Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 3rd November 2020
Time: 1:30pm
In light of Government advice regarding social distancing, the Governing Body will meet virtually until further notice. The meeting will be accessible to members of the public. Please see our website for more details.

Agenda Number :	6.1
Title:	Recovery and Phase 3 Planning
Purpose: For Information	
Key Points for Discussion: To brief Governing Body members on the detail of the final BNSSG Phase 3 Plan which has been completed and submitted to NHSE/I on 5 October 2020.	
In recent months the Governing Body has been provided with a series of papers that describe the approach and progress being made to system recovery following the initial Covid-19 peak and the work being undertaken at system level to plan for Phase 3 (the period August 2020 to March 2021 including. The Phase 3 planning process has now been completed and work is underway to implement and deliver this plan. The following paper sets out the key features of the BNSSG Phase 3 Plan covering areas including acute activity recovery, addressing health inequalities, performance measures and the financial plan.	
Recommendations:	The Governing Body is asked to note: • The key requirements as set out within the 2020/21 Phase 3 planning guidance • The details of the final Phase 3 Plan that BNSSG has committed to deliver.
Previously Considered By and feedback :	The approach BNSSG is taking to Phase 3 planning has been reported to previous Governing Body meetings, particularly in September 2020. In addition Phase 3 planning has informed discussions and been developed within the following groups/meetings: • Healthier Together Executive Group • System Finance and Analytics Cell • System Capacity and Impact Cell • System Change Command Cell

	• BNSSG CCG Strategic Finance Committee
Management of Declared Interest:	None identified specifically related to this item.
Risk and Assurance:	Key risks: • **Future Covid-19 peaks** – scenario modelling is updated on a weekly basis however there are significant risks to the stability of the system if there are future peaks of Covid-19, particularly if this occurs in the winter months where pressures on the NHS are already expected. • **Affordability** – as described within the paper BNSSG has submitted a deficit plan. This deficit is currently driven by shortfalls against operating income at our acute providers and the impact of the expected change in the annual leave accrual across the system. As a result of increased pressures on the system there is a risk that we overspend further against our system funding allocation for Phase 3. • **Staffing** - As a result of COVID-19 sickness, shielding and self-isolation, and linked to Test and Trace, there is a risk of inadequate staff to maintain services, which may result in patient harm • **Inequalities** - As a result of the pace and scale at which health and care needs and is being asked to plan, commission, design and deliver services in the context of COVID-19 and recovery, there is a risk that the differential impact on outcomes and access to services that COVID-19 has had / is having on different parts of our communities will not be rectified. This may result in our planning, commissioning, design and service delivery unintentionally maintaining or widening inequalities in outcomes and access.
Financial / Resource Implications:	As noted within the paper BNSSG has submitted a deficit plan which is driven by shortfalls against operating income and the impact of the expected change in the annual leave accrual across the system.
Legal, Policy and Regulatory Requirements:	The CCG has a statutory duty to operate within its resource allocation each year and to meet regulatory requirements as described by NHSE/I.
How does this reduce Health Inequalities:	Covid-19 has particularly highlighted the need to focus on reducing health inequalities – particularly those inequalities that have arisen as a direct result of Covid-19. Phase 3 planning guidance has a key focus on the actions systems need to take to reduce inequalities and BNSSG has set out its approach to addressing health inequalities as described within this paper.

How does this impact on Equality & diversity	There is significant diversity across our BNSSG population and any actions taken as part of phase 3 delivery need to be impact assessed – particularly when Covid-19 has been shown to have differential impacts on different populations groups.
Patient and Public Involvement:	Work to engage with and involve patients and public is undertaken within the projects and programmes of work being undertaken as part of the phase 3 response. Details of insight work which has been undertaken has been described in other papers for Governing Body in June and July, and in COVID-19 Recovery Planning reports to Governing Body, June 2020 and July 2020. The findings of these listening events are supporting the system's approach to phase 3 planning.
Communications and Engagement:	The insights team have been running listening events with the public over recent months and findings are supporting the system's approach to phase 3 planning.
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Sponsoring Director / Clinical Lead / Lay Member:	Sarah Truelove, Deputy Chief Executive and Chief Finance Officer, BNSSG CCG

