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 7th July 2020 at 1.30pm

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Colin Bradbury	Area Director, North Somerset	CB
Peter Brindle	Medical Director Clinical Effectiveness	PB
John Cappock	Lay Member Finance	JC
Deborah El-Sayed	Director of Transformation	DES
Jon Evans	GP Locality Representative South Gloucestershire	JE
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
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
Julia Ross	Chief Executive	JR
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Martin Jones	Medical Director Commissioning and Primary Care	MJ
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
In attendance		
Will Bradbury	Communications Manager	WB
Sarah Carr	Corporate Secretary	SC
Dominic Moody	Deputy Head of External Communications	DM
Andrea O'Connell	Independent Consultant, CHC Transformation Programme	AO

Lucy Powell	Corporate Support Officer	LP

	Item	Action
1	**Apologies** Apologies were received from Martin Jones and David Soodeen. Jon Hayes informed the Governing Body that David Soodeen had attended his last meeting as the GP Locality Representative for Bristol Inner City and East and he thanked David for all his work as a Governing Body member for both Bristol, North Somerset and South Gloucestershire CCG and for Bristol CCG. Jon Hayes described David as a champion for equality of healthcare services who was a supportive and enthusiastic member of the Governing Body.	
2	**Declarations of interest** There were no declarations of interest pertinent to the agenda. Nick Kennedy declared a new interest as Non-Executive Director of LinkExec. This began in April 2020 and had been recorded on the declarations of interest register.	
3	**Minutes of the previous meeting of the 2nd June 2020** The minutes were agreed as a correct record with some minor spelling mistakes amended.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 03-Mar-20 11.1 – Lisa Manson (LM) confirmed that the specific pharmacy queried remained open but it was unknown whether this was due to covid-19 contingencies. 02-Jun-20 7.3 – Sarah Truelove (ST) confirmed that the Customer Services Manager had met with the Head of Insights and Engagement to ensure feedback would be incorporated in the quarter 1 report. The action was closed. 02-Jun-20 8.1 – The information requested had been included as part of the quality and performance report. The action was closed. 02-Jun-20 8.1.1 – The information requested had been included as part of the quality and performance report. The action was closed.	
5	**Chief Executives Report** Julia Ross (JR) noted that the phase 3 guidance for recovery had not yet been received but the CCG continued to develop and implement plans. Consideration has been given on how to return to the office safely in the future and individual risk assessments were being completed by all staff.	

	JR reported on the vibrant and dynamic work ongoing through the Wellbeing Cell which was focused on looking after staff during this difficult period and noted that the teams would find a way to share with the Governing Body the positive work that has been developed. JR noted that there had been really positive engagement around Integrated Care Partnerships and a formal paper would be presented to the Healthier Together Partnership Board and noted the positive progress on moving forward.	
6.1	**Recovery Planning and Non-Covid-19 Activity Planning** Peter Brindle (PB) presented an update on recovery progress and what has been achieved during phase two. PB noted that updates on cancer screening and children's and maternity services had not been included as these had not been received but assured that recovery work continued in these areas. PB reported that routine services were running and the system was planning for the strategic and operational changes that were needed. PB reported there was 50% - 80% of pre-existing capacity currently within the system for elective care. PB noted that the capacity concerns would be exacerbated by the existing waiting lists, the back log from the stopped work and the number of people who had not yet presented. PB explained that communications had been sent to those on waiting lists explaining the delays and providing advice on how to manage conditions whilst waiting for treatment. PB confirmed that patients were being prioritised based on clinical priority, and work continued to maximise efficiencies for the prioritisation process. PB reported that there had been a significant increase in people waiting 104 days for cancer treatment which included patients who did not wish to attend a hospital setting. There were also challenges with endoscopy due to the aerosols generated. PB noted that the 2 week wait referrals had increased and were back to 75% of previous referrals. The system continued to utilise the independent sector hospital capacity for diagnostics and physiotherapy. PB noted there was a 6 to 12 week delay in diagnostics due to the backlog. PB explained that only 50% of pre-existing capacity was available for routine care as urgent and emergency care capacity had been prioritised.	

