NHS
Somerset
Clinical Commissioning Group

Report to the NHS Somerset Clinical Commissioning Group on 23 September 2021

Title: Minutes of the Part A NHS Somerset Clinical Commissioning Group Governing Body Meeting held on 22 July 2021	**Enclosure B**

Version Number / Status:	N/A
Executive Lead	James Rimmer, Chief Executive
Clinical Lead:	Dr Ed Ford, Chairman
Author:	Kathy Palfrey, Executive Assistant to the Governing Body

Summary and Purpose of Paper

The Minutes are a record of the meeting held on 22 July 2021. They are presented to the NHS Somerset CCG Governing Body, and also published in the public domain through the NHS Somerset CCG website, to provide clarity and transparency about the discussions and decisions made, and to ensure the principles of good governance are upheld.

Recommendations and next steps

The NHS Somerset Governing Body is asked to **Approve** the Minutes of the meeting held on 22 July 2021 to confirm that the Chairman may sign them as a true and correct record.

Impact Assessments – key issues identified				
Equality	N/A			
Quality	N/A			
Privacy	N/A			
Engagement	There is lay representation on the Governing Body. The Minutes are published on the NHS Somerset CCG website at: https://www.somersetccg.nhs.uk/publications/governing-body-papers/			
Financial / Resource	N/A			
Governance or Legal	The Minutes are the formal record of the meeting held on 22 July 2021.			
Risk Description	N/A			
Risk Rating	Consequence	Likelihood	RAG Rating	GBAF Ref
	-	-	-	-

NHS
Somerset
Clinical Commissioning Group

Minutes of the **Part A** Meeting of the **NHS Somerset Clinical Commissioning Group Governing Body** held on **Thursday, 22 July 2021** via **MS Teams (Virtual Meeting)**

Present:	Dr Ed Ford	CCG Chair, GP Partner, Irnham Lodge Surgery, Vice Chair, Health and Wellbeing Board
	Lou Evans	Non-Executive Director CCG Vice Chair and Chair of Audit Committee (Lay Member)
	Trudi Grant	Director of Public Health, Somerset County Council
	Wendy Grey	Non-Executive Director, Member Practice Representative
	Neil Hales	Interim Director of Commissioning
	David Heath	Non-Executive Director, Patient and Public Engagement (Lay Member)
	Alison Henly	Director of Finance, Performance and Contracting
	Val Janson	Acting Director of Quality and Nursing (representing Sandra Corry)
	Trudi Mann	Non-Executive Director, Member Practice Representative
	Grahame Paine	Non-Executive Director (Finance and Performance) (Lay Member)
	James Rimmer	Accountable Officer and Chief Executive
In Attendance:	Sara Bonfanti	Head of Communications and Engagement (for item SCCG 067/2021)
	Judith Goodchild	Chair, Healthwatch (Observer)
	Dr Alex Murray	Clinical Director, Fit For My Future
	Phoebe Sherry-Watt	Associate Director of CHC Services (for item SCCG 068/2021)
	Emily Taylor	Engagement Lead Officer (for item SCCG 067/2021)
	Sandra Wilson	Observer Lay Member, Chair of Chairs of the Somerset Patient Participation Groups (PPGs)
	Sophie Wainwright	HR and Recruitment Lead Officer (for item SCCG 069/2021)
	Eelke Zoestbergen	Quality Lead for Community Services, Learning Disabilities and Mental Health (for item SCCG 068/2021)
Secretariat:	Kathy Palfrey	Executive Assistant to the Governing Body
Apologies:	Dr Jayne Chidgey-Clark	Non-Executive Director, Registered Nurse
	Basil Fozard	Non-Executive Director, Secondary Care Doctor
	Maria Heard	Programme Director, Fit For My Future

SCCG 054/2021 WELCOME

Dr Ed Ford welcomed everyone to the NHS Somerset Clinical Commissioning Group Governing Body meeting

SCCG 055/2021 PUBLIC QUESTIONS

As we work through the Covid19 period, members of the public are invited to submit their questions in advance to the Governing Body meeting via our website and guidance for how to do this is provided at the following link:
https://www.somersetccg.nhs.uk/publications/governing-body-papers/

Note: All Public Questions are minuted anonymously unless the person raising the question has provided specific consent for their name to be published.

We had received two Public Questions in advance:

1 **From Eva Bryczkowski (member of the public):**

Regarding the proposal to close St Andrews Ward in Wells and move it and the patients to Yeovil, does the Clinical Commissioning Group not agree that the principle of community care, (decided upon when the old county mental hospitals were closed), is that mental health services are available as closely as possible to where users and their families actually live?

2 **From Emma King (member of the public):**

The consultation and the decision to close St Andrew's ward was made before the Covid pandemic hit.

Last September, the Office for National Statistics revealed that suicide rates in England and Wales hit a two-decade high.

Furthermore, according to the Guardian last week, the number of beds in mental health units in the UK has declined by 25% over the last ten years, in spite of the fact that the number of people in touch with NHS mental health services has risen from 117,000 in January 2016 to 141,000 in March this year – a 21% increase. The number of specialist mental health beds decreased by about 1,500 during that time, NHS England data shows. The number of people in contact with mental health services who were subject to the Mental Health Act, many of whom were sectioned into residential care for their own or others' safety, also rose over almost the same period, from 13,437 in March 2016 to 20,494 in March this year, up 53%.

The loss of beds has led to a doubling in the number of patients sent on an "out-of-area placement" more than 300km (186 miles) from their home – so that they have a bed and can start being treated – from 38 in 2017 to 75 last year. There have also been two suicides in Shepton in the last month and a person in need of a mental health bed in Street has been sent to Kent, along with people in mental health crisis being regularly checked into budget hotels.

