion would take part in the private part of the meeting. Only a small proportion of patients would need to go to Hull and these would become tertiary referrals. In terms of individual wards this would form part of the longer term review NLaG would need to undertake with regard to Scunthorpe hospital. The TD suggested Governing Body members, as well as all GPs, should be provided with the paper presented to OSC in relation to haematology services in order to provide clarity. A summary should also be provided for Practice Despatches. *Post meeting note: Haematology Services Briefing Paper circulated to members on 12 January 2017.* The TD advised that how messages should be communicated to the Local Authority and elected members had also been discussed at the meeting yesterday. Governing Body members agreed that the CCG should be transparent about issues and patients should be involved and engaged in the process. A different methodology was needed to ensure patients received the best care.	**Decision: Noted**	TD
10.0 QUALITY & PERFORMANCE		
10.1 Integrated Reporting Executive Summary • **Quality Report** • **Performance Report** • **Month 7 Finance Report** • **Contract Management Report**	**Decision**: **Noted**	DoN &Q

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The QM advised that a summary would be provided this month and then an integrated Governance report would be provided for future meetings. The QM advised that the purpose of the new report was to streamline the approach to assure the Governing Body of the CCG's delivery against its corporate responsibilities. It was proposed that the current standalone reports be replaced by one integrated report, which would include Finance, Quality and Performance and that this would take effect from February 2018. It was proposed that the integrated Governance Report would include: • An Executive Summary, including an overview of the CCG's financial position and a summary of the CCG's achievements against constitutional, national and local quality and performance measures. • Detail on the key points to note, in relation to finance, quality and performance, including areas of concern and risk. • Update on recovery actions being taken, and due to be taken, to mitigate any potential risk. <u>Quality Report</u> The Head of Quality outlined the key points from the Report for the Governing Body. The Chair advised that she had received a question from RS, who could not be present at today's meeting. RS had noted the number of complaints over the Continuing Health Care (CHC) process and queried how the Governing Body could be reassured that these were being dealt with appropriately and in a timely manner. The QM advised that there were currently no outstanding complaints relating to CHC and the quality team had been working closely with the Head of Nursing, the DoQ&N and the CHC team. It was possible there were some residual actions, but none relating to outside of the system. The Chair queried what had happened to the outpatient working review as an update had not been provided for some time. The Chair also queried what was being done about the long waiting times detailed in the report. The DoC advised that this work had not progressed with any pace due to other priorities within the system, but he would provide an update at the next Governing Body meeting. <u>Performance Report</u> The CFO highlighted the key points including a significant improvement with A&E delivery of waiting times. It was noted that the Activity Summary illustrated that not a big enough dent was being made to tackle waiting lists. The Chair advised just giving single numbers was not very helpful instead the rates should be per thousand population. The CFO advised that this report was currently a work in progress. It was also noted that Dr Bhorchi did not practice any longer and the practice there was now South Killingholme Surgery. The Chair advised that Lay Member, Governance had also advised that she was	DOC	

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concerned that apart from A&E the areas that were in red in the quality report continue to deteriorate, over 10% in some cases over the last 12 months. There was no sign that this was turning and she was not personally assured that improvements could or would be made. SM advised that the graphs illustrated that for some specialties the highest admissions 6 percent of population occupied 60 percent of the beds and this was where the CCG could start to move forward and easily save money. Respiratory, heart and COPD patients should be managed outside of hospital. This illustrated why this needed to be part of CCG's strategy and why the CCG needed to invest in out of hospital alternatives. The DoC advised that a clinical group had been set up to look at needs management in the system which was led by Dr Andy Lee. This group would look at some of the referral data, so data could be used more intelligently in the future. With regard to COPD, the CCG could revisit some of the decisions which had been made. This would return to planning in due course. It was noted that that NLaG had also been failing to keep records of dementia lead codes. As the dementia rate increased locally this data was useful for advanced planning purposes. <u>Month 7 Finance Report</u> The CFO introduced the financial report. The salient points were: • the CCG had a YTD overspend of £3.4m. The main areas of overspend continued to be CHC (£1.5m over) and Prescribing (£1.6m over). • At Month 7, the CCG had continued to report a year end forecast surplus of £90k to NHS England, with a £6.3m of risk. It was anticipated that the risk would be moved in to forecast at Month 8. The CFO reported that a conversation with NHS England would take place this week regarding the forecast position for the rest of the year. There was still some risk on top of the forecasted amount of risk. The CO advised that hopefully the CCG would be able to hold its position. The Chair advised that Lay Member, Governance had commented that it would be important to submit a realistic forecast. She personally considered the £6.3m to be at the lower end of what the CCG would end up with as a deficit, as there was a J curve in savings that had to be achieved the amount the CCG fell behind would get larger. The CCG also needed to agree a number of contract changes and these were not all likely to be favourable to the CCG. If the true position needed to be recognised. These were not risks to plan they were crystallised losses and this should be reflected in the numbers. Also, if there was no cash forthcoming if the CCG went over, then the CCG needed to understand now what we could do to stop, delay, or slowdown in order to hit the cash number. This would be prudent even if it was not needed. The CFO advised that these were very good points. With regard to what the CCG		