	PB reported that the remote consulting for outpatients had proved popular and successful, and mitigations had been put in place for the sections of the population who were unable to undertake remote consultations. PB explained that there will be an estimated 30% increase in mental health service demand due to covid-19 and a business case was being developed to prepare for this increase. PB also noted that Primary Care was currently back to similar activity levels however continued to work in a different way. PB highlighted the key risks associated with service capacity and service access and acknowledged the inequalities identified for population groups. It was agreed that a paper specific to these inequalities would be presented to the Governing Body at the next meeting. PB noted that there were a number of mitigations in place for urgent care to ensure an efficient service whilst keeping patients safe. PB reported that work was ongoing to understand the value of procedures and identifying low value procedures which could be stopped in favour of high value investigations. Felicity Fay (FF) noted that colorectal surgery was currently showing at 185% activity and asked how the service was managing this. Sarah Truelove (ST) confirmed that the percentage was referrals into the service and not activity. FF queried whether radiology and ultrasound had been triaged like endoscopy and PB confirmed that the diagnostics cell was reviewing how to prioritise and triage tests in order to provide guidance for the investigations which were being over utilised and support and educate referrers to use other methods. FF also asked whether there had been any modelling for the projected demand for the potential long term respiratory complications from covid-19. PB noted that covid-19 had proved to be a multi system disease and had affected people in different ways. The Clinical Cabinet were reviewing how the effects of covid-19, including fatigue, could be managed within the existing services, or improved if existing services were insufficient. Consideration was being given to psychological and respiratory services and those	**PB**

	members of the population with reduced immunity. PB noted that currently the scale of these potential complications was unknown. David Jarrett (DJ) noted that there had been a decrease in dermatology two week wait referrals and asked whether there needed to be a campaign focussed on skin referrals. PB noted that the referrals in the table were compared to last year where there had been a significant number of skin referrals compared to previous years. PB highlighted the work on teledermatology and noted that work was ongoing to upskill patients and GPs to use photos. Jon Evans (JE) asked about provider capacity as a whole and the strategy for the independent sector and the Nightingale Hospital. PB noted there were a number of options being considered for the Nightingale Hospital, however due to the restricted conditions the options may require additional investment. Proposals were being considered from across the South West and these would be developed into business cases for consideration. JR confirmed that the wider health system wanted to utilise the capacity. JE also asked whether referral management was consistent across all providers. PB confirmed that the plan was for there to be a single triage process but there was additional work needed between the referral service and secondary care. JE commented that the NHS 111 service had been redirecting patients to their GPs and setting the expectation that their GPs would be able to see them within 2 hours. JE noted that this was unrealistic. Lisa Manson (LM) explained that there was a clinically led workshop later in the week to discuss the service. Alison Moon (AM) noted that she would welcome a paper on health inequalities at the next meeting and as well as more detail on care providers in the next iteration of the recovery paper. AM also noted the changes in development for urgent care and suggested that these changes needed to happen quickly as the A&E attendance rates were increasing rapidly. LM confirmed that additional support from Sirona to patients admitted through the emergency department would be in place in October. Consideration was being given on how to manage A&E with social distancing at the workshop this week using experiences from across the country.	

	The Governing Body discussed the delays to treatment and the communications provided to patients. PB noted that while most people understood the main reason behind the delays, ongoing communication with people on waiting lists was important. Kirsty Alexander (KA) suggested that communications support was provided to GPs to help them explain the delays to patients. PB noted that there was work ongoing to develop the communications approach. JR noted that there was much that the CCG was unsure of currently and therefore were being careful that incorrect and misleading communications were not being circulated and suggested that KA discuss this further with Michelle Smith who will be able to feed back through the communications cell. Rachael Kenyon (RK) noted that there had been increased contact with patients with questions regarding delays in treatment but also noted that communication with GPs would also be helpful in terms of the potential effects of covid-19 and what services and support GPs can offer for these. PB agreed and noted that this was the work that was being led by the Clinical Cabinet. It was agreed that a paper on the wider communications work would be presented to the Governing Body. Nick Kennedy (NK) agreed with the importance of the value and prioritisation conversations but noted that these needed to be driven by the providers. PB confirmed that the conversations had been led by the providers who were prioritising within specialities and reviewing processes across specialties as well as within specialties. **The Governing Body noted:** • **the updates from the key services areas to date and the planning underway to recover services** • **the work undertaken to understand the direct and indirect impact of covid-19 on our population** **The Governing Body supported:** • **the ongoing work to recover services in a way which minimises health inequalities which have been exacerbated as a result of covid-19, and seeks opportunities to address historical inequalities** • **the work to restore services aligned with BNSSG strategic priorities, where possible using opportunities to accelerate transformational change**	**DES**

