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 April 2020 at 9.00am

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
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
Brian Hanratty	GP Locality Representative Bristol South	BH
David Jarrett	Area Director South Gloucestershire	DJ
Martin Jones	Medical Director Commissioning and Primary Care	MJ
Nick Kennedy	Independent Clinical Member Secondary Care Doctor	NK
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
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Colin Bradbury	Area Director, North Somerset	CB
Christina Gray	Director of Public Health	CG
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
In attendance		
Sarah Carr	Corporate Secretary	SC
Lucy Powell	Corporate Support Officer	LP
Michelle Smith	Head of Communications	MS

	Item	Action

1	**Apologies** Apologies were received from Colin Bradbury, Christina Gray and Kevin Haggerty.	
2	**Declarations of interest** There were no declarations of interest pertinent to the agenda. Felicity Fay and Jon Hayes noted that they were joint directors of Hanham Secure Health, responsible for custodial healthcare. Sarah Talbot-Williams noted that she was Chair of a learning disabilities charity in Somerset.	
3	**Minutes of the previous meeting of the 3rd March 2020** The minutes were agreed as a correct record with the following amendments: Page 9, paragraph 2: Felicity Fay (FF) asked for clarification to be added that the increased referrals related to those from private providers. Page 9, paragraph 4: Alison Moon (AM) asked the comment on planned care be amended to read urgent care.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 05.11.19 6.2 – Lisa Manson (LM) confirmed the mental health review update would be provided in June. 05.11.19 6.4 – Deborah El-Sayed (DES) confirmed that the transgender guidance Equality Impact Assessment (EIA) continued to be developed, however this had paused given the need to engage further with the public. Julia Ross (JR) asked that the developing EIA was presented to the Governing Body in closed session next month to review progress. It was confirmed that once the EIA was completed it would be presented in open session. 07.01.20 7.2.2 – AM asked that the action was clarified that there was a higher incidence of learning disabilities in men rather than autism. It was agreed to discuss this further with Rosi Shepherd (RS). 03.03.20 8.1.1 and 8.1.2 – JR noted the importance of IAPT related performance and asked that detailed discussion of this was not deferred due to Covid-19. It was agreed to discuss IAPT further at the next Governing Body meeting. 03.03.20 8.1.2 and 8.1.3 – RS noted the updates and explained that further information had been included as part of the performance and quality report. The actions were closed.	
5	**Chief Executives Report** JR thanked the system for the significant work happening as part of the covid-19 response and thanked staff who were working on preparing for recovery. JR noted that the CCG teams were	

	challenging what routine care was being cancelled so as not to create future problems for the healthcare system. JR was proud of how the current work was demonstrating how well the system worked together. JR thanked Lisa Manson and Sarah Truelove for their silver command work. JR highlighted the Bristol Nightingale Hospital and noted that a great leadership team had been set up and the running of the Hospital had now been handed over to North Bristol Trust (NBT). The Nightingale Hospital would provide an additional 300 ventilated beds. JR thanked Steve West and the University West of England for their flexibility and support in setting up the Nightingale Hospital. JR noted that she would be formally writing to Steve West to express the thanks of the Governing Body.	**JR**
6.1	**Covid-19 Update** LM highlighted the operational changes that had been put in place which included providing additional support to minor injury units to move activity from A&E. Outpatients arrangements have changed to advice and guidance with virtual outpatient appointments taking place where required. SevernSide have moved to telephone triage and would be utilising video conferencing solutions. LM highlighted the additional capacity from the Nightingale Hospital and noted that capacity had been reviewed across the acute trusts and community services. Emersons Green Treatment Centre would be maintained as a site for urgent cancer surgery if the other providers could no longer provide these services. LM noted that there were a variety of options in place to support people to return home safely including additional pathways for Continuing Healthcare (CHC) and support for rehabilitation. The Local Authorities were working with hotels to provide potential additional care housing and arrangements were being supported by work with the voluntary sector. Resilience arrangements were being reviewed and decisions taken through the silver and gold command meetings. LM also highlighted the significant work taking place within Primary Care. Personal Protective Equipment (PPE) was being distributed and the CCG had procured a local depot for holding stock which	

