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 January 2021 at 1.30pm

Minutes

Present		
John Cappock	Lay Member Finance (Chair)	JC
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Colin Bradbury	Area Director, North Somerset	CB
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
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
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		
Peter Brindle	Medical Director Clinical Effectiveness	PB
Jon Hayes	Clinical Chair	JH
Umber Malik	GP Representative Bristol Inner City and East	UM
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
In attendance		
Will Bradbury	Communications Manager	WB
Sarah Carr	Corporate Secretary	SC
Rebecca Dunn	Deputy Director of Transformation	RD
Alex Layard	Programme Manager, Healthier Together	AL
Lucy Powell	Corporate Support Officer	LP
Alex Ward-Booth	Head of Insights and Public Engagement	AWB
Adwoa Webber	Head of Clinical Effectiveness	AW

Sharon Woma	Inclusion Coordinator	SW

	Item	Action
1	**Apologies** Apologies were received from Jon Hayes, Peter Brindle, Umber Malik and John Rushforth.	
2	**Declarations of interest** There were no new declarations of interest and no declarations of interest pertinent to the agenda.	
3	**Minutes of the previous meeting of the 1st December 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) thanked all health and care staff who worked over the Christmas break to ensure that hospitals remained safe, and primary care staff who worked to vaccinate people. JR thanked, on behalf of the Governing Body, all NHS staff for their work and acknowledged that although staff were tired and facing the challenges of a third lockdown, their commitment to caring for people remained. JR stressed the importance of the lockdown to allow the system to get ahead of the virus again and noted that locally levels of covid-19 were rising and was challenging an already pressured system, however the system was working well together to manage the seasonal and covid-19 related pressures. JR highlighted the numbers of patients with covid-19 across the three Acute Trusts. JR explained that despite challenges at Weston General Hospital, there was no intention for the hospital to become a covid-only hospital and added that patients who were admitted elsewhere were done so to ensure that Weston General Hospital could operate normally as quickly as possible. JR noted that focus continued to be timely discharge and supporting people at home and in the community. JR thanked local hospital colleagues and those of Somerset and Taunton, Sirona Care & Health, Avon and Wiltshire Mental Health Partnership Trust (AWP) and Primary Care for their support. JR acknowledged the challenges of lockdown and thanked the people of Bristol, North Somerset and South Gloucestershire for their part in relieving the pressure on the NHS. JR thanked the people who agreed to have their experiences of covid-19 published and noted how powerful these stories were.	

	JR reported that the vaccination programme had commenced and JR thanked colleagues who were working hard to ensure people were vaccinated. JR highlighted that the system had worked hard to vaccinate those in the priority groups and thanked the Primary Care Networks (PCNs) for their work in vaccinating people over 80 in the community and in care homes. JR noted that GPs would be contacting people in the relevant groups to arrange their vaccinations. JR noted that work continued to support people who were suffering from long covid and for people whose mental health resilience was challenged during this stressful period. Christina Gray (CG) acknowledged the role of the local authorities and thanked those who had supported people through marshalling and the volunteers who provided additional community support.	
6.1	**Governing Body Assurance Framework** Sarah Truelove (ST) presented the Governing Body Assurance Framework for quarterly review noting that the strategic risks had been updated in December. ST highlighted the review of Governing Body agendas against the assurance framework and the paper highlighted which areas had been reviewed. ST noted that the Executive Team reviewed the assurance framework monthly and asked that the Governing Body members consider the questions within the paper. It was proposed that the Governing Body cover papers were amended to include the requirement to reference the relevant principle objective. ST highlighted that current focus was on the covid-19 capacity related principle and the Executive Team continued to review processes to ensure the incident was resourced. ST invited Executive Team members to talk about the principles they led. Lisa Manson (LM) noted that the CCG continued to work with the Local Authorities as part of the principle to improve children's services. LM noted the clear improvement plan in place for children's services and the convening of an Operational Children's Board to ensure services were coordinated. Rosi Shepherd (RS) highlighted the principle around funded care delivery and explained that although assessments had been deferred for 6 months, performance on the deferred assessments was strong and an action plan was in place. RS noted that for the principle related to learning disability and autism more narrative would be included next month following work with primary care.	

