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 2nd March 2021 at 2.00pm

Minutes

Present		
Jon Hayes	Clinical Chair	JH
Kirsty Alexander	GP Locality Representative Bristol North and West	KA
Colin Bradbury	Area Director, North Somerset	CB
Peter Brindle	Medical Director Clinical Effectiveness	PB
John Cappock	Lay Member Finance	JC
Deborah El-Sayed	Director of Transformation	DES
Jon Evans	GP Locality Representative South Gloucestershire	JE
Felicity Fay	GP Locality Representative South Gloucestershire	FF
Christina Gray	Director of Public Health	CG
Kevin Haggerty	GP Representative North Somerset Weston and Worle	KH
Brian Hanratty	GP Locality Representative Bristol South	BH
David Jarrett	Area Director South Gloucestershire	DJ
Nick Kennedy	Independent Clinical Member Secondary Care Doctor	NK
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		
Rachael Kenyon	GP Representative North Somerset Woodspring	RK
In attendance		
Will Bradbury	Communications Manager	WB
Sarah Carr	Corporate Secretary	SC
Lynn Haywood	Same Day Urgent Care Manager SDUC (Bristol), Sirona care and health	LH
Mark Hemmings	Head of Children's Transformation (SEND)	MH
Lesley Le-Pine	Quality - Lead & LeDeR Programme Manager	LLP

Deborah Lowndes	Programme and Service Director, BrisDoc Healthcare Services	DL
Lucy Powell	Corporate Support Officer	LP
Lesley Ward	Clinical Care Pathway Lead for Unplanned Care	LW
Anne Whitehouse	Deputy Medical Director, BrisDoc Healthcare Services	AW

	Item	Action
1	**Apologies** Apologies were received from Rachael Kenyon. Jon Hayes (JH) highlighted that this would have been Rachael's last Governing Body meeting and thanked her for her care and commitment to patients as part of the Governing Body.	
2	**Declarations of interest** John Cappock (JC) declared a new interest. A family member was employed by Keys Group, a provider of care and education to children and young people. Nick Kennedy (NK) declared a new interest as advisor to Somerset CCG on developing the System Clinical Strategy. There were no declarations of interest pertinent to the agenda.	
3	**Minutes of the previous meeting of the 5th January 2021** The minutes were agreed as a correct record with the following amendments: • Page 2, paragraph 2 amended to read "…had been admitted elsewhere…" • Page 3, paragraph 3 amended to read "…asked the Governing Body members to…" • A typographical error was amended on page 15.	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: **05/01/21 7.1** – Action plan to be presented to the Governing Body in April. **05/01/21 7.3** – The deadline for submission of the Trust reviews had been moved and these were completed late last month. The reviews would be considered as part of the Quality Surveillance Group in April and presented to the Governing Body in May. **05/01/21 8.1** –The safeguarding team have reviewed training in relation to pressure injuries and providers have updated their training and reviewed policies. This action was closed.	
5	**Chief Executives Report** Julia Ross (JR) highlighted that the NHS England/Improvement white paper had been published which showed that CCGs would be folded into Integrated Care Systems (ICSs) and therefore disestablished. JR highlighted the employment promise to the	

	majority of staff noting that this had been agreed to minimise disruption to staff but did not apply to Board level staff. JR noted that HR guidance would be received in April. JR highlighted the progress the CCG had made in moving towards an ICS and acknowledged the challenge given covid-19 and acknowledged that NHS staff were feeling tired and were coping with their own lockdown challenges. JR highlighted that balancing organisational change with service recovery would be a challenge over the next few years. JR highlighted that due to the clinical leadership review this could be the last Governing Body meeting for many of the GP Locality Representative members. JR thanked all the members for their support over the past 3 years and for the work they would continue to do for the local population. JR also thanked the GP Locality Representatives for their support in ensuring new members were prepared for the role. JR reported that the Riverside unit would unfortunately not be reopening as planned in April 2021 and was now expected to reopen in June 2021. This delay was due to the need to replace the roof, which was not part of the initial planned refurbishment. The CCG has asked for an update on the impact including the number of people who have had to travel out of area for care. The alternative services that have been put in place would continue. JR reported that the Brazil variant of covid-19 had been discovered in South Gloucestershire and noted that surge testing was underway. JR encouraged people who live in the defined postcode areas to get tested. JR welcomed the opening of the Safe Haven centre in Weston to face to face appointments and noted that this had been an outcome of the Healthy Weston programme to support people with complex mental health needs. JR noted that the position of ICS Chair had not been appointed to following the recruitment process but an interim arrangement would be put in place soon. Healthier Together have produced a video to describe how 200,000 people had been vaccinated in 70 days. JR highlighted this fantastic achievement and noted that this had been a	

