Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

DRAFT

Bristol, North Somerset, South Gloucestershire CCG Governing Body meeting

Minutes of the meeting held on Tuesday 3rd November 2020 at 1.30pm

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Colin Bradbury	Area Director, North Somerset	CB
Peter Brindle	Medical Director Clinical Effectiveness	PB
John Cappock	Lay Member Finance	JC
Deborah El-Sayed	Director of Transformation	DES
Jon Evans	GP Locality Representative South Gloucestershire	JE
Felicity Fay	GP Locality Representative South Gloucestershire	FF
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
Brian Hanratty	GP Locality Representative Bristol South	BH
David Jarrett	Area Director South Gloucestershire	DJ
Martin Jones	Medical Director Commissioning and Primary Care	MJ
Nick Kennedy	Independent Clinical Member Secondary Care Doctor	NK
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
Umber Malik	GP Representative Bristol Inner City and East	UM
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member Registered Nurse	AM
Julia Ross	Chief Executive	JR
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Christina Gray	Director of Public Health	CG
In attendance		
Will Bradbury	Communications Manager	WB
Sarah Carr	Corporate Secretary	SC
Lesley Le-Pine	Quality Lead and LeDeR Programme	LLP
Lucy Powell	Corporate Support Officer	LP

	Item	Action

1	**Apologies** Apologies were received from Christina Gray.	
2	**Declarations of interest** Sarah Talbot-Williams (STW) outlined amendments to her declarations: • Vice Chair of One25 • Non-Executive Director for Solon South West as well as United Communities and Senior Independent Director for both organisations. There were no declarations pertinent to the agenda.	
3	**Minutes of the previous meeting of the 6th October 2020** The minutes were agreed as a correct record.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log and all due actions were closed.	
5	**Chief Executives Report** Julia Ross (JR) highlighted the increase in covid-19 cases across Bristol, North Somerset and South Gloucestershire. The acute trusts have put measures in place to keep everyone safe including reducing visiting times for patients. The system was managing the situation well. The incident control centre has been stood up to operate seven days a week and the learning from the first wave was being used to put support mechanisms in place. The wrap around support for care homes continued and JR noted the importance for patients to continue to be treated in the community. JR reported that the independent review into the Oliver McGowan LeDeR review had been published. The CCG recognised the challenges the report identified with the processes undertaken for the initial review. The CCG had embraced the recommendations, which had been reviewed by the LeDeR Steering Group and the Quality Committee, and an action plan on how the CCG would address the recommendations would be presented to the Governing Body. JR noted that there were a number of recommendations which the CCG had already addressed. The CCG was due to meet with the National Director for Learning Disabilities to discuss the recommendations and future actions. JR reported that the review highlighted comments regarding bullying within the CCG and therefore the Remuneration Committee had also considered the review. The Committee acknowledged the comments had been made in 2017 by staff who had now left the organisation and concluded not to	

	investigate further, but had requested further assurance on the policies and processes in place within the CCG. JR highlighted that the most recent staff survey had identified that 95% of staff had not experienced bullying or harassment in the workplace. Alison Moon (AM) commented that the LeDeR Steering Group worked well with the system, but noted that the CCG needed assurance that the system was also focused on the recommendations to provide improved services for people with learning disabilities. JR reported that the interim CCG People Plan had been published which documented how the CCG would look after staff and foster a culture of belonging as well as outline actions to increase workforce training and system working to meet people's needs. JR would Chair the People Plan Steering Group, which included staff representation, and would consider the People Strategy. JR highlighted the work included within the People Plan such as the wellbeing work during lockdown, the mental health first aiders and development of the learning and development programme. It was noted that David Jarrett was appointed to be the Executive lead for wellbeing in support of this continuing work. The final People Plan was expected to be published by March 2021. JR informed the Governing Body that this was the last meeting for Dr Martin Jones, who was leaving the CCG. JR thanked Martin for his huge contribution to commissioning health services for Bristol, North Somerset and South Gloucestershire and his work in developing the culture and values for integrated care and leading the change for Primary Care Network (PCN) driven care. JR noted that the system respected Martin for his work as a value driven leader who was not afraid to put himself in the firing line for what he believed and everyone at the CCG would miss him. Jon Hayes (JH) agreed with the comments and thanked Martin for his support to the CCG clinical leads, for providing challenge and support and thanked Martin for the personal support he had received. Martin responded that it had been a pleasure to work at the CCG and he appreciated the determination of the staff at the CCG to deliver better health outcomes for the local population.	
6.1	**Recovery and Phase Three Planning** Sarah Truelove (ST) presented the paper noting that the planning had been rapidly developed at system level. The key risk was highlighted as managing covid-19 whilst keeping recovery on	