Agenda item: 6.1

Report title: Recovery and Phase 3 Planning

1. Background

The NHS has been operating its Covid response since March 2020 and the Governing Body have been receiving detailed updates on local service provision throughout the period. We have now moved into Phase 3 of the expected four-phase national NHS response. As a reminder the four phases can be summarised as follows:

Phase	Timeframe	Purpose
Phase 1 – Covid-19 level 4 incident Response	March 2020 – April 2020	• Enable NHS to deal with peak covid-19 demand
Phase 2 – Covid-19 level 4 incident response and critical services switch-on	May 2020 – July 2020	• Identify critical services risks and impacts during Covid-19 preparation and peak. • Start to restore safe service levels for critical services, lock in service innovation and signal re-start to some routine services. • Develop monitoring tools to measure and reassure.
Phase 3 – Ongoing covid-19 management and NHS open for business	August 2020 – March 2021	• Ensure capacity in place for ongoing covid-19 activity • Return critical services to agreed standards • Address backlog of services • Retain changes from pandemic we wish to keep
Expected Phase 4 – New NHS	April 2021 onwards	• BAU covid-19 service in place including sufficient critical care headroom • NHS priorities established

The purpose of this paper is to provide a summary of the final BNSSG Phase 3 plan which has been completed at the start of October 2020.

2. National Phase 3 Planning Guidance

Headlines

As previously described to Governing Body, the national Phase 3 planning letter as issued by Sir Simon Stevens and Amanda Pritchard on 31 July 2020 fulfilled three main functions:

- To update on the latest Covid national alert level;
- To set out priorities for the rest of 2020/21; and
- To outline financial arrangements heading into autumn as agreed with Government.

The letter describes the following priorities for the NHS for the Phase 3 period:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.
- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

The letter contains many specific ambitions for the NHS such as restoring cancer services, recovering the maximum elective activity before winter, and expanding and improving mental health, learning difficulty and autism services. Winter demand pressures are also expected to be significant, therefore Phase 3 planning has needed to focus on preparations for winter such as delivering a significant flu vaccination programme and working with local authorities to ensure resilience of social care. Significant focus is given to addressing health inequalities and notes the need to restore health services inclusively and accelerate prevention programmes that engage those at greatest risk of poor health outcomes.

3. BNSSG Approach to Planning

Our shared ambition as system is to best serve the people of BNSSG this Autumn and Winter by:

- Accelerating the return to near-normal levels of non-Covid health services and reducing the backlog of patients on waiting lists for diagnostics and treatment.
- Building resilience to meet seasonal increases in demand over Winter and so that we are able to respond flexibly to the ongoing the Covid-19 pandemic.
- Learning the lessons of the past six months by locking in beneficial changes in the ways that services are delivered and supporting our population groups and staff that are most at risk from Covid-19.

The work to develop and finalise Phase 3 plans has required significant resource and commitment from across the system in order to mete the challenging timeframes of completion by 5 October 2020.

Key areas of the planning process have included:

- Ongoing Covid scenario modelling – to understand the likely demand on our health and care system
- Activity, workforce and performance planning at both individual organisational level as well as at aggregate system level
- Developing system transformation plans and mitigations to support the recovery during Phase 3
- Financial planning – to ensure the system can operate within its resource limits.

4. Recovering Elective Services and Planning for Phase 3

The NHS faces a significant challenge to recover planned care services including responding to new demand and addressing the backlog of patients waiting longer as a result of responding to the incident.

There are a number of challenges in recovering activity:

- delivering activity with revised Infection Prevention Control measures
- a backlog of demand from the pause of routine work in Phase 1, resulting from changes in public health-seeking behaviours,
- workforce capacity to continue to respond to the pandemic,

- physical space and infrastructure to adequately define Covid-minimal pathways for more efficient lists.
- progress with testing and isolation regimes for staff and patients

BNSSG remains committed to restoring acute hospital activity to near-normal levels and to reduce the backlog of patients on waiting lists.

The Adopt & Adapt: Accelerating Planned Care Recovery Programme is a national approach focused on the 5 key service areas or points of delivery within the planned care pathway: Endoscopy, CT&MRI, Outpatients, Theatres and Cancer.