	partnership endeavour across the whole system. JR thanked the Primary Care Networks (PCNs) for their enormous amounts of work as part of the vaccination programme. Alison Moon (AM) asked about the impact on healthcare colleagues and whether decompression would be considered. JR highlighted that there was anxiety amongst healthcare staff but noted that there was real determination to undertake the vaccination programme and continue to manage population health needs alongside covid-19. JR noted that there acknowledgement on the impact on staff and discussions continued on how to support staff across the system.	
6.1	**Healthy Weston Progress Update** Colin Bradbury (CB) provided the background for the Healthy Weston Programme noting that some actions had been unavoidably delayed due to the pandemic. CB outlined the progress for key actions within the acute service model: • PushDoctor has been implemented within the emergency department to allow people to have online consultations • University Hospitals Bristol and Weston (UHBW) are considering how best to initiate direct admission pathways, which would allow people to stay closer to home for treatment • Additional overnight capacity has been put in place meaning that people who attended the emergency department overnight could be assessed • Critical care projects have been completed or are on track but there have been operational pressures due to covid-19 • A new Standard Operating Procedure has been enacted for patients requiring emergency surgery overnight to be transferred to the Bristol Royal Infirmary. There was no overnight rota at Weston General Hospital and therefore the transfers would ensure that emergency clinical standards were met • Recruitment to the paediatric model was delayed to April 2021, this was aligned with the integration of acute paediatrics across UHBW CB noted that the Health Overview and Scrutiny Panel had requested a review on the impact of the Healthy Weston programme and the timing for this review would be discussed at the next panel meeting on the 18th March 2021. The outcomes monitoring framework from the programme would form the basis	

	of the review and this approach, as well as timings for the review, would be confirmed at the panel meeting. **The Governing Body:** • **Noted the update provided on the individual workstreams in Section 2 of the report** • **Noted the intention of the North Somerset Health Overview and Scrutiny Panel to conduct a review of Healthy Weston Impact**	
6.2	**NHS 111 First** Deborah El-Sayed (DES) introduced the item noting that the NHS 111 First programme went live nationally in December 2020. DES noted that the outcomes were not those as expected as lockdown had changed the profile. DES noted that more work needed to be undertaken on the directory of services and direct access to urgent care. It was noted that the programme was clinically led and based on the right place first time approach. Lesley Ward (LW), Lynn Haywood (LH), Anne Whitehouse (AW) and Deborah Lowndes (DL) were welcomed to the meeting to talk about the programme. LW noted that the programme was funded for quarter 1 2021/22 and the system needed to consider the value and benefit of the service as well as the opportunities the programme has enabled for future funding. LW confirmed the programme had support from across the system and despite system pressures the weekly clinical meetings were fully attended. LW explained that these meetings provided a key link between all parts of the urgent care systems. LW highlighted the communications programme which included advertising on social media and coverage on the local news. LW highlighted the work of the programme including developing the phase two priorities and review of the Same Day Emergency Care (SDEC) services as well as review of the Directory of Services. This work was supported by emergency departments and Sirona. LW highlighted that many patients were being directed to pharmacies as the most appropriate place to receive care and it was noted that review of the most appropriate settings for care was part of the phase two priorities. The Sirona and Severnside Clinical Assessment Service (CAS) pilot was highlighted which had been implemented to identify	

