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 April 2021 at 2.00pm

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Julie Boardman	GP Representative Bristol Inner City and East	JB
Peter Brindle	Medical Director Clinical Effectiveness	PB
John Cappock	Lay Member Finance	JC
James Case	GP Locality Representative South Gloucestershire	JCa
Matthew Cresswell	GP Representative North Somerset Woodspring	MC
Deborah El-Sayed	Director of Transformation	DES
Jon Evans	GP Locality Representative South Gloucestershire	JE
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
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 Truelove	Chief Financial Officer	ST
Apologies		
Colin Bradbury	Area Director, North Somerset	CB
Sarah Carr	Corporate Secretary	SC
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
In attendance		
Simon Bailey	Performance Improvement Facilitator (Mental Health)	SB
Fiona Cormie	Internal Communications Manager	FC
Kerry Geoghegan	BNSSG Transformation Delivery Lead, Avon and Wiltshire Mental Health Partnership	KG
Faye Kamara	Head of Safeguarding	FK

Dominic Moody	Deputy Head of External Communications	DM
Lucy Powell	Corporate Support Officer	LP
Matthew Truscott	Service Manager, 999 and Emergency Response Pathway, Avon and Wiltshire Mental Health Partnership	MT
Neil Turney	Transformation Manager – Mental Health & Learning Disabilities	NT

	Item	Action
1	**Apologies** Apologies were received from Colin Bradbury, Sarah Carr and Sarah Talbot-Williams. Jon Hayes (JH) informed the Governing Body that Felicity Fay had stood down from the Governing Body and thanked Felicity for her hard work and energy in representing the South Gloucestershire Locality. JH welcomed James Case as Felicity's replacement and explained that it was expected that James would be representing the South Gloucestershire Locality alongside Jon Evans once elected by the membership. JH welcomed Julie Boardman as the new locality representative for the Bristol Inner City and East Locality and Matthew Cresswell as the new locality representative for the North Somerset Woodspring Locality.	
2	**Declarations of interest** Kirsty Alexander (KA) declared a new interest as Co-Chair of the North and West Locality Partnership Board. James Case (JCa) declared a new interest as Chair of the South Gloucestershire Locality provider Board. There were no declarations of interest pertinent to the agenda.	
3	**Minutes of the previous meeting of the 2nd March 2021** The minutes were agreed as a correct record with the following amendment: • Christina Gray (CG) asked that an action be included as part of item 8.1 for review of the continuation of the infection prevention and control service.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: **02/03/21 8.1** – Lisa Manson (LM) confirmed that the clinical validation of waiting patients would continue through the recovery process. It was agreed to close the action. All other due items were closed.	
5	**Chief Executives Report** Julia Ross (JR) explained that from 1st April 2021 every system became an Integrated Care System (ICS) noting that Bristol, North Somerset and South Gloucestershire CCG has been part of	

	an ICS since the end of last year. National guidance on the changes was in development and the CCG was undertaking the work to contribute to the guidance. JR informed the Governing Body that the 6 Localities would be the ICS place based footprints and the footprints of the Integrated Care Partnerships (ICPs). JR reported that discussions held at the most recent ICS meeting included focus on ICPs and place based partnerships and how local authorities played a critical part in these. JR reported that Jeff Farrar had been appointed as the new interim Independent Chair for the ICS and noted that Jeff had been the Chair of University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Recruitment for a substantive Chair continued. JR reported that the CCG had been shortlisted for an HSJ award for the work of the staff wellbeing group through the covid-19 pandemic, which included the virtual kitchen club, the mental health first aider work and other initiatives set up to keep staff well. JR noted that the CCG had been the only CCG shortlisted and despite not winning, the feedback had been very positive. JR reported that David Behan had visited the system to discuss the system working as part of the Innovation Hub. Discussions were had regarding the legacy of the Nightingale Hospital, the work of Avon and Wiltshire Mental Health Partnership (AWP) on trauma based care, the local health inequalities work and the vaccination Programme. David had been impressed with the work and noted that Healthier Together were leading in some of these areas. JH thanked the CCG on behalf of the Governing Body for supporting staff and providing resilience for their roles and for the system.	
6.1	**Governing Body Assurance Framework (GBAF)** Sarah Truelove (ST) presented the assurance framework to the Governing Body for quarterly review noting that the principle risks had been agreed at the October meeting. ST asked the Governing Body to consider the questions outlined on page 4 of the report. ST noted that the limited focus on workforce had been discussed and this area had been included within the Strategic Finance Committee Terms of Reference for oversight.	