	track for the system. ST highlighted the graphs showing the progress trajectories. Lisa Manson (LM) confirmed the trajectories would be reflected within the performance report next month. AM asked whether the providers were actively sending communications to patients waiting for care informing them what to do whilst waiting. ST noted that this was an area of focus for the CCG and there were discussions ongoing on how best to support patients who were waiting. AM asked that more information on communications to patients was included in the next report. Rachael Kenyon (RK) highlighted the importance of this as patients were attending primary care unsure of what to do about cancelled scans and delayed appointments. Peter Brindle (PB) confirmed that Trusts were clinically validating their waiting lists which was a significant mandated process and was expected to be completed by next month. The CCG needed to be assured that this process was being undertaken and that health inequalities were being considered. Nick Kennedy (NK) asked about independent sector usage. LM confirmed that the system was still utilising the independent sector as per the national framework. LM confirmed additional capacity had been identified for endoscopy and Emersons Green Treatment Sector continued to undertake surgeries with support from North Bristol Trust (NBT). LM highlighted that the national contract allowed independent providers to undertake 25% of their own activity and some of this included work through choose and book. LM confirmed that the work undertaken included specialities not usually at the site but consultants from other sites had been utilising the space. LM highlighted that two further categories had been included as part of the waiting list validation P5 and P6, those exercising choice not to attend and those choosing not to attend due to covid-19. The CCG needed to understand why people were choosing to delay their treatment so the CCG could support people to attend. Kevin Haggerty (KH) highlighted the difference in public opinion between the first and second waves noting that people were more apprehensive now. ST thanked KH as it was useful to hear from primary care as this would help develop communications to the	**ST**

	public. JR asked that primary care colleagues raise these issues through the Strategic Communications Cell who would be able to address any concerns though communications to the public. **The Governing Body noted:** • **The key requirements as set out within the 2020/21 Phase 3 planning guidance** • **The details of the final Phase 3 plan that Bristol, North Somerset and South Gloucestershire has committed to deliver**	
6.2	**Children's Services Update** LM provided the detail on the broader work ongoing as part of the children's services noting that children's services were a key priority identified in the Governing Body Assurance Framework. LM noted that the Executive Team had discussed the complexity of children's services and how to join up the directorates to ensure there were no gaps or overlaps. LM highlighted that since April 2020, Sirona were the single provider of children's services which improved equity across the population and the CCG was working with the Local Authorities to deliver the best health outcomes for children. LM highlighted the Healthier Together Children's and Young People Programme Board where the wide scope of the children's services work was discussed. LM noted that progress on improvement continued but there was still further work to undertake across the system. There were a number of key elements of work related to covid-19 including the considerations of blended pathways for both digital and face to face appointments for children as well as supporting schools. Kirsty Alexander (KA) welcomed the paper and asked whether updates could be provided more regularly as they provided a view on the complexity of children's services. KA also asked whether there could be more data on children's services included within the performance report. LM explained that the intention was for an update paper to be provided quarterly which included deep dives into specific areas and the team would consider how to show increased performance reporting through the CCHP contract. Jonathan Evans (JE) highlighted the importance of the transition from children's to adults services, noting that individual children	

