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 1st December 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
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
Umber Malik	GP Representative Bristol Inner City and East	UM
Lisa Manson	Director of Commissioning	LM
Alison Moon	Independent Clinical Member Registered Nurse	AM
Julia Ross	Chief Executive	JR
John Rushforth	Deputy Chair, Lay Member Audit and Governance	JRu
Rosi Shepherd	Director of Nursing and Quality	RS
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Felicity Fay	GP Locality Representative South Gloucestershire	FF
Christina Gray	Director of Public Health	CG
In attendance		
Victoria Bleazard	Head of Transformation, Mental Health and Learning Disabilities	VB
Will Bradbury	Communications Manager	WB
Sarah Carr	Corporate Secretary	SC
Geeta Iyer	Primary Care Provider Development Clinical Lead	GI
Lucy Powell	Corporate Support Officer	LP

Michelle Smith	Associate Director of Communications and Engagement	MS

	Item	Action
1	**Apologies** Apologies were received from Felicity Fay.	
2	**Declarations of interest** Sarah Talbot-Williams (STW) as Vice Chair of One25 declared an interest in item 6.1 as One25 worked with women. It was agreed STW could contribute to the discussion. Jon Hayes (JH),Kirsty Alexander (KA), Jon Evans (JE), Kevin Haggerty (KH), Brian Hanratty (BH), Rachael Kenyon (RK) and Umber Malik (UM) as clinical leaders for the CCG all declared an interest in item 6.4. It was agreed all of the above could contribute to the discussion. STW declared an interest in item 7.1 as she was the Chair of a learning disability charity which was working with Mrs McGowan on her introduction to learning disability training. It was agreed STW would contribute to the discussion. John Rushforth (JRu) declared an interest in item 9.2 as he provided advice to businesses around governance and these organisations may be interested in bidding for the external review work if approved. It was agreed JRu could contribute to the discussion. There were no new declarations of interest.	
3	**Minutes of the previous meeting of the 3rd November 2020** Alison Moon (AM) highlighted that a discussion around bed base and whether there were any additional actions the CCG could take to support elective and cancer patients was missing from the minutes for item 8.1. It was agreed to rewrite this section to better reflect the conversation. With this amendment the minutes were agreed as a correct record.	
3.1	**Minutes of the 30th September 2020 Annual General Meeting** The minutes were agreed as a correct record.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log and all due actions were closed.	
5	**Chief Executives Report** Julia Ross (JR) reported on a paper NHS England had discussed at their Board meeting about the potential future of Integrated	

	Care Systems (ICSs) which for Bristol, North Somerset and South Gloucestershire was represented by the Healthier Together Sustainability and Transformation Partnership. JR believed that ICSs built on the work happening at a local level and consolidated the work of the NHS and Local Authorities which was a welcome transformation. The paper referred to a number of changes for the whole system including the join up of providers within the community, secondary care and acute mental health sectors. The paper also referenced optimising use of resources and data sharing to support people in their care as well as a new financial model. JR outlined the two options within the paper: a statutory ICS Board/Joint Committee with an accountable officer or a statutory ICS body. JR noted that either option would have implications for CCG staff and highlighted the importance of communicating with and supporting staff. JR explained that the options moved the NHS forward in terms of the ambitions of Healthier Together as well as built upon the shared system response to the covid-19 pandemic.	
6.1	**Transgender Toolkit Equality Impact Assessment (EIA)** Deborah El-Sayed (DES) reminded the Governing Body that the toolkit had been reviewed in November 2019 and highlighted that the purpose of the toolkit was to outline the experiences of transgender people to help health and care practitioners understand the issues facing transgender people. Michelle Smith (MS) noted the purpose of the EIA was to assess the impact of the toolkit on people with one or more protected characteristics and explained that the EIA had been developed following feedback from clinicians, women's groups and members of the public. The EIA highlighted potential negative impacts on the basis of sex, age, disability and faith/religion. The potential impact on all other characteristics was identified as neutral, apart from gender reassignment where a positive impact was noted. A number of edits to the toolkit were recommended to mitigate against the identified impacts. MS outlined these as: • Removal of the references to hormone blockers in young people pending the outcome of the national review • Clarifying that the treatment pathway section was illustrative rather than a definitive treatment pathway • Including acknowledgement of sex as a protected characteristic in the crisis management section • Removal of the reference to suicidality in young people and improvements to the use of statistics	