	JR noted that the CCG had been recognised as an Integrated Care System (ICS) and progress had been positive. The challenge around developing the Memorandum of Understanding and joint working was outlined. JR noted the risk score reflected the structured programme in place which provided assurance on delivery. Deborah El-Sayed (DES) noted the objective around mental health and highlighted the community mental health framework and the significant focus within the phase three planning. DES noted that despite the significant focus, the risk score would remain the same due to factors such as lockdown and increased stress affecting people's mental health. Felicity Fay (FF) noted that the work reviewing the agendas to inform the frequency of updates was useful and helpful for the members in terms of mitigation of risk and challenge. Alison Moon (AM) welcomed the updates and the inclusion of the previous narrative for understanding. AM noted that the sub-committees also reviewed the relevant principles. AM also welcomed the proposed changes to the cover sheet. AM noted the risk around covid-19 and asked how the Governing Body could provide support. ST noted that the key risks had been identified and the overarching risk was around sufficient resource, however review of processes continued to ensure that focus could also continue on other aspects of the business. Kirsty Alexander (KA) highlighted the huge amount of effort to complete the milestones set for the children's programme by January 2021 and asked how the teams would keep the actions on track. LM confirmed that the challenge was continuing the work despite the covid pressures and noted that quarterly deep dives continued to review the programme. Sarah Carr (SC) noted that the change to the cover paper would help to provide the explicit links between the items and the assurance framework and corporate risk register. **The Governing Body:** • **Considered whether the Governing Body agendas were giving enough focus on the objectives and risks reported through the Governing Body Assurance Framework and identified additional information required**	

	• **Confirmed assurance that the CCG has properly identified the risks it faces and that the CCG has appropriate controls in place to manage those risks** • **Approved the proposals that the template cover paper for Governing Body agenda items is amended to include a requirement to reference relevant principal objectives and standing item reports on specific issues** • **Considered the integration of workforce issues into the functions of an existing assurance committee of the Governing Body and to confirm which committee this would be**	
6.2	**Phase Three Covid Response Update** LM noted that the current numbers of cases of covid-19 were similar to those during wave 1 and highlighted the actions the system has taken to support access to beds, including the cancellation of non-urgent inpatient elective treatment and increasing staff capacity in nursing homes to support discharge. All organisations have reviewed their workforce to ensure clinical staff have been released to support clinical work. The vaccination programme continued with the inclusion of the Oxford vaccine. The system continued to work through the prioritised groups of patients, front line workers and care homes. Jonathan Evans (JE) asked whether the Nightingale Hospital would be stood up. LM confirmed these were additional intensive care beds agreed across the Severn Network which had been included into the modelling and planning across the network. JE also asked about independent sector capacity and LM confirmed that these providers were prioritising elective treatment. CG noted that the majority of infections were across the working age population and the system was managing the impact of this as well as the impact from the school closures. LM noted that providers were testing staff to ensure that asymptomatic staff were identified and the system was supporting schools to remain open for the children of critical workers. RS noted that providers were following Public Health England guidance and working hard to minimise outbreaks. Nick Kennedy (NK) asked about staffing provision for the Nightingale Hospital and LM confirmed that there was an agreed plan in place across the Severn Network which included staffing.	

