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 June 2020 at 1.30pm

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
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
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
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	STW
Sarah Truelove	Chief Financial Officer	ST
Apologies		
Colin Bradbury	Area Director, North Somerset	CB
David Soodeen	GP Locality Representative Bristol Inner City and East	DS
In attendance		
Sarah Carr	Corporate Secretary	SC
Alison Ford	Head of Children and Maternity	AF
Lucy Powell	Corporate Support Officer	LP
Alex Ward-Booth	Head of Insights and Engagement	AWB

	Item	Action

1	**Apologies** Apologies were received from Colin Bradbury and David Soodeen.	
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.	
3	**Minutes of the previous meeting of the 5th May 2020** The minutes were agreed as a correct record with the following amendments: Page 10, paragraph 2: Amended to "KA noted that practices would know the numbers of patients whose elective treatment had been postponed and returned to the practice, cancelled or offered alternative pathways where they had received notification from secondary care or other relevant provider. Postponements would be added to the list of pending referrals. What was needed was clarity around how to prioritise re-referral in the recovery phase."	
4	**Actions arising from previous meetings** The Governing Body reviewed the action log: 05.11.19 6.2 – Lisa Manson (LM) confirmed an update would be provided to the Commissioning Executive Committee in June and presented to the Governing Body in closed session in July. The action was closed. 05.11.19 6.4 – Deborah El-Sayed (DES) confirmed that engagement around the transgender guidance Equality Impact Assessment (EIA) was scheduled for July with the intention to present at the August Governing Body. 03.03.20 11.1 – The timescale on this action was reviewed for July 2020. 07.04.20 8.1 – Long waiters for paediatric ophthalmology had been reflected in the month 12 report. The action was closed. 07.04.20 9.1 – Alison Moon (AM) asked for confirmation that methods other than twitter had been used to communicate the threat of cyber-attacks to the public including the website. DES confirmed this was the case and explained that the reach on CCG social media was far more significant that the website. 05.05.20 6.1 – The structure diagram for the covid-19 governance arrangements had been circulated to the Governing Body. The action was closed. 05.05.20 6.2.2 – The position on held referrals had been discussed at the primary care cell and the final position would be reviewed through the Clinical Cabinet. The action was closed.	

5	**Chief Executives Report** Jon Hayes paid tribute to Dr Kate Mansfield who passed away after a brave fight against a cancer related illness. Kate was a GP at West Walk Surgery in Yate for many years before moving to the Wellington Road Practice with her husband Nick, with whom she job shared, to ensure the continued delivery of single-handed GP services to patients registered there. She stepped forward to sit on the Governing Body at South Gloucestershire CCG and was a much loved, valued and respected Governing Body member. Kate had a strong moral compass in terms of quality of services and patient care and helped with the smooth transition from South Gloucestershire CCG to Bristol, North Somerset and South Gloucestershire CCG, whilst maintaining her role as clinical lead for children's and women's health services. For several years Kate took on the safeguarding lead GP role, which she undertook admirably working jointly with the Local Authority in South Gloucestershire. Kate was highly thought of and well respected by all of her colleagues. Jon extended sympathies to Kate's husband Nick and their children. Julia Ross remembered Kate as a wonderful woman and how her focus was always caring for the population she served with a particular passion for children. She will be sorely missed. Julia Ross (JR) began by talking about the covid-19 outbreak at Weston General Hospital and explained that closing the hospital from the 25th May had been the right thing to do for patients following a challenging weekend. The closure had been initiated after 5 patients on a designated non-covid-19 ward had tested positive following the usual testing processes, the system therefore took the decision to close the hospital. JR noted that the response to the outbreak has been robust by University Hospitals Bristol and Weston Trust. Since the closure no new cases had been reported and another round of testing would start tomorrow. JR noted that the system response had been outstanding with the South Western Ambulance Service, Sirona and Pier Health Group stepping up to support the hospital. JR reflected on the Healthier Together Partnership Board where the system leaders had presented their covid-19 organisational achievements. JR noted there had been a sense of action, delivery and shared endeavours. JR outlined the seven goals that had been agreed as priorities for recovery phases 2 and 3:	