In BNSSG we have developed a suite of initiatives within these areas including:

- Demand management initiatives
- Extended hours/productivity changes
- Maximising use of the independent sector
- Reducing DNAs
- Clinical validation of existing referrals and follow ups including Patient Initiated Follow Up

Including Adopt and Adapt, the system has been undertaking a significant piece of work to develop and prioritise a series of both system-level and provider-level initiatives/mitigations to support our recovery. This process has been coordinated by planning leads and has sought to prioritise the areas in the following order:

- Urgent clinical priorities (inc. Mental Health business case; Covid rehabilitation; Care Homes support; and, NHS 111 First)
- Adopt and Adapt programmes (inc. Revenue costs of capital schemes that are being funded nationally)
- System priorities in Urgent Care, Cancer and Mental Health (inc. Endoscopy; Winter preparedness; Learning Disabilities)
- Other schemes ranked according to the volume of patients supported

The impacts of these mitigations are now incorporated into our planning trajectories which are described at an overall level below.

5. Mental Health, Learning Disabilities and Autism

Mental Health

There is an estimated 30% increase in demand on mental health services, which forms the basis for additional investment in the recent BNSSG Mental Health COVID-19 response business case. Extensive modelling has been undertaken, involving partners across the system to understand the impact of Covid-19 and the areas expected to see increased demand with a focus on where inequalities may widen.

Services are already experiencing pressure, with increasing out of area placement numbers, IAPT, CAMHS and adult crisis services back to pre-Covid levels. There has been pressure at the Place of Safety leading to EDs being used.

Local Phase 3 plans include: agreement to fund additional services/capacity on a recurrent basis has been agreed by the system. This includes assertive outreach, personality disorder service,

CAMHS 24/7 crisis response support to refuges, additional capacity in dementia service and support to our most complex service user groups.

Learning Disabilities and Autism
We need to expand and improve services for people with learning disabilities and autism and deliver on NHSE Long Term Plan and Phase 3 actions. In BNSSG our plans include:

- New model to improve performance and increase delivery of annual health checks across BNSSG agreed and being implemented.
- LeDeR delivery plans underway – all 2019 cases are on trajectory to complete NHSE target of December 2020, recruitment programme for new reviewers in place.
- System plan for improving the autism pathway agreed, bid for funding outcome imminent.
- Care & Treatment Reviews continue to be conducted on a virtual basis prior to and following child and adult inpatient admission, within the 6 week target.
- Host commissioning in place to drive provider quality assurance.

6. Activity and Performance Trajectories

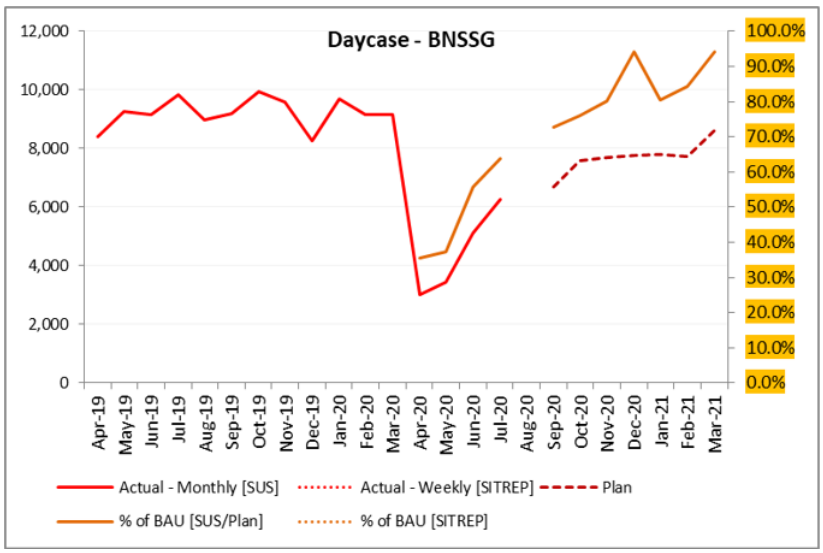
The national Phase 3 priority has been focused on recovering acute hospital services (particularly elective activity) with targets set against each 'point of delivery' using as a benchmark 19/20 activity levels. Having factored in the impact of key plans (such as Adopt and Adapt) we have developed recovery trajectories with our main acute providers.