	NK asked whether the staffing plan was achievable. LM confirmed the plan had been agreed and would be reviewed if required. **The Governing Body noted:** • **The current position on covid and its impact** • **Progress towards complete mobilisation and delivery of the vaccination programme**	
6.3	**Long Covid Pathway** Rebecca Dunn (RD) and Alex Layard (AL) were welcomed to the meeting. RD noted that long covid clinics had been set up nationally to support people with their symptoms. The Bristol, North Somerset and South Gloucestershire system offer went live in December with Sirona as the lead provider. RD confirmed that the service would continue to learn as it developed and performance on milestones was reported to the programme steering group. RD noted that £245k had been received to support the service and further consideration would be given on how to deploy the service in the long term. RD noted the team were working with the Communications team to ensure that information about the service was communicated to the local population. KA noted that the funding had been used to set up processes and infrastructure and asked how patient expectations would be managed. AL noted that the funding was provided as non-recurrent funding for set up costs including setting up the single point of access and buying the required equipment. AL noted that the referral criteria had been agreed and referrals were being triaged by the service. RD noted the whole process was clinically driven and there had been significant engagement from clinicians across all areas of service design. RD noted that linking and coordination with existing services was a key focus. FF asked whether the signposting to other services could be undertaken by primary care. AL noted that consideration had been given to the capacity of primary care and coordination of complex patients. It was confirmed the programme had been developed around the “your covid recovery” website which had been developed to help people self-manage their symptoms. The support had been developed to avoid adding patients to existing waiting lists and the programme was reviewing different ways of working. AL noted that the majority of patients would be managed	

	within primary care with a small cohort of patients who would need multi-disciplinary support. JE highlighted that assessment of patients was key and noted that a criteria would be needed to manage capacity. AL noted that there was no formal criteria but the service was following NICE guidance for assessment and patients were directed to the national website depending on need. RD noted clinically led work continued regarding screening and assessment. NK welcomed the process but asked whether other secondary long term syndromes were being managed as well and asked how demand would be managed. RD noted that supporting join up of services including psychosocial support was part of the next phase of development to support secondary care by utilising community care. **The Governing Body:** • **Reviewed the draft future state description and provided feedback to the programme team** • **Acknowledged the progress to date, noting that funding beyond the end of March 2021 was not agreed and that governance of the programme was via the Integrated Care Steering Group** • **Approved the indicative programme timeline**	
6.4	**Health Inequalities** Adwoa Webber (AW) was welcomed to the meeting and presented the developing health inequalities plan. AW explained that the action plan had been developed based on communities with poorer outcomes and through community involvement. Actions had also been developed through the CCG investigating how and why opportunities had been missed and this was identified as being during the decision making part of programmes. One of the actions was therefore ensuring that terms of reference for sub-committees were explicit in their responsibilities for reducing health inequalities. AW confirmed that Peter Brindle was the Health Inequality lead for the system and the CCG and responsible for the detailed action plans. AW confirmed that the CCG action plan had been tested with CCG staff including those within staff networks. Actions have been shared with executive directors and input has been received from staff, directors and the Governing Body.	

	FF asked about inclusion of performance statistics related to deprivation and ethnic minorities within the performance report noting that there could be a different baseline within these cohorts of patients. FF also asked whether patients with learning disabilities had been included within the action plan. AW noted that the actions were specific as directed by NHS England/Improvement however no group was excluded and the CCG could include other groups as required to support the local population. AW noted that clinical analysis of the data would be needed in order to develop the appropriate actions around performance reporting. KA asked how the CCG would use the action plan to change the approach to commissioning and contracting to ensure that resource was optimised. AW noted that some of the data received would improve allocation decisions and could link with the ethical decision making framework with the ambition that these processes would be considered as part of business as usual. JE asked how ambitious the CCG could be and whether clinical lead representation for health inequalities was a sensible idea. AW noted that the CCG could implement this any way that worked for the local population and noted that it was important to develop work with communities throughout the CCG rather than only have small groups engaging. AM highlighted the importance of including learning disabilities and noted that the information regarding health inequalities was available but needed to be linked throughout the system. AW noted that groups were undertaking this work but not consistently across the CCG. There needed to be a quick and easy way to receive the information needed from communities. AM asked who would monitor the plan. AW confirmed this would be the executive team and regular reports would be received by the Governing Body. CG asked whether the CCG work had been incorporated into the wider system work as the local authorities were also involved in this work and AW confirmed this was the case. CG noted the importance of ensuring that diversity was a part of decision making at all levels including senior management and at Board level. Kevin Haggerty (KH) highlighted that there was work with Public Health England ongoing in North Somerset regarding the workforce element. AW confirmed that diversity was included in	