	• Responding to people the right time the first time and building on the progress made with digital innovations and the strong relationships developed between primary, community and secondary care. • Proactive care and ensuring that discharge was efficient and care at home and the community was prioritised. As well as emphasising messaging on self-care and prevention. • Supporting vulnerable and shielded patients through the response, including support with access to innovative service solutions. • The flexibility of workforce throughout the response. • The continued sharing of data and to build on this to develop a single dashboard for the system. • Continued support to mental health patients such as the 24 hour support line. • Continued support from primary and community care providers to care homes. JR explained that further description of the phase 3 recovery plans including the financial model was expected in June. Alison Moon (AM) appreciated the system ownership of performance and praised the idea of the single system dashboard and noted that the challenge with this approach would be holding organisations to account. Deborah El-Sayed (DES) noted that not all system performance dashboards would be system wide and the approach continued to be developed. Sarah Truelove (ST) noted this work had begun before covid-19 and although the System Oversight Group had been paused this was effectively the Silver Command group managing the incident. It was noted that a whole system approach would have formal arrangements in place on how performance was managed going forward.	
6.1	**Recovery Planning and Non-Covid-19 Activity Planning** Peter Brindle (PB) noted the paper outlined the work from phase 2 and the plans for phase 3. PB explained that understanding the current situation and how this affected the future had developed the planning for phase 3 and the system had reviewed the changes to be maintained and work had begun to understand and develop the long term benefits of these. PB reported that cancer services had been restarted although noted that endoscopy continued to be a concern as the ability to undertake this was limited. PB noted that 2 week referrals were	

	increasing and work was ongoing to treat delayed patients. PB noted that independent treatment centres would be utilised for diagnostic work to ensure that there was as much capacity as possible. The Clinical Cabinet had discussed how to refine the investigation work to that which would make the most difference whilst acknowledging that the numbers attending A&E had risen. PB noted that actions were in place to explore the changes within the system including numbers of referrals. PB noted that the transformation opportunities highlighted as part of phase 3 needed to be based on intelligence such as population insights and research from across the country whilst adjusting services for covid-19 demands. PB acknowledged that large sections of the community had been disproportionally adversely affected by the virus and new groups were being identified as the pandemic continued. Jon Evans (JE) noted that covid-19 was an unwelcome catalyst for positive healthcare service change and asked how the changes would be embedded within contracts. PB highlighted that the system goals were jointly owned by system leaders and managed through the system transformation group who monitored the outcome measures. These goals were clinically led but enabled by contractual and financial levers. Kirsty Alexander (KA) added that provision for children was currently reviewed each week and this was an example of a change that should be retained. KA asked whether there was capacity within the CCG teams to undertaken modelling for diagnostic work and prioritisation or whether this was work the Trusts were expected to undertake. PB noted that patient flow was being reviewed as well as capacity modelling particularly around diagnostics and scopes through the system wide diagnostics cell. PB noted that prioritisation systems were being developed and noted that the diagnostic and analytic cells were both working on this. Felicity Fay (FF) asked whether detailed plans had been developed for trigger points, when reopened services may encounter circumstances where services may need to be paused again. PB noted that data was being triangulated from several different sources to review early warning systems. The Department of Public Health was also working on early warning	

	systems and triggers were being identified as well as the levels these needed to reach to instigate action. Nick Kennedy (NK) asked how the independent sector was utilised and how long the resource would be available for. ST noted that the national contract established would continue in the current form and the system would make best use of the resource. Currently, 7% of planned care activity was directed to the independent sector but this would change throughout the recovery process. ST highlighted that this was a crucial resource due to the reduced productivity of other providers and was expected to be available for some time. AM commented that it would be a challenge to re-contract the additional capacity. AM commented that learning from the LeDeR programme should be taken into account as part of recovery and suggested that the system needed to return to an improved position rather than the previous performance levels which were under target. AM praised the joint working and asked whether there was any modelling to show what the new ways of working would provide in terms of improved performance. PB noted that there some areas such as 2 week waits where the system would want to return to pre-covid-19 levels, however for A&E attendances and some planned care there was a strong ambition to improve through recovery. PB noted the ambition was to review each service and identify efficiencies and opportunities for system working. LM confirmed that this would be part of the phase 3 planning as the learning through phase 2 was reviewed. LM noted that clarity on the performance trajectories would be through this work. DES highlighted that the planning work had begun through the strategic change command including early warning triggers, thresholds and capacity. DES confirmed that the investigations were taking place into what and how we can deliver. Christina Gray (CG) referenced the attached intelligence report and noted that as part of the risk work the Local Authorities were building the risk assessments into work with BAME communities and staff. The data from Public Health England had been reviewed and the outcomes have been correlated at a local level and would be linked with NHS data to provide robust local data to inform decisions.	

