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 4th August 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
Christina Gray	Director of Public Health	CG
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
Brian Hanratty	GP Locality Representative Bristol South	BH
Nick Kennedy	Independent Clinical Member Secondary Care Doctor	NK
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member Registered Nurse	AM
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
Julia Ross	Chief Executive	JR
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		
Felicity Fay	GP Locality Representative South Gloucestershire	FF
David Jarrett	Area Director South Gloucestershire	DJ
Martin Jones	Medical Director Commissioning and Primary Care	MJ
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
In attendance		
Sarah Carr	Corporate Secretary	SC
Lucy Powell	Corporate Support Officer	LP
Michelle Smith	Head of Communications	MS
Adwoa Webber	Head of Clinical Effectiveness	AW

	Item	Action

1	**Apologies** Apologies were received from Felicity Fay, Rachael Kenyon, Martin Jones and David Jarrett.	
2	**Declarations of interest** There were no new declarations of interest or any declarations pertinent to the agenda.	
3	**Minutes of the previous meeting of the 7th July 2020** The minutes were agreed as a correct record with the following amendments: • Page 5, an action related to the Health Inequalities paper on the August agenda was added to the action log. It was agreed this action would be closed. • Page 7, Alison Moon (AM) highlighted that the comment regarding potential harm had also included cancer referrals. It was agreed to amend the paragraph and include an action for Lisa Manson (LM) to provide an update at the next meeting.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 05-Nov-19 6.4 – Deborah El-Sayed (DES) confirmed the timescale for the toolkit had changed to September 2020. All other due actions were closed.	
5	**Chief Executives Report** Julia Ross (JR) noted the attached Integrated Care Partnership paper which had been approved by the Healthier Together Board and was now progressing at locality level. JR reported that the draft report for the national review of the local LeDeR case has been sent to the CCG and publication was expected in the next month. Deborah El-Sayed (DES) briefed the Governing Body on the NHS 111 First programme which was being implemented to support the system by ensuring people get the right care in the right place at the right time. DES confirmed that the programme was due to go live in September as per the national programme. The programme aimed to support patient transfer from the Integrated Urgent Care Service via Brisdoc into A&E and Minor Injury Units using the local Directory of Services database. DES clarified that the NHS 111 First programme had been developed to continue to protect the NHS from overcrowding in A&E departments. DES confirmed the programme had been piloted in Cornwall and the learning was being disseminated and had included the need for	

	communications with the public to start early and DES noted that this was happening locally through the citizens panel. DES noted that a substantive item would be presented to the September Governing Body meeting with more information. Jon Evans (JE) emphasised the necessity for patients to be given advice on which service to use prioritised on need and not just sent to primary care as the easiest option. DES noted that this was an important point and explained that the CCG needed to engage with clinicians to ensure that advice and guidance was undertaken correctly. It was noted that as part of the iterative process, a group of clinicians would meet weekly to review and suggest improvements. Alison Moon (AM) requested that the paper in September also provided an update on the progress on the single electronic record across the system. DES agreed to include this and noted that some elements of the single electronic record had gone live last month. Lisa Manson (LM) confirmed that the EMIS roll out for children's community services was progressing. Kevin Haggerty (KH) highlighted that the communications should build on the Protect our NHS messaging from the covid-19 pandemic as it was important over winter for the public to continue to only use A&E when absolutely necessary. DES noted that this was the approach Cornwall had taken with communications. JR agreed and noted that it was important to note that this would ensure NHS resources were used most appropriately.	**DES**
6.1	**Transgender Toolkit Update** DES provided the background to the toolkit noting that the CCG welcomed the opportunity to improve healthcare experience for transgender people but noted that there were a number of edits the CCG had requested in order to endorse the toolkit. DES confirmed the CCG were developing an Equality Impact Assessment (EIA) to guide decision making. DES highlighted the national review of hormone blockers and how this would affect the toolkit. DES noted that there had been unavoidable delays in the EIA process and proposed that the EIA be presented at the October meeting. The EIA had been developed with the public and	**DES**