	the people plan considering remote working and work continued with educational organisations to empower local communities. DES highlighted the coproduction work being undertaken by the insights team and the work with the voluntary sector and those links to the local communities. AW considered that there were opportunities for further joint working recognising the importance of community feedback in this work. DES noted that it was important to ensure that engagement and coproduction was a part of all the work of the CCG. JR noted the connection piece was critical and asked how successful embedded coproduction was measured and noted that the CCG needed to consider how to engage with communities rarely engaged with. **The Governing Body noted the developing health inequalities plan**	
7.1	**LeDeR System Action Plan** RS explained that the action plan included the recommendations from the system Multi Agency Review (MAR) for Oliver McGowan. The action plan had been updated with system leads who would lead on progressing the actions. RS outlined the recommendations noting that progress had been included in the plan. KA asked how the CCG supported patients and families by ensuring that there were practical actions behind the recommendations. RS noted that the actions behind the recommendations needed to be developed but it was acknowledged that these actions needed to be robust and audited once implemented. JR asked what the ambition was for the plan and how success would be measured including ensuring that other organisations received robust training. JR noted that the plan was a useful high level overview but the actions behind the recommendations needed to be more detailed. RS noted the next step was for the system leaders to meet and discuss the actions needed to fulfil the recommendations and noted that each recommendation would have a multi-disciplinary response plus scheduled audits. RS noted the system needed time to develop these actions and it was agreed that an updated plan would be presented to the Governing Body in March, which would include a clear update on timeline and the links to wider system work plans.	**RS**

	CG asked whether the action plan reflected a system approach. RS confirmed this was the case and noted existing learning disabilities groups were being utilised to ensure a consistent approach. **The Governing Body:** • **Received the MAR system action plan associated with the review** • **Received the quarterly update on progress against the actions outlined in the MAR**	
7.2	**Quarterly Customer Service Report** ST explained that the Customer Services team continued to work with other teams across the CCG to streamline standard operating procedures particularly around Continuing Healthcare (CHC) and Primary Care. ST noted improvements to processing has taken place where learning has been identified. It was reported that there were no significant shifts in numbers of contacts. JE noted that the CHC were now undertaking weekly meetings to discuss complaints and asked whether this change had had any effect on the numbers of complaints. ST noted that it was too early to tell as there were several aspects to review however monitoring continued including the impact of covid-19. Sarah Talbot-Williams (STW) thanked the customer service team for including previous year statistics within the report so trends could be compared, including the effect on the service of covid-19. **The Governing Body noted the contents of the report.**	
7.3	**Ockenden Review of Maternity Services** RS noted that the presented report outlined the emerging findings following the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. RS noted that once completed the review would consist of the largest number of clinical reviews undertaken for a review. NHS England and Improvement have requested a self-assessment of services to be completed and North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW) have submitted their returns which have been shared internally. The returns show compliance and some actions have been identified. Ongoing oversight would be undertaken through the Healthier Together Local Maternity	

	System (LMS), the submissions would be reviewed and ongoing work included in the forward work plan. RS reported that the Trusts were completing a further submission for January. John Cappock (JC) asked how the Governing Body could gain assurance on the local maternity services. RS noted that a Quality Surveillance Group was planned and a maternity service overview would be presented to the Governing Body. RK noted the importance of receiving assurance from the Trusts and JE highlighted how integration between services could impact services. RS agreed with the importance of ensuring there was effective joint working. JR suggested a full update was provided to the Quality Committee and an overview presented to the Governing Body to include analysis and actions with deadlines. NK asked whether there were any immediate actions identified for the local system. RS confirmed there were none but further work was ongoing to review the detail beneath the self-assessments. NK asked whether the local system should also receive assurance from other nearby systems such as Wiltshire and Somerset. LM confirmed that although the self-assessments would be completed by each system there was an expectation that these would be shared. AM emphasised the importance for the Quality Committee to review the full details of the self-assessments as well as the wider local maternity services overview. AM noted the importance that cultural changes were treated as important as the transactional process improvements. RS highlighted the opportunity to share serious incident reporting across the system to shift the culture and the importance of engaging with families throughout. STW asked how the learning around culture would feed into training staff. RS noted that learning would be lifted into systematic work across the system wide learning. **The Governing Body noted the report and the progress and actions underway for the system**	**RS**
8.1	**BNSSG Quality and Performance Report** LM presented the key points from the performance report: • 4 hour A&E performance worsened to 76.6% and was worse than national average for type 1 emergency departments • Covid-19 escalation planning continued with the system response agreed, incorporating 3 phases of response escalation	