	included donations from the public and the University West of England. These stocks would be used to ensure there were no equipment gaps in primary care, domiciliary care and care homes. Vita Health have been running virtual sessions however some session were continuing face to face when appropriate. Avon and Wiltshire Mental Health Partnership (AWP) have undertaken work to ensure resilience and have clear support in all areas. Martin Jones (MJ) confirmed that the Primary Care cell had been running for some time, the membership included the Local Medical Committee (LMC), One Care, the localities and the CCG. Team meetings were held daily and updated communications sent to primary care each day. The CCG continued to work on collating the list of patients that needed shielding. Discussions had been held on how primary care can help with this work. The team were currently working through the guidance that had been received, this had resulted in the identification of a large cohort of patients and the CCG was working through this with NHS England. Work continued on ReSPECT and end of life care to ensure that there was appropriate planning for patients. Felicity Fay (FF) asked about hotels provision and whether this was related to a possible shortage of pathway 2 beds. LM clarified that any additional beds would be commissioned to maintain beds for patient flow in regards to domiciliary care packages. This was confirmed as part of managing length of stay and patient flow. FF highlighted the importance of primary care and community care knowing when patients were leaving hospital and where they were discharged. FF highlighted the searches for shielded patients and explained that primary care could have undertaken some of this work and noted that it would be useful for primary care to know who was considered shielded as those at the highest risk may require services at home. It was highlighted that clean sites had been identified so shielded patients could attend for blood tests etc. Nick Kennedy (NK) asked about private hospital capacity. LM confirmed that Spire and Nuffield had each been aligned to an acute trust with Emersons Green Treatment Centre utilised as a specific urgent cancer treatment site. Private hospital ventilators	

	were being transferred, with the purpose of maintaining Intensive Care unit (ICU) provision at the acute trusts. AM asked about PPE provision within the providers and asked whether the CCG were assured PPE was being used correctly and staff were content. LM confirmed that PPE was available at the trusts and push deliveries were taking place on a routine basis. It was confirmed that AWP and Sirona had the same deliveries. The highly specialist masks were available to the acute trusts with the less specialist masks going to the community providers and primary care. LM noted that there were difficulties for organisations outside of the hospital sector as they ordered their own supplies of PPE. The local depot would ensure that contingency arrangements were in place. LM highlighted the risk of lack of eye protection and explained that the NHS had received offers for people to 3D print eye visors. LM noted that the difficulty would be risk assessing these visors for use. Jon Evans (JE) asked whether Emersons Green Treatment Centre would be expected to receive new cancer patients or only existing patients. LM confirmed that the site would be used for cancer surgery only and advice and guidance on this would be provided to primary care. JE noted that other CCGs have begun to decommission care homes and asked whether BNSSG CCG was considering this. LM confirmed the CCG had not planned to decommission and was utilising additional capacity where there were staff. It was reported that St Monica's had bed capacity, and the CCG were ensuring that any additional capacity came with staffing. LM also confirmed that the learning from the Nightingale Hospital in London would be shared throughout the system. Rachael Kenyon (RK) asked about testing for health care professionals out of hospital as well as PPE provision. LM confirmed that deliveries were being made to care homes and domiciliary care providers. It was confirmed that a second analyser would be online at NBT and it was noted that the teams were working on ensuring that healthcare professionals were tested quickly and noted that this included AWP and Sirona and there was consideration on how to support the Local Authorities as social workers continued to visit vulnerable people. AM noted that the initial modelling of the Nightingale Hospital suggested 1000 additional beds. JR confirmed that the original	

