Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 9th May 2019 at 8.30am, CCG Conference Room, South Plaza, Bristol.

Minutes

Present			
Kirstie	Alexander	Clinical Lead for Children's and Maternity, BNCCG CCG	KA
Andrew	Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA
Janet	Baptiste-Grant	Interim Director of Nursing & Quality, BNSSG CCG	JBG
Alison	Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Terry	Dafter	Director for Adult Social Care, Bristol City Council	TD
Deborah	El Sayed	Director of Transformation, BNSSG CCG	DES
Jon	Evans	Clinical Commissioning Area Lead for South Gloucestershire, BNSSG CCG	JE
Kevin	Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Jon	Hayes (CHAIR)	Clinical Chair, BNSSG CCG	JH
Geeta	Iyer	Clinical Corporate Lead for Primary Care Provider Development, BNSSG CCG	GI
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
Martin	Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJo
Lisa	Manson	Director of Commissioning, BNSSG CCG	LM
Jeremy	Maynard	Clinical Lead	JM
Shaba	Nabi	Clinical Corporate Lead for Prescribing, BNSSG CCG	SN
David	Peel	Clinical Corporate Lead for Planned Care, BNSSG CCG	DP
Justine	Rawlings	Area Director for Bristol, BNSSG CCG	JRa
Julia	Ross	Chief Executive, BNSSG CCG	JR
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS

Present			
Sarah	Truelove	Director of Finance, BNSSG CCG	ST
Lesley	Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Sarah	Weld	Public Health Consultant, South Gloucestershire Council	SW
Apologies			
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Anne	Clarke	Director for Adult Social Services, South Gloucestershire Council	AC
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Kate	Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
Alison	Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AJW
In attendance			
Sarah	Carr	Corporate Secretary, BNSSG CCG	SC
Julia	Chappell	Senior Contract Manager, Mental Health & LD, BNSSG CCG	JC
Helena	Fuller	Deputy Director of Commissioning (Contracting & Procurement), BNSSG CCG	HF
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker)	JHo
Janette	Midda	Emergency Preparedness Resilience & Response Manager, BNSSG CCG	JM
Chris	Moloney	Living Well With & Beyond Cancer Project Manager, BNSSG CCG	CM
Sara	Stiddard	Transformation Manager, BNSSG CCG	SS
Claire	Thompson	Deputy Director of Commissioning (Planning & Performance Improvement), BNSSG CCG	CT

	Item	Action
01	**Welcome and Apologies** Jon Hayes (JH) Chair welcomed members and attendees to the meeting. Apologies were noted as above.	
02	**Declarations of Interest** **02a. To consider any changes to attendee interests since the last meeting** None declared **02b. To consider any conflicts of interest arising from this agenda** None declared	

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03	**Minutes of the meeting and matters arising from 14th March 2019** The minutes were agreed as a true and correct	
03.1	**Action log from 14th April 2019:**	

Item 61 – deferred to June	Item 94 – closed
Item 77 – deferred to June	Item 96 – closed
Item 79 – deferred to June	Item 97 – open
Item 80 – deferred to June	Item 98 – closed
Item 81 – deferred to June	Item 99 - closed

04	**BNSSG Mental Health Strategy** Richard Lyle (RL) was welcomed to the meeting to present the paper. Deborah El Sayed (DES) introduced the background to the draft paper. The purpose of the report was to: • Update the Commissioning Executive on the development of the draft strategy (Appendix 1) • Present the key strategic objectives, with a key focus on considering the types of services and changes that BNSSG may need to commission to meet these objectives. • Gain insights and ideas from Commissioning Exec members on models of service that should be explored DES explained the document was a first draft of strategic objectives developed from significant user engagement (almost 1,400 users to date), clinicians, LA's and police with further involvement from the education sector to be undertaken. The core objectives, a mission statement and strategic objectives had been to Clinical Cabinet and were with Commissioning Executive to gain views and ideas on what was useful, viable, to be explored further or might have been missed. DES advised that Professor Geraldine Strathdee, NHSE National Clinical Director for Mental Health, had been working with BNSSG and of the design sessions scheduled for 14th and 15th May intended to build on feedback gained from this meeting. DES asked for comments on the approach undertaken to date. KA commented this was a good starting point and endorsed the approach taken and asked if it was still in the early stages. DES advised the strategy not necessarily in early stages, the approach had evolved through data, needs and drivers across an all agency approach before going into implementation. KA commented that from a children's perspective there could be more within the strategy around the wider social determinants, adverse childhood experiences and working with other partner organisations to	