	• Including more case studies to bring people's experiences of accessing local health and care services to life MS noted that North Bristol Trust (NBT) and Avon and Wiltshire Mental Health Partnership Trust (AWP) were supportive of the edits and should the consultation period be extended then any additional comments received would be considered for incorporation into the EIA. DES noted that the additional two week extension would continue to be for comments relating to the purpose of the toolkit. JH asked how comments would be received and MS confirmed that there would be an opportunity to submit comments on the CCG website based on questions relating to the scope and remit of the toolkit. AM welcomed the level of detail included in the EIA and asked for assurance that with the mitigations the areas of negative impact would be neutral. MS confirmed that the impacts identified would be mitigated by the edits to the toolkit and would bring the impacts back to neutral. Peter Brindle (PB) highlighted the recommendation for more case studies within the toolkit and asked about the process after the two week extension. MS noted that one of the strengths of the toolkit was the quotes from transgender people describing their experiences and noted that the original intent of the toolkit was to help health and care professionals to have compassionate conversations with transgender people and it was felt that additional case studies would strengthen this. JR noted that the suggested edits were about improving healthcare experiences for transgender people. The recommendation was that following the two week extension, the Chair and Chief Executive of the CCG would approve the EIA. STW asked to be part of the approval process as lay member for patient and public involvement and JR agreed that STW's input would be important. MS noted that if feedback was received which made a material difference to the EIA, this would be presented to the January meeting for approval. **The Governing Body:** • **Noted the contents of the EIA and subsequent recommendations** • **Approved the recommendations**	

	• **Approved for the EIA process to remain open for a further two weeks to incorporate any additional views following publication of the document** The Governing Body agreed to answer public questions relating to the toolkit following the discussion. A member of the public asked: It has been made clear that the Transgender Toolkit is not a policy. Why then did the CCG carry out an EIA? MS confirmed that EIAs were good practice for many documents and not solely for policies and recognised that in the case of the toolkit it was important to obtain the views of the whole population. JR noted that the CCG recognised the importance of sharing the experiences of transgender people when accessing healthcare to ensure their needs were met. A member of the public asked: Will the Governing Body make the revised draft of the toolkit available to the public before it is approved? MS noted that the edits approved by the Governing Body would need to be discussed with the group who wrote the toolkit and it would not be the place of the CCG to make those decisions and publish the toolkit. MS highlighted the importance of the toolkit to support clinicians. A member of the public asked: Can you clarify what the process will be after tonight's meeting. e.g. will we, members of the public, have an opportunity to comment on the new draft guide before it is finished? Can you let me know the timescale? MS confirmed that the process would be extended for two weeks and following this, the EIA would be approved by the CCG's Chair, Chief Executive and Lay Member for Patient and Public Involvement.	
6.2	**Adult Community Mental Health Services** DES presented the paper noting that the overarching programme was owned across the CCG and had been produced in response to the long term plan and the national mandate around community mental health services. DES noted the opportunity to provide fully integrated wrap around care for patients. Victoria Bleazard (VB) was welcomed to the meeting and highlighted the system challenges in supporting people with mental health needs. VB highlighted the "I " statements which outlined the expectations of patients and highlighted what they wanted from the service. VB noted a key focus was ensuring	

