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 5th May 2020 at 9.00am

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
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
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
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
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
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Colin Bradbury	Area Director, North Somerset	CB
In attendance		
Sarah Carr	Corporate Secretary	SC
Lucy Powell	Corporate Support Officer	LP

	Item	Action

1	**Apologies** Apologies were received from Colin Bradbury.	
2	**Declarations of interest** There were no declarations of interest pertinent to the agenda. Felicity Fay and Jon Hayes noted that they were joint directors of Hanham Secure Health, responsible for custodial healthcare. Sarah Talbot-Williams noted that she was Chair of a learning disabilities charity in Somerset.	
3	**Minutes of the previous meeting of the 7th April 2020** The minutes were agreed as a correct record with the following amendments: Page 4, paragraph 4: Felicity Fay (FF) asked that her concern that there would be delays in identifying shielded patients be recorded. Page 9, paragraph 4: David Soodeen (DS) asked that it be made clearer that the patients referred to were those with breast cancer and it was both chemotherapy and surgery which had been cancelled. Page 10, paragraph 2: The last sentence was changed to read "JR requested that the CCG routinely reported on LeDeR in the quality and performance report."	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 05.11.19 6.4 – Deborah El-Sayed (DES) confirmed that the transgender guidance Equality Impact Assessment (EIA) would be discussed at the closed session of the Governing Body where the timescales for presenting to the open session would be discussed further. 07.01.20 6.3.2 and 6.3.3 – DES noted that OFSTED and SEND inspections and reviews had been postponed during the pandemic and it was unknown when these would continue. DES reported that the Bristol Written Statement of Action had been approved but publication had been delayed. Julia Ross (JR) noted that co-production of the SEND Strategy could continue in lockdown and highlighted the importance of public engagement. DES noted that co-production with parents and carers had been prioritised however the CCG had received feedback that people were feeling overwhelmed with the amount of information being received during isolation. 03.03.20 11.1 – Lisa Manson (LM) noted that the CCG was working with NHS England to understand the arrangements for approval and closure of community pharmacies. It was agreed to carry forward the action to September to provide a full response	

	on how this process worked with primary care. It was agreed that LM would review the reasoning behind the specific closure mentioned by Mr Blestowe and provide a response. 07.04.20 5 – JR confirmed that the letter had been sent. The action was closed. 07.04.20 8.1.1 – Cancer plans would be discussed as part of the recovery planning item. It was agreed to close this item. 07.04.20 8.1.2 – Rosi Shepherd (RS) confirmed a LeDeR update had been included as part of the quality report. This action was closed. 07.04.20 9.1 – DES confirmed that the CCG had released advice via twitter on being vigilant to cyber-attacks using covid-19. The action was closed. 07.04.20 12 – DS confirmed that following discussion with Michelle Smith, an action plan has been developed for the population where English is a second language. This would be held by the Strategic Communications cell. The action was closed.	
5	**Chief Executives Report** JR reported that the system continued to focus on managing the covid-19 challenge but was also considering recovery planning. JR reported that Sarah Truelove (ST) and Peter Brindle (PB) were leading the recovery work alongside the Healthier Together Clinical Cabinet. The CCG was considering how to maintain the system changes that have been made and how to keep the transformation momentum. Regular meetings were taking place with local MPs who were looking to the CCG to provide them with information regarding the pandemic. JR had met with North Somerset MPs alongside the Chief Executive of North Somerset Council and this had been a useful joint meeting. JR reported that the Bristol Nightingale Hospital had opened but had not yet been used. It was noted that the Severn Network had ensured that staffing was ready for the hospital. JR explained that the equipment for the hospital would be made available when required. JR reported on the national roadshow noting that Simon Stevens and Amanda Pritchard had spoken to the South West Chief Executives which had highlighted that there were to be no regrets with setting up covid-19 contingencies such as the Nightingale	