	were very different at 16. JE suggested that an integrated response could provide the flexibility needed. LM noted that transition was being addressed as this was an area of concern. JR noted the paper was missing coproduction and engagement of families and highlighted that there was an error in the paper which should read that the children's services did not always deliver the best outcomes for children. LM noted that coproduction was woven throughout the narrative but agreed that it should also be included as a priority. JR highlighted the Adverse Childhood Experience approach and asked for clarification on this. LM noted that this was a change of approach for commissioning, instead of a pathway approach, this was a trauma based approach considering the child's needs and experiences. JR asked about a single point of access and LM confirmed that there were a number of phases to work through to get to a single point of access and this was a challenge for a number of reasons including working across services. JR highlighted the importance of involving children and families in this redesign. STW noted that the voluntary sector delivered children's services including engagement with children and suggested that the CCG utilise these services. LM confirmed the CCG continued to work with the voluntary sector throughout the covid-19 response and the sector was involved in the work of the Children's and Families Programme Board. Deborah El-Sayed (DES) noted the importance of integrated care being reviewed in terms of SEND, education and considering the whole life of the child. Coproduction continued with the UX labs and work continued within the localities where children's services were a priority. Martin Jones (MJ) agreed and noted that children's services were a good example of integrated services and highlighted the benefits of a single point of access and coproduction with families, noting that the services were being developed for the public and not the professionals. **The Governing Body noted the contents of the report.**	
7.1	**LeDeR Activity Update** Rosi Shepherd (RS) asked Lesley Le-Pine (LLP) to present the LeDeR update. LLP confirmed that all cases from 2019 have	

	been completed and closed on the LeDeR platform. All cases notified prior to 30th June 2020 had been allocated to reviewers following identification of additional reviewers due to increased investment. Panels were being held every two weeks to review cases and there was a recommendation to reduce the risk score on the risk register related to timeliness of reviews as reviews were now being completed within the timeframe. LLP noted that there were concerns regarding ethnicity coding and work was underway to investigate potential under reporting from BAME communities. LLP highlighted the findings of the clinical case reviews noting that 61% of cases identified care that was satisfactory, 28% of cases identified good care and 11% of cases identified care that fell short of what was expected. LLP confirmed that a Multi-Agency Review (MAR) would be undertaken for the 11% of cases where care fell short. LLP noted that pneumonia had been the highest cause of death. One covid-19 death had been reported in October, following a period of 0 covid-19 deaths. LLP reported on the effect of covid-19 on the annual health checks and noted that currently 7% of these had been completed and the CCG was undertaking a significant piece of work which included ensuring resources were available to GPs and setting up a training forum for GPs. RS confirmed that regular reporting on the annual health checks would be taken through the Primary Care Commissioning Committee. KA asked whether the number of people trained to undertake LeDeR reviews was sufficient. LLP outlined the timescales for allocation and completion of reviews noting that the CCG were currently allocating cases from April 2020. RS confirmed that the CCG were currently meeting the national targets but had set up a workflow pattern for the next financial year to complete reviews faster than nationally required. STW asked whether the development of annual health check action plans was monitored. LLP explained that easy read templates for action plans and guidance to support practices in there development had been distributed. RS noted that the annual health checks were expected to take place face to face	