Taking this information into consideration, surely claiming that the fact that the number of beds in Somerset is not being reduced is simply an insufficient response to the looming mental health crisis caused by the pandemic and that we, in fact, need urgent provision for more vulnerable people in crisis in the county: Keeping St Andrew's ward open, reopening Phoenix ward (sister ward to St Andrew's) and building the new ward in Yeovil would surely be a good way to provide for these needs?

Neil Hales thanked the members of the public for their questions regarding the relocation of St Andrew's Ward in Wells and mental health services generally, and provided the following in response to both:

We recognise your desire to improve the support to people with mental health needs in Somerset, and share your concerns in relation to the potential surge in mental health demand on services across the nation as a result of the pandemic. However, we have a different view as to how we respond to these issues to improve the support offer to people with mental health needs in Somerset.

It is not correct that the decision was made to relocate St Andrew's before the impact of the pandemic was known. The CCG's Governing Body made the decision to relocate St Andrew's at their public meeting in September 2020, six months after the initial national lockdown. If anything, the pandemic demonstrated yet further the need for higher quality, safer and more sustainable inpatient services, with closer links to district general hospitals. The decision was also made after a full public consultation, (17 January – 12 April 2020), that was preceded by more than two years of public engagement, and included speaking with patients, their carers, clinical staff, regulators, partner agencies, including voluntary sector partners, and the wider community.

Although the public consultation was led by the CCG, as it is our statutory duty, it was supported by the whole health and social care system under the multi-agency Fit For My Future strategic programme, which includes the County Council, Somerset Foundation Trust and Yeovil District Hospital Foundation Trust.

Also, it should be noted that there will be no reduction in the number of adult mental health beds in Somerset as a consequence of the relocation of St Andrew's, and no ward will be closed. There are also no financial savings associated with the relocation of St Andrew's.

Both national policy and best clinical evidence is clear that the most appropriate and effective support for the majority of people with mental health needs is via community-based interventions. We agree with this. The inpatient beds in the County are a small but highly valued part of our overall mental health support offer, and we want them to be the highest quality they can possibly be.

Although you cite some very disturbing figures in relation to the experience of some people receiving mental health support across the country, with people being placed in units far from home, this is not the case in Somerset. The local services in Somerset have an exceptionally

low rate of instances of people with mental health needs being sent out of area for treatment – one of the lowest rates in the country.

You also reference the increasing numbers of people in contact with mental health services generally, even before the pandemic. In many regards this is a very positive thing. For over 20 years there have been many successful programmes to reduce the stigma associated with mental ill health and expand mental health support in the community, for example, the Improved Access to Psychological Therapies programme (IAPT). Although more work is still required in this area nationally, there is no indication that the increase in mental health demand warrants an increase in the number of mental health beds.

We have contacted Somerset Foundation Trust in relation to the person you reference being sent to Kent for treatment; they have confirmed that no-one with mental health needs requiring an adult acute bed has recently been placed out of area in Kent.

We can also confirm that no-one with mental health needs in Somerset has ever been placed in a hotel by the Trust's mental health services as an alternative to a hospital admission.

Whilst we all are concerned about the reported increase in demand on mental health services as a result of the pandemic, the appropriate response is exactly as you indicate: an increase in community support, including crisis provision, closer to people's homes to avoid the need for a hospital admission. It is for this reason that the Somerset health and social care system has expanded the community support offer, including the following:

- Appointed an additional 35 community-based staff (in the Mendip area alone)

- Created four community Crisis Safe Spaces, (two in Shepton Mallet, one in Wells, and one in Glastonbury). These centres are open to anyone over 18 who needs face-to-face support and are staffed by mental health professionals, (see Mental health crisis - Somerset NHS Foundation Trust (somersetft.nhs.uk))

- Piloting the use of four step up/step down beds in Wells to provide a bridge between inpatient wards and local services (plus a further seven in Yeovil).

- Developed a new and expanding talking therapies service for people with complex mental health trauma needs.

- Established an all age 24/7 mental health line providing wellbeing support: Tel. 01823 276 892 and see Mindline - Mind in Somerset

- Delivered a national trailblazer community mental health initiative, Open Mental Health, a partnership between statutory mental health services and the voluntary sector in the county. For more information on the Open Mental Health work please click on the following link – https://youtu.be/MdooCvn9zpg

We hope that you will be reassured that far from a dilution of mental health services being provided in-county, and in the Wells area

specifically, there is in fact a nationally recognised new model of expanded community and crisis support for those who require it – closer to their home, in less stigmatising settings, and via better collaboration with all our partners. For those who do require an inpatient admission they will be supported in an improved environment, receiving higher quality and safe care, in closer proximity to a district general hospital, all of which we believe will improve their recovery and outcomes.

SCCG 056/2021 APOLOGIES FOR ABSENCE

Apologies for absence were noted from Dr Jayne Chidgey-Clark, Basil Fozard and Maria Heard.

SCCG 057/2021 REGISTER OF MEMBERS' INTERESTS

The Governing Body received and noted the Register of Members' Interests, which was a reflection of the electronic database as at 15 July 2021.

SCCG 058/2021 DECLARATIONS OF INTEREST RELATING TO ITEMS ON THE AGENDA

Under the CCG's arrangements for managing conflicts of interest, any member making a declaration of interest may be able to take part in the discussion of the particular agenda item concerned, where appropriate, but is excluded from the decision-making and voting process if a vote is required. In these circumstances, there must be confirmation that the meeting remains quorate in order for voting to proceed. If a conflict of interest is declared by the Chairman, the agenda item in question would be chaired by the Vice Chairman, or – in his absence – another Non-Executive Director.