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	help address those wider social elements that underpin mental health in society. S Weld (SW) commented that within the Children and Family's Severe Mental Health and Wellbeing work stream this was already happening and from a Public Health view it was very important to tie in this preventative work with the whole strategy. J Ross (JR) commented on the overall approach in breaking down the broad ambition statements into bullet points and questioned whether this could be expanded. D Soodeen (DS) flagged the slight differences in the MH services within BNSSG areas such as crisis teams having different opening hours' dependant on the area and that recognition of this and the need to have something equitable across BNSSG be taken into account. G Iyer (GI) asked that the mental health be properly linked with the primary care strategy as this also contained a significant element of mental health. P Brindle (PB) referred to the Manchester example about developing the partnerships to see greater improvements in quality and care and asked for clarification on the key ingredients of their success and how success had been measured. DES clarified the paper contained a range of examples from areas raised by and collected across BNSSG and were included in order to gain a steer on what was felt right to pursue and research further. A Appleton (AA) commented positively on the emphasis of communications and the information flows effectively ensuring the care follows the patient, and its inclusion within the paper. JR valued the usefulness of gaining input from other regions and noted BNSSG needed to understand what works for BNSSG. DES agreed the purpose was about using externals ideas to fuel our own innovation and design. J Evans (JE) asked if the intention was to offer a service which provides sufficient provision for everyone or was the intention to look at specific groups, were would the resource be put? Do we have the resources and timescale to do this? RL advised options and more sustainable ways of delivering resources yet to be tapped into were known and the ambition was to refocus	

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	efforts to ensure people accessed the right treatment in the right setting. Mapping was currently being carried out to enable this. DES advised an example was around Sect.117 were expenditure was high but if people were better supported use of Sect. 117 would reduce. Knowing what the range of support services was available and having those options would aid in doing this. JE noted that following development, re-allocation and re-structuring and after placing a person in the right place the importance of having the outcomes measured. DES agreed and stressed the measurement and data piece was a very important feed; one of the key parts of the strategy was to ensure there was a data and financial strand as part of the strategy. SW referred to the structures with regards to delivering the strategy and the localities which in the past had quite different strategies and delivery models, and suggested the two things might be managed in parallel. DES advised that this was one of the core tenants of what was trying to be achieved and that the Commissioning Executive thoughts on the what's and how's would help inform this further. PB with regards to potential interventions questioned whether BNSSG had linked up enough to gain an understanding of the specific cohorts of the population and the work done on the data sources to better inform the interventions that might be implemented. DES confirmed that there were opportunities for data sharing, i.e. the BCC Troubled Families Database which if linked up with GP data there was an opportunity to reduce the number of children at risk rather than dealing with the aftermath. JR noted this was not currently in the strategy and identified that as a critical piece should be included. D Peel (DP) highlighted firstly a new Planned Care service, the new symptoms' clinics intended for consultants to refer patients into and the work being done to raise its profile within the trusts and secondly borderline personality disorder which tended to fall between the gaps in MH provision. RL spoke about services becoming more flexible, how people presented linked to the services commissioned, pilots carried out via the turnaround process around personality disorders and identifying how to best meet the needs of the population and communicate services. DS commented on IAPT and secondary care noting the need for more information on social prescribing in the strategy. DS referred to the Long Term Plan which indicated activities to be undertaken such as	

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	physical health checks, screening, improving uptake of the BME communities etc. which did not currently come across in the document. S Nabi (SN) referred to the statements relating to the integration of physical and mental health and the current segregated training undertaken by the workforce highlighting the need to prioritise the dual training of the workforce over the next 5 years. SN considered GPs were best trained in the duals aspects which tied in closely with the primary care strategy but that GPs also need to be trained differently. L Ward (LW) referred to the work done by K Rush on high intensity users and the associated CQUINs and the possibility of expanding on that and the outcomes which was part of the Urgent Care Work stream. KA – stressed the need to ensure enough substance in services to which patients/families were referred. A Bolam (AB) referred to item 4.1 regarding the high suicide rate in Bristol but not a huge amount on how that is being approached being almost double the rate nationally. DES noted there were existing plans that would feed into the strategy. JR noted that given the size of the issue for BNSSG it should appear explicitly in the strategy. T Dafter (TD) thanked colleagues from the CCG and noted that BCC had been fully involved and consulted on the issue. TD suggested that one outcome would be more integration within the LA approach and noted that BCC was interested in how this would fit with the STP and the move towards locality and GP working in a more localised approach. Open to looking at some of the lessons other areas around closer integrated budgets, standards of practice etc. There is much more commitment to enable a joined up approach at the end of this. PB highlighted the need for more detail on social isolation and loneliness specifically around accessing health and social care as he considered that joint working between health and social care could make a real difference to these patients. JE raised the issue of MDTs where MH was often not addressed in particular within the younger population and queried whether there was a need to look at this MDT approach and expand into other different populations of MH. JE noted these issues were often situational and help was required before to stabilise the situation and considered the reactiveness, responsiveness and timing of that was very important to these patients.	