	what opportunities there were for a system wide CAS. The feedback from this had been positive. AW agreed that the pilot had been a positive experience for the system and noted that of the 74 cases which were handled, only 34% of those went on to have a face to face appointment at an Urgent Treatment Centre and feedback from staff had been positive particularly around the ability to provide good quality of care. Discussions were being had regarding a longer term model. LH noted that one of positives from a patient perspective was potentially not travelling to an Urgent Treatment Centre unnecessarily, but being redirected to local services such as a pharmacy. Staff had noted that as less people were being directed for face to face appointments, staff were able to offer more time for these consultations. LW highlighted the digital support for the programme and DL outlined a digital system which could be deployed anywhere and highlighted the metrics dashboard and noted the aspects to be developed such as tracking patient journeys. Brian Hanratty (BH) praised the work of everyone involved and highlighted the long term benefit of clinical validation and remote assessment where appropriate. BH noted that this work fit with Integrated Care Partnership (ICP) development. Felicity Fay (FF) noted that there was an error on page 13 where suing instead of using had been written. FF noted the programme was important in determining patient behaviour and noted the importance of public feedback and suggested that the elderly may struggle to access the new system. DES acknowledged this and noted that although the pilot feedback reflected staff feedback, feedback from the service had included less frustration from patients and the service would be tested and developments for future investment worked through. LH noted that Did Not Attend rates were lower than expected during the pilot which suggested that the patients that attended were appropriate. AM noted that formal evaluation of the pilot would be important for decisions involving investment as there needed to be clear value for money based on evidence. DES agreed and noted that robust evaluation was planned but noted that the initial baseline assumptions had changed as people had accessed services differently during the pandemic. Jon Evans (JE) highlighted these changes due to the pandemic and asked about evaluation of the	

	CAS. BH noted that relationships built as part of the CAS were key and highlighted the importance of a multi-specialist hub. The need to risk assess and train staff was noted as important to take decisions in the safest way and provide care. JR highlighted the programme as a great piece of work and a great example of the level of collaboration as a system. JR noted that the community should be the default setting of care and NHS 111 First was a critical part of this. Lisa Manson (LM) highlighted the programme as a testament to some of the work that has been achieved despite the pressure of covid-19. JR highlighted the phase two plan and asked for more information. LW confirmed that some of the projects had commenced and progress on the plan continued. It was explained that the plan within the papers rated the progress of the projects and it was confirmed that blue projects were complete. **The Governing Body:** • **Noted the progress against delivery of phase 1 of the programme** • **Noted the phase 2 programmes priorities** • **Supported the decision at Strategic Finance Committee on 26.02.21 in respect of Q1 2021-22 funding**	
7.1	**Children's Services Update Report** LM introduced the report and noted that not all aspects of children's services had been included as this was a huge programme of work. The CCG has been approached to be involved with the Framework for Integrated Care as the vanguard site for the South West. LM listed the objectives of the framework and noted that these were areas that wouldn't necessarily be covered by the healthcare system but would be developed jointly to build on the assurance framework core risks. A development group would be established and a user engagement group would be convened to feed into the Children's Programme Board. LM reported that the CCG continued to review the impact of covid-19 on children's services and review recovery of the affected services. This included the school immunisation programme and considering how best to support children with	

