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 6th October 2020 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
Peter Brindle	Medical Director Clinical Effectiveness	PB
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
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
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		
Brian Hanratty	GP Locality Representative Bristol South	BH
Jon Hayes	Clinical Chair	JH
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
In attendance		
Will Bradbury	Communications Manager	WB
Sarah Carr	Corporate Secretary	SC
Andy Newton	Head of Planned Care	AN
Lucy Powell	Corporate Support Officer	LP
Michael Richardson	Deputy Director of Nursing and Quality	MR

	Item	Action
1	**Apologies** Apologies were received from Jon Hayes, Brian Hanratty and Rachael Kenyon.	
2	**Declarations of interest** Umber Malik was welcomed to the Governing Body as the new GP Representative for Bristol Locality Inner City and East. Umber declared two interests that had not yet been included on the register: • Locum GP within the Inner City and East locality • Worked with the Training Hub There were no declarations pertinent to the agenda.	
3	**Minutes of the previous meeting of the 1st September 2020** The minutes were agreed as a correct record with the following amendments: • There were two grammatical errors on page 3 and these were corrected.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 01.09.20 7.3 – Deborah El-Sayed (DES) confirmed that feedback had been provided to the South Gloucestershire and North Somerset SEND groups and feedback would be provided to the Bristol SEND group later in the week. The action was closed. All other due actions were closed.	
5	**Chief Executives Report** Julia Ross (JR) reported that the phase three final plan had been submitted which outlined the actions to reinstate activity whilst keeping patients and staff safe. JR thanked Sarah Truelove, Lisa Manson, Sebastian Habibi and their teams for their hard work developing the plan. North Bristol Trust (NBT) announced their new Chief Executive Officer, Maria Kain, who was currently Chief Executive Officer at North Middlesex University NHS Trust. Evelyn Barker would be interim Chief Executive Officer until Maria joins. An Executive to Executive meeting was held between the CCG and North Somerset Council where the shared vision to improve children's services was discussed. The North Somerset parents and Carers forum also attended and shared their experiences of children's services.	

	The CCG has been invited to participate in the national population health management programme which aligned with the work the CCG had already begun. JR noted that population health management discussions had started at Primary Care Network (PCN) level and these had been paused whilst responding to covid-19 but were now restarting.	
6.1	**Transgender Toolkit** DES confirmed the CCG were progressing the Equality Impact Assessment (EIA) the completion of which had been delayed as meetings arranged to discuss the toolkit were postponed due to the covid-19 response. A series of meetings have now been held with clinicians and women's groups and a meeting has been held with SARI to discuss the evidence received and potential edits to the toolkit. DES highlighted the national review into hormone blockers, the outcome of which would be need to be reflected in the toolkit. Felicity Fay (FF) highlighted the suggested pathway amendments and DES noted that part of these were linked to the national review and would need alignment with national policy. DES highlighted that for inclusion in the toolkit the lived experience of the pathways was a more important consideration. FF asked if the feedback from the women's groups had been incorporated into the suggested toolkit changes. DES confirmed that the feedback had been included as part of the EIA process which informed the amendments. JR noted that the toolkit was not a clinical document but provided effective ways for engaging with transgender patients. It was noted that the document should reference the pathways but was not a clinical guide. **The Governing Body noted:** • **the progress made in relation to the Transgender Toolkit Equality Impact Assessment, including the completion of public and clinical engagement sessions to inform it** • **the revised timeline for next steps**	
6.2	**Recovery – Cancer Services** Andy Newton (AN) was welcomed to the meeting and highlighted that for cancer services the focus throughout the covid-19 response was to maintain services and ensuring patients were seen promptly and safely. The current focus was identifying patients who had not attended services with symptoms and therefore had not been referred into services. AN noted that	

	referral activity had increased to near pre covid-19 levels in the last month. The concern continued to be access to endoscopy services which had been closed to all but emergencies but was now increasing capacity. Patients with suspected cancer would be prioritised for endoscopy services if required. It was expected that there would be an increase in referrals as some patients did not attend health services during May to July. AN mentioned screening services noting that these were commissioned by NHS England. All screening services had been ceased nationally but all patients who were in the system have now been processed for screening, the focus was now on the patients who had not been referred for screening due to the pause. AN noted the areas of concern: • Patients not visiting their GP with possible cancer symptoms. The Communications team were working to communicate that services were open and to visit a GP if patients had any health concerns. • The impact of the screening backlog. The majority of patents assessed by the screening service are not found to have cancer but delays in screening may result in cancers being diagnosed later. • Access to endoscopy. Patients on cancer pathways or with suspected cancer have been prioritised for endoscopy capacity. AN highlighted the challenge for winter but noted that services were in a good position for patients currently within pathways and highlighted the focus on raising awareness for attending services if people have health concerns. Alison Moon (AM) welcomed the paper and agreed that the focus needed to be on those patients not attending and asked if the current approach to communications was enough. AN noted that the ambition was to identify specific groups and cancer sites where there were concerns and focus the communications strategy in these areas such as the low rate in referrals for lung cancer. This approach continued to be reviewed. Jon Evans (JE) raised that there would be different reasons why cohorts of patients were not attending and highlighted the importance of	