	Rachael Kenyon (RK) noted that a benefit arising from the crisis had been the service integration across the system and suggested that should this continue as this would reduce waiting list sizes. PB noted that a significant ambition was to reduce health inequalities and to use the data collected to identify the patient groups who have poor access to services etc. and processes were in place to understand why and therefore how to improve services. **The Governing Body noted the update on recovery and supported the ongoing work to recover services in a way which minimises health inequalities which have been exacerbated as a result of Covid-19, and seeks opportunities to address historical inequalities.**	
6.2	**Covid-19 Update** ST confirmed work was ongoing to understand the scale and effect of the pandemic on the local population and healthcare system and highlighted the key issues faced, noting the impact of covid-19 on widening health inequalities, care homes and the long term impact of the pandemic. The CCG was working with the University of Bristol to develop a model that used local data from the hospitals to provide an up to date projection of covid-19 activity forecasted for the future months and updated weekly. The scenario modelling included the easing of lockdown restrictions and the potential impact. ST noted that the system had seen reductions in mental health referrals and work continued to understand this as well as considering what the future demand for mental health support may be based on the issues people raised as concerns during lockdown. ST reported that during phase 2 of recovery, work had been undertaken to understand activity levels. ST highlighted that there had been a significant impact on productivity caused by the infection prevention control measures, and noted that the phase 3 planning would build on this and optimise available capacity. The system was undertaking analysis on the impact of the covid-19 response on the population particularly the BAME population	

	and patients with multiple health conditions. The CCG was working with these groups in terms of recovery and developing actions to mitigate the impacts. LM presented what had been learnt from the response to covid-19 and what work would be continued and integrated into the system: • Patient centred approach to care • System collaboration, joint working and mutual aid • Greater awareness of staff health and wellbeing • End to end service integration • Deploying resources as a single system • Designing services based on data and evidence • Embracing new digital technologies • Innovation mind set continuing • System standardisation of policies and processes, enabling system flexibility • Joined up clinical leadership LM noted that during the pandemic the system hadn't discussed organisational boundaries and have supported each other through mutual aid and sharing equipment. Workforce had also been shared across the system and LM reported that training requirements had been shared to allow this to happen efficiently. LM reported that there had been an increased in test uptake and antibody testing was to be launched across the system. LM noted that by increasing testing, the recovery plans could be accelerated. DES thanked primary care for the clinical leadership shown in driving through the digital agenda which has transformed the way primary care has developed. JE asked how the clinical leadership would be continued and noted that it was important that assurances were provided that the current situation for clinical leadership wasn't a temporary situation. JR noted that it was the whole systems responsibility to keep this level of clinical leadership but noted that there were considerations on how this commitment continued with limited resources. **The Governing Body received the update on the covid-19 response.**	

6.3	**Finance and Contract Cell Update** LM explained that the finance and contract cell brought together the contractual and financial frameworks to maintain control and transparency through the covid-19 response. NHS Trusts were currently contracted through a block payment system which had been nationally defined and NHS England have commissioned independent sector capacity. LM noted that additional funding had been made available to improve the timeliness of hospital discharge also facilitated by changes to processes. The CCG has agreed a financial support package with the Local Authorities to support care homes and the CCG continued to fund the budgets allocated to the voluntary sector. LM noted that in addition, the government published a package of support which enables voluntary organisations to access funds. LM explained that Any Qualified Provider zero activity based contracts remain unsigned but during phase 2 the finance and contract cell would re-engage with these providers. LM noted that there were funds available for these providers if services were required. John Cappock (JC) confirmed that the Strategic Finance Committee had been kept updated on the developments and noted that the Committee continued to receive assurances on the decision making processes. CG asked whether joint contracting arrangements would be agreed through the finance and contract cell going forward. LM clarified that this was dependent on the type of contract. ST highlighted that the finance and contracting cell had replicated the Local Authority contracts with care homes to ensure the work was joined up. **The Governing Body noted the progress and actions taken within the finance and contract cells.**	
7.1	**Special Educational Needs and Disability (SEND) Update** Alison Ford (AF) was welcomed to the meeting and provided the background to SEND across Bristol, North Somerset and South Gloucestershire. AF reported that the outcome from the January inspection of SEND in South Gloucestershire had been received, and in 6 of	

