Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Item 12.3

Commissioning Executive

Minutes of the meeting held on 5th April 2018 at 2.00pm at South Plaza.

Minutes

Present		
Chair Julia Ross	Chief Executive, BNSSG CCG	JRo
Sarah Truelove	Director of Finance, BNSSG CCG	STr
Anne Morris	Director of Nursing and Quality, BNSSG CCG	AM
Deborah El-Sayed	Director of Transformation, BNSSG CCG	DES
Colin Bradbury	Area Director for North Somerset, BNSSG CCG	CB
David Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Justine Rawlings	Area Director for Bristol, BNSSG CCG	JRa
Martin Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJo
Peter Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Jonathan Evans	Clinical Commissioning Area Lead for South Gloucestershire, BNSSG CCG	JE
Kate Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
Kevin Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Michael Jenkins	Clinical Care Pathway Lead for Integrated Care	MJe
Kate Rush	Clinical Leadership Development	KR
Lesley Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Jeremy Maynard	Clinical Corporate Lead for Quality, BNSSG CCG	JM
David Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Alison Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Alison Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AW

Andrew Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA
Sara Blackmore	Director of Public Health, South Gloucestershire Council	SB
Apologies		
Lisa Manson	Director of Commissioning, BNSSG CCG	LM
Jon Hayes	Clinical Chair, BNSSG CCG	JH
Geeta Iyer	Clinical Corporate Lead for Primary Care Provider Development, BNSSG CCG	GI
Shaba Nabi	Clinical Corporate Lead for Prescribing, BNSSG CCG	SN
David Peel	Clinical Care Pathway Lead for Planned Care, BNSSG CCG	DP
Mark Pietroni	Director of Public Health, South Gloucestershire Council	MP
In attendance		
Gemma Artz	Head of Performance Improvement Planned Care, BNSSG CCG (For item 6)	GA
Mike Pingstone	Associate Director of Procurement, CSW CSU (For item 6)	MPi
Niall Mitchell	Head of IFR – BNNSG and Somerset, BNSSG CCG	NM
Lucy Powell	PA to Lisa Manson, Director of Commissioning, BNSSG CCG	LP

	Item	Action
01	**Apologies** Apologies were noted from Lisa Manson, Jon Hayes, Geeta Iyer, Shaba Nabi and Mark Pietroni.	
02	**Declarations of Interest** **02a. To consider any changes to attendee interests since the last meeting** None. **02b. To consider any conflicts of interest arising from this agenda** None.	
03	**Minutes of the meeting and matters arising from 14th March 2018** The group reviewed the minutes of the last meeting and they were	

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	agreed as a true and accurate record.	
03.1	**Action log from 28th March and Forward Planner** Please see attachment 3b.	
04	**Commissioning Executive Terms of Reference** The Committee reviewed the updated Terms of Reference. The Committee had no further comments.	
05	**Urgent Care Update** **05a. A&E Delivery Dashboard – Headlines and Executive Summary.** Julia Ross (JRo) presented the dashboard to the Committee noting that Urgent Care is a key priority for the CCG. Following on from a difficult winter period, there was a performance improvement within the system during the Easter period. The Committee discussed system wide performance, noting that BNSSG performs above average in the South West for the 4 hour wait performance. This led to a discussion about what key areas the CCG should prioritise on monitoring. The Committee noted that the dashboard contained possibly too much detailed information and JRo noted that the report could be refined for the Committee once decisions have been made on the key focus areas. Peter Brindle asked whether the report could compare yearly statistics rather than monthly. It was highlighted that this data was available within the report but perhaps could be shown in a more helpful way. The Committee discussed how data from primary care and out of hour's provision was fed into the dashboard. Jonathan Evans (JE) asked whether the length of delays could be shown within the report as well as a clarification around whether GP referrals shown were in or out of hour's referrals. Martin Jones (MJo) highlighted that there was a piece of work required to scope Urgent Care and bring all the various data streams together in a meaningful way. Deborah El-Sayed (DES) suggested that the teams involved in Urgent Care propose to the Committee which data should be scrutinised at the meetings. Lesley Ward was asked to work with the team to prepare a paper for the next meeting to review the metrics required for the Commissioning Executive Committee to make informed decisions	**LW**