	people have wider support networks to stay well and healthy. VB explained the “no wrong door” approach where patients would be directed to the right place of care for their needs from any NHS service and explained that part of the ambition was the integration of primary care and the formation of new relationships. VB highlighted the funding of £12m over three years and the development of a new core model of support building on the existing support, with a one team approach. Model to be developed in early 2021 with decision in April 2021. The model was being developed through events with key partners with consideration on what needed to be provided at different system levels. VB noted the importance of clinical support as well as access to support with debt and housing. KA highlighted that this was a huge piece of work and asked how would communication and coordination with other organisations work. VB noted the CCG was already in discussions with the localities and GP leads and a series of events had been arranged to develop the models. VB noted that there were 30 meetings and events planned within the next few weeks. Lisa Manson (LM) noted that the previous discussions held with partners from the mental health strategy work would be built upon. JE highlighted the importance of personal and shared outcomes. VB agreed and noted that work had taken place on outcomes from a service user and system perspective and these would be sense checked through the events and discussions with other regions who were trail blazing this work. JE noted the importance of aligning this work with existing national schemes and the work of the independent mental health services so that people don’t leave the area in crisis. STW highlighted the importance of considering the physical health needs of patients with mental health considerations and training at the front door in understanding and working with people with communication and behavioural issues. DES confirmed both considerations had been included in the planning and noted that the wrap around people approach would require people to work differently to include trauma informed staff teams and further work around organisational development needs would be undertaken. VB noted that there were pilots ongoing to ensure that people’s physical needs were met and the organisational	

	development work had been undertaken by the trail blazers and consideration was being given to how this could be embedded at the start. AM highlighted that shared purpose across the system was crucial and agreed with the no wrong door principle. AM highlighted the slides and noted that there was no reference to emergency departments which was the most likely attendance location for people in crisis and asked whether this had been factored into the model. VB noted that there was a connected piece of work from a dedicated task and finish group with system partners and another model developed by AWP around push liaison services; both included emergency departments. JR noted that the model within the slides was the community services model from the specification and not specifically written for mental health services. JR highlighted that the work sat within the context of moving to an ICS and noted that there needed to be join up of all the ongoing work. JR asked for further clarification on dates and noted that the themes of engagement appeared to be around specialist mental health and suggested that further engagement with Vita Minds and community mental health services needed to take place. JR also noted that crisis and children's mental health needed to be included. VB noted that it was expected that the specification would be agreed by March 2021 and that the programme was expected to take until 2024 to embed, recognising that this was a major transformation programme with the funding provided over three years. JR noted that there needed to be assurance for the localities that there would be service transformation sooner than 2024. DES noted that some services were procured and that the specification would drive the decision making and the integrated approach. LM noted the commitment to deliver would be part of the Integrated Care Provider (ICP) contract allocation next year and would be used to build on the work in the localities. DES noted that the engagement was building on previous work developing the mental health strategy. David Jarrett (DJ) noted that the integrated localities had identified community mental health services as a key priority and asked that the team engage with the groups. VB confirmed that there was daily dialogue between these groups and the team. BH highlighted the great breadth of these discussions.	

	JRu asked whether the programme would review any potential gaps in funding or resource. DES noted that these were being considered and the transformation team was working with the finance team to understand the financial implications. UM noted that the paper didn't mention liaison with drugs and alcohol services and also noted that the model needed to allow flexibility for each locality to design around the needs of the local population. VB confirmed that drugs and alcohol services were within scope of the model and noted that following discussions with the localities tailoring services for the local population was recognised as important and the process would be iterative to allow for this. RK noted that considering an individual's needs was particularly important during crisis as well as utilisation of the voluntary sector. JR asked whether joint commissioning with the Local Authorities had been considered. It was confirmed that this had been discussed at the programme board and discussions around pooled budgets continued. **The Governing Body:** • **Noted the overall aims, vision and timeline for the programme** • **Noted the approach for the discovery phase** • **Offered suggestions and support to ensure effective engagement and to ensure the transformation work was well integrated with wide programmes**	
6.3	**Bristol City Council health Overview and Scrutiny Working Group Report** LM noted the session of the Health Scrutiny Committee had been helpful and a wide range of partners had participated in explaining the pressures and challenges across the system. The group had been briefed on the covid-19 impact for health and secondary care including the impacts on staffing and mental health services. LM noted that a key reflection had been the system assumption that the population had access to digital platforms and how the system supported the digital literacy of people. LM confirmed that the same information had been presented to North Somerset and South Gloucestershire local authorities.	