	KA noted that as part of the principle to develop ICPs, the Primary Care Network (PCN) maturity matrix would be presented to the Primary Care Commissioning Committee (PCCC) and asked whether this provided the assurance required by the Governing Body. Deborah El-Sayed (DES) explained that the document mapped out the assurance processes and a report would be presented next month with the elements that fed into the assurance framework to produce an overarching assurance report which listed the sources of data. KA agreed that the agendas did focus on the reported risks but asked, given the significant scope of some of the items, how did the CCG review the work that underpinned the risks and queried whether the Governing Body was robust enough in challenging whether the right processes were in place across the system. JR noted that risk appetite needed to be considered and that Governing Body members needed to take responsibility for ensuring that risks were discussed at the appropriate sub-committees, operational groups or discussed with the relevant Executive Director to add items to the Governing Body agenda if further information was required. Jon Evans (JE) considered deep dives into specific risks useful as these allowed the Governing Body to analyse the detail. ST agreed and noted that these took place at the sub-committees responsible for the specific risks. **The Governing Body:** • **Considered whether Governing Body agendas were giving enough focus on the objectives and risks reported through the GBAF and identified any additional information required** • **Confirmed it was assured that the CCG had properly identified the risks faced and that the CCG had appropriate controls in place to manage those risks**	
6.2	**Frenchay Site Update** David Jarrett (DJ) provided an update noting that clarification on bed capacity had enabled the agreement of a Memorandum of Understanding and commencement of the delivery process for the facilities. A specification has been developed for North Bristol Trust (NBT), South Gloucestershire Council and the CCG to appoint a real estate agent to lead on the delivery of the health and social care vision. The procurement of a real estate agent had begun and the appointed party would commence in Quarter 2 2021/22.	

	JH asked whether the timelines set out in the paper were realistic. DJ noted that although conservative the timelines were the most realistic at this point. JE noted the number of beds and asked whether the commissioning requirement had changed given the impact of covid-19 and asked whether the development remained viable. DJ confirmed that the commissioning requirement had been reviewed and was viable. JE also asked whether the development had been considered in terms of the stroke public consultation and it was confirmed that options would be included as part of the consultation. Peter Brindle (PB) asked whether this development was an opportunity to address health inequalities. DJ noted that the pathways were already in place but these would be reviewed to ensure they were covering population needs. JR noted that the local authorities were embedding the wider discharge to assess work and noted that the development was an additional facility for the system. CG highlighted that the opportunity for reducing health inequalities may be around recruitment. JR confirmed that delivery of the service would be through the Sirona Contract. CG noted that recruitment opportunities could be through the building of the development and JR agreed noting that South Gloucestershire Council would procure this on behalf of the system. **The Governing Body noted the progress, process and timeframes related to the development of the Frenchay Hospital site**	
6.3	**Mental Health Crisis Response** DES introduced the paper and welcomed Kerry Geoghegan (KG) and Matthew Truscott (MT) to the meeting. DES explained that the paper outlined the work underway and planned to improve the crisis response and pathway. DES highlighted that the system wide group convened to review services included the CCG, AWP, local authorities, the police and people with lived experience. LM highlighted the great work from across the system and explained that the work continued and had been presented to the Governing Body to share the collaborative work and ask for comments. Neil Turney (NT) noted that the 4 priorities had been developed from system wide workshops and further workshops would be	