	Special Educational Needs and Disability (SEND) outside of the school setting when appropriate. The Children, Families and Maternity Steering Group has developed a strategic intentions document which outlined the key deliverables across a number of programme areas and programme leads have been identified from across the system organisations. LM provided an update on SEND. South Gloucestershire has two areas outstanding and a progress review meeting has been held to review these. The CCG was awaiting formal feedback of the review. Bristol has received a progress review where it was acknowledged that 89% of the milestones have been delivered or were on track to be delivered by January 2021. The re-inspection was expected once the inspection activity begins. Delivery of the Written Statement of Action (WSoA) continued in North Somerset and a peer review had been undertaken in November 2020 to provide support to the work. A meeting has been arranged between North Somerset Council and the CCG to discuss the outcome of the review. DES highlighted the coproduction of the North Somerset plans and noted that the UX lab had been utilised in this area to ensure that services were based on patient centred design. Kirsty Alexander (KA) highlighted that throughout the pandemic children's community and acute services had been supporting each other. Umber Malik (UM) highlighted the organisational development work around health inequalities and it was agreed that LM and UM would discuss this further outside of the meeting. KA noted that the model of work on ICPs and Localities also included children's services. AM highlighted that continuity of carer was important when considering health inequalities in children. Mark Hemmings (MH) noted that this was a key focus of the maternity work programme and would be added as a metric to the Quality Committee dashboard once worked through. Rosi Shepherd (RS) noted that the maternity dashboard was also reviewed at the Heathier Together Local Maternity System regularly. JR asked for assurance that the North Somerset action plan against the WSoA was on track and highlighted the importance of parent/carer engagement in plans. JR also noted that there was	

	clear alignment for children's services into ICPs and noted that this needed to be included in the ICP model. MH confirmed the actions were broadly on track and regular meetings were held with the Chair of the parent/carers group and monthly meetings continued with the provider to ensure progress. MH noted that the peer review has led to a refreshed action plan which would be presented to the Partnership Board and the main focus would be joint discussion on how to progress the actions. Sarah Talbot-Williams (STW) asked about the ambition for service excellence and asked how would this be demonstrated. LM noted the ambition to aim for excellent was defined in the Children's Programme Board. MH explained that currently the system was improving the basics and the next step was to engage with the parent/carer groups and children across the system to further meet children's requirements for services. DES noted that further consideration on co-designing pathways continued and highlighted the importance of integration with education. RS highlighted that a different approach to commissioning to consider the lifetime of the child was needed which would drive the system to excellence. FF highlighted the importance of routine to children and asked about recovery following schools reopening. LM noted that some schools were reluctant to allow external people such as therapists in and so other alternatives were being reviewed. LM noted that the right solutions for both the schools and the children were being considered. **The Governing Body received the report and were made more aware of the current developments and challenges in Children's Services**	
7.2	**Learning Disabilities and Autism Service** Lesley Le-Pine (LLP) was welcomed to the meeting to present an update on Annual Health Checks (AHCs) for people with learning disabilities. LLP reported that 30% of AHCs were completed at quarter 3, with 41% completed as of 31st January 2021. If the 10% increase per month continued then 61% of AHCs would be completed by the end of March which was 6% off the 67% target. LLP reported that the CCG was currently showing the highest level of delivery in the South West. LLP highlighted the learning disability leads within GP Practices who were providing support and advice and LLP noted that following feedback the AHC	

	template would be redesigned for next year. The redesigned template would draw out the associated health plan which could be easily printed. LLP reported that there had been a successful AHC event in December and a second event would take place with GPs in March to discuss covid-19 vaccinations for people with learning disabilities as well issues such as consent, best interest and reasonable adjustments. FF highlighted the progress being made but noted that the data showed practices where no AHCs had been undertaken and asked whether these practices had been targeted for support. It was noted that the numbers per practice were not included within the paper and therefore depending on patient numbers 80% completion could only be 2 patients. RS noted that the practice data was reviewed by the Primary Care Operational Group and coding and data accuracy issues were being checked. LLP noted that practices were expected to support across PCN level with lessons learnt. JR commented that the target of 67% was too low and the CCG should be aiming for 100% to be completed. JR noted that the data needed to be normalised against patient numbers so that the numbers of AHCs undertaken were comparable so that the team could focus on the practices who needed further support. JR highlighted the risk of patients not being able to access the digital platforms to undertake the AHC and asked whether guidance had been received which suggested AHCs should be undertaken face to face. It was agreed to check this with the team. JR noted that there needed to be clarity on whether there were any patient safety issues with undertaking the AHCs online. LLP reported that work continued with practices to ensure they had the resources and tools needed and an audit would be undertaken with practices to review these. JR highlighted the importance of AHCs in how care for patients was planned. JE noted that this cohort of patients was varied and remote consultation may work for some but not others and also highlighted the importance of personalised care. KA noted that GPs needed to challenge how reasonable were the adjustments they were making for challenging patients and welcomed the focus and join up of services.	**RS**