There were no declarations of interest relating to items on the agenda. The quoracy of the meeting was confirmed.

SCCG 059/2021 MINUTES OF THE PART A MEETING HELD ON 27 MAY 2021

The Meeting received the Minutes of the Part A meeting held on 27 May 2021. By a virtual show of hands, the Minutes were approved for signature by the Chairman as a true and correct record.

SCCG 060/2021 MINUTES OF THE EXTRAORINARY PART A MEETING HELD ON 10 JUNE 2021

The Meeting received the Minutes of the Extraordinary Part A meeting held on 10 June 2021. The meeting was to approve the Annual Report and Accounts for 2020/21 and the Minutes were approved by Lou Evans (Acting Chair) by special Chair's action in order that they could be submitted within the timescales dictated by NHS England. By a virtual show of hands, the Governing Body endorsed the Minutes of the Extraordinary Meeting held on 10 June 2021.

SCCG 061/2021 MATTERS ARISING AND ACTION SCHEDULE

There were no matters arising. The action schedule was noted.

SCCG 062/2021 CHAIRMAN'S REPORT

The Meeting received and noted the Chairman's Report, which included the Communication and Engagement Report for the period 1 May to 30 June 2021, together with the various meetings attended by Dr Ford during this time.

SCCG 063/2021 CHIEF EXECUTIVE'S REPORT AND LATEST NEWS

The Meeting received and noted the Chief Executive's Report, together with a verbal report from James Rimmer, who highlighted the following:

- Covid-19 Pandemic: case numbers are rising rapidly but there has been an excellent response to the vaccination programme. The majority of restrictions were eased on 19 July 2021 and we are watching carefully to see the impact.

- System pressures: operationally all systems are extremely busy, reporting OPEL 4 – the highest level of escalation – on 21 July across primary care, secondary care and ambulance services. The pressures are not due to Covid-19; rather, they relate to people with underlying conditions and there is a week-on-week doubling of inpatients.

- Health and Care Bill: this has progressed through both the first and second readings. Country-wide, services will be based around 42 Integrated Care Systems (ICSs), with Somerset being one of those. The functions of the CCG will transfer to an NHS Integrated Care Board (ICB), with a wider system partnership between health and care partners: this will be known as the ICP (Integrated Care Partnership). The ICB will be a statutory organisation and, whilst the ICP will not be statutory, it is nevertheless a requirement that both the ICB and ICP will work together, which fully aligns with Somerset's aspirations.

- South West Leadership for Inclusion Programme Launch: James Rimmer, together with other NHS Chief Executives, attended the programme launch on 8 June 2021, and the Governing Body would be attending a Development Session this afternoon for further Equality and Diversity training.

- Mental Health: in addition to the Public Questions discussed today (item SCCG 055/2021 above refers), the CCG had received a petition at Wynford House on 27 May 2021. We believe that the issues raised in the petition have been picked up but it is important that we continue to listen.

- Heatwave: the Met Office has issued its first ever Amber Extreme Heat Warning, as large parts of the UK will continue to see hot conditions this week, with daytime temperatures in the south west reaching 30 Celsius. James Rimmer thanked all colleagues across the CCG for their exceptionally hard work, across Covid-19, the vaccination and recovery programmes, and acknowledged the difficulty that some colleagues would be experiencing while they continue to work from home in extreme heat.

SCCG 064/2021 COVID-19 UPDATE: PUBLIC HEALTH POSITION AND VACCINATION PROGRAMME

The Meeting received and noted the data for the Covid-19 pandemic as at 13 July 2021, as produced by Somerset County Council's Public Health team. Trudi Grant and Alex Murray provided a verbal report about the latest position and it was noted that:

- the number of Covid-19 cases has doubled within the past week, to 361 per 100,000 population: this is approximately where we were in January/February 2021, and arises from the increase in social mixing

- Somerset has now moved out of the 'locally contained' phase and into the 'reducing direct harm from Covid' phase, which changes how we manage outbreaks, clusters and triage

- the increase in Covid-related hospital admissions is likely to continue for a couple of weeks before coming back down

- although the lockdown restrictions have eased, people should continue to social distance, wear masks when appropriate, continue handwashing and continue testing

- more than 700,000 vaccinations have been given across the county, but we are seeing a slowing-down of the uptake

- we are now focusing on pop-up vaccination sites, eg at supermarkets, at Taunton Pride etc to try and reach the hard-to-reach communities

- national guidance is that no second dose should be given any earlier than within eight weeks of the first

- we are also planning to deliver booster vaccinations, starting in September. We are awaiting guidance about the type of vaccination, cohorts and about vaccinations for children

- we are in discussion with the Primary Care Networks (PCNs) and pharmacies, and by the end of July we should know which will opt back into the programme

Dr Ed Ford commented that patients are confused about the difference between lateral flow tests and PCR tests: Trudi Grant responded that the PCR is more robust. In the event of people having a positive lateral flow test, they will need to self-isolate until they have received a negative PCR. There is quite a lot of pressure on PCR testing so results are taking a little longer but people must stay self-isolated until they have received the result.

Grahame Paine queried why the report does not include the number of hospital admissions compared to cases: Trudi Grant responded that Public Health does not have a direct NHS feed into the dashboard – the NHS national data is only published once a week and only provides information about Acute Trusts. The published information needs to be relevant to Somerset and it is difficult to filter out, for example, patients

from Dorset who are being treated at YDH. James Rimmer advised that the number of Covid admissions remain very low – on 19 July, there were 12 Covid patients at the two Somerset hospitals, and a fortnight before that there were only three. However, this is a week-on-week doubling so it is important that people continue to observe the infection control measures such as handwashing etc.