	the 8 areas of concern, sufficient progress had been made. The two areas when progress has not been sufficiently made were; the quality of Health, Education and Care Plans (ECHP) and educational outcomes for children and young people with SEND. The CCG was working with NHS England and the Department of Education to develop co-produced Accelerated Improvement Plans. The Bristol Written Statement of Action (WSOA) has been approved and implementation of the actions were underway. The CCG and council SEND teams have attended a number of Parent Carer Forum events to listen to how SEND services should be improved in Bristol. Delivery of the North Somerset WSOA continued, most notably with the transfer of children's services provided by Weston Area Health Trust and North Somerset Community Partnership to the Community Children's Health Partnership (CCHP). An agreed Local Area Co-Production Charter has been embedded within the SEND Strategy which provided commitment that the CCG and local partners would work together to improve services. The revisit has been delayed from Spring 2020. Through the covid-19 response the legal obligations of the CCG have continued and the system has prioritised keeping children with complex medical needs with their families in the community. The system has developed a list of these children and shared workforce has ensured that staff levels have remained at 95%. CCHP have made adjustments to services in line with guidance and digital platforms are being utilised for assessments. AF confirmed that SEND Partnership Boards continued virtually. DES provided an update on the engagement element of the SEND work noting that the CCG has re-profiled the support given to parent and carer forums and £10k of funding has been earmarked for each of these groups. Co-production has been referenced throughout the Strategies and the findings that were identified following engagement have been included. The new Bristol, North Somerset and South Gloucestershire user experience lab has been set up to analyse engagement outcomes and measure the service experience. DES confirmed the first project had been for SEND. The aim was	

	to embed experience measures into contracts and contract, quality and performance monitoring. Following engagement with the parent and carer forums, what mattered most was seamless service changes, length of waiting times and advice on action that can be taken whilst waiting for services. DES confirmed that parents and carers were keen to work together across Bristol, North Somerset and South Gloucestershire and the CCG teams were considering innovative approaches to ensure that the ambitions for services were correct for all. JR praised the engagement work and asked how children were being engaged. AF confirmed that the CCG commissioned Barnadoes to undertake engagement with children and young people and they had most recently engaged regarding lockdown and what support children and young people felt they needed. AF confirmed that there was a clear plan on engagement with children and young people but this needed to be reflected strategically. Sarah Talbot-Williams (STW) was pleased that funds had been provided for the forums and asked how the CCG would manage this going forward. DES confirmed that the team were reviewing the funding for engagement work and a strategic decision would be taken on prioritisation of funding. JE asked that where gaps had been identified by the inspections were these due to the co-produced outcome implementation and the timings of the reviews. AF confirmed there were a number of reasons and this included the gap between implementation and review but also the impact felt by families once actions were implemented. The CCG and Local Authorities had been encouraged to improve communication of the changes to services. DES confirmed that the user experience lab would be reviewing these gaps and ensuring that communications were widely distributed. **The Governing Body noted:** • **The outcome of the Ofsted/CQC revisit of SEND in South Gloucestershire and the next steps** • **Ofsted's fit for purpose approval of the Bristol Written Statement of Action**	

	• **The ongoing action to deliver the North Somerset Written Statement of Action** • **The CCGs legal responsibilities to children and families with SEND during the covid-19 pandemic and the action being taken** • **The ongoing actions to develop and embed co-production with parents and carers and to develop more sophisticated insights to ensure we understand how services are meeting the needs and what further changes we need to make.**	
7.2	**Citizens Insights – Covid-19** DES provided the background explaining that the CCG wanted to further understand the experiences of the local population and what mattered to them to inform the recovery phase plus the redesign and transformation of services. Alex Ward-Booth (AWB) was welcomed to the meeting and outlined the approach taken to review the breadth and depth of the insights received. The aim was to be able to support decision making across the CCG using the data as well as engaging and including data from Healthwatch and Citizens Advice. AWB suggested the Governing Body members were included in the distribution list for the fortnightly update on the work. Recommendations identified from the work had been included as part of the recovery phase. AWB noted that a consistent theme from engagement was concerns around access to health care services for both physical and mental health. AWB reported that the Citizens Panel had been set up so some of the same questions were asked each time so improvements could be monitored. The questions also provided insight into the groups that may need more support to access or use services. The Citizens Panel highlights areas of concern where consistent themes were identified, the current focus of the panel was noted as Covid-19 and the panel identified that there were concerns around working from home with children, less exercise and drinking more alcohol. AWB noted it was important to review this data in terms of future challenges for healthcare services. AWB highlighted that the panel was also used to inform communications and advice and guidance where there were	**DES**