	JR asked whether there was an evaluation plan and LLP confirmed that gaps in service were being identified through LeDeR and discussed at the events. Christina Gray (CG) asked for more information on the practice learning disability champions. LLP noted that these were practice staff who championed patients with learning disabilities and ensured that appointments were made. CG highlighted the importance of involving patient champions in the quality improvement work. **The Governing Body noted the contents of the paper and supporting action plan and supported:** • **The actions to improve the uptake of Annual Health Checks** • **Local arrangements for the LD DES as requirements shift over to the PCNs giving opportunities for more integrated working between practices/PCNs and the specialist LD teams to facilitate screening services, mainstream community services and support around reasonable adjustments**	
8.1	**BNSSG Quality and Performance Report** LM provided the key points from the December performance report: • During January, the peak number of patients with covid-19 was higher than wave one of the pandemic. • Trust A&E performance worsened to 69.3% and was worse than the national average. • Escalation planning continued via the incident control centre. • Patients waiting over 52 weeks has continued to increase. Phase 3 planning and modelling of the covid-19 response to understand the impact elective performance continued. • Cancer 62 day performance has worsened. This was being reviewed by tumour site to understand the issues. RS provided the key points from the December quality report: • There has been a rise in concealed pregnancies where conception occurred during the first lockdown. It was noted that there had been a national increase and no significant harm has been identified in the local cases. • There had been a number of 12 hour trolley breaches, no harm had been identified from these. • The quality of care provided to patients queueing in ambulances has been reviewed and no harm has been	

	identified from the care provided outside of the emergency department. • The expanded infection prevention and control team continued to work with community care supporting outbreak management. This has led to a better understanding of Healthcare Acquired Infections. • Funding has been agreed for wipes to be used to aim to reduce MRSA in the community and this would be reviewed to see if there was an impact in MRSA rates. NK asked about the independent sector provision. LM confirmed that contracts would revert back to local arrangements from April 2021 and noted that the system currently continued to utilise the independent sector to support elective care. LM highlighted that from April 2021, the contracted activity would continue to support elective activity as part of the phase four planning. NK also asked about locked rehabilitation at Avon and Wiltshire Mental Health NHS Trust (AWP). RS noted that there were challenges in managing covid-19 testing and social distancing in these settings and explained that blue and green pathways had been implemented to manage these challenging outbreaks. Discussions around risk mitigation have been held through the Infection Prevention and Control Cell to support decision making. FF noted that the report would be adjusted to reflect the transition into the ICS and asked for more information. LM explained that this would include developing a performance report which reported against the performance and improvement frameworks rather than contractual outcomes. RS explained that for quality this would reflect the quality impact of performance and both reports would be incorporated into one. FF also asked how the wipes were being distributed. RS confirmed that this was through the normal community teams. AM asked how assured the CCG was that communications were ongoing with the waiting patients and asked whether the system was able to cope with the amount of queries. LM noted that as per the system recovery plan the system continued to prioritise those patients that were clinically urgent. The clinical validation process was proactive in response to patients and should a patient's condition become more urgent then the patient would be	