	and the teams were working through the flexibility of this considering the challenges of covid -19. JE noted the concerns regarding catheters and constipation and asked whether system education would be reviewed. LLP confirmed the CCG was planning development of clear pathways for these issues. Feedback from families and carers had highlighted that often families were better at caring for catheters and this feedback would be included in any transformation work. Felicity Fay (FF) noted that she was investigating the data discrepancies for the annual health checks alongside Zain Patel to identify where practices could make improvements. David Jarrett (DJ) asked which organisations the reviewers worked for. It was confirmed that the majority worked for Sirona, some within the Trusts and a couple in the CCG. RS noted the ambition was for more CCG staff to be trained. DJ also asked what was the right number of reviewers for the system, this was confirmed as 25 minimum. RS noted that staff were undertaking reviews alongside their employed roles although the CCG was utilising an agency member of staff to solely undertake reviews. JR noted that there was further consideration required on how reviews were undertaken and RS explained this was ongoing. JR noted that the ambition should be for 100% of annual health checks to be completed noting that although GP Practices were the best place for these to be completed this was about how to best serve the local population. JR suggested that the update report needed more information regarding outcomes and what progress was being made to complete the annual health checks and what was being done to investigate the 11% that fell short. LLP noted the good response from the learning disability leads at practices who were enthusiastic about the forum and how this would work. LLP explained that a MAR would be held for the 11% of cases, which would include family, carers and anyone involved in the care. The MAR would identify actions and these would become an action plan for organisations which would be expected to be closed within two months. NK asked about the time taken to undertake the reviews and asked whether the reviews needed to be so detailed. RS highlighted that the process was nationally prescribed and would	

	eventually move to an improvement process rather than learning reviews. NK also asked how the number of cases where care fell short compared to other areas of the South West. LLP noted that this data was not available on a regional or national basis. LLP suggested that the reports needed to be completed in depth as the learning was very useful for the system. JR reiterated the importance of LeDeR as care for people with learning disabilities was inequitable with other patients and the reviews needed to be considered in depth until there could be assurance that patients with learning disabilities weren't disadvantaged. STW noted that it would be useful to understand the type of learning received through the reviews and identify how the system would receive that assurance. **The Governing Body noted the contents of the report and supported the outlined work programme and approved that the completion of Annual Health Checks was added to the Area Risk Registers.**	
8.1	**BNSSG Quality and Performance Report** LM provided the key points from the performance report: • There has been a decrease in urgent care performance during August partly due to supporting social distancing. Covid-19 management continued via the Incident Control Centre and work continued on supporting handover delays. • A&E attendances returned to pre covid-19 levels and work continued on supporting the emergency departments through management of bed flow. • Waiting list sizes increased and the management of this has been included in the phase three planning including the monitoring and clinical validation of patients. • Additional support has been put in place for waiting patients, including community paediatric capacity and additional MRI capacity. • Long waiting patients were clinically reviewed daily and treated in order of priority and the CCG was monitoring patients who were choosing not to attend treatment due to covid-19 or other circumstances. • The system was working through supporting initiatives as part of the phase three planning including independent sector capacity support. • Cancer performance remained challenged and additional endoscopy capacity through Prime Endoscopy would start to improve performance.	

	• There has been an increase in IAPT waiting times and referrals were above contract. JE asked about Prime Endoscopy and the capacity to see two week wait referrals. LM confirmed that Prime Endoscopy were not taking direct referrals but referrals through GPs and Trust pathways for patients on cancer pathways. JE also asked about stranded patients within urgent care and whether the Trusts were operating differently. LM confirmed that although working from a different bed base there was no reason for the Trusts to operate differently. AM asked whether there was anything else that could be identified to support patients with cancer. LM noted that there was a mixture of work being undertaken as well as reviews at speciality level to identify what could be optimised. It was confirmed that the outcomes of this would be reported to the Governing Body. FF noted the decreased GP referrals from last year and asked whether these included advice and guidance referrals. LM confirmed that these referrals were not included and noted the artificially lowered position. JR asked what processes were in place for individual patients to understand the impact of the delays and how was this being monitored. RS noted the CCG was working with the Trusts on the harm review process and the CCG was reviewing a sample of these to ensure they were consistent and provided assurance. RS confirmed that the reviews also considered psychological and emotional harm and were reported to the Quality Committee on a regular basis. RS agreed to discuss with South West colleagues how this process was undertaken elsewhere. The Governing Body discussed patient communications particularly when patients were waiting for treatment. MJ highlighted the referral service and noted the service could be utilised as a single point of access for patients. MJ noted that it was important that the waiting patients were visible to the system and highlighted that community colleagues were aware of these patients.	**RS**