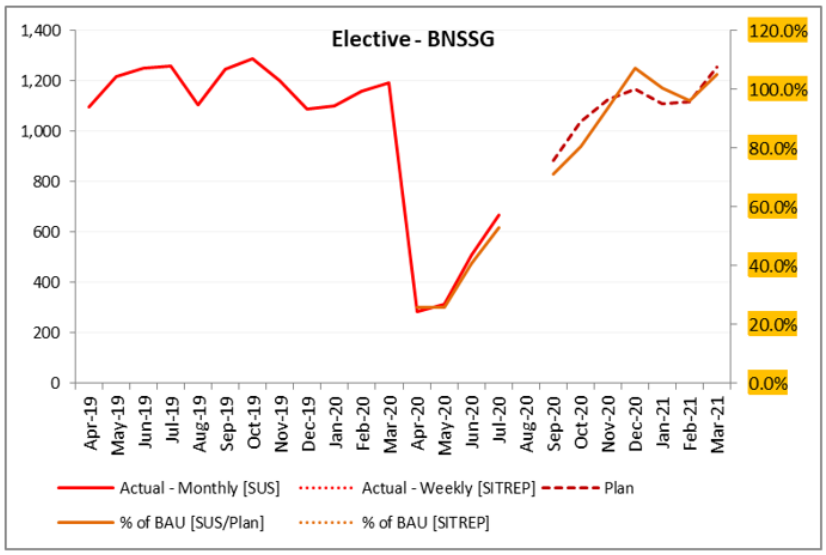
The overall system position (for the final months 7-12 of the year) is summarised as follows.

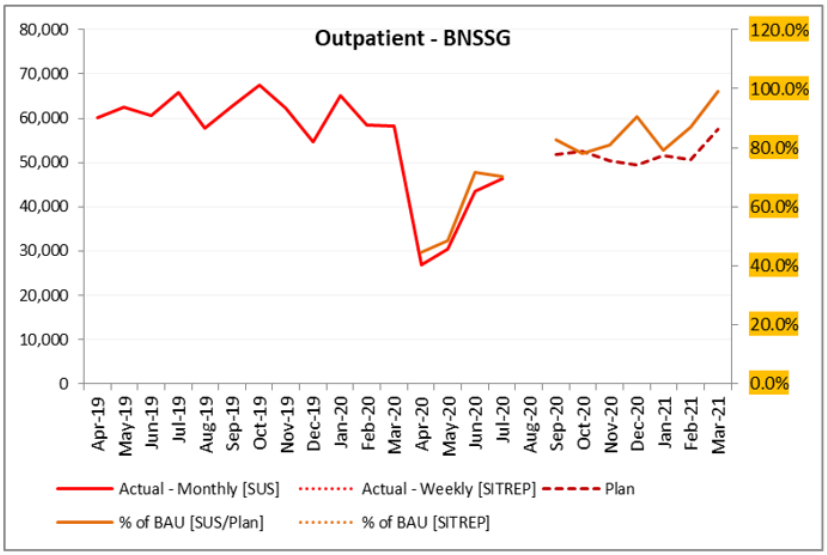
- **Endoscopy and Imaging** (excluding non obstetric ultrasound) significantly above 19/20 (target 100%)
- **Elective/Daycase** between 65% and 91% (target 90%)
- **Outpatients** between 75% and 87% (target 100%)
- **Referrals** between 70%-101%. Significant increases in 52ww (8000+ by Mar 20) and the total waiting list (the latter 18% higher in Feb, 32% in March)
- **A&E** between 89%-99%;
- **Non-elective admissions** between 96%-103%
- **Cancer treatments** between 72% and 94%, rising in year
- **Cancer first outpatients** between 91% and 108%

Therefore our acute activity plans fall significantly short of national targets on percentage recovery to 19/20 activity levels for Daycase/Elective, Outpatients and Non Obstetric Ultrasound. We continue to work across the system to further mitigate these shortfalls.

To provide more detail on how our planned recovery trajectories compare with actual activity levels, please see the graphs on the following page. These are system level views of daycase, elective and outpatient activity. It should be noted that these views incorporate BNSSG activity that is currently commissioned via the national independent sector arrangements.