	AM welcomed the joint working and sharing of concerns and noted that the planned care concerns included screening programmes as well as people waiting for appointments and highlighted that the same principles of communication for patients waiting should be taken for those waiting for screening. LM confirmed that screening services were being re-established and agreed that it was important to ensure that communications were issued to the public on the safety of services and that consideration was given on how to provide services flexibly including alternative ways of providing endoscopy services. RK noted that primary care was generally mindful of the digital limitations of patients and ensured that people without access continued to receive primary care services. RK noted that patients were contacting primary care as they were unsure about their elective treatments and asked what primary care could do to support these patients. LM noted the system was learning how to better communicate with waiting patients and reassurance continued that patients were being clinically validated and that the system was working together, and utilising the independent sector, to offer more appointments. STW noted that the issues raised through utilisation of digital solutions was wider than digital exclusion and included those with hearing disabilities. DES agreed that there was more than one type of digital exclusion, which also included translation services and noted that the UX lab was extending and testing systems with the relevant populations. KH noted the positive aspect of using digital solutions as the phone lines were now less busy for those who needed to use the phone for appointments. LM noted the key was access to a range of solutions to suit all patients. Nick Kennedy (NK) welcomed the use of volunteers and mutual aid groups. LM noted the system was fortunate to have a great voluntary sector cell who provided a range of services including the coordination of community volunteers. **The Governing Body noted the contents of the report.**	
6.4	**Clinical Leadership Review** Geeta Iyer (GI) provided the next steps in the review noting that these had been reviewed in the closed Governing Body and feedback regarding the place based roles had been incorporated into the paper for the Remuneration Committee, where the next	

	steps were approved. The principles which would drive the recruitment were highlighted and GI noted that there was an ambition to recruit for a wide skill mix. Discussions continued regarding the support structure and training model for the clinical leads. GI highlighted the job description for recruitment noting that there was an ambition to recruit to various levels of leads to fulfil the roles required. Feedback was being received on what was working well and what needed to be built on and feedback from senior managers and clinical leads would continue to be received. JE noted the evolving state of commissioning and asked about the potential contract lengths. GI noted that this consideration was part of the continuing conversations with HR noting that the posts needed to be attractive but flexible. AM suggested considering shorter term contracts to adapt to system needs. KA highlighted that the job descriptions were high level and not role specific. GI confirmed that the job description was a baseline and would be amended for the specific roles. UM noted the move to integrated working and suggested the roles were mixed between clinical roles. GI noted this was the ambition and discussions with the training hub had been arranged. **The Governing Body noted the current status and the proposals for the next steps in the review.**	
7.1	**Independent Review - LeDeR** Rosi Shepherd (RS) informed the Governing Body that the independent review into Oliver Thomas McGowan's LeDeR process phase two had been published. This report alongside the second LeDeR review, had been commissioned by NHS England following unresolved concerns expressed by Oliver's family regarding investigations which had been undertaken previously. The CCG was deeply sorry for the mistakes made during Oliver's original LeDeR review and recognised that the systems and governance that were in place at the time were not good enough. As identified in the review the CCG did not have previous experience of undertaking LeDeR reviews and should have recognised that Oliver's case needed to be referred to a higher level independent review. RS noted that both reports provided significant learning for the CCG and system partners. The CCG accepted the recommendations and would implement these in full. The CCG	

	would also take this opportunity along with system partners to reflect on the learning from these reviews and make sure it informs and supports learning and improves practice as well as informs systematic improvements to services with the ambition of improving quality, safety and experience of care received by people living in the community with a learning disability and/or autism. RS noted that in the three years since the first review the CCG had significantly improved the LeDeR process and governance. The LeDeR process was robustly managed and the support for reviewers was significant. The independent review provided 21 recommendations. Of the 10 recommendations for the CCG, 7 have already been implemented and the remaining three were in train and would be reviewed by the LeDeR steering group and an updated action plan provided to the Governing Body. Of the 10 recommendations to the national LeDeR team, 5 have been implemented by the CCG and the CCG would continue working with the national team to understand any further recommendations for implementation. Following the updated Multi Agency Review (MAR), the action plan has been reviewed by the LeDeR steering group and additional actions have been identified. These include triage of reviews to the most skilled reviewer, fast track of reviews if the mitigations would support other patients, the commissioning of independent reviews if required and planned regular audits of the LeDeR process. RS also noted that there was opportunity to ensure that there was a robust feedback mechanism for families. RS highlighted the themes for improvement throughout the reviews which included supported service transition between children's and adults services, improved safeguarding processes and ensuring staff were proficient in advocacy. RS also noted that Annual Health Checks and support plans needed to be robust and include crisis needs and wishes. Julia Ross (JR) apologised to Oliver's family and noted that the CCG welcomed the report and recognised the recommendations that the panel made. The CCG has acknowledged the updated MAR and was working hard to address any outstanding recommendations.	