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	LM acknowledged whilst there was the LTP and its aspirations around mental health this was a real opportunity for BNSSG to be as ambitious as it would want to for its populations in regards to MH and how it would integrate together particularly given the position in Bristol city was different to other areas. JR – Agreed with LM and recommended there should be more focus on what our population health management staff told us about the needs of our people, less process based strategy, much more connection around what we knew about the population we served and then the reasons behind the priorities. DES thanked the Committee for their input, stressed that all contributions were extremely important to the process and asked colleagues not to hesitate to continue to engage with members of the transformation team to raise any other questions, thoughts or contributions.	
05	**Adult Mental Health Services in BNSSG** Julia Chappell was welcomed to the meeting. Lisa Manson introduced the item and gave some background to the paper. LM advised that the Bristol health services contracts were due to expire in September 2021 and there were currently three different specifications relating to the three CCG areas. This gave a real opportunity, building on the new strategy, to review what was needed from our service offer going forward. This piece of work being proposed was to evaluate current services, build on existing learning and start by using the good elements of the current service models. J Chappell (JC) advised the paper had been discussed previously at the Strategic Finance Committee and was with Commissioning Executive Committee seeking organisational priority and approval to proceed with the piece of work. In addition to this JC asked for comments and feedback on the evaluation areas listed on page 11 of the report to identify if there was anything else that might need to be added to this. JC flagged that the improved data and BI available in the current structure was not available at the time when Bristol services were commissioned therefore wanted to highlight there were some gaps in term of ability to evidence certain areas and reliability of that information. JC noting the challenge around BNSSG in relation to data and ensuring provision when evaluating by giving clarity around were gaps existed. It was noted that when the review paper returned in September 2019 for a decision it would clearly show consideration of performance and, in addition to looking to the future, the options available in order to achieve a consistent approach across BNSSG.	

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	SW asked how this worked linked with the MH Strategy and whether this was actually more a needs assessment by way of assessing the needs of the population and if that was the case Public Health could assist with that. LM advised that in relation to the MH Strategy a needs assessment would form a piece of work within that however in this particular case it was more an evaluation of current provision and both overlapped. JR agreed that a needs assessment was essential in deciding in how to procure services and noted the expectation was that the Mental Health Strategy was fulfilling that and this was included in the focus areas on page 11 of the report. It was agreed that population health management was at the core of this and without this developing a MH Strategy would not be possible. SW offered the input of Public Health and this was welcomed by LM. M Jones (MJ) agreed the two elements were linked with information from one helping the other in terms of writing a strategy. MJ suggested this was an opportunity to review previous measures taken in Bristol to resolve issues which were thought to have been the answer at the time but might now be thought of differently. LM advised that North Somerset and South Glos had moved forward but crucially all were running different models. LM considered that with a full evaluation it was not possible to say that the Bristol model was the one to go forward with or whether it should it be a hybrid of this or curtailed through. JR noted the need to ask about value in order to ascertain if the value gained in Bristol was relative the expenditure made. DS stressed with regards to the evaluation around Bristol was more about what didn't deliver as expected such as a system leadership and what didn't happen such as social prescribing. PB highlighted the importance of protecting strategic processes in 5-10 years ahead by putting into place now processes to collate the right data strand identifying what gave best value and what didn't. DES agreed the importance of this data strand and that it would be incorporated into the Strategy going forward.	

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	LM noted that by doing this now it would inform BNSSG contracting going forward. JE asked to see personalised outcomes included within the evaluations and accepted that this may be difficult due to the current gaps in data however going forward this should be incorporated. LM emphasised that this was an evaluation of the current service model not a proposal about future contracting arrangements. JR noted the paper was scheduled to return to Commissioning Executive in September 2019 for a decision and asked about the next steps. LM advised that in parallel with the evaluation work would be carried out on any potential contractual options so that by September 2019 there would be a procedural process in terms of legal advice and testing to enable an evaluation of the current service model, the MH strategy would then be in place and BNSSG in a position to discuss options going forward. JR asked about the involvement of NHSE and LM confirmed NHSE would shortly be involved in discussions to gain a better understanding of the parameters. DES highlighted the need to ensure enough resources across the organisation to enable the prioritisation and completion of this piece of work. **Commissioning Executive supported the further development of the review paper which would be a priority area for BNSSG**.	
06	**Psychiatric Liaison Service – Options Appraisal** Lisa Manson (LM) introduced the paper for discussion by the Commissioning Executive. LM gave an overview of the report and progress made since the initial review paper discussed to the last Commissioning Executive meeting which focused on the provider perspective of psychiatric liaison. As a result of that discussion the focus of the current report had been on the population base needs and the requirements needed to be put into place to serve that need. LM advised that the report detailed out the core national standards in regards to the current configuration in terms of 'core 24' and the various levels such as the work carried out around medically unexplained	