	undertaken. MT explained the Rapid Response Pods approach to crisis response noting the geographical challenge of the local system and the limited ability to undertake face to face responses. MT noted that the pod based system increased face to face response times and divided the service across the geographical areas for rapid response. MT explained that a skill mix review had been undertaken alongside successful recruitment. There was one contact number for the crisis team and pods 1 and 2 were interchangeable in their roles as phone line contact and street triage. MT explained that pod 3 was the ambulance hub and pod 4 was the overnight service. MT highlighted the short term pilot to deliver a 5th medic led pod which would be evaluated by the CCG and AWP. MT noted that AWP was able to review the calls and review which situations could be responded to by the crisis response team. DES noted that the pods were situated in areas of high demand with pods 1 and 2 situated in the city centres of Weston Super Mare and Bristol and one pod was situated near the motorway for access to South Gloucestershire. DES noted that the aim of the crisis response service was to reduce interventions by the police and ambulance services as this was not always the right approach for people. KG highlighted the development of pod 4 as a twilight and overnight response period which had been evidenced as the busier periods for emergency services. KG noted that the response team were able to safely divert individuals from health based places of safety and emergency departments and refer onwards to other more appropriate services. MT outlined the pod 5 pilot and noted that with the support of mental health practitioners patients were responded to, seen and discharged sometimes within 1 to 2 hours. This process was previously taking between 11 and 21 hours. MT highlighted the potential for the pod but noted that the funding was due to end at the end of April 2021. MT believed that the 5th pod model should continue in order to continue to support response to high risk situations. Simon Bailey (SB) provided an update on the voluntary sector support and noted that face to face support was offered across Bristol, North Somerset and South Gloucestershire, linked with the emergency department, AWP and out of hours services. The	

	services allowed for people to be referred into a safe space to deescalate. SB noted that voluntary sector support was a key part of the offer and noted that this would be evaluated and reviewed alongside the rest of the response service. JR asked for more detail on the pods and how they worked together. MT clarified that should a call be received from Weston pod 1 would respond as street triage and the phone lines would be diverted to pod 2 until pod 1 had returned. JR agreed that consolidating phone lines was an easy way to release resource and noted that the team should consider the role of localities within this work. AM welcomed the work and asked about the conveyancing reduction due to pod 3 and asked whether the evaluated figures were actual or projected. NT noted that the pilot had been successful in reducing ambulance conveyances and evaluation had shown the potential for the offer. KG explained that the pilot had been funded through winter pressures and had been developed as a business case which had been delayed due to covid-19. MT noted that performance reporting was completed through the ambulance service particularly around mental health related incidents and following a yearly review it was found that not only had conveyances reduced but also see and treat incidents. JE highlighted the modelling and the projections and noted the useful hours of service. JE suggested that community nurses and GPs should be incorporated somehow as the providers of the earlier service. JE asked whether there were resource issues with pod 5, given the clinical position required. DES noted that the service could access the Directory of Services for next steps and agreed that linking with community and primary care was part of the next steps. MT noted that the pod 5 was currently running through core hours but would be formally evaluated for effectiveness across those times. MT clarified that pod 3 was currently running until 10pm but there had been interest to run to midnight from other CCGs. John Rushforth (JRu) asked whether the service was meeting the current demand and whether increased level of demand had been modelled into future planning. MT noted that this had been included in the long term plan and additional funding had been	

	received to expand the service with the intention to meet surge demand. DES highlighted that the aim was to stop people attending A&E and section 136 suites if this was not the most appropriate place for them. DES explained the approach to understand the impact and build a model to respond to the demand in a different way. JR noted that the service needed to reduce the demand on A&E and provide a response which kept people well and healthy. It was agreed that the business case needed full integration with localities and specialised services. **The Governing Body received the update on current developments within Mental Health Crisis Services and impact on the wider system**	
6.4	**Operation Plan and Financial Plan 2021/22** ST noted that NHS planning guidance had been published. The approach to operational planning recognised the significant uncertainties in terms of covid-19 and non covid-19 demand. The guidance also recognised the key role NHS staff have played in the covid-19 response and therefore the need to balance recovery whilst supporting staff. ST outlined the 6 priorities and noted that the system was well placed to respond to these. The financial regime would be similar to the latter half of 2020/21 and noted that availability of workforce would be the biggest challenge. Final submission was due on the 6th May 2021 with final activity, workforce and narrative due on the 3rd June 2021. AM asked what had been learnt from remote outpatient appointments and what from the past year would the system want to retain as an ICS. DES highlighted work ongoing regarding digital literacy and how digital advice and guidance was utilised for outpatients. DES highlighted the work of the local authorities with communities to ensure people knew that the products were available and supported in their use. ST noted the general importance of clinical leadership within the system and how this would be included in broader workstreams. LM highlighted the E-consult work within primary care and noted the importance that the right patients were being identified for face to face appointments. JR highlighted the work of Healthier Together on professional leadership and how this needed to be wider than doctors and nurses. KA highlighted that previously patients had attended one place for several interventions but these were now spread across the system and noted the importance that services were well coordinated. ST noted the integration of services and	