Trudi Mann asked why Somerset cases were predicted to reduce in a couple of weeks when the national reports were that cases would continue to rise much higher before stabilising: Trudi Grant responded that, according to the local modelling, the expectation is that case numbers will level off in August and start to reduce in September, which is very close to the national picture. The number of cases in Somerset has always been lower than the national average and this is due to the tremendous efforts made by the Somerset population. We are hopeful that the peak can be suppressed, but the modelling is not an exact science because we are dependent on people's behaviour. However, any apparent levelling off may be due to the delay in PCR test results.

Wendy Grey commented on the number of staff who are being 'pinged' which requires them to self-isolate, and whether the system will manage: Alex Murray responded that this is a national problem affecting all providers across the country. There has been a national announcement that a system may be introduced to enable frontline health and care colleagues to be exempt in some circumstances. However, the guidance is still unclear and further information is awaited. Trudi Grant stated that care would need to be taken when the guidance is received – we would not wish anyone who is infected to transmit the virus, so whatever we do, it must be under exceptional circumstances based on the balance of risk of transmission versus the risk of not being to stand a service back up.

SCCG 065/2021 PATIENT STORY: "MEND THE GAP" ANNUAL HEALTH CHECKS

We had hoped to bring a patient story to the Governing Body via video. However, the video had not been received and the item has therefore been deferred to September.

SCCG 066/2021 FIT FOR MY FUTURE: UPDATE AND PETITION RELATING TO RELOCATION OF THE MENTAL HEALTH WARD

The Meeting received a short update paper outlining the progress of Fit For My Future. In addition to the Public Questions that had been addressed (item SCCG 055/2021) and the Chief Executive's report (item SCCG 063/2021) Dr Alex Murray provided a broader verbal report and it was noted that:

- we are working across the system to consider how we finalise the strategy and move towards its delivery
- we have reviewed the learning from Covid-19 pandemic and have updated our aims to reflect this and also to explicitly address inequalities
- the vision and aims have now been adopted across the system, including the majority of voluntary partners

- the NCSOC (neighbourhoods and community settings of care) community model is starting to be delivered and we continue to work on finalising the vision for community hospitals and rehabilitation

- as outlined in today's Public Questions and the Chief Executive's Report, on 27 May 2021 the CCG received a Petition relating to the relocation of St Andrews Ward: we believe that the issues have been addressed but we are keen to continue to listen, and further public engagement events are being planned

- we are keen to enact the prevention agenda and Dr Tom MacConnell is working with the long-term conditions teams, public health, neighbourhoods and PCNs, focusing on hypertension (stroke indicator) as a first step

The Meeting noted the FFMF update.

SCCG 067/2021 **FIT FOR MY FUTURE: IMPROVING COMMUNITY HEALTH AND CARE SERVICES - COMMUNITY ENGAGEMENT FINDINGS REPORT**

The Meeting received the summary and full version Improving Community Health and Care Services Community Engagement Findings Report. Sara Bonfanti and Emily Taylor provided a verbal report and it was noted that:

- the community engagement programme took place from 30 January to 12 April 2020

- the results were independently analysed by Participate but public release was paused due to the Covid-19 pandemic

- the FFMF Programme Board approved the release of the results on 17 June 2021

- overall response from those in support of the proposals felt that:

  - supporting care at home can lead to better patient outcomes
  - if care were provided at home, it may mean that families/carers could travel less
  - Urgent Treatment Centres (UTCs) may offer an enhanced range of services to take pressure away from A&E

- overall concerns focused on:

  - the potential travel impacts for all, particularly carers, elderly and those with a disability
  - a rural geography with poor public transport provision
  - an ageing population that would struggle to travel further for urgent care
  - perceived loss of access to local services
  - worries that community hospitals may be closed
  - insufficient professionals to run a GP-led service
  - potentially inadequate provision of community-based beds for those that require a hospital stay

- some gaps were identified in the engagement process: we will continue to work with Spark Somerset to ensure we engage better with those communities

- a cascade and communications plan has been developed and the findings will also be presented to key stakeholders

- we are continuing to work with Somerset Foundation Trust to support the engagement on the vision for community hospitals

David Heath commented that while the care at home concept has widespread support, it will be important for all organisations to work together to ensure there is no gap between promise and consequence. We must ensure that everything we do is centred on the patient, and that we provide seamless care, despite it coming from various areas. This is not a low-cost option – it requires investment in the right solutions, and there will be a continuing need for crisis support: people are generally unaware of what an Urgent Treatment Centre (UTC) is.

Dr Alex Murray confirmed that all of David Heath's concerns were being thought about and addressed. In terms of UTCs, although updated guidance has recently been received, the definition of a UTC is still under debate. Minor Injury Units (MIUs) will be known as community treatment centres. Person-centred care is a principal aim of the FFMF programme and good feedback has been received about the intermediate care model, where people will have a direct point of contact. In terms of cost, this is not a cheap alternative; rather, it is better for patients and there will be no mass closure or sudden decision to close any of the community hospitals. Our focus is on planning what we need to better serve our population, and there would be a gradual transfer. People have told us that they would prefer their care to be at home or as close to home as possible, and the community hospitals should be a hub providing a range of services.

Trudi Mann noted that people had expressed concern that there are insufficient professionals to run a GP-led service. Given that we are building a multi-disciplinary workforce, people need to understand that they may be in touch with a primary care team rather than a GP ie. that they may be seen, for example, by a Nurse Practitioner instead. Trudi Mann also noted that the map on page 41 of the report is out of date.

Dr Alex Murray agreed that many people have been GP-focused, but their first contact is likely to be a practitioner. Dr Ford felt that it was an education process, and in the majority of cases, people are very happy with the service provided by an allied healthcare professional.