	Hospitals. JR noted that the teams were reviewing the possible options to use the Nightingale resource, these included hibernating the hospital when not in use, extending to patients discharged from the acute trusts to reduce the pressure of long staying patients, or used as a space for renal replacement therapy. The options would be taken through an options appraisal process with the recommendation being taken to the Severn Network Chief Executives for decision. JR was proud of CCG staff and the way they have connected despite the challenges and whilst working from home. JR highlighted the round the world challenge, where CCG staff are recording their steps to see if they can walk around the world whilst in lockdown. Alison Moon (AM) agreed that it was better to have the Nightingale Hospital resource even if not required for the purpose it was built. AM asked about the modelling of covid-19 cases in the South West. ST confirmed that the University of Bristol had undertaken modelling using the actual activity recorded to produce a predictive model which was cross checked with the national team. ST noted that the modelling was based on lockdown continuing but highlighted that as the model was produced using actual activity data once lockdown was lifted the CCG would have accurate modelling to predict activity. JR explained there was ongoing work to review surge capacity. It was noted that for Bristol, North Somerset and South Gloucestershire, ventilators would potentially be moved back to the independent sector hospitals. FF asked whether the Nightingale hospital could be used for rehabilitation. JR noted that the options were as noted due to the layout and facilities of the hospital. Brian Hanratty (BH) asked whether there was a time limit on how long the hospital could remain open. JR confirmed the expectation was that the hospital would continue until the end of the financial year and the University West of England were considering how to utilise the hospital for possible medical training. JR highlighted the importance of utilising the resource whilst it was available.	

6.1	**Covid-19 Update** LM reported that the system was considering recovery and restructuring operationally and considering how the accelerated transformation work can continue at scale. The papers circulated included the Terms of Reference for the silver and bronze operational commands and the super cell structure. LM explained that Silver command fed into Gold command with the operational and tactical Bronze command feeding into Silver. The system change command had been set up to ensure that the key transformative changes continued and to ensure that these were tested and evaluated. LM also highlighted the finance and analytics cell which provided the strong governance structure to provide robust financial decision making and financial oversight of the other cells. DES noted the highlight report and confirmed this was an example of reporting arrangements and noted that this was the document provided to Silver command for review. ST noted that the Terms of Reference continued to be reviewed as there was further work on recovery to include. Jon Hayes (JH) asked where recovery would be discussed and ST clarified that this would be within Silver linking with the Clinical Cabinet, managing both covid-19 and non-covid-19 activity. AM asked about the remit of Silver in making clinical decisions. ST confirmed that silver command could advise the Clinical Cabinet who made the clinical decisions. It was noted that Martin Jones (MJ) as Chair of the Clinical Cabinet was a member of Silver command. DES noted that transformation directors from across the network were working together to support change and this was an example of the joint working arrangements that would be beneficial to continue post covid-19 and these had been outlined in the highlight report. JR emphasised that the current engagement and leadership of clinicians during the crisis was one of the most important things to continue. MJ noted that Clinical Cabinet had been well attended by primary care and there was a sense of ownership and support for senior clinicians. Jon Evans (JE) asked whether the governance decisions made at Gold command would be reviewed by the Governing Body. JR noted the requirement for fast paced response and explained that	

	authority had been delegated to the command structure to make decisions on the response to covid-19. The challenge would be to retain the current flexibility in decision making when reverting to previous governance arrangements. Kirsty Alexander (KA) asked that a governance structure diagram be developed so that the enthusiasm to make changes was contained within robust governance arrangements. JR agreed that roles and responsibilities needed to be clear so there was clarity on the decisions that could be made. ST agreed to circulate a governance structure once developed. LM reported that testing had increased and arrangements were in place to test all patients on admission and discharge. Testing continued at Bristol Airport and further testing sites were being considered to increase NHS staff and key worker testing. Consideration was also being given on how care homes can be supported. LM reported that the CCG was providing support to organisations where additional Personal Protective Equipment (PPE) was required. LM noted that there were national shortages in renal replacement therapy and anaesthetic drugs, however there were robust delivery processes in place and supply was being managed well. BH asked about patient testing in Primary Care. LM confirmed that Public Health England were working through the expansion of contact tracing. Home testing continued and Ambulance services were providing support for this. Primary care patient testing could be possible but not likely. However, LM confirmed that testing capacity was changing rapidly. KA noted that understanding the prevalence within primary care patients would be helpful for modelling workforce as those who are in contact with patients who have tested positive would need to self-isolate for 14 days. LM noted that Sirona were undertaking a pilot for staff testing. JE asked how often people needed to be swabbed for an accurate result. LM explained that pathology clinicians at North Bristol Trust (NBT) had confirmed that only 2 to 3 virus particles were required for a positive result following swabbing and so there was no encouragement for retesting.	**ST**