	perceived gaps across local groups as well as the whole population. AWB highlighted the opportunity for consistency of coproduction of processes through the panel and noted that the review to adapt processes was being undertaken for this. AWB highlighted the Working with People and Communities Charter and explained how this sets the foundations of the approach going forward including the development of toolkits to apply consistent principles to engagement taking place across the CCG as well as the development of a steering group to formalise the work. DES noted that all the insights work has been undertaken in partnership. STW noted it was great to see the insights work and the integration that the team has achieved. STW recognised that there was a wealth of information and bringing this together would encourage system learning. STW noted that she supported the Charter and highlighted that the toolkits were key to changing how engagement was incorporated into planning. JE asked whether the insights were fed back to the providers as there were lessons for the system being identified through the panel. AWB confirmed that some of the data was provided by the providers and the CCG wanted to analyse and add value to the data for the system. AWB noted that satisfaction data was hard to analyse as there were variables to consider. AWB noted that in some circumstances the team therefore needed to consider how services could be perceived differently rather than focus on improvements. PB asked how the insights can be integrated into service design noting that behaviours have changed over the past few months and certain population groups have been able to take greater care of themselves whereas others have needed more support. AWB confirmed that the team were investigating how the positive habits could be kept and what tools could be utilised to further support the groups that needed it. PB also asked how confident the insights team were that the CCG was taking a qualitative approach to engagement. AWB noted that the team were actively exploring how to have conversations with key groups to gain the insights required for service improvement.	

	Brian Hanratty (BH) praised the work and Charter and noted that this was an important part of developing Integrated Care Providers. John Rushforth (JRu) was supportive of the work but noted the recommendation that "all opinions, feelings and thoughts should be equally valued.." and felt that there were certain opinions that shouldn't be valued such as comments deliberately insulting to groups of people. AWB noted that ground rules were an important part of engagement work and consideration had to be given to the groups that were attending the engagement. AWB noted that the intention of the comment was around inclusion but acknowledged that there was an ethical element that needed to be considered. JRu agreed that everyone needed to be listened to but perhaps not all comments should be given value. **The Governing Body agreed the recommendations included in the paper.**	
7.3	**Customer Services Quarter Four Report** ST noted that the team had made improvements to the timeliness of responses as well as the methods for capturing and monitoring contacts. This combined with an awareness campaign for the team had led to an increased number of complaints and patient contacts recorded for quarter 4. FF noted the themes of patient contact and ST explained that the team would further develop this by working with the teams to providing feedback on consistent themes within patient contacts. AM supported the work outlined in the paper and noted it was important to ensure that the feedback received on the patient experience was used to make improvements. STW agreed and suggested that the customer services team work with the insights team to ensure the knowledge was shared and that this was reflected within the customer services reports. **The Governing Body noted the contents of the report.**	**ST**
8.1	**BNSSG Quality and Performance Report** LM presented the performance report for month 12 noting that due to the challenge presented by covid-19 it had not been possible to collate and include up to date commentary for some of the areas of underperformance noted in the report. LM provided the key points:	

	• Overall 4hr A&E performance improved to 80% and remained better than national average for type 1 emergency departments. This was due to a reduction in demand due to covid-19. Winter plans were extended to ensure additional capacity was available. • There has been a significant increase in waiting list sizes, including those waiting 52 weeks. Support continued to treat waiting patients prioritised by clinical need. • 62 day referral to treatment time for cancer patients improved in March but the monthly trajectory and the 85% national standard was not achieved. University Hospitals Bristol achieved the standard throughout 2019/20. • 2 week wait performance worsened in March and remained worse than the 93% national standard and monthly trajectory. Jon Hayes (JH) asked how the covid-19 response affected 2 week wait performance. LM explained that services had been reorganised and at North Bristol Trust (NBT) teams had been reorganised into mega teams across specialities. LM noted that there had been a reduction in referrals and a reluctance from patients to attend appointments in an hospital setting. Teledermatology had been utilised to a greater extent as part of the response. NK asked whether financial penalties for 52 week waiters would continue and LM confirmed that there was expectation that there would be no penalties, and that patients were expected to be treated as quickly possible through efficient use of the system. LM noted that the independent sector capacity was important in ensuring that patients were treated against a clinically prioritised list. JE asked where the referrals were originating from. LM noted that referrals were increasing between consultants and explained the CCG had discussed this with the providers. JE noted that certain referrals such as those for dental may have increased during the response. FF asked about Faecal Immunochemical Tests and whether these were in place. PB confirmed that the testing had not ceased but was being made available in order to reduce the demand for colonoscopies. It was noted that the continued use of the approach had been discussed at Clinical Cabinet. LM noted that additional CT scanner capacity had also been made available.	