Action 798: Map on Page 41 to be updated (Sara Bonfanti)

Lou Evans noted that 837 people had participated in the engagement programme but expressed concern that this was only 0.15% of the Somerset population. He also noted the concerns expressed, including people's worries about community hospital closure, the models of care proposed, and patient transport, and suggested that a Governing Body development session might be required:

Dr Alex Murray reassured the Governing Body that the response rate was relatively good in comparison to other surveys, and answers would be forthcoming as we work alongside the ongoing engagement.

In terms of the number of responses, Emily Taylor clarified that 837 is, in fact, impressive, because most people – unless they need to access services – are relatively 'unbothered'. However, it was acknowledged that we need to reach a broader demographic, as most of the responses were from females and older people. Emily confirmed that we will use a wider range of engagement tools moving forward and welcomed the opportunity for a Development Session.

Grahame Paine agreed that the number of responses was a very good result and also that the proposal was not a cheap alternative. In terms of the social care element, we are still waiting for the views of the government, and it is clear that the private care providers have been unable to keep up with demand, which will need to be planned for going forward. Grahame Paine agreed that a Development Session would be useful.

Action 799: FFMF: Improving Health and Care Services Community Engagement Findings report to be included on the Development Session forward agenda (Maria Heard)

By a show of hands, and subject to minor amendments relating to the PCN map and correction of certain spellings (Bridgwater), the Governing Body approved the FFMF Improving Community Health and Care Services Community Engagement Findings report, and the recommendation to release the report and promote to members of the public.

SCCG 068/2021 LEARNING DISABILITY MORTALITY REVIEW (LeDeR) ANNUAL REPORT 2020/21

The Meeting received the LeDeR Annual Report for the period 1 April 2020 to 31 March 2021. Eelke Zoesbergen and Phoebe Sherry-Watt provided a verbal report and it was noted that:

- since 2017, we have been required to review the deaths of all people with a learning disability. The overall aim of the programme is to reduce health inequalities and prevent early death
- the Covid-19 pandemic has had an impact on the LeDeR workforce, and we have had to rely heavily on volunteers
- 22% of deaths in people with a learning disability was as a result of Covid-19
- a total of 54 deaths were notified, five of which related to 2019/20
- the majority of Covid-19 deaths were seen in the 50-69 year age group
- in addition to Covid-19, most common causes of death were aspiration pneumonia, respiratory conditions and additional health issues such as heart disease/cardiac failure, and old age/frailty

- in Somerset, 86 reviews were completed between April 2020 and April 2021. The backlog has been cleared and we will now focus on the learning from those reviews

- three main themes have been identified:

  - annual health checks: we are working with partners to increase the quality and uptake of annual health checks, which is a crucial factor for addressing inequalities for people with a learning disability

  - Mental Capacity Act (it should never be assumed that people with a learning disability lack capacity)

  - holistic commissioning for epilepsy and dementia for people with learning disabilities and/or autism

- a new national policy for the LeDeR programme has been launched taking effect from 1 June 2021: "Learning from Lives and Deaths – People with a Learning Disability and Autistic People LeDeR Policy 2021"

- the LeDeR team comprises three part-time reviewers, a senior reviewer, administrative support and a new Local Area Co-Ordinator (LAC)

- as we move towards an ICS, we will be focusing less on the clinical aspects and more on the *experience* of health and social care for people with a learning disability. There will be an ICS governance team, with senior representation from Somerset-wide organisations, with the aims of decreasing the number of preventable deaths and taking forward the learning

Dr Ed Ford asked that the learning from the report be tracked and included in next year's report to indicate where we are/are not making progress: Phoebe Sherry-Watt confirmed that an operational toolkit is being produced to ensure we have a clear understanding of how the learning and improvements are being taken forward, and this will be tracked on a monthly basis.

Referring to the priorities for 2021/22, Trudi Mann noted that a key performance indicator of how we are achieving the overall aims of the programme is that reviews are undertaken in a timely way, but asked how we will measure 'improved informed decision making' (Improvement Priority 2 refers): Phoebe Sherry-Watt responded that SMART (specific; measurable; attainable; realistic; time-bound) action planning will sit with the ICS to determine the required actions. In the interim, we will require a monthly return from providers, to drill down to the measurable outcomes, and a template has been produced to support this. We may also set up separate steering groups to sit alongside the panel.

By a virtual show of hands, the Governing Body approved the LeDeR Annual Report for 2020/21, the learning points for development and the local LeDeR improvement priorities for 2021/22.

SCCG 069/2021 **WORKFORCE RACE EQUALITY STANDARD (WRES) AND ACTION PLAN 2020/21**

The Meeting received a report about the CCG's position against the five key performance measures of the WRES for 2020/21, including a comparison against the measures from 2019/20. Sophie Wainwright provided a verbal report and it was noted that:

- the WRES looks at measures of race equality throughout the organisation and has five specific indicators:
    - WRES Indicator 1: pay banding and differences in terms of white and black and minority ethnic (BME) colleagues:
        * 2020/21: 87.5% of BME colleagues are working at or below Band 7, compared to 72.3% of white colleagues
        * 2019/20: 83.3% of BME colleagues were working at or below Band 7, compared to 71.4% of white colleagues
    - WRES Indicator 2: relative likelihood of white and BME colleagues being appointed from the shortlisting process across all posts
        * 2020/21: 33 BME applicants were shortlisted, of which five were appointed (15.15%). 192 white applicants were shortlisted, of which 52 were appointed (27.08%). Therefore, a shortlisted white applicant is 1.8 times more likely to be appointed at interview than a BME applicant
        * 2019/20: 25 BME applicants were shortlisted, of which one was appointed (4%). 247 white applicants were shortlisted, of which 65 were appointed (26.32%). Therefore, a shortlisted white applicant was 6.6 times more likely to be appointed at interview than a BME applicant
    - WRES Indicator 3: difference between white and BME colleagues entering the formal disciplinary process
        * 2020/21: the relative likelihood of a white colleague entering the formal disciplinary process was 0% and this was the same for BME colleagues. (NB: No colleagues entered a disciplinary process during 2020/21)
        * 2019/20: the relative likelihood of a white colleague entering the formal disciplinary process was 0.76% and 0% for BME colleagues
    - WRES Indicator 4: relative likelihood of white and BME colleagues undertaking learning, education, training or development activity which is neither a statutory nor mandatory requirement
        * 2020/21: 12.5% of white employees, and 12.5% of BME employees accessed non-mandatory training courses and CPD (continuous professional development)

    * 2019/20: 10.98% of white employees, and 0% of BME employees accessed non-mandatory training courses and CPD (continuous professional development).

- WRES Indicator 5: percentage difference between the organisation's Board voting membership and its overall workforce; and, the organisation's Board executive membership and its overall workforce

    * as of 31 March 2021, the CCG employed 292 colleagues. 272 identified as white, eight as BME and 12 did not disclose their race. The percentage of BME colleagues is therefore 2.7%, which aligns with the estimated BME population of 2% of the total Somerset population

    * as of 31 March 2020, the CCG employed 275 colleagues. 264 identified as white, six as BME and five did not disclose their race. The percentage of BME colleagues was therefore 2.1%, which aligned with the estimated BME population of 2% of the total Somerset population

    * as of 31 March 2021 and also 31 March 2020, no BME colleagues are/were voting members of the CCG Governing Body

    * as of 31 March 2021 and also 31 March 2020, no BME colleagues are/were part of the Executive membership of the CCG

    * therefore, the difference in BME colleague representation on the Governing Body, both with respect to voting members and executive members as compared to the organisation, is -2.7% (-2.1% in March 2020)

- action plan summary:

    - we will look at any barriers BME colleagues may be facing in terms of banding

    - GPs: we will ensure we continue to advertise fairly

    - further analysis of the recruitment process: we currently ensure name and detail blind recruitment up until the time of interview. In this phase, we will also remove any references that have been provided

    - we will continue to keep supporting people's progression through training and recording of CPD activity

    - Governing Body and executive membership: where vacancies occur, we undertake equitable recruitment practices, including ensuring that agencies have similar standards. We have actively sought and encouraged BME colleagues to join the staff forum and other committees/forums to ensure their voice is heard by senior colleagues

James Rimmer highlighted the importance of this report and that there was still work to do, but was encouraged to see the progress that had been made. James reminded the Governing Body they would be receiving Equality and Diversity training in the afternoon's Development Session.

Grahame Paine commented that NHS Improvement had previously offered senior people an opportunity to shadow the Acute Trust Boards and asked if this had been extended to CCGs: Sophie Wainwright responded that a paper had recently been written relating to reciprocal reporting, for senior staff to be paired with an Executive or Non-Executive Director, and this will be developed.

Wendy Grey advised that a further initiative had been launched by the Leadership Academy relating to mentorship for international registered healthcare professions and offered to forward the details of this to any interested parties. Lou Evans suggested that the CCG HR department could liaise with YDH HR, which operates an international recruitment scheme.

By a virtual show of hands, the Governing Body approved the action plan to address the areas for improvement identified by the WRES report.

SCCG 070/2021 RISK MANAGEMENT UPDATE REPORT

The Meeting received the Risk Management report, which provided updates on corporate risks which were new, escalated, de-escalated, increased, decreased or closed on the Corporate Risk Register since the full review by the Governing Body in March 2021. Neil Hales provided a verbal report and it was noted that:

- a new risk had been added, 463, relating to the financial plan, with a current risk rating of 20:
    - planning for 2021/22 has been split into two periods. We have submitted a balanced plan for H1 (April-October 2021) and are waiting for guidance relating to H2 (November 2021-March 2022). From a system perspective we continue to have an underlying deficit but this will be updated
- increased risk, 9, with a current risk rating of 16 (from 12): There has been a significant growth in urgent and emergency care, and this is likely to increase further
- reduced risk, 292, with a current risk rating of 12 (from 16) relating to workforce sustainability: we are on track for the recruitment of overseas nurses and for the apprentice programme
- reduced risk, 406, relating to Covid-19 and the potential for increased demand in mental health services, with a current risk rating of 12 (from 16): additional non-recurrent funding has been made available nationally to support the anticipated rise in demand
- reduced risk, 425, relating to the Ofsted/ CQC SEND inspection and neuro-developmental pathway, with a current risk rating of 12

(from 15): further meetings have taken place, particularly around the autism pathway

- closed risk, 427, relating to Covid-19 and the Children and Young People's (CYP) access rate. Due to changes to the national access definition and the growth in CYP services, we are confident that we will achieve the national standard

- closed risk, 397, relating to the CCG financial plan for 2020/21, as the financial year 2020/21 has now concluded

- risk 362, LeDeR programme, de-escalated from the Corporate Risk Register (CRR) to the Directorate Risk Register (DRR), with a current risk rating of 9. The risk has been de-escalated due to achievement of the April 2021 key performance indicator and the recruitment of the substantive LeDeR team including a new Local Area Co-ordinator

- risk 386, Covid-19 PPE, de-escalated from the Corporate Risk Register (CRR) to the Directorate Risk Register (DRR), with a current risk rating of 8. The risk has been de-escalated due to good availability of PPE both locally and nationally, together with the increase in the methods of infection control

Lou Evans asked about the timetable for the H2 financial plan, and if we will be asked to make savings:

Alison Henly responded that guidance is anticipated in September and it is possible that efficiency savings will be required, based on H1. Neil Hales advised that the long-term plan is due for refresh in quarter 4, and discussion is taking place nationally about whether the plan should be for an extended period, for example, to cover the next three years.