	Nick Kennedy (NK) asked whether PPE was being utilised as per national or local guidelines. LM confirmed that PPE was used as per Public Health England guidelines and organisations were ordering PPE responsibly. A stock control system had been put in place and providers including care homes had been inputting their stock levels. Changes to use or ordering were being investigated and infection control guidance for PPE had been distributed. John Rushforth (JRu) asked for further information regarding care homes and LM noted that care homes were being supported with PPE requirements and infection control advice and guidance. RS confirmed that the CCG was working with the Local Authorities and Sirona to provide multi-disciplinary wrap around support for infection control guidance. The analytics cell was working through the numbers of infections in care homes. DS asked about the ordering of PPE for Primary Care and LM confirmed that OneCare were co-ordinating this with mutual aid provided when the practices were unable to obtain the supplies they needed. DES noted that the flows from OneCare to the providers were modelled against demand to understand the PPE requirements. **The Governing Body received the update.**	
6.2	**Recovery Planning and Non-Covid-19 Activity Planning** It was recognised that many service delivery changes had been made in response to covid-19 and the CCG was quantifying the changes and the risks that have resulted. PB highlighted the modelling that had been undertaken on the possible consequences of the pandemic. The CCG was considering the actions that could be taken to mitigate the changes to service delivery. PB acknowledged that there was a disproportionate effect on some members of the population during lockdown. PB explained that cancer services were expected to be maintained as normal but noted that there had been a marked drop in referral activity which could be due to the public not utilising services. PB highlighted that this could result in serious implications for some people as cancers can go from treatable to untreatable very quickly. PB also highlighted that endoscopy had ceased except for the most serious cases due to the aerosols generated. The CCG was working through how endoscopy could continue using the independent sector and prioritising the most urgent cases. PB also noted the CCG was considering other	

	potential diagnostic tools such as Fecal Immunochemical Tests (FIT) and CT scans. PB noted that the cancer alliance were considering a cancer hub should the modelling show that this was required. A cancer working group had been convened to review the possibilities. PB highlighted Musculoskeletal (MSK) services as a challenge noting that the numbers of patients treated was significant. Currently all these services had been paused. PB also noted that routine diagnostics having ceased could cause problems for Primary Care referrals and highlighted that the independent sector could be utilised to restart diagnostics. A system wide group has been developed to address non-covid-19 activity to restore services in a systematic and prioritised way that would be consistent across the system and utilising existing infrastructure. FF thought FIT had been suspended. PB noted that the logistics of home testing was being worked through and noted that the approach was currently a suggestion but agreed to provide an update at the next meeting. FF asked whether patients could be tested for Covid-19 prior to investigations taking place. PB highlighted the significant logistical challenge this would present. FF noted the importance of shielded patients who may need tests and the requirements to keep sites clean. ST noted that the expectation was that patients who were undertaking elective treatments would have self-isolated before attending, however the CCG was reviewing whether dedicated staff could be set up in certain sites to ensure they remain clean. PB noted that the acute trusts were reviewing how to regular test staff members. JR noted that considering health inequalities was critical for the decisions on what to restart as there was evidence to suggest that some parts of the population were suffering more due to covid-19. JR asked that future papers show increased level of detail regarding health inequalities including the evidence of predicted impact on restarted services and why these have been chosen above others. JR expected the teams to use population health management data to prioritise services and monitor the value added by restarting these services. JR highlighted the potential cancer hub and noted that the system needed to base the decisions taken at the current rapid pace on evidence. PB	**PB**

	noted that two key sub groups had been developed in regards to Health Inequalities; one to review the impact of covid-19 including the changes to services and one to review data. Together the groups would be able to understand which parts of the population have been affected and how this can be effectively managed. John Cappock (JC) asked how the CCG monitored the capital requirements and managed people concerned about attending services. PB noted that communications have been posted to assure the population that the NHS was "open for business". Once services have been reopened this would be communicated to the public with assurances. PB noted that capital and resources would be reviewed and noted that the NHS had an obligation to best use resources. JE asked about referrals that were not processed; how many were being held and could this data be used to model which services need to reconsidered for recovery. PB agreed to update on held referrals at the next meeting and explained that it was important to restart in a measured and controlled way as well as continuing the transformations which have been accelerated during the pandemic. JE noted the need for assurance on the held referrals and MJ agreed to review this through the primary care cell. Rachael Kenyon (RK) suggested reviewing the modelling against the quality report to ensure that the CCG was linking recovery with managing services. RK asked whether there was a way to review where elective treatments had been cancelled and who was responsible for onward referral to ensure no further delays. PB reported that there were multiple sources of data being reviewed including the quality report to triangulate data. PB acknowledged the referral issue and agreed to review and update at the next meeting. Sarah Talbot-Williams (STW) asked how the recovery plans would include data from social care and the voluntary sector. PB noted that the Local Authorities had been included within the criteria and noted that the points raised at Governing Body would further inform the recovery work. AM asked that more information regarding risk was included in future papers to ensure that there was assurance that the risk	**PB** **MJ** **PB**