	• There was an increase in numbers of patients waiting over 52 weeks for planned treatment, these patients continued to be clinically reviewed • Cancer 62 day and 2 week wait performance improved but has not met the national standard. Additional capacity for endoscopy and MRI has been put on line • Reporting for children's services would begin next month FF highlighted the increase in breast cancer referrals and queried the comment that this may be due to less face to face investigations as GPs had been offering safe face to face appointments. LM suggested that the increase was a combination of people not attending their GP by choice and potential delayed presentation to primary care. A deep dive would be undertaken on the increase. AM asked whether a consistent approach had been developed for communication to waiting patients and asked whether the system had the capacity to answer all associated queries. LM noted that patients were being responded to individually by the CCG or providers and there was currently no consistent approach as patients were waiting for different services. LM noted that consideration was being given to utilising the referral service as a communication mechanism as part of the phase 4 planning. ST highlighted that the ambition was to have a situation informed approach for each patient. RS presented the key points from the quality report: • There has been significant progress with the deferred funded care assessments. Fast track case numbers have decreased following reviews • The Infection, Control and Prevention cell continued to support providers in managing and reducing the risk of covid-19 outbreaks • LeDeR reviews have been completed for all deaths notified by 30th June. Outstanding reviews will be subject to MARs • AWP have received a favourable CQC inspection • Safeguarding partnerships have been reviewed and feedback has been provided to the national teams • The CCG was chosen to be one of the seven systems to participate in the review into DNACPR. The review has been completed and informal positive feedback has been received	

	KA noted pressure ulcers had increased at NBT and asked whether the CCG could intervene through targeted safeguarding training. RS agreed to ask the team what plans were in place. LM noted that real time performance was shared across the system daily and modelling was built into this. RK highlighted the importance of receiving further detail regarding the never events at UHBW. RS noted that the team was working with UHBW to understand these further. RK also asked whether the IAPT reported increase in self-harm had been triangulated across the system. RS noted that these were being reviewed in terms of covid-19 and lockdown plus review by age profile. **The Governing Body received the Quality and Performance report**	**RS**
8.2	**BNSSG Finance Report** ST highlighted that some expected covid costs had not yet been recovered and the CCG has received confirmation that NHS England had not yet processed all claims. ST reported that the risks related to the prescribing budget had reduced following the month 9 review. **The Governing Body noted the financial position at month 8**	
9.1	**Equalities Annual Report** Alex Ward-Booth (AWB) and Sharon Woma (SW) were welcomed to the meeting. AWB noted that the Equalities Annual Report had been reviewed by the Quality Committee and the comments made had been incorporated into the report. AWB reported that the related statutory duties had been met despite the pandemic and any actions were being developed and shared with the system. SW noted that the CCG had implemented Equality Impact Assessment (EIA) training for staff and improved communication with local communities. SW noted work was ongoing to create strategic targets around staff experience and the Inclusion Council would meet early in 2021 to prioritise activities and develop key performance indicators. DES noted that the 2019/20 report included more infographics to ensure that the report was more accessible than the previous annual report. AWB highlighted the improvement in the EIA processes and the link to improving health inequalities.	