Lou Evans noted that the risk rating for risk 9, demand for urgent and emergency care, had risen from 12 to 16 and asked if this was high enough: Neil Hales advised that, if the risk register were run today, risk 9 would attract a rating of 20 – it was an issue of the report timing.

By a virtual show of hands, the Governing Body approved the additions and amendments to the CCG Corporate Risk Register.

SCCG 071/2021 FINANCE REPORT FOR THE PERIOD 1 APRIL TO 31 MAY 2021

The Meeting received the Finance Report for the period 1 April to 31 May 2021. Alison Henly provided a verbal report and it was noted that:

- the ICS has received an overall system allocation, which confirms funding for the first six months of the financial year. This is based on the same arrangement as for 2020/21 and includes continuation of the system top-up and Covid fixed allocations. The financial settlement for months 7-12 will be confirmed in due course

- a balanced plan for the first six-month period was submitted, both on an individual organisation and system basis. These plans form the base on which the CCG's budgets have been determined,

which have been reviewed and supported by the Finance and Performance Committee

- the report highlights a variance of £5.9 million, which relates to the costs of the Hospital Discharge Programme and the Covid-19 vaccination inequalities programme. These costs have been claimed via our monthly reclaim process and funding is expected in due course

- no variances have been highlighted at this stage. Financial performance against budgets will be kept under close review as we move through the financial year. A detailed budget statement is reviewed by the Finance and Performance Committee on a monthly basis

- regarding the Better Payments Practice Code, the CCG has continued to support the local economy through ensuring fast payments, and is routinely paying 100% of invoices within 30 days

By a virtual show of hands, the Governing Body approved the Finance Report for the period 1 April to 31 May 2021.

SCCG 072/2021 **QUALITY, SAFETY AND PERFORMANCE EXCEPTIONS REPORT FOR THE PERIOD 1 APRIL TO 31 MAY 2021**

The Meeting received the Quality, Safety and Performance Exceptions Report (Integrated Board Assurance Report) for the period 1 April to 31 May 2021. Neil Hales and Val Janson provided a verbal report and it was noted that:

- Initial Health Assessments within 28 days for Children Looked After (CLA): performance has decreased significantly, from 62% to 45%

- the number of CLA has increased, which makes the target more challenging – this is due to issues outside our control – foster care availability, late notifications etc - but we are working with system partners to resolve

- dental checks for CLA have increased since the easing of Covid-19 restrictions, but performance, at 37.1%, is below an acceptable level

- Continuing Healthcare (CHC): performance against the 28 day standard has improved to 74% as at the end of May 2021, and informally, we achieved 80% for Quarter 1 overall, which was ahead of projection. Fast track performance has been excellent, with 99% of referrals being ratified within 24 hours. With providers, we continue to review and improve the quality of referrals

- LeDeR performance: as discussed above, at item SCCG 068/2021

- infection prevention and control:

  - there has been one community-acquired case of MRSA in a high-risk individual; a review is being undertaken

- peer review of C diff and MSSA cases, and identification of themes, took place on 25 June 2021 and we are discussing with the regional team the possibility of sharing our practices

- the aims of the peer review are to reduce current and healthcare acquired infections, and to ensure we have the correct coding for initial and recurring infection. We are working with primary care to raise awareness and improve diagnosis

- Venous Thromboembolism (VTE): VTE assessments have gradually increased within both Somerset Foundation Trust (SFT) and at Yeovil District Hospital (YDH)

- SFT is above the 90% national reporting standard for nutritional screening but YDH is currently not meeting this requirement

- patient demand for primary care is high, with approximately 284,000 appointments in April 2021. Reporting has been enhanced, linked to OPEL status for primary care as a whole

- there are no GP Practices with an Inadequate rating. Three practices are currently rated as Requires Improvement and we expect these to be rated as Good upon CQC reinspection. In Somerset, 85% of Practices have an overall rating of Good compared to 83% nationally

- demand on the 111 service has increased significantly and is now at a level similar to that seen in Winter 2019/20

  - one caller made 6,000 calls to the service within one month – the patient is receiving support through an MDT (multi-disciplinary team) approach

  - 25% of calls related to self-care; 12% were referred to A&E; 11% were directed to the ambulance service

- SWAST has seen unprecedented levels of demand, with the number of calls this week reflecting those on New Year's eve

  - call validation: for category 3 and 4 calls in May 2021, 87% were downgraded by the clinical assessment clinicians with only 65 resulting in an ambulance being despatched

- A&E front door:

  - demand increased in quarter 1 and is now at a pre-Covid level

  - A&E departments are impacted by social distancing measures etc and performance has reduced against the four-hour standard

  - the number of walk-in patients has rapidly increased, with 25% of attendances being seen between the hours of 5.00 to 8.00 pm

- we have been notified by Public Health England of a significant risk, nationally and internationally, relating to paediatric respiratory disease, with a greater occurrence in children under 4 years old

- elective surgery:

    - 3,063 patients have waited for longer than 52 weeks (a reduction on the previous period due to a decline in the number of referrals)

    - there has been an increase in the number of 78-week waiters and 43 patients exceeded a waiting time of 24 months. A plan is in place to reduce the number of 24-month waiters to zero by the end of March 2022, with work taking place around pre-operative pathways, advice, guidance, additional pathways and rapid diagnostics