	processes were in place to identify the patients who were affected. AM also asked that the processes and systems for decision making were outlined in future iterations. KA noted that practices knew the numbers of patients whose elective treatments had been cancelled and highlighted the need to prioritise getting the recovery decisions completed and the work in place rather than discussing how to do it. Kevin Haggerty (KH) noted that immunisation rates had lowered and queried whether it was a good time for the CCG to run a communications campaign on the importance of immunisations. MJ responded that there were considerations on how practices would provide access for patients in a safe way. NK commented that evidence from international experience suggested that clean sites were important during the medium term restoration and recovery process. **The Governing Body noted:** • **Areas of concern related to consequences of actions taken to respond to the covid-19 pandemic** • **The risks to patient care in particular patients with other conditions** • **The impact on Primary Care** • **The actions being taken by the system to respond**	
7.1	**LeDeR Annual Report 2019** RS presented the LeDeR annual report highlighting that 32 reviews had taken place in 2019 with 91% of the cases concluding that care had been good or satisfactory. None of the cases reviewed showed that the care received had been the cause of death. The good practice noted by the clinical review panel was highlighted in the report. FF asked about patients with learning disabilities who were not receiving annual health checks and flu vaccinations and how these indicators had been determined as contributing to the reduction of deaths. RS noted that the actions had been developed as recommendations following the reviews and noted that the recommendations were quality assured. JR highlighted that it was good to see the positive aspects as well as the learning but requested an action plan that showed the	

	work the CCG was taking forward. JR also noted that the target of timeframe for reviews had not been met and the report did not contain any assurances that this would be improved. JR also commented that the table on page 11 showing the South West figures wasn't clear and asked that the table be made clearer. RS confirmed that the LeDeR action plan would be reviewed by the LeDeR steering group and then Governing Body. JE agreed that the progress made had been good and asked whether there was a need for specialist services for those patients with learning disabilities or whether the current services would need expansion to accommodate the additional patients. RS confirmed that everyone should have equitable access to services and noted that whether there needed to be tailored core services for patients with learning disabilities was a question for those patients. RS noted that service user groups were being set up where these questions would be asked. STW highlighted the importance of co-production and engagement and asked how the CCG planned to engage with people with learning disabilities and RS confirmed that co-production would be robust and an easy read version of the report would be available. DS noted that none of the cases reviewed were rated as excellent and as a LeDeR panel member, he needed to disagree and reported that there were some instances where the care had been excellent. DS noted that the reviews had made it clear that the annual health checks were inconsistent across the system and these were key to instigating systematic learning from LeDeR. DS considered whether there should be specific pathways for patients with learning disabilities and noted that there were occasional frustrations in how health care professionals did not undertake the reasonable adjustments required. AM agreed with the comments and agreed that a clear action plan was required and noted that a new learning disability quality schedule had been shared with the Quality Committee and represented a contractual mechanism to improve provider services. RK reminded that the councils and public health also had an obligation to provide services for the population with learning disabilities and highlighted that training clinicians to undertake	

	effective health checks was useful. DS noted the training undertaken by Gloucester and suggested that the CCG adopt their approach in terms of training and support, and explained that REMEDY contained all the information to undertake an effective health check. JR reminded the Governing Body that the LeDeR programme was about learning from deaths and the learning disability programme would develop based on the recommendations made through LeDeR. DES noted that these two programmes would link at an executive level and activity would be considered through the learning disability and autism cell and the programmes to accelerate would be considered. **The Governing Body noted the contents of the report.**	
8.1	**BNSSG Quality and Performance Report** LM provided the key messages from the month 11 performance report, noting that this was the last month before the covid-19 response: • A&E performance was 75.1% which was below target but above national average. There had been an increase in attendances. • The total waiting list size for planned admissions increased in February. • Patients waiting over 52 weeks worsened in February, failing the CCG target of 0. This continued to be driven by the acute trusts. It was noted that this would be further affected by the covid-19 response. • 62 day referral to treatment time for BNSSG cancer patients worsened in January. • 2 week wait performance improved for BNSSG but remained slightly worse than the 93% national standard. • Outpatient activity, planned admissions and A&E attendances were above plan. Total referrals and non-elective activity were below plan. JR noted the high February A&E attendance and explained that currently the attendances had decreased and the CCG needed to ensure that this trend continued post covid-19. PB highlighted that A&E had not yet been considered in terms of recovery. JH suggested the emphasis needed to continue with the “right place at the right time” approach. LM noted that there was learning from the covid-19 response around A&E attendances and how this	