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could do about the negative cash position, until the CCG knew the outcomes of the two current on-going negotiations with NLaG and BCF it would be difficult to say, as these could potentially change the CCG's position. Lay Member, Patient & Public Involvement advised that it had been discussed at the Finance & Performance meeting that the CCG had not been as transparent as should have been. Lay Member, Primary Care Commissioning questioned whether NECS had any estimate of the likely impact of the widely reported hike in generic medicines. During the last financial year he understood that 5 percent to an excess of 10 percent also showed that prescribing performance provided a significant variation in QIPP prompts generated by the Optimise RX system and queried why the range was that wide. However, he was supportive of attempts to address the variation. The CFO advised that the cost of generic drugs was being discussed with NHS England in a bigger conversation. In terms of variances, use of Optimise RX was in its early stages and a lot of GP practices were using it from a quality perspective rather than a financial one. Initiatives such as incentive schemes were being looked at in order to move this agenda forward. <u>Contract Management Report</u> AL advised that he had a contract management question and wanted to know if any action was planned over NLaG systematically breaching their contract on a daily basis. Examples had been provided to the CCG. The CO queried whether a Contract Performance Notice (CPN) had been served. The DoC advised that the CCG had now written to senior management regarding some of reported incidences AL had alluded to. However, a discussion was now needed regarding whether to take this a stage further. It was noted that this did not just relate to poor performance, but also to the extra work being generated in general practice relating to consultants refusing to undertake activities they had been contracted to undertake.		
11.0 GENERAL		
11.1 Suicide Real Time Surveillance IC in PH advised that this was about understanding the different roles and keeping people informed. One of key things would be support from GPs. Adult care had also offered additional support but this had not been taken up. A mapping activity was being undertaken and other options explored e.g Yorkshire & Humber was doing a piece of work regarding a peripatetic model. Developing a sub group was being looked into. Lay Member, Equality & Diversity advised that Cruse did not have capacity in North Lincolnshire and queried whether this was having an impact. IC in PH advised that was one of the reasons the mapping exercise was being undertaken. The Samaritans had increased their support and were quite proactive in offering training to organisations. It was important to know what was being offered, to establish whether other models needed to be looked at and to collaborate with others. It was agreed that it was good to see pro-active engagement in this area. The CO queried whether the IC in PH was asking the Governing Body to note the presentation or whether something specific was needed from the Governing Body. IC in PH advised that after the mapping exercise, Public Health would	**Decision: Noted**	I C in PH

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discuss the gaps with the CCG and would like our involvement regarding decisions around support. Primary care had been discussed with FB and training with GPs and primary care about prevention would take place in February 2018.		
12.0 REPORTS FOR INFORMATION ONLY		
12.1 Children with Special Educational Needs (SEND) This report was noted.	**Decision: Noted**	Doc
13.0 PUBLIC QUESTION TIME		
There were no questions from members of the public. The Chair advised that in future questions from the public should be submitted 48 hours in advance. This would enable the CCG to provide the answer at the meeting or to have the appropriate member of staff available to answer the question at the meeting.	**Decision: Noted**	Chair
14.0 ANY OTHER BUSINESS		
There was no other business.	**Decision: Noted**	Chair
15.0 DATE AND TIME OF NEXT MEETING		
Public and Private meeting	**Decision: Noted**	Chair
Thursday 8th February 2018, 13:30 – 17:00 Board Room, Health Place, Brigg		
Workshop	**Decision: Noted**	Chair
Thursday 11th January 2018 13:30 – 17:00 Board Room, Health Place, Brigg		