	organisational comments included. It was noted that the CCG would be meeting with SARI to discuss the proposed changes. **The Governing Body noted the update.**	
6.2	**Recovery Planning Summary** Peter Brindle (PB) assured that although covid-19 continued to be endemic in the population, NHS services continued. PB confirmed that the phase three recovery guidance had been released and the draft plan was to be developed for the 1st September with the final plan submitted on the 21st September. Routine surgery was running at 60% of pre covid-19 capacity and PB highlighted the challenge outlined in the phase 3 recovery planning to reach 90% of capacity. Cancer 2 week referrals continue to rise to pre covid-19 levels as people began to present with their symptoms. Endoscopy continued to be a challenge for diagnostics and the system continued to maximise use of the independent sector. PB noted advice and guidance to Primary Care continued to improve and video consulting continued to be utilised. Options continued to be developed to increase bed base and ensure that A&E was used correctly, this included the NHS 111 First programme. PB noted that the 24/7 mental health support phone service had begun and the system was prepared to meet the challenge of increased requirement for mental health services following lockdown. Kirsty Alexander (KA) asked how realistic the 90-100% recovery in time for winter was given the backlog of waiting patients. PB acknowledged the significant challenge this presented and highlighted that the providers were reviewing the guidance, developing processes and assessing the likelihood of success. PB highlighted that all providers were aware of the significant challenge in clearing the backlog and achieving the recovery targets. JE highlighted the independent sector contribution and suggested that the activity should be included in the performance report and asked whether there had been a reduction in the normal independent sector activity. LM confirmed that the data was included in the performance report but was a low percentage of activity compared to the acute trusts. It was noted that the independent sector continued to work through the nationally	

	commissioned contracts and were managing activity using the same prioritisation guidelines. The system was working to optimise all activity and this include working through how to safely provide endoscopy services. JR added that work was ongoing to determine whether diagnostic services could be supported by the Nightingale Hospital. JR noted that colorectal surgery was showing at 201% of baseline and asked what the baseline was. PB noted that the percentage reflected the number of referrals and noted that the increase was likely due to people presenting. PB confirmed that the baseline was set at 10 weeks before the covid-19 response and explained that there were no seasonal differences for most referrals except skin referrals which had been compared against last year's data. LM confirmed that the data could be amended to compare against last year's data. JR asked what percentage of the backlog was due to patients choosing not to come to hospital for treatment. PB clarified that the two main reasons for delays in treatment were patient choice and endoscopy and agreed to include the proportions in the next recovery report. Nick Kennedy (NK) asked whether the system had the workforce to achieve the recovery targets and would asking people to do more affect the budget. Sarah Truelove (ST) confirmed that work was ongoing with the providers to identify the risks of achievement within the system so mitigations could be developed. ST noted that the funding arrangements post September were not agreed so it was unknown whether costs would be reimbursed as covid-19 costs. NK asked whether there were any local changes to services such as moving staff to where they are most useful. PB confirmed that this was happening and gave some examples such as upskilling nurses. Christina Gray (CG) asked where winter planning was detailed as the Local Authorities would need to be involved in the proposals. PB confirmed that winter planning would be included as part of the phase three recovery work. LM explained that there was a workshop being held on Emergency Preparedness Resilience and Response (EPRR) regarding winter planning to review previous winters, discuss further ideas for discharging patients and model rates for infection. LM clarified that planning was	**LM** **PB**

	further complicated by the need to work around the current mitigations. CG noted the importance of working across the system on the flu vaccination programme. It was agreed that the report for next month would include the draft phase three recovery plan and the elements of recovery which have changed. **The Governing Body noted the updates from the key service areas to date and the planning which was underway to recover services over the coming months.**	**LM/ST**
6.3	**Covid-19 Impact Health Inequalities** PB provided the background noting that the covid-19 pandemic has highlighted health inequalities as people have been further disadvantaged by covid-19 and the response to the crisis. Resources were scarce and so these needed to be prioritised to the people who would benefit from them the most. Adwoa Webber (AW) highlighted that health inequalities had been reviewed nationally and the CCG needed to understand the impact on the local population. AW asked the Governing Body to consider what role the CCG had in addressing the issues including collecting ethnicity data and recovering services. JE noted the importance of intelligence and highlighted that collecting ethnicity data could be difficult. AW noted that there were a number of challenging aspects when collecting data including ensuring both patients and staff understood the reasoning for collecting the data. AW highlighted that messaging would need to be clear but initiatives within primary care such as text messaging could be utilised. NK asked whether the CCG could prioritise services differently to reduce health inequalities and noted that the key to improvement was to ensure that considering health inequalities was a key focus across the system. JR noted that the priority was to collect the data and CCG would support clinical colleagues to enable this. JR highlighted that primary care colleagues were the most appropriate group to collect the data. JR asked what was the progress on clinical prioritisation of waiting lists. LM confirmed that waiting lists were prioritised against the Royal College of Surgery guidelines which were based on clinical prioritisation. PB noted that this had been	