	AM asked for assurance that elective patients were being treated against clinically prioritised lists and asked that the CCG understood the impact on patients not presenting for treatment and whether there was robust clinical assurance in terms of clinical harm for these patients. LM noted that the various impacts of covid-19 would feed into the clinical harm review process. LM confirmed that patients had begun to accept appointments and emphasised that this was why it was so important to maximise the independent sector capacity and to provide assurances to the public on the separation of hot and cold wards. LM highlighted that patients would be asked to self-isolate before attendance and testing would take place at admission and discharge. Rosi Shepherd (RS) confirmed that the system Directors of Nursing had discussed the system approach to clinical harm reviews. JR asked how the system would balance the covid-19 response with restarting activity. RS noted that alongside the recovery work covered by PB, work continued with Public Health colleagues and the local healthcare system to review how recovery can be managed. LM noted that the potential harm caused would also be considered in terms of the emotional impact on people. KA asked whether the trajectories expected would be adjusted. LM confirmed that the national targets would not be adjusted but it was expected that the CCG would refine the plans following review and adjust the trajectories and review the core actions to ensure these would achieve the objectives set. KA commented on IAPT performance and noted that some service users continued to wait for second appointments and also that the data appeared out of date. LM clarified that the CCG did not receive timely information from IAPT, the CCG continued to work with Vita Health to improve this. KA suggested the CCG needed to understand why it appeared that there were larger numbers of patients who did not need 1:1 support. LM agreed to discuss this with Vita Health and update. RS presented the quality report noting that the format had been amended and any feedback on the presentation of the detail included was welcomed. RS provided the key points to the report: • The Infection Prevention and Control cell had set up a 7 day service for providing advice to all providers in the system. A review of the support was now underway.	**LM**

	• System working for Serious Incidents continued. The CCG had joined provider Serious Incident process meetings which enabled incidents to be closed quicker. • The CCG was working with Sirona to peer review actions for recovery. • CHC performance had been included within the report and it was highlighted that the team were significantly above average on the percentage of referrals completed within 28 days. JR asked how the CCG was ensuring that people with learning disabilities were not being disproportionality impacted by covid-19. RS noted that the number of deaths had been highlighted in the LeDeR section and it was agreed to update the figure for May and provide more up to date information for June at the next meeting. JR addressed the level of data in the report and suggested that the key points needed to be included within the report. RS agreed to include an executive summary for quality and input further information in the cover sheet. **The Governing Body received the Quality and Performance report**	**RS** **RS**
9.1	**Information Governance Policy** ST explained the policy had been updated following annual review and noted that there were minimal changes. **The Governing Body approved the policy.**	
9.2	**Local Counter Fraud, Bribery and Corruption Policy** ST explained the policy had been updated following annual review and noted that there were minimal changes. **The Governing Body approved the policy.**	
10.1	**Minutes of the Quality Committee** **The Governing Body received the minutes**	
10.2	**Minutes of the Strategic Finance Committee** **The Governing Body received the minutes**	
10.3	**Minutes of the Commissioning Executive Committee** **The Governing Body received the minutes**	
10.4	**Minutes of the Primary Care Commissioning Committee** **The Governing Body received the update**	

11	**Questions from Members of the Public** **Does the CCG know yet if the Covid-19 outbreak began in Weston General Hospital or in the community?** Public Health England were undertaking the review of the results to understand where the outbreak originated from. **Is the CCG confident in Weston General Hospital's record on infection control?** The CCG was confident that Weston Hospital had strong oversight and controls in place for infection prevention and control. The recent merger between UHB and Weston Area Health Trust would only increase the robustness of the infection control processes. **How will test and trace be implemented locally?** Test and trace had been implemented in North Somerset due to the outbreak and supported by Public Health England and coordinated through the local Director of Public Health.	
12	**Any Other Business** There was none.	
13	**Date of Next Meeting** Tuesday 7th July 2020, at 1.30pm	

Lucy Powell, Corporate Support Officer, June 2020