	understanding these reasons when reviewing communication approaches. Nick Kennedy (NK) asked what the actions were to support patients with unequal access to services and asked whether the comparator of pre covid-19 activity levels was the right comparison. Peter Brindle (PB) explained that as a baseline the cancer referral rates pre covid-19 were used as a comparator but more work was being undertaken to understand the referrals. PB advised that further work was ongoing on the targeted approach to identify these groups and review how to improve access. AN gave an example of working with practices on communicating the positive impact of the increase in bowel screening to certain cohorts of patients. FF noted that early cancer diagnosis was included on the Quality Outcomes Framework at PCN level and was also part of the national Directed Enhanced Service and so there were initiatives in place for Primary Care. FF referenced the Lancet paper cited in the paper and asked whether the evidence from the paper would be built into plans. PB noted the paper had been published in July and was predominantly a modelling paper that modelled the life years lost from delays in cancer presentation and diagnosis. AN noted that this included faster growing cancers that were diagnosed later and those diagnosed in A&E rather than through GP referral. PB noted that the data may be helpful in guiding where the CCG focuses review. Kirsty Alexander (KA) noted the importance of scanning in diagnosing cancer and the importance that diagnosis interventions were available. JR highlighted that the phase three plan expected these services to be back at 100% capacity. JR highlighted that the Communications team had undertaken a significant amount of work during the covid-19 response to ensure that a geographical and cultural approach was taken to send out important messaging. Umber Malik (UM) highlighted the work undertaken in translating messages to a number of languages and ensuring the harder to reach communities were included and suggested that this work be utilised. **The Governing Body noted the contents of the report.**	

6.3	**Community Services Transition Update** Lisa Manson (LM) noted that the community services contract commenced on the 1st April 2020 and this report updated on the contract 6 months following commencement. There were a number of stranded services which were not part of the adult community services contract which had been provided by the incumbent services. These stranded services had been transferred to Sirona successfully and included children's services, musculoskeletal services, podiatry, and bladder and bowel services. Sirona mobilised staff and initiated training throughout the covid-19 response via virtual training. LM also reported staff at Sirona had been redeployed to fulfil roles required as part of the covid-19 response and transformational projects in train had been accelerated during the response. Where schemes were not yet in place discussions continued on timescales for delivery. LM noted that due to the pace to implement schemes a number had been undertaken without engagement and consultation and work was now ongoing to engage with staff on the reconfiguration of teams. The transfer of beds at South Bristol Community Hospital from the University Hospitals Bristol and Weston (UHBW) contract to the Sirona contract was underway and both UHBW and Sirona were reviewing the flow of patients. LM highlighted the move of North Somerset Children's services to Sirona and noted that the North Somerset Parent and Carers Forum had met with Sirona to talk through their concerns. Sirona continued to support children throughout the covid-19 response and LM noted that services that paused were done so on national mandate. LM reported that CAMHS data had been transferred to IAPTUS and the provider was undertaking a data validation process. LM also noted that the autism hub went live in August. John Cappock (JC) asked about the dispersed funds from the incumbent organisations. LM confirmed that the monies from Bristol Community Health and North Somerset Community Partnership had been transferred to a number of charities and voluntary sector organisations within the local area. FF asked about the planned services in North Somerset that were paused. LM confirmed that these were reopening with staff being released from supporting care homes and discharge to assess schemes to undertake the planned care work. LM noted that work	

	to assess capacity to respond in an appropriate way was being undertaken taking into account that there were some face to face therapies which couldn't yet be provided safely. **The Governing Body noted the successful transfer of Adult Community Health Services and the transfer of Specialist Community Children's Services to Sirona care and health.**	
7.1	**Looked after Children Peer Review Action Plan** Michael Richardson (MR) highlighted that the actions had been developed through the August workshop which was well attended by the system. The outcomes of which had been the requirement for a directory of resources for Looked After Children and care leavers and the requirement to improve system communication. MR announced that the CCG had been confirmed to be part of the NHS England/Improvement care leaver pilot. MR outlined the next steps noting that it was important that the action plan resulted in measurable outcomes and improvements in care and support for Looked After Children. JC asked whether the improvement approach taken could be applicable for other areas of care. MR noted that the local health system was complex particularly as there were three Local Authorities but the map of resources could be applied in other areas and the improvement work undertaken would provide learning in other areas. RS noted that the work overlapped with the commissioning of care for children with complex needs. JE asked whether any improvements had been seen in identifying children with needs and assessing these children noting that the system was working in a different way due to the covid-19 response. MR noted that there would be a review undertaken to assess improvements. RS noted that services were being monitored for improvements and feedback from Sirona had indicated that a mixed approach to virtual check ins and home visits would be beneficial for most children. It was also noted that communication between the Local Authority and Community Nurses had improved. FF asked for more information regarding the care leavers pilot including start date and more information on key workers. MR noted the CCG would be meeting with NHS England/Improvement for more details on how the pilot would	