	discussed by the Clinical Cabinet and noted that the guidelines were a very basic tool to prioritisation and prioritisation was not considered in terms of health inequalities. It was highlighted that nowhere had considered prioritisation in this way and therefore there was no best practice or learning from other areas. The Governing Body acknowledged that prioritising groups would ultimately deprioritise other groups and this was a significant challenge. KH highlighted that health inequalities affected other areas such as service access. KA agreed and noted the challenge for primary care to collect data for areas of the population who only engage with healthcare services in extreme circumstances. NK asked whether the system has been explicit in the need to reduce health inequalities. JR confirmed that reducing health inequalities was a large part of the phase three recovery planning and was a system endeavour. PB noted that a system wide approach has been developed including a system group convened with champions across the system. **The Governing Body:** • **Noted the impact that covid-19 has had on inequalities of outcome and access and the work that needs to be built on** • **Considered the role the CCG has in ensuring comprehensive and quality ethnicity data collection and recording and discussion and decisions on prioritising care and resources for people with poorer outcomes both for covid-19 and non covid-19** • **Considered the role of the Governing Body sub-committees in addressing health inequalities**	
7.1	**Looked After Children Peer Review Workshop – Update** Rosi Shepherd (RS) confirmed the Peer Review Workshop had taken place and system partners had discussed the findings of the review to ensure there was a collaborative approach to the actions and outcomes. RS provided some of the learning from covid-19 which had been discussed at the workshop. The virtual engagement had been seen as positive by children and young people but the Looked After Children teams were aware that there needed to be a mixed model of engagement in the future both face to face and virtual.	

	There had been greater attendance at virtual strategy meetings and these would continue in this way. RS confirmed 5 actions had been developed through the workshop: • Create a “map” of Looked After Children services, meetings and staff. This also included reporting arrangements. • Develop the Bristol, North Somerset and South Gloucestershire wide vision for Looked After Children. • Develop the Bristol, North Somerset and South Gloucestershire wide action plan to improve Looked After Children. • Develop a joint Looked After Children training plan across Bristol, North Somerset and South Gloucestershire for all providers and professionals. • Develop a Bristol, North Somerset and South Gloucestershire wide engagement plan for Looked After Children. RS confirmed there was a further workshop planned for August and multiple task and finish groups had been set up to work through the actions. Sarah Talbot-Williams (STW) welcomed the actions and noted that these were fundamental to improving health inequalities. It was confirmed that additional detail on the system wide action plan would be presented to the Governing Body in September. RS noted it was important that the actions were ambitious. JE asked whether the learning from covid-19 had been identified from one case study or many. RS agreed to check. RS confirmed that the workshop had been providers only but the next stage would involve service users. JR suggested that the action plan should be coproduced with service users rather than asking service users to comment on the drafted plan. JR asked whether the Local Authorities would have single action plans or a joint plan. RS confirmed that the ambition would be to have one action plan for the three Local Authorities but this would need to be further discussed across the system.	**RS**

	KA supported collaborative working across the system as it was very difficult for children and staff when moving around the system and noted that a joint plan would simplify this. **The Governing Body noted that a system wide plan will be developed for Looked After Children and oversight of this action plan will be via the Children's and Family's Partnership Board.**	
8.1	**BNSSG Quality and Performance Report** LM provided the key points from the performance report: • The report outlined performance from April and May and some data was not available due to the covid-19 response. • There was a rise in 52 week waiting patients. The phase three recovery planning prioritised these patients for treatment following category one patients. • There was a decrease in 62 day referral performance with neither provider achieving this standard. • 2 week wait cancer performance improved for North Bristol Trust (NBT) who achieved the 93% national standard. • The number of attendances at A&E significantly decreased during the covid-19 response. • Patients were discharged promptly from hospital and have been supported following discharge. JR noted that cancer related activity had continued throughout the response and queried why the 62 day performance had decreased. LM confirmed that treatment had continued but performance had been affected by pauses in treatment. JR highlighted the timeliness of receiving the data and LM noted that the CCG needed clarity on what performance targets the system was aiming for during the response. RS provided the key points from the quality report: • Following the transfer of North Somerset Children and Adolescent Mental Health Services (CAMHS) to Avon and Wiltshire Mental Health Partnership (AWP) there have been 2 episodes of self-harm and 1 suicide. A service improvement plan was in place and the CCG continued to support the system. • A mental health homicide has taken place in Weston. One service user was currently in custody and one has been released on bail.	