	the importance of primary care as part of this. JE highlighted the importance of advice and guidance as well as personalised care and noted that hybrid appointment systems were important as virtual platforms were more accessible but face to face appointments were more appropriate for some people. KA asked about the expansion of smoking cessation and weight management services and whether the funding was included within the local authority funding. ST confirmed that clarity had not been received but the CCG continued to review guidance to understand the impact. **The Governing Body noted:** • **Planning was to be completed at system level** • **Finance submission and draft activity, workforce and narrative due 6th May** • **Final activity, workforce and narrative due 3rd June**	
7.1	**LeDeR Action Plan Update** Rosi Shepherd (RS) updated on the significant progress made on the action plan by executive leads from across the system. RS explained that the actions from the second Multi Agency Review (MAR) were being implemented in full and the details had been included in the paper. The actions continued to be reviewed by the CCG LeDeR Steering Group and system Quality Surveillance Group until all actions were complete and embedded fully into business as usual for all providers. RS noted that not all improvements had been made across all providers and the Learning Disability Provider Network would link with the Population Health Management Programme and the West of England Academic Health Science Network to support with quality improvement programmes. RS outlined the actions which had been closed and those that remained outstanding and the outcomes which would be monitored. JR highlighted learning point 2 and suggested that the action had been around a single point of contact across the system rather than within the individual organisations given that patients with complex needs were often patients of various services. It was agreed that this action would be reviewed. JR requested that a report be presented in 6 months on all the actions as well as the	**RS** **RS**

	ongoing work. JR asked how the safeguarding actions were included within the ICS safeguarding processes. RS noted that this was a longer term piece of work to involve a clinical leader and the Transformation Board. It was confirmed that this was for both children and adults and noted that the Learning Disability Transformation Board would include this work. JR asked for a timeframe and RS agreed to update this. KA noted that safeguarding link workers were a good asset for continuous care when they remained with a person for a long time and noted that when people left, a written document would be developed for continuity of care. RS noted that the combination of the annual health check, care and support plans and hospital passports would aid with continuity of care. JR noted as part of learning point 2 it was the human link that was missing. AM noted that a lot of work had been completed and that there was a lot expected of the Learning Disability Provider Network in terms of reviewing the improvements to ensure these were sustainable. AM noted the importance of experts by experience being included in these conversations. AM noted learning point 2 and highlighted that the key worker programme was reliant on the funding of the community learning disability team and asked how this would impact the action for people. RS noted that this had been part funded and the work needed to be sustained and owned by all providers across the system. JR highlighted that the programme needed to include ICPs which needed to provide wrap around care for patients with complex needs. LM asked whether as part of learning point 5 staff from emergency departments, minor injury units and Severnside would receive training. RS noted the national training guidance would be reviewed and these providers considered. LM highlighted the importance of providers building this training into their own programmes as part of service delivery. **The Governing Body received the update and approved the recommendations to:** • **Close learning points 3,6,8 and 9** • **Lead ongoing delivery through the Learning Disability and Autism Provider Network** • **Provide ongoing oversight through the LeDeR Steering Group and BNSSG Quality Surveillance Group** • **Receive a further update in July 2021**	**RS**