	work. Key areas were ongoing educational, financial and emotional support for longer than the current system allows. JC noted that the banks often approached higher education with information on improving financial management skills in children and agreed to provide a contact to MR. JR noted that the same level of support for children, young people and parents and carers needed to be provided across Bristol, North Somerset and South Gloucestershire and stressed the importance of co-producing plans with children and their parents and carers. KA agreed that the action plan outcomes should be wider than Looked After Children. KA noted the emotional difficulty in working in the area of Looked After Children and asked how staff and parents were supported. RS noted that these conversations were ongoing and the focus was on embedding a system strategy across the child's life journey. **The Governing Body received the paper for information, assurance and discussion.**	**JC**
7.2	**Customer Services Report Quarter 1** ST presented key points noting that the learning from complaints had been included in the report. ST highlighted section 7 of the report which outlined the developments in the team during quarter 1 including linking across the whole organisation to further improve the experience of people who raise concerns. **The Governing Body noted the contents of the report.**	
8.1	**BNSSG Quality and Performance Report** LM provided the key points from the performance report noting that the data reflected July activity as lockdown was lifted: • Trusts A&E performance worsened to 87.5% which was worse than the national average for type 1 EDs of 88.9% • UHBW have been challenged maintaining social distancing in A&E and have submitted a bid for capital to increase the size of the waiting room. • Total waiting list size increased including the number of 52 week waiting patients. These patients waiting over 52 weeks have now been included as part of the prioritised lists for treatment. The phase three plan included plans to address the waiting patients.	

	• 62 day referral to treatment time for cancer patients improved to 80.7% but the 85% national standard was not achieved. • 2 week wait cancer performance worsened and the 93% national standard was not achieved. • All activity continued to show a decrease and referrals remained low. Work was ongoing to ensure that virtual and face to face referrals were captured. • Moving out of lockdown, the focus was to balance virtual and face to face appointments particularly outpatient appointments. JE noted the increasing number of patients waiting for dentistry and asked whether this was a PPE issue. LM confirmed that the increase was due to a number of issues including the loss of space in recovery rooms due to social distancing and the productivity loss due to operating in different ways. FF asked whether the GP referrals included referrals for advice and guidance. LM noted that the system had asked for clarity on the referrals to ensure that referrals were not double counted. RS provided the key points from the quality report: • CQUINS have been suspended nationally. One exception was flu vaccination targets. • The summary report of the findings and the recommendations from the Root Cause Analysis Investigation into the outbreak of covid-19 at Weston General Hospital had been published. The CCG would review the recommendations. An independent review was underway. • Additional capacity has been sourced for the LeDeR reviews and only 2 remained outstanding for allocation. These were expected to be allocated before the December deadline. • C. Diff cases have reduced. A deep dive into the cases during June was being undertaken and early indications showed that the cases were related to antibiotic prescribing. The quality team were working with the medicines management team to further understand this and put learning in place for primary care.	

	• NBT has been chosen as an early adaptor for the Patient Safety Incident Reporting Framework. The intention was to ensure rapid dissemination of learning across the system. Christina Gray (CG) asked about the impact of covid-19 on patients with learning disabilities. RS noted that the details were outlined in the report and confirmed that deaths and the impact was being monitored. **The Governing Body received the Quality and Performance report**	
8.2	**BNSSG Finance Report** ST presented the report noting that the current financial regime would continue until the end of month 6. The CCG was reporting a deficit of £4.3m and this was expected to be reimbursed to bring the CCG back to breakeven. **The Governing Body discussed and noted the financial position and noted the changes to the NHS financial regime.**	
9.1	**Governing Body Assurance Framework 2020/21** ST noted that the Assurance Framework had been developed alongside the phase three planning process. The priorities have been identified and the strategic risks to achievement have been considered. ST highlighted the significant risk related to the impact of covid-19 and noted that it would be a challenge to deliver the priorities whilst a response was in place, however the CCG was mitigating this risk. ST highlighted the section of the paper which outlined the Committee oversight structure of the risks. KA asked how the Assurance Framework linked with the Integrated Care System and how financial management would be incorporated. ST confirmed that financial sustainability had been included as a risk and noted that the significant change in the financial regime required a cultural shift in how the system worked together. ST highlighted the challenge for 2021/22 as it was expected that the financial regime would be similar and it would take time as a system to embed this. ST noted that population health management, adding value and best use of resources had been included as delivery mechanisms for financial sustainability.	