6.2	**Covid-19 Phase One – Lessons Learnt** LM noted that the paper provided a retrospective review on phase one of the covid-19 response and the lessons learnt. The review took place with the Chairs of the Cells and the positives and negatives of the processes had been discussed including how the Cells ensured that work was not duplicated and how interdependencies were managed. It was noted that the Cells had not been consistent on engagement with patients and those Cells that had increased contact with patient representatives had praised the added value in understanding the impacts. LM reported that the NHS Futures platform had helped to link providers, local authorities and the voluntary sector who did not have access to NHS systems. FF noted the delays in national guidance and asked how this issue could be reported and asked whether the CCG was able to make decisions whilst waiting for the guidance. LM explained that delayed guidance was common during incidents and the issues encountered would be fed back through the Local Resilience Forum and the regional NHS England teams. LM noted that local decision making was undertaken whilst waiting for the guidance and decisions had been documented and risk assessed. AM highlighted that the cover paper stated that potential for patient harm in all pathways was currently reduced, and AM disagreed with this statement. LM clarified that this was the view of the Cell Chairs and was likely due to A&E staff being able to transfer patients through to services quicker. JRu asked whether system Boards had been engaged on how they had helped during the pandemic including the CCG Governing Body. LM noted that each organisation would have undertaken their own phase one review which would be aggregated for EPRR assurance. LM noted that further consideration needed to be given on how the Governing Body contribution could be reviewed. JE asked how the transformational changes would be embedded into contracts. LM explained that this was being considered in terms of what needed to be separated from the covid-19 response to business as usual. Deborah El-Sayed (DES) explained that work was ongoing to align the transformational	

	work to the seven system goals and the long term plan objectives and this was being continuously developed. Christina Gray (CG) highlighted the regional strategic brief which brought together the guidance from the NHS, Public Health England and the local government. CG noted that the system would be working through recovery. LM agreed and noted that part of the learning was moving through recovery but transitioning during surges. JR suggested that for future reports the learning was more explicit in terms of the outcomes and what we plan to do different. JR asked how the CCG was using the learning to plan. LM noted that this had been incorporated into the phase three planning as well as influenced the phase three plans through the Cells. JR also noted that the feedback was predominantly positive. LM explained that where the cells had reported negative experiences these had been adapted to at speed. LM confirmed that further information would be contained in the next debrief paper. **The Governing Body noted the report and the key information in appendix 1.**	
7.1	**Peer Review of Looked After Children** Rosi Shepherd (RS) provided the background to the paper noting that the system had undertaken a review on how services were provided for looked after children. Andrea O'Connell (AO) was welcomed to the meeting and presented the actions and next steps. AO reported that there were a number of areas highlighted in the report where the system was working well. AO noted that Sirona were now the only provider which had reduced the variances between previous services. It was noted that waiting times and implementation of national guidance needed to be improved and there needed to be a more developed and focused vision for the future of the services. There were also concerns around the clarity on roles and responsibilities for named and designated roles. It was confirmed that a development programme for looked after children nurses was being developed with clear training and career progression. AO noted that there was a workshop planned, facilitated by the looked after children nurse who developed the report, to identify 3 or 4 key objectives to improve the services as a system.	

	FF asked what a decliner pathway was. AO explained that this was when a child declined to have an annual follow up review. The pathway was in place for the nurse to find a way to meet with the child and gave the example of giving the child the choice of where to meet. FF also asked whether the workforce had the resource capacity to improve services. AO noted that the CCG had a team dedicated to looked after children and part of the improvement action plan was to undertake a review of staffing. RS noted that Sirona had a Contract Performance Notice in this area and it was hoped that the workshop would develop a robust enough action plan that the Notice could be removed. AM confirmed that the Quality Committee had discussed the plans and the workshop and had agreed that alongside the medium and long term plans there needed to be short term plans to make improvements in year. JE asked whether the Local Authorities were part of the plans and AO confirmed that there was a consistent approach from each Local Authority and there was data processing in place to enable this. The Local Authorities were invited to the workshop to develop the plan and actions would be developed to support them together as well as individual actions where required. JR noted that it was good to have the report which identifies what the system needed to review but had there been any improvement in the interim. RS noted that this had been difficult as initial health reviews for looked after children had been stood down due to covid-19 but noted that there had been an improvement in relationship and motivation. AO added that Sirona were moving their information to one database and were identifying different ways to engage looked after children. There was a determination by the nurses, doctors and named professionals to improve services. Kirsty Alexander (KA) noted it would be helpful to have assurances on the staffing levels but also that the IT would be in place to facilitate any improvements to service. DES explained that part of the work would be to review how best to use existing resources but noted that a small part of Sirona continued to work	