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	relating to Urgent Care.	
06	**Commissioning of Integrated MSK Services for BNSSG (For discussion)** Dave Jarrett (DJ) introduced this paper to the Committee and welcomed Gemma Artz (GA) to the meeting. DJ explained that GA and David Soodeen (DS) had led the design of a new MSK model for BNSSG which had been informed by opportunities recognised through RightCare and noted that MSK service improvement was a priority for the CCG and the STP. DJ highlighted the service model improvements which had occurred which included changes to the referral pathways and operating models. DJ explained that the paper today informed the Committee on the proposed new clinical model for MSK services and the possible options for procuring the service. It was noted that the paper was for discussion only at this point in time. DS noted that the current MSK pathway had been identified by focus groups as requiring simplification. The model proposed has been reviewed by patients and clinicians and feedback has been incorporated into the model. GA outlined the service model proposed: Tier 1 – Self Management, including virtual tools and Community based services. Tier 2 – Locality based services, either through self or GP referral but with services available through a single point of access Tier 3 – Outpatients in specialities such as Rheumatology and Orthopaedics Tier 4 – Inpatient care such as elective surgery. This tier would also include emergency admissions. It was noted that the tier service level would be adapted based on patient needs and patient choice was a fundamental part of the clinical pathway.	

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	GA highlighted the financial modelling noting that there were further costs that were not included within the paper. These included costs from the community providers or costs associated diagnostics that were not yet known in exact detail. GA noted that the current service changes had resulted in savings for 2017/18 within the MSK service however the changes had not addressed the convoluted pathway and improved patient experience. Sarah Truelove (STr) asked whether the new clinical model would address any RTT issues in the system. GA clarified that further investment into the front end would improve RTT, as the clock starts at referral into Tier 3. GA explained the further RTT advice is required from NHS Improvement on the new model. Mike Jenkins (MJe) asked whether patient self-referral to tier 2 will bypass primary care and thus clinical input. GA explained that the triage system will use clinical expertise to refer to the most relevant tier which could potentially be tier 1 or referral to a GP. GA reiterated the need for an effective single point of access for the service. Alison Wint (AW) asked about the current issues to the interface services and DJ highlighted that there would be reinvestment into these services. GA noted that the BNSSG boundaries would be removed and resources for interface services shared. AW highlighted that for younger service users some types of pain managed by the MSK service can be red flags for cancer diagnosis. DS noted that key questions asked at triage should pick up on symptoms that could potentially point to cancer. The Committee discussed the age range for the clinical model and it was noted that this service would be for adults and it was agreed that this needed to be made clearer in the specification. Peter Brindle (PB) asked how the service outcomes could be measured and how the CCG would measure improvement. GA noted that there were existing tools that could be utilised to measure outcomes such as patient experience. The Committee discussed the improvement measures and it was asked that the specification included further detail including baseline measurements. JE asked that the triage to team mechanic was detailed further in the	

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	specification. Lesley Ward (LW) noted the need for blood results to be shared across the local healthcare system and asked that this was considered in the specification. The Committee discussed the IT systems required to enable the new model to function and DES noted that the system used would need to be embedded across all services to aid joined up working. Sarah Blackmore (SB) highlighted that positive lifestyle choices were a key preventative of future conditions. GA noted that part of tier 1 would be providing information on healthier life style choices. Mike Pingstone (MPi) was welcomed to the meeting to discuss the procurement options with the Committee. MPi outlined the 4 possible options: Option 1 – Full OJEU process advertised throughout Europe. Option 2 – High speed OJEU compliant assurance process. MiP noted that this process would have less administrative burden during the competitive stage but could result in the necessity to redo the procurement if suitable bidders do not get through at the start. Option 3 – Directly negotiated solution. MiP noted that this option would require the CCG to provide evidence that there was only one suitable provider for the service. Option 4 – Directly negotiated solution through contract modification. MiP highlighted that this option would require the CCG to modify each of the contracts held, ensuring that each contract was modified legally. Part of this would be ensuring that the MSK element of each contract did not change by more than 10%. The Committee discussed the procurement options including the option to commission a lead provider to manage the whole service. JRo highlighted that the funding arrangements for the service will inform the procurement option decision for example whether it is procured as an end to end pathway based on a population based payment.	