	AM supported the objectives and asked how these could be developed into a Integrated Care System Assurance Framework and noted the risk in not linking objectives across the system. ST confirmed that the objectives were CCG focussed however there was work ongoing on the Integrated Care System development plan and part of this was an Assurance Framework. ST noted the process of engagement planned for the development of the plan and JR confirmed that the Partnership Board had agreed that Non Executives would also be involved in plan development. Kevin Haggerty (KH) highlighted the importance of system working and asked whether organisations would provide assurance of the commitment to system working. ST noted that this was the intent and system work was progressing through the Partnership Board and this was the forum through which issues were escalated. JC noted that the objective around ensuring the CCG was a good workplace had not been mapped against any priorities. ST noted this was a mistake and developing the CCG people plan should map against this objective. **The Governing Body agreed:** • **The Governing Body Assurance Framework for 2020/21** • **The target risk scores for 2020/21** • **The Committees that will provide oversight of the strategic risks**	
9.2	**Corporate Risk Register** Sarah Carr (SC) presented the quarterly report noting that the role of the Governing Body was to assure that the right risks have been identified and that the correct controls were in place. SC highlighted the section of the report where the added and removed risks had been outlined. SC noted that following the risk management framework audit it was recommended that the Governing Body review the risks the sub-committees scrutinise. The Terms of Reference for each Committee would be reviewed and presented to the Governing Body in November. FF asked that in future the Corporate Risk Register (CRR) be emailed to members before the meeting. **The Governing Body:**	**ST/SC** **SC**

	• **Reviewed and assured that appropriate and effective mitigations were in place for the risks reported on the CRR** • **Considered whether the CRR was an accurate reflection of the risks brought to the Governing Body's attention** • **Noted the review of the Committee Terms of Reference underway**	
9.3	**Pay Protection Policy** ST presented the policy for approval, noting that this was a revised policy which aligned the policies from the three legacy CCGs. The proposals had been discussed and determined at the Staff Partnership Forum. JC asked under what circumstances the policy would be utilised and ST confirmed that this would be when the CCG underwent organisational change. **The Governing Body approved the policy for implementation**	
9.4	**Managing Performance Policy** ST presented the reviewed policy for approval, noting that changes have been made to ensure that both managers and employees are supported through the process. JR welcomed the changes to the policy. **The Governing Body approved the policy for implementation**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Commissioning Executive 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 Primary Care Commissioning Committee** **The Governing Body received the minutes**	
11	**Questions from Members of the Public** The Governing Body received one question from the public: "In the document "Transfer of Stoma Prescribing to Stoma Care Nurses: Options Review" you reviewed two options. Did the CCG at any time consider an option of commissioning a third party organisation with a local presence and existing prescribing infrastructure to provide this service at zero cost to the CCG?" PB responded to the question:	

	In 2018, BNSSG CCG invested in employing a Stoma Nurse specialist to look at the current prescribing of stoma products and explore potential future prescribing models. As part of looking at future options, discussions were undertaken with many stakeholders including local Stoma specialists and Patient and public focus group set up, with membership from the local patient self-support group. Patients highlighted their desire for continuity in terms of their care and Stoma prescribing, that they would "*prefer to deal with the same Nurse/ team*", that "*the Nurse knows you*". Four options were initially presented to the Commissioning Executive Committee for consideration, which included an option to procure a commercial company to provide a Primary Care prescribing and review service. It was decided that based on researching models in other areas, lack of evaluation data and the uncertainty of savings which could be released that at this time not to progress with this option. It was requested by the committee to proceed with working up two options further. At a later meeting in April 2019 it was agreed to pilot a model with the acute trust and to evaluate twelve months in to the pilot. The pilot that was due to start in March, will hopefully commence in October.	
12	**Any Other Business** JR informed the Governing Body that Alison Moon was no longer the Chair of the Primary Care Commissioning Committee (PCCC) with Sarah Talbot-Williams taking on this role. JR thanked Alison for her hard work and commitment to the role. CG provided an update on covid-19 cases in Bristol, North Somerset and South Gloucestershire noting that following the national issue with test and trace, it was expected that locally rates would spike, and once the backlog of cases was reported the rates would stabilise again. CG highlighted that the national data flow issue was not related to Public Health. CG highlighted that the situation was being well managed by the Universities.	
13	**Date of Next Meeting** Tuesday 3rd November 2020, at 1.30pm	

Lucy Powell, Corporate Support Officer, October 2020