	• A tripartite summit has been scheduled for August to review the system response and learning from the death of baby “Toby” and the non-accidental injuries to babies “E&F” • Avon and Somerset Constabulary have instigated a criminal investigation into the death of Oliver McGowan. • A Never Event has been reported by University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) relating to the connection of an airflow meter instead of oxygen. An investigation was taking place in line with serious incident arrangements. • The infection prevention and control cell continued to provide training to care providers. There were concerns regarding swabbing in care homes as some insurance indemnities did not cover taking swabs. Mutual aid was currently in place to undertake the swabbing. • There have been no further covid-19 related deaths recorded for patients with learning disabilities. Jon Hayes (JH) asked whether the swabbing concerns meant that swabbing was not taking place before patients were transferred from care homes to the community. RS noted that Sirona were currently undertaking the swabbing but the care provider cell were investigating a more sustainable solution. RS confirmed that home testing kits were not an option as some frail and elderly patients were unable to administer the tests safely. JR raised that LeDeR had been rated as amber for assurance as there were delays in allocating cases. JR suggested that the assurance rating should be green but acknowledging the risk. RS agreed and the Governing Body discussed the need for assurance ratings to be consistent across the report. RS suggested that the assurance ratings were removed from the report. CG highlighted the importance that Public Health were involved in conversations related to extra care housing and LM confirmed that representatives from Public Health were part of the care provider cell. It was agreed that working together as a system was important for the phase three recovery planning. **The Governing Body received the Quality and Performance report**	

8.2	**BNSSG Finance Report** ST noted the temporary financial plan would remain throughout August and September and the post September arrangements were expected to be similar but with a fixed envelope for covid-19 costs. Reimbursement has been received which has brought the CCG back to break even. ST reported that covid-19 reimbursement costs remained consistent per month however the position was changing through recovery as activity levels increased. JE asked which elements of medicine costs were attributed to covid-19 costs and whether these included medicines such as inhalers. ST highlighted slide 8 of the report which showed the increased costs in respiratory drugs as well as the warfarin switch which was indirectly attributable to covid-19 activity. ST noted the CCG has received some reimbursement but there would be cost pressures related to these changes. **The Governing Body discussed and noted the financial position and noted the changes to the NHS financial regime.**	
9.1	**Governing Body Assurance Framework** Sarah Carr (SC) noted that due to the delay in planning guidance there has been a delay in reviewing the 2020/21 objectives. A discussion was due to take place with the Executive Team in August and the Governing Body Assurance Framework would be presented to the Governing Body in September. **The Governing Body noted the extension of the review of the 2020/21 objectives and the identification of risks and other actions for the Executive agreed at the July Closed Governing Body meeting.**	
9.2	**Lone Working Policy** RS noted the policy had been reviewed by the Quality Committee, the Corporate Policy Review Group and the Staff Partnership Forum and all groups had supported the policy which provided support to staff working across Bristol, North Somerset and South Gloucestershire. AM highlighted that the Quality Committee had not reviewed the policy but had discussed whether the policy had been appropriate for Quality Committee review.	

	The Governing Body approved the Lone Working Policy.	
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 Strategic Finance Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Commissioning Executive Committee** **The Governing Body received the minutes**	
10.5	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the minutes**	
11	**Questions from Members of the Public** There were none.	
12	**Any Other Business** RS noted that operational planning guidance for learning disabilities and autism had been received. A working group would be convened to review the guidance and the outcomes would be presented to the Governing Body in the future.	
13	**Date of Next Meeting** Tuesday 1st September 2020, at 1.30pm	

Lucy Powell, Corporate Support Officer, August 2020