	KA noted the waiting lists for dental treatment and the concerns with estate and asked how business as usual could be continued. LM highlighted that dentistry was commissioned by NHS England and noted that treatment had been actively encouraged and dental work would be continued during the second lockdown and this would be optimised for the local population through the use of the dental hospital. Umber Malik (UM) highlighted concerns around the Priory Hospital. LM confirmed that these services were commissioned by NHS England and explained that Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) was working on reconfiguring services and undertaking capital work at Riverside. The mental health business case supported additional investment in Children's and Adolescent Mental Health Services (CAMHS) as well as additional support for tier two services. LM confirmed that a 24/7 support line had also been put in place. RK highlighted the importance of a central point of contact for patients and their queries around waiting for treatment as well as emotional support. LM highlighted the importance of clear, good quality communications to support patients and noted that NBT had developed an app to support their patients. PB noted that the planned care team were reviewing waiting list arrangements and the referral service was an important resource for this work. MJ noted the importance of minimising the number of contacts to primary care for advice and guidance by standardising this service. JR highlighted that this was important for all patients and not just those on an elective pathway. JR suggested that a group was convened to further discuss this with the referral service. RS provided the key points from the quality report: • Following the increase in covid-19 cases the CCG was monitoring the pressure on A&E. Any 12 hour trolley breaches would be reported to the Governing Body. • There have been two suspected cases of covid-19 infection at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and the situation was being monitored. • The learning report from the covid-19 Weston site closure has been received and a system learning event would be arranged to ensure the learning was shared. • A deep dive into C Difficile cases had been presented to the Quality Committee where inappropriate prescribing of	**PB**

	clindamycin was found to be an issue and an action plan was agreed. • A total of 4 never events have been reported at UHBW and the CCG was working with the Trusts to understand these, and would host a learning event in addition to the regular review meetings. • Venous Thromboembolism was noted as a concern in UHBW as the trajectory had not been achieved and remedial actions were being put in place. Kevin Haggerty (KH) suggested that remote working could be the cause of the lower thresholds of prescribing. RS noted that UHBW had a different approach to other systems and so this was being reviewed. MJ noted that the concern had been driven by microbiologists and so further discussions needed to be had and noted that this would be further discussed at Clinical Cabinet. KA noted that complaints and incidences of pressure sores had decreased at NBT and asked whether this was due to a lack of reporting. RS confirmed that this would be monitored and there would be a future deep dive into falls and pressure sores. NK highlighted that three of the never events related to checklists. RS confirmed that these had been different teams; two related to pre op and one was in the checking of a device. The CCG was working with the Trust to understand what it was about the checking processes that was allowing these to happen and also whether staff were comfortable to challenge checking processes. **The Governing Body received the Quality and Performance report**	
8.2	**BNSSG Finance Report** ST highlighted that this was the last month of the amended financial framework. The CCG currently had a deficit of £8.7m and this was expected to be received to bring the CCG back to a break-even position. The national team increased their level of scrutiny on the covid-19 spend during this last month and the CCG has responded to all queries. ST confirmed that covid-19 costs had been higher this month because of a number of issues including clarity on what could be funded and so additional claims for months 1 to 6 were submitted.	