	would be built into future services and communications to the public. FF noted that opening up pathways to take people direct to specialists was positive and asked whether this would be sustainable. LM noted that there were a number of reasons why this had worked for A&E and gave the example of NBT redesigning teams to be mega teams by widening the cases the specialities take. The CCG would be reviewing the lessons learnt and developing services change which improved performance. JE highlighted that the "other" treatment function for long waiters continued to show a significant number and asked that the numbers were expanded to show the individual specialities. LM agreed to expand this per speciality and noted that the teams have been focussed on tackling the patients waiting long times and following the covid-19 response there would be additional treatments cancelled which would need to be prioritised through recovery. RS provided the key messages from the quality report: • The CCG met with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and reviewed the key risks and risk based approach to quality going forward. • The first draft of the quality assurance approach for the independent sector had been supported by the Quality Committee • Safeguarding concerns have increased following isolation advice and healthcare staff have been provided with domestic abuse guidance as well as ensuring that staff are equipped to signpost people to the most appropriate help. RS confirmed a safeguarding cell had been set up for each local authority. • RS presented the new LeDeR slide which would be included each month. It was confirmed that this would include appropriate timescales for actions. • Within BNSSG 10 people with learning disabilities had died due to covid-19, these deaths were consistent with those of the general population. This continued to be monitored. **The Governing Body received the Quality and Performance report.**	**LM**

8.2	**Finance Report** ST noted that the annual accounts had been submitted in line with the timetable with the final position as per the month 9 forecast outturn of a deficit of £34m. ST reported on the changes to the financial arrangements for the first 4 months of 2020/21 and noted that there had been no confirmation for arrangements after July. ST confirmed that clear processes were in place to ensure the savings plans for 2020/21 continued to be monitored. **The Governing Body received the Finance report.**	
9.1	**Approval of Annual Report and Accounts** ST noted that due to the submission timescales for the annual report and accounts, the Governing Body were asked to delegate final approval of the annual report and accounts to the Audit, Governance and Risk Committee. This was approved. **The Governing Body approved authority to be delegated to the Audit, Governance and Risk Committee to approve the final annual report and accounts 2019/20.**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Strategic Finance 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 Primary Care Commissioning Committee** **The Governing Body received the update**	
11	**Questions from Members of the Public** What measures are being taken to assist the socially isolated who lack the necessary support network of families and friends? *JR commented that the first question was the responsibility of the local authorities. The CCG was working in partnership with the local authorities to support people who were shielding during this stage of the pandemic response. The CCG had co-ordinated the review of the lists of vulnerable patients with GP Practices and hospital specialists to ensure that people were not missing from the lists. The lists were shared nationally and with local authorities to ensure patients were supported. Dr Christina Gray, Director of Public Health, Bristol City Council, was present and commented that each local authority had in place arrangements in place to support vulnerable people. A single point of access*	

	was available for each local authority who would respond to requests for help including food and medicine deliveries. The local authorities were using volunteer and community networks to provide social support. It was agreed to ask the questioner if there was a specific concern about a person known to him he wished to raise. What resources have been directed for mental health services to help families and individuals cope with the effects of physical distancing and income insecurity? *This question was more specific to the work of the local authorities. Dr Christina Gray explained that the first principle was to ensure was to provide the social support necessary to help people's mental health and wellbeing. Local authorities were working with businesses to ensure all grants and other financial support available were being accessed. It was important to address the issues that most concerned individuals. The local authorities were working jointing with local NHS services and the CCG through the through the Mental Health and Wellbeing Cell to ensure a link between the wider determinates of mental health and mental health services. it was understood that people with experience of mental health issues would experience challenges differently, it was important to ensure that patients with a higher level of need obtained the community support required.* What guidance and practical support have been provided to the disabled to enable them to cope with any particular disadvantages that might be exacerbated during the pandemic? *The local authorities were working jointly with the CCG and NHS services to ensure that the needs of people with disabilities were identified and supported through local community and voluntary services. Specific responses to individuals would depend on their needs. GP practices were contacting their vulnerable and disadvantaged patients regarding their health requirements. Local authority partners were focusing on the social issues facing people with disabilities.* As a result of the COVID-19 crisis, is the CCG prepared to instruct all NHS trusts, commissioned providers of health care services and GP surgeries NOT to conduct eligibility checks, including residential and national origin, thereby allowing all patients to use the NHS without fear of incurring any financial costs?	

	It was explained that eligibility checks were not carried out in primary care or emergency care settings. Eligibility checks related to elective treatment which was currently suspended. The CCG, and local NHS providers were subject to national guidance on this issue.	
12	**Any Other Business** None	
13	**Date of Next Meeting** Tuesday 2nd June 2020	
	The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by JH and seconded by JRu.	

Lucy Powell, Corporate Support Officer, May 2020