7.2	**Safeguarding Report Quarter 3** Faye Kamara (FK) was welcomed to the meeting and provided the key points from the safeguarding report: • There had been an increase in undisclosed pregnancies which could be attributed to the first lockdown. The CCG was working with system partners to develop recommendations from the rapid reviews which included ensuring that women knew where to go for support and communications that services were open. FK noted that the same messaging was being used for sexual health services. • The CCG compliance for safeguarding training was currently at 77% and 78% for safeguarding children and safeguarding adults training respectively. The target was noted as 85%. The importance of training has been highlighted to staff through the newsletter, line manager bulletins and appraisals. • Provider safeguarding training has been affected by the covid-19 response. Work was underway with quality and commissioning teams to agree a realistic trajectory for compliance. • There has been an increase in referrals regarding domestic abuse incidents. The CCG continued to work with providers to ensure early signs were identified and reported. FK noted that the report was descriptive and that future reports would provide further detail on the impact of the Safeguarding Team to improve reporting and evidence for a learning assurance approach. KA highlighted level 3 training and noted that often the training did not include the multi-disciplinary teams. FK noted that named GPs were undertaking training online and social care representatives were included in these sessions and noted the importance of having the whole system involved in the training. RS explained that this was being explored as part of the ICS and across the three Safeguarding Boards. JR noted the importance of peer review of cases as part of the training to ensure a culture of learning. KA supported this and suggested information sharing and experience was key to development. JE noted that the virtual platform made it more difficult to discuss complex cases in terms of ensuring all the relevant voices were heard. RS agreed to review the training to incorporate online peer case review. **The Governing Body noted the combined Adults and Children Safeguarding Quarter 3 Report**	**RS**

7.3	**Customer Services Quarterly Report** ST reported that 515 contacts had been received by the Customer Service team during Quarter 3 and outlined the types of contact. It was noted that the comparisons to the previous years had been included. As expected, there had been an increase in contacts relating to the mass vaccination programme. Customer services training would be rolled out to the CCG as the Standard Operating Procedure (SOP) had been completed. KA noted that people liked to speak to someone when they had an issue or complaint and highlighted the importance of staff resource. ST noted that how to have those conversations had been included in the SOP as it was important that in order to investigate any issues, the team needed to be clear on what the issue was and what the desired outcome was. JH asked whether primary care complaints were reviewed through PCCC. LM confirmed that they were monitored through Governing Body but particular issues were reviewed though the resilience scorecard which was presented to PCCC. **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: • The combined position on 4 hour waits deteriorated to worse than national average in January following a high rate of covid-19 admissions • The waiting list size position improved in January and was above the phase 3 planning trajectory. The system continued to utilise the independent sector and surgical admissions for urgent patients. • 52 week waiting patients remained high and planning to reduce the number of patients waiting was part of the elective recovery plan • Cancer 62 day and 2 week wait performance were below standard LM reported that the recovery plan incorporated plans to improve all aspects of performance. KA noted that haemodialysis at the Children's Hospital had been suspended and asked when this would be reopened. RS agreed to provide an update. KA also noted that there were a number of	**RS**

	specialities within paediatrics with waiting patients and asked for more detail. LM explained that the key challenge was parental choice with many waiting for the school holidays to book appointments. LM noted that the patients were being clinically validated. JE asked about the trajectory for recovery and asked whether the CCG was meeting the plan. LM noted that the system had succeeded against the plan in some areas due to independent sector support. The system continued to develop the recovery plan to include the impact of covid-19, as well as considering how to best review cancer performance as there were differences in referral pre and post covid-19. AM noted that the performance across the system had not been perfect before the pandemic and asked whether there was any external support or reviews that could take place to identify if there was anything else the system could implement. LM confirmed this had taken place and additional work would take place following review of the ICS performance framework and a regional check and challenge session would take place following submission of the plans. ST noted that as part of the recovery work an independent review of the Infection Prevention and Control measures would be undertaken to review the various sources of benchmarking to review what else could be implemented. JR noted that this would be a whole system approach so that the impact on the system could be reviewed. The challenge was for the system to review capacity and deliver care in a different way. CG highlighted the importance of reviewing all aspects of a patients journey to improve outcomes. RS provided the key points from the quality report: • The system has experienced higher levels of 12 hour trolley breaches. Reviews undertaken reported that patients had received a poor experience but no clinical harm. • Capacity had been released from the Continuing Healthcare (CHC) team to support additional surge capacity within discharge to assess pathways. It was noted that performance in 28 day referral activity would decrease but these assessments would be completed in May. • Support continued from Public Health England regarding the MRSA wipe pilot	