	review suggested 1000 beds across multiple sites. However, it was considered better to have 300 additional ventilated beds at one site. It was noted that there was capacity for additional step down beds if required. AM asked whether there was process for providers to raise concerns regarding PPE. LM confirmed that there were multiple plans for resilient PPE arrangements and risk assessments on products were taking place and 7 day troubleshooting was in place. LM noted that there was a prioritisation framework to ensure that PPE was issued as per guidance. LM confirmed that the biggest challenge was getting PPE out consistently to all organisations but this was being managed. AM asked how the CCG was capturing the accelerated transformational work that was happening. LM noted that this was monitored through silver command, the workload of which had been split into new areas, an operational cell and accelerated transformation cell both of which fed into silver command. LM explained that the transformational work was then reviewed and recorded without affecting the key operational matters. It was hoped that this structure would provide the resilience to embed the transformational work. Kirsty Alexander (KA) asked about staffing for the Nightingale Hospital. LM noted that the workforce cell was chaired by the HR Director at NBT who was working through arrangements. The system was providing a coordinated response, and testing and challenging the ratio of beds to staff to include learning from the London site. It was noted that were recruitment drives ongoing and University West of England had identified qualified lecturers who would work alongside students. KA asked about the consequences on planned care procedures. LM noted that the assumption was that as many planned care procedures as possible would take place and explained that the CCG had set up the recovery cell who were modelling this and investigating whether there were providers with capacity to undertake procedures. This was currently work in progress but would ensure that the system would be able to return to business as usual as soon as possible. JR acknowledged the additional staffing pressure for the Nightingale Hospital and noted that following discussion amongst	

	the Severn Critical Care Network there was a piece of work ongoing to map the workforce requirement and capacity across the area, not just focussing on typical healthcare settings and not solely within BNSSG. JR also picked up on KA's earlier point noting that Peter Brindle (PB) was leading on elective activity, working with the system on whether the right work has stopped. This work would also consider the effect stopping would have on the population, noting that if there was capacity there was no reason why the work shouldn't continue. JE asked about oxygen supplies and whether the modelling matched supply and demand. LM confirmed that modelling continued and there was a national programme of work considering the size of pipes, supply to machines and how this can be supported. **The Governing Body received the update.**	
6.2	**Covid-19 Decision Making Framework – Governing Body** Sarah Truelove (ST) highlighted the challenge faced by the NHS and noted that covid-19 was unlike anything the NHS had faced and there was uncertainty on the length of the crisis. ST noted that the Governing Body decision makers were made up of clinicians and so it was important to consider how the Governing Body would continue to make critical decisions if these members were unable to attend. ST noted that option 2 was the recommended option which allowed for only the quorum to be invited to participate in meetings. This would release the time of several clinicians. JR agreed option 2 as the primary preference but noted that all three options may need to utilised depending on future circumstances. Jon Hayes (JH) noted that the ideal situation would be to continue to meet as a Governing Body regularly in order to receive updates on the situation and not reduce the frequency of meetings. KA noted that having shorter meetings made sense, and noted that there were other considerations outside covid-19 that would still need proper Governing Body consideration and so would prefer the suggested options to only be used if required. ST explained that the CCG would continue to review the business that needed to be presented to Governing Body and would consider this alongside guidance received from NHS England. At	

	the present time the Governing Body would continue with invitations to the full membership and it was preferred to continue on with full clinical input. JH noted that he would feel anxious to take Chairs actions at this time without the support and advice from the Governing Body and it was noted that should that be required, possible options to ensure discussion would be reviewed. **The Governing Body agreed option 2 noting that all three options could be utilised depending on the circumstance.**	
8.1	**BNSSG Quality and Performance Report** LM provided the key messages from the month 10 performance report: • BNSSG Trusts' 4 hour performance improved to 78.4% in January. The Trusts would maintain their winter schemes through the covid-19 response with focus on admission and discharge of patients. Platinum reviews were taking place on patients waiting 7 days. • Following the sustaining the system week, the Trusts were maintaining outputs and continuing the actions with positive outcomes. It was noted that the winter wrap up session had been cancelled but the learning regarding urgent care capacity would be taken forward. • There continued to be patients waiting over 52 weeks for treatment. LM noted that part of the recovery cell work was to maximise elective capacity to address the long waiters and considering how choice would be offered through the crisis. • LM noted that there continued to be issues regarding diagnostics, however it had been suggested that the independent providers could be utilised for diagnostic support to primary care during the crisis. • Cancer 2 week wait performance decreased in January. LM noted that urgent cancer surgery would continue throughout the crisis at Emersons Green Treatment Centre with chemotherapy taking place at the oncology centre. Modelling continued on the activity the system needed to maintain. • The IAPT waiting list has been validated and there were currently 6000 patients waiting for services, this was being addressed and expected to be resolved by the end of 2020. Activity was continuing with virtual options available where appropriate.	