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	STr asked that the team look into the VAT implications of the new model of care as this could also affect the procurement option decision. The Committee discussed the advantages and disadvantages of procurement over redesign. The Committee agreed that procurement was the preferred option. The Committee agreed that the next steps would be for the specification to be developed with detailed non negotiables included but with some scope for the future provider to decide on certain details such as stratification tools. The Committee agreed that the draft specification should be presented to the locality forums and presented to the next Commissioning Executive meeting.	**LM**
07	**Progress of Individual Funding Request (IFR) Review** Niall Mitchell (NM) provided the background to this report explaining that an external review into IFR had taken place which made recommendations on the future structure and governance processes. The report provides progress to date on the recommendations and the suite of policy documents outlines the future governance process for Governing Body approval. NM outlined that the most significant change to the process was that social factors will no longer be included as an element for the IFR panel to consider. The IFR panel would be considering cases based on clinical factors only. The Committee discussed this, noting that this felt much fairer for patients due the subjective nature of the current process. The Committee highlighted the requirement for educational events for GPs to explain the IFR policy changes but also the need to provide support to GPs to manage patient expectation. NM explained that the new governance arrangements outline the differences between requests managed by IFR and those managed by the referrals team. Prior approvals will be managed as business as usual by the referrals team as these involve conditions for which policies exist. Any conditions which are clinically exceptional and for which the policy doesn't apply would be taken through the IFR panels. The Committee agreed that the new governance policies would ensure that the right cases would be discussed at the IFR panels and it was highlighted that all decisions would be underpinned by the strong ethical framework. Martin Jones (MJo) suggested that the website contained a section with information for clinicians on the definition of exceptionality and links to the various policies to aid with applications. The Committee	

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	further discussed the need to support clinicians to develop this change in culture. JRo noted that the Commissioning Policy Review Group (CPRG) would become a sub group of the Executive Commissioning Committee and decisions made at the CPRG would be approved by the Commissioning Executive members. Kate Mansfield (KM) noted that she agreed with the paper and the proposed policies and that the process felt much more equitable under the new policies. Kate Rush (KR) asked whether new forms would be developed and distributed. It was confirmed that following approval the policies and associated forms would be distributed to practices alongside leaflets for patient information. The Committee highlighted the risk of IFR panel membership not involving the correct people. JRo explained that lay membership would be a key part of the panel and the new IFR panel would be recruited to soon and relaunched. The Committee agreed that the IFR policies would be presented again at the May Commissioning Executive meeting with the following three key questions: 1 – Ethical Framework. The Commissioning Executive to review the Ethical Framework and recommend to the Governing Body for approval. 2 – CPRG Terms of Reference. The Commissioning Executive to review the Terms of Reference of the CPRG and recommend to the Governing Body for approval. 3 – IFR Policy development. The Commissioning Executive to discuss and review the policies and recommend to the Governing Body for approval.	LM
08	**Priorities Framework** Sarah Truelove (STr) presented a draft priorities framework for comment noting that this would provide a resource for the CCG when making decisions that would ensure transparency of decisions and ensure investment decisions are consistent. The Committee reviewed the matrix and highlighted that the scale of impact was not consistent with the BNSSG population area and would need to be revised. The Committee noted that the matrix needed clarification on the	

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	CCG position if a decision was high risk but mandatory. Jonathan Evans (JE) suggested that comparison with other prioritisation matrix formats is considered and existing tools used locally are shared. Peter Brindle (PB) highlighted the need for the evidence row to be reviewed by the Research team. STr noted that there were two outstanding actions on the Commissioning Executive Committee action log which require a prioritisation matrix and once finalised these actions would be taken through the prioritisation matrix and the outcome presented at the next Committee meeting.	LM/STr
09	**Any Other Business** Alison Bolam asked that the BPCAg/Non-core Primary Care Services ToR be added to the agenda for the next meeting.	AB
	Next meeting: 10th May 2018 **Boardroom, Lower Ground, South Plaza**	

Lucy Powell
PA to Lisa Manson, Director of Commissioning
12th April 2018