Comparison to actual activity – national ISTC <u>included</u> in plan

Daycase
BNSSG, UHBW and NBT Sep plans are above July actuals for BNSSG [SUS Monthly] and above Sep actuals for providers [Weekly SITREP]

Average monthly impact (% of BAU) of including ISTC nationally contracted providers:

- +6% BNSSG, +12% NBT, +4% UHBW

Elective
BNSSG Sep plans are above July actuals [SUS Monthly] and increase in year

NBT, UHBW improve on the un-amended position, but still below Sep actuals [Weekly SITREP]

Average monthly impact (% of BAU) of including ISTC nationally contracted providers:

- +12% BNSSG, +7.5% NBT, +3% UHBW

Outpatient
BNSSG Sep plan remains higher than July actuals [SUS Monthly], marginally improved

NBT Sep plan remains higher than Sep actuals [Weekly SITREP], marginally improved

UHBW Sep plan remains lower than Sep actuals [Weekly SITREP], marginally improved

Average monthly impact (% of BAU) of including ISTC nationally

Mental Health Plans
Our updated plans are compliant with the Mental Health Investment Standard (MHIS) and show significant improvements in Long Term Plan performance trajectories:

- Children and Young People's Mental Health – Improved position from 23% to 25.6% through adding transformation impacts and activity via IAPT.
- Perinatal – Marginally improved position from 1st Sept. Updated plan gets us to the nationally expected rate in the month of March 2021 (but not for the 12 months overall).
- IAPT – Improved position (600 additional spells). As an access target, like with CYP, reduced demand at peak of Covid-19 impacts the whole year.
- Out of Area Placements – Plan to achieve target by Q4 for the acute adult cohort.
- Community Serious Mental Illness (SMI) – New model of care due next year in BNSSG and significant progress expected thereafter.
- SMI Physical Health Checks – Improved plan now meets 2020/21 target, reaching 51%.
- Individual Placement Support – Improved planned level of activity in Q4. Delays in releasing funding has held up progress in mobilising the new service model.

7. BNSSG People Plan

The NHS People Plan 2020-21 sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after our staff and foster a culture of inclusion and belonging, as well as actions to grow our workforce, train our people, and work together differently to deliver patient care. The Plan describes the NHS as being made of people in many different roles, settings and organisations. Some of those providing NHS services work for NHS trusts, others are employed by community interest companies, partnerships (such as GP practices, dental surgeries, pharmacies and optometrists). There is also recognition that we work closely with partners in social care and local government, as well as the voluntary and independent sectors, and also unpaid volunteers and carers.

All systems following publication of the People Plan were required to develop their local responses. The BNSSG People Plan sets out our response and describes the priorities and actions we have set ourselves. The delivery will be overseen by the People Steering Group as part of the Healthier Together system governance structure.

Priority: new ways of working

- One system workforce approach, to enable an agile, system way of working across health and care

Priority: growing for the future

- Deliver on our commitment to a joint Learning Academy, working in collaboration with the Community and Primary Care Training Hub;
- Develop our hubs of resourcing and deployment and work together to recruit and retain more people into health and care including working with schools and colleges

Priority: looking after our people and belonging

- Develop our Employer Value Proposition, treating staff fairly, consistently and inclusively, making health and care a great place to work and thrive through flexibility, development and valuing our staff and support all our services to be safe, resilient and supportive places to work.

8. Delivery Oversight

Healthier Together Executive Group holds the overall ownership of Phase 3 planning and delivery at a system level. The System Delivery Oversight Group will be maintaining the weekly system oversight of implementation and delivery and has strong representation from operational and finance leads from across partner organisations. The SDOG meeting is supported by a suite of sub-groups who are responsible for coordinating data and information on the many components parts of the plan including:

- Reporting on actual activity levels compared to plan trajectories.
- Reporting on the key workforce metrics
- Reporting, by exception, on delivery of the agreed mitigations and system change activities supporting Phase 3 recovery trajectories.
- Reporting on progress of reducing health inequalities
- Overall system financial reporting

9. Financial resource implications

The financial envelope for BNSSG from October to March has now been confirmed as £1.3bn. Partner organisations are permitted to deliver surplus and deficit positions, but the BNSSG system is expected to break-even against this envelope.

For the rest of the financial year there is a continuation of many aspects of the national NHS financial framework as seen in months 1-6. For example:

- Continuation of block contracts with most providers with values calculated nationally,
- Independent sector coordinated at national level,
- PPE nationally procured and funded,
- Testing nationally funded,

For BNSSG we have received an additional £48m Non Recurrent allocation for Covid Costs – at System level. Also an additional £14m Non Recurrent allocation for growth – at System level.