	ST reported an increase in CHC spend on fast track and end of life pathways and this was being monitored. **The Governing Body discussed and noted the financial position and noted the changes to the NHS financial regime**	
9.1	**Primary Care Commissioning Report** LM presented the report noting that this was a summary report on the work of the Primary Care Commissioning Committee during quarters 1 and 2, which included the operational response to covid-19 and all the aspects of this including the digital roll out and management of equipment. The wider scope of the work was included in the report and was extensive. LM noted the importance that the Governing Body was aware of the scale of the work within the Primary Care Commissioning Committee remit. JR highlighted the huge amount of work the primary care and primary care contracts teams undertake and noted that NHS England had confidence in the way the CCG operates delegated commissioning. The Governing Body members confirmed that receiving the report at Governing Body was useful and agreed that this should continue. **The Governing Body recognised the work that the Primary Care Commissioning Committee has undertaken during quarters 1 and 2 2020/21 and received the report to support Governing Body decision making**	
9.2	**Risk Management Framework** Sarah Carr (SC) presented the Risk Management Framework highlighting the changes following a recent audit of arrangements. The revisions made were in line with the recommendations of the audit report and SC outlined the Committees, groups and people the framework had been shared with for comment. The key revisions were noted as; further alignment with national guidance, the roles of the Committee had been strengthened and changes had been made to the format of the risk register. SC noted that next steps included reviewing risk appetite and the refinement of this and embedding the risk management framework across the organisation. SC noted the key actions were for Executive Directors to lead on risk register reviews and to ensure that key risks were reviewed by the Executive Team and monitored and challenged which included deep dives into specific areas of risk. Jon Hayes (JH) asked how the Framework would be disseminated across the organisation and SC confirmed that this	

	would be discussed at the next whole organisation meeting, included in the internal newsletter and, most importantly, discussed at directorate meetings. JR highlighted the importance of directors owning and managing risks. **The Governing Body approved the Risk Management Framework and noted the next steps including the commitment to refining the risk appetite statement for the final quarter of 2020/21**	
9.3	**Review of Committee Terms of Reference October 2020** SC presented the paper noting that the roles of the Committees had been amended following the recommendations from the risk management audit. SC noted that the Primary Care Commissioning Committee had agreed the amendments related to the audit but there were further discussions to be had regarding Committee membership before approval. STW highlighted that the Public and Patient Involvement Forum had been stood down during the first wave of covid-19 in favour of a working group set up by the insights and engagement team which was working well. The future arrangements of the forum were under discussion and the outcome of this would be presented to the Governing Body. John Cappock (JC) noted that the Strategic Finance Committee had received a number of deep dives into specific risks and the risk register was now discussed at the start of meetings. AM noted the Quality Committee was supportive of the renewed focus on risks and highlighted that the risk register was discussed at the start of the meeting and any new risks arising at the meeting were considered at the end. **The Governing Body approved the revised Committee Terms of Reference and agreed the areas for which Committees will seek assurance**	
9.4	**Organisational Change Policy** ST highlighted this was a policy which had been developed from the three legacy policies and noted that there was a change to the percentage for job matching from 51% to 66% following concerns raised with the 51% job matching percentage with some staff being matched to 30 roles during the merger of the three	

	CCGs. ST noted the policy had been reviewed by the Staff Partnership Forum. **The Governing Body approved the policy for implementation**	
10.1	**Minutes of the Audit, Governance and Risk Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.3	**Minutes of the Commissioning Executive Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Strategic Finance Committee** **The Governing Body received the minutes**	
10.5	**Minutes of the Primary Care Commissioning Committee** Last meeting as chair and pleased to chair. Great Committee. **The Governing Body received the minutes**	
11	**Questions from Members of the Public** A member of the public asked: Since the two Priory Hospital wards have been closed where have the young people requiring residential mental health care been transferred to? Has this been to emergency beds outside the Bristol area, and, if so at what cost and for how long? LM confirmed that the children at the Priory who were from Bristol, North Somerset or South Gloucestershire had not been transferred out of area but had been moved to different care settings within the local area. LM noted that each child had a discharge plan to facilitate the transition and had been placed on an individual basis in the most appropriate setting. DES noted that wrap around support had been provided for these children from the Local Authorities and AWP. It was confirmed that this could be care provided from home but with a higher level of support. DES noted that the CCG was monitoring the situation but the service was commissioned by NHS England.	
12	**Any Other Business** The Governing Body thanked Martin Jones and wished him the best for the future.	
13	**Date of Next Meeting** Tuesday 1st December 2020, at 1.30pm	

Lucy Powell, Corporate Support Officer, November 2020