	AM highlighted that the Quality Committee had requested the risks were clearer within the annual report and this had been actioned. AM welcomed the focus on the quality of EIAs and improving the consistency of these and noted that the Inclusion Council sounded important in terms of increasing diversity at the CCG. FF asked for more detail on the information received from HR on workforce reporting such as the gender pay gap. ST noted that due to Agenda for Change staff would almost always be paid the same for the same role and noted there was some disparity in who applied for senior roles and work was ongoing to review this. JR noted that building relationships with protected characteristic groups and communities was an important objective and asked that the related action be strengthened and outline how the CCG would engage with the local communities. JR noted the impact covid-19 had on engagement work but asked that a timeline be set for future work. AWB explained that a mapping exercise was ongoing on what actions were needed to reach the communities and how this would be achieved. STW asked if inclusion leadership was an internal approach. It was confirmed that the CCG had a leadership role to drive inclusion across the system and champion inclusivity. **The Governing Body approved the report with the amendments discussed, and noted the recommendations highlighted in the report**	
9.2	**Emergency Preparedness Resilience and Response (EPRR) Assurance Self-Assessment** LM reported that a self-assessment had been undertaken against CCG EPRR processes as well as provider processes highlighting the challenge of this due to the covid-19 response. LM noted that provider assessments had maintained or increased compliance. LM noted that due to the pandemic response the CCG Incident Response Plan and Business Continuity Plan had not been updated and therefore the CCG recorded a decrease in compliance. JR asked for more detail on the reduction in the CCG compliance as the CCG response to the pandemic had received positive feedback. LM noted that due to the response to covid-19, EPRR policies had not been refreshed as EPRR staff had been busy working through the pandemic response.	

	The Governing Body noted: • **The decrease in compliance status of the CCG; due to the pandemic response, the Incident Response Plan and Continuity Plan are now out of date** • **The increased compliance of our commissioned providers: in particular AWP, Severnside Brisdoc and Care UK**	
9.3	**Corporate Risk Register** Sarah Carr (SC) noted that the sub-committees were undertaking focused reviews of the Risk Registers to assure that mitigations were in place and actions appropriate when risks were recommended closed. SC noted that it had been agreed to use a new risk register template and, with approval, this would be implemented in April. SC noted there were 4 risks scoring 20 and above and these had been on the register for some time. JE asked for assurance that the highest scoring risks were discussed adequately. SC highlighted the risk relating to cancer patients and noted that discussions would have taken place with the cancer leads and would be further discussed at the cancer steering group and a deep dive into this risk had been reviewed by the Clinical Executive. SC also noted that discussions continued at various forums regarding the mental health risk. SC explained that the highest scoring risks reflected areas of such magnitude and scale that they would very difficult to mitigate completely. ST confirmed that these high scoring risks were discussed at Clinical Executive in detail and the Executive Team reviewed the corporate risk register monthly and highlighted the importance that each risk had an identified executive lead. s **The Governing Body reviewed the Corporate Risk Register and approved:** • **The addition of the risks detailed** • **The removal of the risks detailed** • **The migration to the new risk register template for April 2021**	
9.4	**Recruitment Policy** ST highlighted that this was a policy which had been developed from the three legacy policies and highlighted the significant level of engagement when developing this policy. ST highlighted that the Staff Partnership Forum had requested that all posts be advertised internally before external advertisement. Following consideration, this request had been excluded from the policy as	

	there were situations where this was not appropriate. ST noted that vacant roles were always communicated to staff. **The Governing Body approved the policy**	
9.5	**Primary Care Commissioning Committee Terms of Reference** The changes to the Terms of Reference were highlighted in the paper and included the nomination of a Vice Chair when required per meeting. It was noted that the Primary Care Commissioning Committee would continue to review its Terms of Reference, noting that the Medical Director, Primary Care post was vacant. **The Governing Body noted the revised Terms of Reference**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Clinical Executive Committee** **The Governing Body received the minutes**	
10.3	**Minutes of the Strategic Finance Committee** **The Governing Body received the minutes**	
11	**Questions from Members of the Public** There was no questions from the public	
12	**Any Other Business** There was none	
13	**Date of Next Meeting** Tuesday 2nd February 2021, at 1.30pm	

Lucy Powell, Corporate Support Officer, January 2021