    - six-week diagnosis: the highest volume of breaches occurred in MRI, echocardiography and endoscopy, with performance at 67% compared to a target of 99%. Additional MRI capacity has been sourced from the independent sector and we are also looking at the possibilities for mobile capacity

    - 62-day cancer performance was at 73.8% compared to a target of 85%. Breaches were predominantly in lower gastrointestinal (GI); head and neck; urological; upper GI; gynaecological, and skin cancers

    - patients with suspected prostate cancer are now being triaged straight to test (MRI scan)

- Improving Access to Psychological Therapies (IAPT):

    - the number of people accessing treatment during April-May 2021 was below plan, due to the annual target being profiled evenly across the year. We anticipate an increase over the course of the year as new staff commence in post and new access routes are introduced eg. for long-term conditions, Long Covid etc

- Children and Young People (CYP): during the 12 months to April 2021, there were 3,016 contacts with CYP mental health services, compared to a target of 3,564. Performance is expected to improve in the future, as two more teams are being recruited and will start training at Exeter University in January 2022

Grahame Paine commented that the MIU at Shepton Mallet would be closing early for a few days and asked if performance would be impacted: Neil Hales responded that the reason for the early closure was predominantly a staffing issue, arising from staff being 'pinged' and needing to self-isolate. James Rimmer advised that SFT is committed to doing all they can to ensure that MIUs adhere to the advertised opening times as much as possible, as they recognise the potential knock-on effect of early closure.

SCCG 073/2021 INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2020/21

The Meeting received the Infection Prevention and Control (IPC) Annual Report for the period 1 April 2020 to 31 March 2021. Val Janson

provided a verbal report and it was noted that:

- 2020/21 was a critical year for IPC: during the Covid response, and in partnership with the Public Health team, we increased IPC capacity to expand our remit to both health and care:

    - the team previously comprised two whole-time equivalent (WTE) staff; during the pandemic this was increased to six and has now returned to approximately four WTE

    - team members worked well together, attending informal meetings, assurance committee meetings, strategic and operational meetings

    - the team mobilised very quickly to carry out 100% IPC training to providers plus further in-depth training

    - outbreak management processes were established, supporting all providers including primary care

- MRSA: cases rose from two in 2019/20 to seven in 2020/21. We are committed to reducing the number of infections this year and are working with the Foundation Trusts on associated action plans. Case numbers are in line with the national average

- C diff: 133 cases were identified versus a target of 124. Somerset was third lowest in the region but slightly higher than the national average

- MSSA bloodstream infections: 142 cases were identified compared to 173 in 2019/20. In terms of infections per 100,000 population, this was higher than both the regional and national average. The main learning from the post-infection reviews indicate that improvements are necessary for in-dwelling devices

- Gram negative bloodstream infections: NHSE had previously set a target to reduce infection rates by 50% by March 2021 – this has now been extended to 2023/24. The majority of infections occurred before people were admitted to hospital and often related to a urinary tract infection

- key priorities for 2021/22:

    - MSSA deep dive
    - actions around gram negative bloodstream infections
    - anti-microbial stewardship, to reduce the number of anti-microbial prescriptions
    - support for a primary care infection prevention and control link practitioner

Dr Ed Ford commented on the rise in some infection cases: Val Janson agreed that an increase had been seen compared to previous years, which was a reflection of the national picture. The rise was surprising, given the increased focus on IPC, but emphasises that further work is required in the community.

By a virtual show of hands, the Governing Body approved the Infection Prevention and Control annual report for 2020/21.

SCCG 074/2021 COMPLAINTS ANNUAL REPORT 2020/21

The Meeting received the Complaints Annual Report for 2020/21, which is a statutory requirement under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Val Janson provided a verbal report and it was noted that:

- 58 formal complaints were received during the year
- main areas of dissatisfaction related to access to services; quality of care; diagnosis
- three referrals were made to the Ombudsman, two relating to continuing healthcare and one to end of life care
- the report as presented was a high level summary. Detailed reports of complaints received, their outcome and any learning are reviewed by the Patient Safety and Quality Assurance Committee
- a broader patient experience report is being collated, to increase the learning via a wider range of feedback

Dr Ed Ford asked if any complaints had related to Covid: Val Janson advised that various Covid enquiries had been made to PALS (patient advice and liaison service) but there had been no formal complaints.

Trudi Mann was encouraged to see how the learning from the complaints had led to three significant improvements across a number of services: a new Autistic Spectrum Condition /Attention Deficit Hyperactivity Disorder pathway; resolution of access issues relating to the system used to transfer diagnostic images; and improving access to mental health services and making them more person-centred.

At the request of Grahame Paine, it was agreed that some benchmarking activity would be conducted, picking up the themes from PALS as well as complaints.

Action 800: Complaints and PALS benchmarking report to be produced (Val Janson)

By a virtual show of hands, the Governing body approved the Complaints Annual Report for 2020/21.

SCCG 075/2021 ANY OTHER BUSINESS

There were no items of other business.

SCCG 076/2021 DATE OF NEXT MEETING

Our Annual General Meeting will be held via MS Teams on Tuesday, 14 September 2021, from 7.00-8.15 pm. Members of the public are welcome to attend and are invited to submit their questions to kathy.palfrey@nhs.net in advance

The next full meeting of the Governing Body will be held on Thursday, 23 September 2021, starting at 9.30 am via MS Teams. Papers will be published in advance on our website and members of the public are invited to submit their questions to kathy.palfrey@nhs.net by midday on Tuesday, 21 September 2021.

The Chairman brought the Part A Meeting to a close and advised that the Governing Body would now move into closed session. Part B meetings are held in private due to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

CHAIRMAN …… DATE ……