	on paper and to make this digital had been prioritised for investment. DES noted that Connecting Care had access to Children and Adolescent Mental Health Service (CAMHS) data as well as EMIS and noted that by developing data sharing agreements other data could be brought onto the system. AO noted that any gaps in resource would be discussed at the workshop. JRu asked whether the teams had reviewed other models of care and looked at whether our system was under resourced. RS confirmed that part of the workshop was to review the Sirona resource as well as the joint resource across the system. JR noted that there would need to be decisions made on investment as we come through recovery and the first question would always be whether the system was making the best use of current resource. It was agreed to review the initial action plan at the August Governing Body meeting with the system wide action plan to be presented once developed. **The Governing Body agreed the next steps outlined in the paper.**	**RS** **RS**
8.1	**BNSSG Quality and Performance Report** LM provided the key points from the performance report: • Due to the impact of covid-19, it was not possible to collate and include updated commentary for all areas of performance. Some national data collections and publications had been suspended during quarter 1 and were therefore not included in the report. • A&E performance improved during April and zoning was in place to manage patients with covid-19 symptoms. • There had been significant growth in elective waiting times as there had been appointment cancellations from March. • Patients waiting over 52 weeks increased from March to April as a result of the cancelled routine surgeries. • There was significant reduction in length of stay at the acute hospitals. This was driven by system work to discharge patient to their home or care home. It was expected that this work would continue through and after recovery.	

	• The numbers of patients declining appointments had reduced and work was ongoing to support services and patients with the longer waiting times expected. RK commented on the work to discharge patients and asked how the system learnt from the work and continued this. LM noted that there was real system benefit to bringing the Integrated Care Bureau (ICB) outside the hospital and highlighted that the accelerated discharge work had meant that where there were issues to discharge the team had the time to investigate these issues and provide other options. It was noted that the out of hospital team had developed an implementation plan for phase three. JE asked whether the dental referrals were coming from GPs or dentists. LM confirmed that routine dental had been stood down so the referrals had come from other services. This was mapped and the dental services had now opened so the referrals could be responded to. FF asked how the waiting list for planned admissions had decreased in April. LM clarified that less people had been referred and so the referrals were artificially lower. FF also noted that there had been more day cases recorded but fewer day admissions and asked whether this was correct. LM agreed to investigate. KA noted the increase in referrals to teledermatology and highlighted that there had been a training course in this area regarding support to the community. KA noted that an increased number of pressure ulcers had been reported and asked whether this was an effect of lockdown. RS confirmed that North Bristol Trust (NBT) reported that this had been due to an increased number of people being cared for in intensive care. RS provided the key points from the quality report: • Oversight was being managed in a range of ways including reviewing Board reports and attending internal meetings as a critical friend. • Both NBT and University Hospitals Bristol and Weston (UHBW) were triaging complaints and only taking through the process when urgent. Complainants were being notified of the inevitable delays.	**LM**