The BNSSG system position for the period m7-12 20/21 is a deficit of £40.1m which reflects a shortfall against operating income of £32.9m, and the impact of the expected change in the annual leave accrual across the system of £7.2m.

10. Legal implications

The CCG has a statutory duty to operate within its resource allocation each year and to meet regulatory requirements as described by NHSE/I.

11. Risk implications

Key risks:

- **Future Covid-19 peaks** – scenario modelling is updated on a weekly basis however there are significant risks to the stability of the system if there are future peaks of Covid-19,

particularly if this occurs in the winter months where pressures on the NHS are already expected.

- **Affordability** – as described within the paper BNSSG has submitted a deficit plan. This deficit is currently driven by shortfalls against operating income at our acute providers. As a result of increased pressures on the system there is a risk that we overspend further against our system funding allocation for Phase 3.
- **Staffing** - As a result of COVID-19 sickness, shielding and self-isolation, and linked to Test and Trace, there is a risk of inadequate staff to maintain services, which may result in patient harm

  Inequalities - As a result of the pace and scale at which health and care needs and is being asked to plan, commission, design and deliver services in the context of COVID-19 and recovery, there is a risk that the differential impact on outcomes and access to services that COVID-19 has had / is having on different parts of our communities will not be rectified. This may result in our planning, commissioning, design and service delivery unintentionally maintaining or widening inequalities in outcomes and access.

12. How does this reduce health inequalities

Covid-19 has particularly highlighted the need to focus on reducing health inequalities – particularly those inequalities that have arisen as a direct result of Covid-19. Phase 3 planning guidance has a key focus on the actions systems need to take to reduce inequalities. These include:

1. Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

2. Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October.

3. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

4. Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes; including more accessible flu vaccinations, better targeting of long-term condition prevention and management programmes such as obesity reduction programmes, health checks for people with learning disabilities, and increasing the continuity of maternity carers.

5. Particularly support those who suffer mental ill health, as society and the NHS recover from COVID-19, underpinned by more robust data collection and monitoring by 31 December.

6. Strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in September in every NHS organisation, alongside action to increase the diversity of senior leaders.

7. Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31 December, with general practice prioritising those groups at significant risk of COVID-19 from 1 September.

8. Collaborate locally in planning and delivering action to address health inequalities, including incorporating in plans for restoring critical services by 21 September; better listening to communities and strengthening local accountability; deepening partnerships with local authorities and the voluntary and community sector; and maintaining a continual focus on implementation of these actions, resources and impact, including a full report by 31 March.

BNSSG Approach

We are asking systems to work collaboratively with their local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress. Across primary care we have been involved in holding listening events with members of our population who are older, those with disabilities, and bridging the digital divide.
The results of these insights along with the results of the GP Patient Survey and the latest wave of the Citizens Panel will be worked into a tailored communication and engagement plan that we will use to address the needs of our population in accessing care.

Working with our Insight Team we have issued two representative surveys to our BNSSG population pre and post Covid. Our post Covid questions focussed on:

- Covid-19 shielding and future plans after shielding programme ends
- Changes in lifestyle and health-related behaviours
- Attitudes towards health, health seeking behaviours and healthcare services
- Experience of remote consultations
- Perceptions towards proposed changes to ways of accessing primary care, outpatients and planned care

From the results of this post Covid survey, we have identified significant differences between our population segments. Below is a short summary of the learning and actions we are taking to address the issues raised in this survey:

- Concerns about access to services is primarily driven by people living in Inner City & East Bristol and South Bristol, people in skilled manual occupations, people out of work, and people from BAME communities
- Those with serious long term conditions were worried more than others about their emotional wellbeing and mental health (71%) and managing their finances (30%)

We are now strengthening this work by collaborating with groups such as, but not limited to, the Bristol Race Equality COVID Steering Group to, during Phase 3:

- engage to do change in Phase 3, rather than get feedback
- solve the problems that patients have faced in addition to those that the service has faced
- ensure that we recover any patient involvement that was understandably lost during Phases 1 and 2.

We are discussing with our Primary Care Networks the leadership role that they have in this work.