	JR noted that the key performance indicators continued to be reviewed and monitored during the pandemic and this linked with the work PB was undertaking for planned care and what would continue. RK noted that there were a high number of long waiters for paediatric ophthalmology and asked whether this could be reviewed and an update provided at the next meeting. RK highlighted that ongoing care for patients with cancer needed to be considered particularly how patients can be looked after in a safe environment. LM noted that the trusts had designated covid-19 areas and non covid-19 areas. The Haematology and Oncology centre had been designated as a non covid-19 site. LM noted that it was important to remember that the NHS was still "open" and, particularly for patients with cancer, treatments would continue. The focus was on ensuring that patients were safe to continue treatments. JH noted that it was important to ensure that resources across the system were best utilised and LM explained that this was being considered for diagnostics etc. JE asked whether there was capacity at Emersons Green Treatment Centre to undertake cancer surgery. LM confirmed that the acute trusts consultants would be undertaking the work, just at a different site and action plans were being developed. David Soodeen (DS) raised that he knew of patients who had received letters telling them that their chemotherapy had stopped. LM asked that anonymised letters be forwarded to her so that the CCG can be clear with the trusts the expectation that chemotherapy would continue. RS provided the key messages from the quality report: • The CCG continued to work with Sirona to ensure the stability and success of transferred services. Sirona were recruiting additional staff to support the community hubs as part of the covid-19 response. • The first BNSSG Quality Sub Group has been delayed and this would be reinstated as soon as possible. • AWP have developed good Standard Operating Procedures regarding internal governance processes, escalation routes and the oversight of quality during the pandemic.	**LM** **DS/ LM**

	• Safeguarding Executive meetings were continuing and there has been a rise in casework following isolation. This continued to be monitored. • Falls are currently being reported in different ways across providers as they have different definitions of injurious falls. This would be discussed through the joint groups and had been included on the recovery tracker. AM asked about the quality schedules and what form these would take. RS confirmed that these had been signed off prior to covid-19 and had been provided to the trusts. The CCG was considering how the information could be monitored with a light touch approach using the processes already available within the trusts. Revised governance arrangements have been received from AWP and the CCG has been invited to sit on the Serious Incident closure panels. The CCG has been clear that during the crisis AWP were not expected to undertake the normal level of investigation except for the most significant of incidents. RS noted that the activity which has been suspended as well as the accelerated transformational work would need to be reviewed against the quality schedules to determine the impact. JR asked whether there were any changes to the LeDeR processes. RS confirmed that LeDeR reviews continued and these were being completed virtually where possible. Checks would be undertaken on the impact on the reviews that cannot be undertaken remotely. It was asked that an update on LeDeR be included in the quality report for next month. AM confirmed that open reviews were being completed from home however NHS England had announced that no new reviews would commence during the crisis. JR noted that the LeDeR programme was incredibly important and would have expected reviews to continue. JR requested that the CCG kept LeDeR as a priority. KA was pleased that safeguarding processes continued and noted that it was important to continue with the 8 week health check maternity reviews and children's immunisations. RS confirmed that safeguarding continued as there were concerns regarding self-isolation for families. The Local Authorities were sighted on this and were reviewing additional accommodation for people who may need to leave their homes. The standard health checks were not currently continuing but it was confirmed that there were different processes in place to support people.	**RS**