	• The CQC released their final report from the review of DNACPR. Informal positive feedback has been received and the CCG was awaiting formal written feedback. **The Governing Body received the Quality and Performance report**	
8.2	**BNSSG Finance Report** ST outlined the changes to the finance regime in relation to covid-19 related year end processes including the additional allocation for retrospective top up. ST noted the £1.4m surplus which was expected to be adjusted. It was expected the finance regime would continue for the next 6 months. **The Governing Body noted the financial position at month 11 and the risk adjusted forecast surplus**	
9.1	**Corporate Risk Register** ST presented the Corporate Risk Register (CRR) for quarterly review. There were two risks scoring over 20, one around services provided by AWP and the other concerning patients waiting over 52 weeks. Two risks previously scoring 20 had been reviewed and the risk scores lowered. The mitigations for these were included in the paper. Five new risks had been added to the Risk Register from the directorate registers and these were outlined in the paper. Five risks had also been reviewed and removed from the CRR to be monitored by the appropriate directorates. ST confirmed that the CRR was reviewed by the Governing Body Sub-Committees quarterly. **The Governing Body reviewed the CRR and approved:** • **The addition to the CRR of the risks detailed** • **The removal from the CRR of the risks detailed**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Clinical Executive Committee** **The Governing Body received the minutes**	
10.3	**Minutes of the Strategic Finance Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the minutes**	
11	**Questions from Members of the Public** A member of the public asked the following questions on behalf of Protect Our NHS: “Julia Ross has helpfully informed Protect our NHS of the shocking situation regarding residential mental health	

	care for children and young people in the CCG area. In the last 10 months forty two young people/children have been admitted to residential beds outside the BNSSG area. This tragic statistic represents a system that sends seriously ill young people far from their family and friends thus adding to the trauma and family anguish of an already desperate situation. How can this have come about in the fifth richest country in the world? How is it that since the closure of beds in The Priory, nothing has been done to resolve the lack of local in-patient facilities? I would be grateful for your urgent clarification of the plans to re-open the Riverside Unit. 1. Is the CCG monitoring and making site visits to the Riverside site? What is the situation as far as being able to re-open in June? 2. How many beds will be available from the first day of opening? If this is not the number planned, which was an increase on previous provision, when will all be beds be open and fully staffed? 3. What contingency plans have been made for the substantial increase in mental health problems due to the Covid epidemic? How and where will extra beds be provided? 4. Your figures indicated that 7 children had been transferred out of the South West region – where did these children go to?" JR explained that it was unintended and unknown that the Priory would be closed at the same time as the Riverside Unit underwent refurbishment. JR noted that NHS England commissioned these services but the CCG was working with AWP to ensure that alternative services were in place for bed based services, noting that children were placed in these services when it was the only option and the CCG worked with partners to avoid the need for bed based care. JR confirmed that the CCG had not been able to visit the site but had discussed the roof replacement with AWP and although it was unfortunate that the additional works needed to take place they were needed to ensure the safety of the Unit. JR explained that a business case for mental health services in response to the pandemic had been approved and was in the process of implementation. LM explained that the 15 beds were expected to be open from June, which would be complemented by the hospital day service. LM noted that one of the key challenges had been treating children	

	with eating disorders but noted that these children would normally be placed out of the area. It was additionally asked how the CCG consulted with children on the quality of services out of area. LM confirmed that NHS England would undertake this work as part of the contract provision. It was agreed that a written response would be sent to the requester. A member of the public asked: "The Alzheimer's Society & North Somerset Council have appointed a Dementia Friendly Communities Champion for North Somerset who is working hard to make North Somerset the most dementia friendly community it can be. May I ask if the board will support our ambitions by agreeing to the CCG signing up to become an organisation working towards becoming dementia friendly?" JR agreed and noted that this was something which the system would want to take forward to the ICS and noted that the CCG also had a responsibility to ensure that commissioned providers were also dementia friendly. A member of the public asked: "The legacy of the Nightingale Hospital was mentioned as part of the Chief Executive's update, can you please confirm what the legacy of the Nightingale Hospital was?" JR highlighted the way the system had worked together to create fast paced innovation and how the system would continue to take this approach to other services including supporting people at home through the localities and aligning with the new build at Frenchay to optimise services for rehabilitation.	**LM**
12	**Any Other Business** There was none	
13	**Date of Next Meeting** Tuesday 4th May 2021, at 2.00pm	

Lucy Powell, Corporate Support Officer, April 2021