	escalated for treatment. LM confirm that there was a mixture of plans for communications but noted that the programme of work was under review. Kevin Haggerty (KH) asked whether cardiac patients had been categorised as urgent. LM agreed to check and provide an update. CG noted that funding for the current infection prevention and control service had been secured for one year. CG highlighted that this service was pivotal and suggested that the service should continue. CG asked that the outbreak monitoring work be shared with the health protection lead consultants to ensure that there was a system response for these outbreaks. RS confirmed that the monitoring data was shared as part of the Infection Prevention and Control Cell whose members included Directors of Public Health. It was agreed that continuation of the infection prevention and control service was important and needed to be agreed as a partnership endeavour. **The Governing Body received the Quality and Performance report**	**LM**
8.2	**BNSSG Finance Report** Sarah Truelove (ST) noted that the described financial regime continued with some areas subject to retrospective top up. During month 10, additional allocation has been received including for months 11 and 12. ST noted that reductions in primary care prescribing, mental health and Continuing Healthcare programme costs had increased performance on savings and the position had improved by £0.5m. **The Governing Body noted the financial position at month 10 and the risk adjusted forecast surplus**	
9.1	**Conflicts of Interest Policy and Gifts and Hospitality Policy** Sarah Carr (SC) noted that there had been a minor amendment to the Managing Conflicts of Interest Policy following the recent conflicts of interest audit. **The Governing Body approved the conflicts of interest policy and the gifts and hospitality policy.**	
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**	
11	**Questions from Members of the Public** JH read out a question received from a member of the public: “The JCVI guidelines for priority group 6 state that the list of conditions is not exhaustive and "the prescriber should apply clinical judgment to take into account the risk of COVID-19 exacerbating any underlying disease that a patient may have". However when patients with ME (classed as a neurological condition by both the World Health Organisation and NHS England) (also known as ME/CFS, CFS & CFS/ME) approach their GP, some are being added by their GP to priority group 6 but the majority are being told that allocation to group 6 is decided centrally and the GP doesn't have the ability or authority to allocate someone to the group. New infections are probably the most common cause of exacerbation or relapse of ME/CFS – as noted in section 3.3.2 of the Chief Medical Officer’s Working Group Report on ME/CFS: https://meassociation.org.uk/wp-content/uploads/CMO-Report-2002.pdf. Can the CCG please confirm that GP's in this region are able to use their clinical judgment to confirm their patient "is at increased risk" of COVID-19 exacerbating their condition and therefore can be added to group 6. Please also confirm that this guidance will be communicated with all local GP surgeries to this effect?” LM explained that the guidance the NHS was following was from the Joint Committee on Vaccination and Immunisation (JCVI) and although chronic neurological conditions were included in Cohort 6, this did not mean that all chronic neurological conditions were included, and currently ME/CFS was not a specified condition within that guidance. In exceptional circumstances GPs could exercise their clinical judgement in vaccinating outside JCVI guidance. JH read out a question from a member of the public: “Is the refurbishment of Riverside Unit on schedule, and when will it open to receive children in need of residential care for acute mental problems?”	

	It was noted that as part of the Chief Executive's update it had been reported that the Riverside Unit would not be reopening as planned in April 2021 and it was now expected that the Unit would reopen in June 2021. This delay was due to the need to replace the roof of the unit, which was not part of the initial planned refurbishment. A member of the public asked how the CCG engaged with the public and whether there was more the CCG could do for public involvement. JR acknowledged that the CCG Governing Body meetings were not well attended by the public but explained that the CCG undertook massive amounts of work in engaging and consulting the public and highlighted the award winning Citizen's Panel where the CCG surveyed public attitudes to health and queried what challenges needed to be addressed. JR highlighted the co-design work where patients with lived experience were engaged in designing new services and the programmes for which the CCG had formally consulted with the public including for the Healthy Weston programme, where extensive public consultation took place. JR also noted that as the ICS was developed the CCG was working closely with patient groups and the voluntary groups to ensure that programmes of work such as the covid-19 vaccination programme reached everyone. The CCG continued to work with community leaders, the local authorities and population health management team to develop ways to engage with groups who don't normally engage. DES outlined the different forums for engagement and noted that for the community mental health service engagement 70 events had been arranged and 1500 people had provided feedback on the service plans. DES noted the Patient and Public Involvement Forum had been developed to ensure that co-design evolved and that the challenges facing the public were addressed.	
12	**Any Other Business** There was none	
13	**Date of Next Meeting** Tuesday 6th April 2021, at 2.00pm	

Lucy Powell, Corporate Support Officer, March 2021