	The Governing Body received the Quality and Performance report.	
8.2	**Finance Report** ST confirmed the CCG continued to forecast a deficit of £34m as at month 9. The finance teams were closing the accounts for 2019/20 in line with the original timetable which had been extended by three days. It was expected that there would be reimbursement for costs related to covid-19 and these were under discussion, particularly around prescribing. Discussions were continuing with providers around year end balances. FF highlighted the slippage on savings delivery in relation to discharge to assess beds and asked if this related to bed closures. LM confirmed that Sirona were increasing the numbers of pathway 1 packages and reducing the numbers of pathway 2 beds. Moving forward after covid-19, the aim was to continue maintaining the pathway 1 packages and continue to reduce the numbers of pathway 2 beds so that more people can be supported in their own homes. **The Governing Body received the Finance report.**	
9.1	**Data Security and Protection Toolkit** ST noted that all the work for the toolkit had been completed prior to covid-19. The CCG met 100% of the mandatory requirements and many of the non-mandatory. The non-mandatory standards were reviewed by the CCG to determine which were achievable. The CCG would like to achieve all of the standards but there are some where the necessary processes required are not in place yet. LM highlighted that there were currently an increased number of cyber-attacks happening under the guise of emails claiming to be covid-19 information. JH suggested that the communications team provide information to the public about being cautious to these attacks. JE queried whether the CCG aimed to achieve the non-mandatory standards. ST confirmed the CCG always aimed to achieve these but they have always been reviewed pragmatically. When undertaking procurements systems were reviewed against the standards to determine whether they would achieve one of the standards. ST noted that other CCGs were in the same	**DES**

	position and although BNSSG CCG was better than average on the non-mandatory standards, no CCG achieved 100%. **The Governing Body noted the successful submission of the Data Security and Protection Toolkit.**	
9.2	**Governing Body Assurance Framework and Corporate Risk Register** Sarah Carr (SC) highlighted the overall risk relating to the impact of covid-19 and noted that the covid-19 risks were managed, resolved and recorded at such pace that it would be difficult to maintain these individually on the Corporate Risk Register. SC noted the process of risk management through silver command with escalation to gold command and management of the risks through the individual cells. It was noted that directorate risk registers would be updated with appropriate risks related to covid-19. **The Governing Body agreed:** • **Reviewed and discussed the Corporate Risk register and Governing Body Assurance Framework** • **Agreed the Corporate Risk register and Governing Body Assurance Framework were an accurate reflection of the risks**	
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 Audit, Governance and Risk Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Commissioning Executive Committee** **The Governing Body received the minutes**	
10.5	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the update**	
11	**Questions from Members of the Public** There were no questions.	
12	**Any Other Business** AM noted the increased workload for the Executives and Clinical Leads and offered to support where appropriate. JR thanked AM and noted the continued support of the Non-Executives. The Governing Body discussed the importance of communications during this period and it was agreed that any further comments on the communications received by primary	

	care should be directed to Martin Jones. It was highlighted that the CCG communications collated all other information received so these were the most important to read. Sarah Talbot-Williams (STW) noted that the Patient and Public Involvement Forum has been stood down but there was a smaller group leading the voluntary sector work. DS noted that further consideration needed to be given to the population where English was a second language as schemes such as online consultations may not be as effective. It was agreed DS would discuss this further with Michelle Smith.	**DS/MS**
13	**Date of Next Meeting** Tuesday 5th May 2020	
	The "motion to resolve under the provisions of Section 1, Subsection 1 of the Public Bodies (Admission to Meetings) Act 1960 that the public be excluded from the meeting for the period that the Clinical Commissioning Group is in committee, on the grounds that publicity would be prejudicial to the public interest by reasons of the confidential nature of the business" was proposed by JH and seconded by STW	

Lucy Powell, Corporate Support Officer, April 2020