	• Reporting timelines for serious incidents were relaxed but these continued to be reviewed for themes and trends. • The Infection Prevention and Control cell had offered training to all care homes in the system and 260 homes have taken up this offer. There has been huge support for this from the system including St Peters Hospice and the Fire Service. Training continued to Primary Care including consistent use of protective equipment. RS reported that the CCG super trainer had been invited to present on super training at a regional event. • Continuing Healthcare (CHC) performance remained strong when benchmarked across the South West. RS noted that fast track referrals had increased and the team were ensuring that this was not being used as an alternative discharge pathway. • RS confirmed that 12 people with learning disabilities had died from covid-19 related illness in April, with 2 further related deaths in May. The reporting for June had so far shown 1 death. Sarah Talbot-Williams (STW) asked what number of deaths would be expected for people with learning disabilities per month. RS agreed to add this comparator into the report for next month. CG also suggested that the age range for the deaths was included within the report as well. NK noted that healthcare acquired infections appeared to be reducing. RS assured that cases continued to be reviewed but the reduction would be investigated as this could be attributable to the reduction in patients attending or the increased protective equipment. **The Governing Body received the Quality and Performance report**	**RS**
8.2	**BNSSG Finance Report** ST reported that the financial framework had been changed in response to covid-19 and the allocation had been amended to represent the first four months and the nationally contracted services. ST explained that the nationally calculated block payment had been set to allow the run rate to be funded going forward. The CCG was currently showing a deficit of £8.2m with an additional £5.3m having been spent on covid-19 costs.	

	ST noted there was a reported overspend in prescribing which was related to covid-19 but not recorded as such, ST gave the example of increased spend on inhalers in March. ST noted that was a national accrual for funded nursing care which had not yet been reimbursed to the CCG. This was expected in Month 3. ST explained that the future financial model was starting to be developed and it looked as though this would be a hybrid model of the system currently and before covid-19. More detail would be provided when avaible in a future finance report. **The Governing Body received the Finance report**	
9.1	**Annual Report and Accounts 2019/20** ST noted that the final annual report and accounts had been approved by the Audit, Governance and Risk Committee and were presented to the Governing Body for information. STW asked about the plans regarding the Annual General Meeting. Sarah Carr (SC) confirmed that the meeting would be held in September and the Communications team were organising a virtual event. SC also confirmed that the Communications team were developing a summary version of the annual report. **The Governing Body received the Annual Report and Accounts 2019/20**	
9.2	**Committee Terms of Reference** SC reported that the Committee Terms of Reference had been reviewed by the Committees and only the Strategic Finance Committee had requested a change. The Strategic Finance Committee requested that the requirement for the Corporate Lead for Finance role be amended to include any of the clinical Governing Body members as this role was effecting quoracy due to the meetings being held on a Friday. It was noted that the Strategic Finance Committee had discussed the importance of a clinician as a member of the Committee. Brian Hanratty volunteered to attend the Strategic Finance Committee. It was agreed to include this role in the terms of reference. PB made a comment on health inequalities section on the covering paper and noted that many of the Governing Body	

	papers did not have enough information in this section of the paper. **The Governing Body recommended the Terms of Reference for the; Audit, Governance and Risk Committee, Primary Care Commissioning Committee, Commissioning Executive Committee, Remuneration Committee, Quality Committee, and Strategic Finance Committee to the CCG membership for approval.**	
9.3	**Corporate Risk Register and Governing Body Assurance Framework** SC highlighted that directorates have reviewed risks and where there were risks which impacted on the covid-19 response these were being highlighted and discussed. SC highlighted that there had been several changes to the Corporate Risk Register. JE asked whether the inequalities experienced due to covid-19 needed to be included as a separate risk. ST confirmed that each cell was undertaking risk assessments which would feed into the silver command system risk register and this would be reviewed by gold command. FF raised that the Corporate Risk Register was too small to see within the papers and it was agreed to circulate this by email next time. **The Governing Body:** • **Reviewed and discussed the Corporate Risk Register** • **Approved the additions to the Corporate Risk Register** • **Approved the removal of the risks highlighted** • **Considered whether the Corporate Risk Register was an accurate reflection of the risks brought to Governing Body attention**	**SC**
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Strategic Finance Committee** **The Governing Body received the minutes**	
10.3	**Minutes of the Commissioning Executive Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the minutes**	
10.5	**Minutes of the Audit, Governance and Risk Committee** **The Governing Body received the minutes**	