Example – identifying our vulnerable and shielded population

Within primary care we have developed an approach to proactive identification and management of our vulnerable and shielded population which we are sense checking with wider clinical leads within the CCG before rolling out to practices. This will link into the wider piece of work for this cohort held by the Integrated Care Steering Group.

There are three approaches we are proposing for prioritisation in general practice:

- **Prioritising people**; e.g. highest risk of a poor Covid-19 outcome
- **Prioritising work**; e.g. reviews for conditions with high risk or poor short term outcomes
- **Prioritising populations or communities** through other means such as targeted communications or focused outreach schemes i.e. flu immunisations

We have also used Population Health Management data to identify those communities most at risk of Type 2 diabetes to ensure we work with those communities and primary care in a targeted way.

The same approach can be used for obesity, smoking, alcohol and physical inactivity, learning disability and serious mental health

Digital Inclusion

As highlighted above a specific phase 3 requirement is to develop digitally enabled care pathways in ways which increase inclusion, with an initial review of usage of new primary, outpatient and mental health digitally enabled care and providing an inclusive response to interventions such as 111 First, Mental health digital services, Outpatients appointments, GP Total triage. Despite an increasing reliance upon digital health solutions, the Good Things Foundation highlights the increasing digital divide across the UK and the strong the correlation between digital and social exclusion (GTF June 2020). They identify numerous challenges associated with digital inclusion that affect both our populations and health and care workforce:

- Data poverty – lack of access to affordable data
- Lack of access to equipment or technologies
- Lack of skills and digital knowledge
- Lack of confidence in using technologies

A summary of BNSSG's digital inclusion challenges and requirements:

- Better data that baselines our current levels of digital inclusion and focussed metrics to measure our progress
- Detailed user experience mapping that improves patient journeys & designs digital health interventions
- Coordinated system-wide interventions to remove barriers to digital exclusion
- System-level leadership to integrate digital inclusion into all health & care interventions.

BNSSG has convened listening events to track our populations' attitudes to digital health services during Covid. These demonstrate:

- A marked increase in concern about accessing health and care services generally
- A significant reduction in GP contacts from populations out of work, with long term conditions and in disadvantaged localities,

- The majority of GP contacts occurred through telephone (76%), with low take up of video (11%)
- 20-30% of population not content with their digital health experience; 13% remain against the idea of "remote by default" (source: Healthier Together Citizens' panel Covid Survey 2 – final results; Aug 2020)

BNSSG's Approach to Digital Inclusion

- By October 2020 we will have established a robust baseline and performance management framework to apply to the initial areas of intervention highlighted above.
- By December 2020 we will have undertaken user journey mapping to co-design the four priority digital health interventions, and deployed the first range of interventions to support digital inclusion.
- By March 2021 we will have deployed our priority digital interventions utilising inclusive design methods.

System Leaders for Health Inequalities

All BNSSG NHS partner organisations have at least one Executive Lead for health inequalities. The majority have one for ensuring equity to services for patients and the other to ensure equity in their workforce.

With regard to workforce development, here are some illustrative examples of work taking place across our partnership to strengthen leadership and accountability for tackling health inequalities:

- Appointment of an "Associate" Non-Executive Director from the BAME community. This individual attends all Board Meetings and is mentored by an established NEDs to help prepare her to take on a formal NED role in the future either within their own organisation or elsewhere in our system
- Supporting the Stepping Up Diversity Leadership Programme being led by Bristol City Council and with eight aspiring leaders from our BAME workforce on that programme
- Set up a Task and Finish Diversity Forum specifically focussing on BAME workforce to advise us on how they address this important area and included a secondment one of a BAME staff member for six months to work exclusively on this area to ensure it is co-designed and informed by staff
- The CCG is producing its People Plan which has been identified by the Governing Body as a key priority for 20/21. This will involve the development of a programme of activities and will include equality, diversity and inclusion across the organisation

13. How does this impact on Equality and Diversity?

There is significant diversity across our BNSSG population and any actions taken as part of phase 3 delivery need to be impact assessed – particularly when Covid-19 has been shown to have differential impacts on different populations groups.

14. Consultation and Communication including Public Involvement

The CCG's insights team have been running listening events with the public over recent months and findings are supporting the system's approach to phase 3 planning.

Appendices:

None provided

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations. .

	Where used abbreviations have been set out in full within the text.