	JRu noted that the second MAR made recommendations for the system and asked whether the CCG was assured that all providers were reviewing the reports and considering the recommendations for their system processes. RS confirmed that this was the case and was addressed through the LeDeR steering group and meetings to discuss LeDeR recommendations were held across the system. JRu asked whether the recommended processes would be embedded and RS confirmed that staff were more confident in safeguarding processes including when to initiate triggers around best interest. AM commented that as Chair of the LeDeR steering group the willingness of the system to work together was clear and dependent on local leadership ensuring that consistent standards were applied. AM noted that there was a risk around making sure that the processes were fully embedded and continued within the system but noted that the learning disability programme board took forward the quality improvement work and the next step was for this work to be taken into the wider improvement programme. RS suggested that this was improving and consideration was being taken to proactive work. AM noted that the LeDeR reviews needed to be robust but there were other areas to learn from. JR agreed and highlighted that under Healthier Together there was a strong and developing programme of transformation of learning disability support. DJ asked about the financial implications of the programme from March 2021 and whether the CCG had the support to complete the reviews. RS noted that the team were developing a business plan to ensure that reviews were completed in a timely way. RS noted that the ambition was to complete reviews within four to five months and resource would be reviewed and costed for next year. **The Governing Body:** • **received the Independent Review into Thomas Oliver McGowan's LeDeR Process Phase two** • **Noted the action plans associated with the review** • **Received an update on progress and further actions that are to be undertaken**	
7.2	**Deaths of People with a Learning Disability from Covid-19** RS reported both University of Bristol and Public Health England had reviewed the deaths of individuals with learning disabilities	

	who had died from covid-19. It was found that during the first wave these individuals were twice as likely to die from the virus and that the age distribution was different from that of the general population. RS noted that the number of deaths within the South West reflected the national incidences. It was noted the clinical presentation for those with learning disabilities tended to be different and the learning from this had been shared with clinicians. RS noted the importance of reasonable adjustments and highlighted the key recommendations from the report. RS confirmed that although rapid reviews had been stood down by NHS England nationally, the CCG took the decision to continue these. JR asked whether data from the local area could be reviewed and local actions determined. RS noted that not all reviews had been completed but tangible actions for the local area would be identified from the completed reviews. PB noted that the work aligned with the covid-19 virtual ward and a common theme was the importance of recognising the severity of covid-19 especially for patients with learning disabilities and ensuring this cohort of patients was considered first for interventions. RS confirmed that the care provider cell had undertaken learning events for the system in this area. KA highlighted the challenge and the importance of community support. NK highlighted patients within secondary care and the use of pulse oximetry and noted that there could be difficulty in receiving accurate results and the need to train people in its use. RS confirmed that the West of England Academic Health Science Network had been working on training and quick guides. **The Governing Body noted the findings of the report and the actions already underway to mitigate**	
8.1	**BNSSG Quality and Performance Report** LM provided the key points from the performance report: • 4 hour A&E performance worsened but was better than the national average for type 1 emergency departments • Patients waiting over 52 weeks for planned treatment increased in September. This continued to be driven by NBT and University Hospitals Bristol and Weston (UHBW). These	