11	**Questions from Members of the Public** **In a letter dated 13 September 2018, the CCG stated, "the community health services re-commissioning process aims to have a new service model commencing delivery in April 2020". Six months later, there is still no sign of activity on the Frenchay site for our new healthcare facility. Why is this?** DJ confirmed that Sirona care and health would provide the clinical rehabilitation service to support patients within the bedded facilities. The expectations for the rehabilitation service, including the use of the Frenchay site, were clearly set out in the CCGs service specification and Sirona have developed a comprehensive service response within their procurement bid. The enhanced rehabilitation service model has been in place since 1st April 2020. Inpatient rehabilitation services for South Gloucestershire would continue to be provided in the Skylark Unit in Yate and the Henderson Unit in Thornbury until the new facility at Frenchay is available. The CCG remains committed to the development of the Frenchay site and South Gloucestershire Council has agreed to act as the lead commissioner for the development. The development of the Frenchay site has been a complicated process involving multiple stakeholders and partner organisations. The CCG was now at the stage of appointing a real estate consultancy to lead the development of the health and social care vision on the Frenchay site. This appointment has been slightly delayed as a direct consequence of system partners prioritising the response to the covid-19 pandemic; however it is expected that the appointment would be made in the near future. **Is there a reason why this project has been delayed and if so would you please give an explanation?** The development of the Frenchay site has been a complicated process involving multiple stakeholders and partner organisations, however the programme was now moving into the development phase. **The project for the Frenchay site seems to have fallen off your agendas. Why is this?** The Frenchay site remains a priority for the CCG and partner organisations and was now moving into the development stage.	

	Could I be provided with a current map of the reserved site shown in relation to the entire Frenchay site and given the acreage in hectares ands acres, please? The reserved Frenchay land, owned by North Bristol Trust, comprises 5 acres (2 hectares). **Had the Frenchay provision been in place there would have been no necessity to have utilised the UWE Nightingale Hospital to house covid-19 patients as we would have already had capacity.** The Nightingale Hospital was designed to provide 300 intensive care beds to care for ventilated patients. The Frenchay scheme was never intended to provide accommodation for intensive care patients and would not be suitable to do so. Therefore, it could not have increased the required critical care capacity to obviate the need for the Nightingale Hospital. **Questions regarding the Annual Report and Accounts 2019/20** **Tables 7 and 8 refer to energy/water usage by the CCG occupants in three office locations. The numbers in these tables are the same as those in the 2018/19 annual report which is highly unlikely to be correct, a lot of the text is also the same.** The lease arrangements include a true up arrangement allowing for adjustment after the end of the financial year. Information sought from the landlords as a result of this question indicate that there has been a reduction on usage at Castlewood and Badminton Road. The corrected figures would be included in the annual report. **In addition the units quoted for energy are not comprehensible i.e. KwH/m2 and water is not measured in Kw.** The templates are part of the mandatory report and are set by central government, the CCG is unable to amend the templates. **As far as I can determine the figures quoted in Table 8 are proportions of the supplies, based on the area occupied by the CCG of the total building consumptions, I assume to give an indication of the staff's usage. As it would appear that it is not possible to determine the actual usage or cost by CCG**	

	staff, it would be better not to include this misleading information. The template is part of the mandatory report and we are required by NHS England to complete the full template. **There is a great need to reduce energy usage in the world today and some general statement may be a better way of indicating the CCG's concern than with erroneous tables. One useful thing that Covid-19 has taught mankind, is that it would be useful for many more people to work from home, the electronic age has really arrived. As far as I can observe a very large amount of the activities of the CCG is the generation of large amounts of paper, which if done at home will save very large amounts of energy, money on rentals and energy used for transportation etc. let us see the organisation lead the way, it may save the world a little bit.** We are always looking for ways to improve our annual reporting and we will look at how we can provide more information in the 2020/21 report alongside the nationally required elements. We take our responsibilities to increase our sustainability as an organisation very seriously. We have worked to reduce our consumption of items such as paper for printing. As an example we stopped printing our governing body papers in 2018 and these are now circulated digitally. This simple move has reduced our printing and postage. The CCG has made good use of its flexible working policy which has been in place to support staff to work remotely which in turn helps to reduce carbon emissions through reduced travel to office bases. Through the provision of technology including the Windows 10 functionality and Microsoft Teams, the CCG workforce has been able to respond to the Covid-19 challenges and continued to work remotely. Staff have fed back through our routine wellbeing surveys that they would like to continue to work remotely more frequently and we will consider how this is accommodated and what opportunities for greater sustainability this provides.	
12	**Any Other Business** There was none.	
13	**Date of Next Meeting** Tuesday 4th August 2020, at 1.30pm	

Lucy Powell, Corporate Support Officer, July 2020