	patients have been reviewed and split by provider and speciality. • Cancer 62 day performance worsened in September and previous levels of activity have not yet been reached. The independent sector was being utilised to recover. • Cancer 2 week wait performance worsened in September however improvements were expected for next month. LM noted that there had been a number of poor quality skin pictures from patients which needed to be resent. RK highlighted that accuRx provided guidance on taking pictures and LM agreed that this was a useful tool. PB noted the lower conversion rate of consultation to cancer diagnosis and explained that this was being reviewed. RS provided the key points from the quality report: • There had been an increase in covid-19 cases. The system was exchanging learning gained from covid-19 infections and a learning event from the Weston outbreak had been arranged. • UHBW reported a Never Event and the CCG was working closely with the Trust. A learning event for Never Events has been arranged. • Serious Incident reporting has been affected by system pressures. Discussions continue with the Trusts around thematic reviews, with a focus on mitigations and learning. • Continuing Healthcare (CHC) planned to review all patients who have been in receipt of fast track funding for more than 12 weeks to ensure they are receiving the care they need. • The CHC team continued to work through the deferred assessments and were currently ahead of the recovery action plan schedule. • There have been improvements in provider staff flu vaccination rates. **The Governing Body received the Quality and Performance report**	
8.2	**BNSSG Finance Report** Sarah Truelove (ST) noted October was the first month of the new finance regime. The CCG was reporting a £12.7m deficit which was likely to be reimbursed by NHS England as part of the temporary arrangements. ST noted that queries on previous covid-19 reimbursements continued to be discussed with NHS	

	England. ST highlighted some additional covid-19 costs including parts of the hospital discharge programme and noted that there was an expectation that these would be reimbursed. **The Governing Body discussed and noted the financial position and noted the changes to the NHS financial regime**	
9.1	**Item deferred**	
9.2	**Governance Review** ST noted the CCG annual review of Committees and reported that it had been agreed for the CCG to implement a more formal process of review and recommended a three year programme of review with one annual review conducted by an external body. It was recommended that the external review was conducted first with the internal reviews informed by any themes identified in the external review. It was confirmed resource implications would be met from the running costs budget with both the procurement and external review taking place during quarter 4 2020/21. JR suggested that ICS development be built into the review and ST agreed that the NHS England paper on ICS recommendations would be incorporated into the external review scope. JRu suggested that stakeholders were interviewed on how CCG governance was viewed by external organisations. **The Governing Body approved:** • **A three year programme of annual governance reviews** • **The scope for the programme of governance reviews** • **The commissioning of an external body to complete the first review** • **The route to market** • **The proposed timescale for the completion of the review** • **To delegate approval of the terms of reference of the external governance review to the Chair of the Governing Body and the Chief Executive**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Commissioning Executive Committee** **The Governing Body received the minutes**	
10.3	**Minutes of the Strategic Finance Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the minutes**	

11	**Questions from Members of the Public** A member of the public asked questions regarding the reopening of the riverside unit: Is the refurbishment work on track for the unit to re-open in March 2021? Will the unit re-open with its full capacity of 12 beds, and if not, what is the schedule for opening each bed? Is the CCG confident that the unit can be fully staffed from that date onwards? LM confirmed that work was on track for opening in March 2021 with the same number of beds. LM noted that staff from the unit were currently providing day hospital provision for children and would be transferred back to the unit once open. The CCG would continue to monitor the situation and report through the performance report. A member of the public asked questions related to the replacement services for the closed riverside unit: How are the additional services being evaluated? What evidence do you have that they are meeting the needs of this patient group and their families? How are the views and experiences of the children and families using the service being sought and reported? Has there been, or is it planned to do, a more in depth consultation process. DES noted that the replacement services had considered how to wrap the correct care around the patients and ensure that the right model of care was applied in each circumstance. DES confirmed that the families, children, education providers, clinicians and social care had been involved in the service provision and feedback had been received. JR noted that as a commissioning organisation the CCG was unable to answer the clinical questions but the CCG was assured that the models of care were providing the right outcomes for the individuals. JR noted that the individual care plans in place had been coproduced with the families and would be reviewed regularly. It was agreed a written response to the questions would be provided.	**LM**
12	**Any Other Business** There was none	
13	**Date of Next Meeting** Tuesday 5th January 2021, at 1.30pm	

Lucy Powell, Corporate Support Officer, December 2020