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	symptoms at UHB which was delivered by consultants from the Psychiatric Liaison Service. LM advised it was not a conversation for decision rather for discussion to enable a series of options to come back to Commissioning Executive with a proposal. LM indicated the review had raised questions around current services provided and the options below were for Commissioning Executive to discuss and give its view in order to allow further work to be done to return with some detailed options for proposal and a decision: • Continue with a 24/7 psychiatric liaison service in line with the Royal College of Emergency Physicians providing a front store model with in-reach back into hospital for older adults as per requirements • Develop a much more comprehensive model such as a 27/7 service which would follow on with the UHB model of provision of outpatients, follow-up of outpatient appointments and development of areas such as the medically unexplained symptoms; whilst NBT would like to specialise in impact of neurological disorders • Not part of the national process but more in line with the BNSSG proposal around strategy in terms considering a crisis service for mental health in the same way as elective and non-elective services in acute medicine would BNSSG consider how it could bolster up the current crisis service in place across the system and put that in place so that the crisis service was responding into A&E as opposed to the current configuration. LM stressed that the options were for discussion and to seek a view on how best to work forward the options as it was felt BNSSG would not be able continue with the current model as it was not equitable. LM noted there was a significant amount of resource invested in the psychiatric liaison service however there was concern this model may not be delivering what was needed for the BNSSG population. The following questions and comments were raised: M Jones (MJ) highlighted the priority of improving within the crisis service, in terms of support, the relationship between an emergency department (ED) and psychiatric liaison especially when those in crisis were discharged from hospital. D Soodeen (DS) raised concern at mental health crisis teams based in an Emergency Department due to the stimulating environment which for anyone in mental health crisis could cause deterioration. DS suggested	

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	the BNSSG strategy focus on future investment be directed to crisis cafes/sanctuaries and consideration given to diverting people without physical needs away from emergency departments to somewhere which would be more psychological informed. DS raised reservations on the ability of crisis teams based in A&E departments to function properly in the community. A Mental Health Trust working in all three emergency departments would be his preferred option. LM noted this was an opportunity to define and secure what was best and wanted for the population. J Ross recommended: • That articulation of what a good crisis pathway would look like and what would be involved in achieving that should come before further development of options. Whilst envisaging some mental health liaison in hospitals the vast majority of the crisis pathway would be outside of hospital. Over time the ambition would be that no one with a purely mental health issue would go into an emergency department. • Further conversations about what services BNSSG required should take place with each provider in isolation. • Support of the Acute work in areas such as medically unexplained symptoms to enable this to be delivered to the whole population. S Nabi (SN) queried the proportions on purely mental health and those with physical requirements commenting that those patients who had a physical need then psychiatrists working in ED alongside medical professionals were best placed to best placed to manage these patients and SN would not want to lose that. LW from an urgent care perspective once the physical need it met then the best course of action would be to remove them from that setting. ST questioned whether all mental health crisis patients with physical needs required treatment via an ED and if those patients with less significant needs could be treated appropriately elsewhere. DS advised of the work already done by the Clinical Senate and their advice on urgent care and a list of conditions and what could be done out of hospital.	

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	DES referred to CBTs and asked CE to be mindful that there was a displaced demand to factor in when trying to provide the right service in the right place. MJ advised that if intervention happened early enough in a crisis pathway before a person attended ED this could be managed via secondary care in the community through an upskilled crisis team of capacity this would avoid the ED admission and the patient would have a better experience. JR agreed and noted that to stop self-harming a different response earlier in the pathway was needed. A discussion took place and it was agreed this should form part of the specification. LM thanked the Committee for the discussion and noted the points to take forward. **The Commissioning Executive noted the paper.**	
07	**Business Case – Expansion of Rapid Assessment Clinic for Older People** Sara Stiddard (SS) was welcomed to the meeting to present the paper for a decision. SS updated the Committee on the purpose of the request to expand the Rapid Assessment Clinics for Older People (RACOP) which provided a one stop rapid assessment and treatment for frail elderly patients who need to be seen in a short time frame or who are deteriorating without cause. SS advised that the service was initially generated through the Urgent Care Control Centre in November/December to help support winter pressures and admission avoidance. The clinic currently operated out of South Bristol Community Hospital, UHB provided the consultant geriatrician with some occupational therapy and physiotherapy support. The current service had seen a total of 339 referrals and showed an increasing trend in referrals. SS advised following an impact assessment carried out to ascertain the effects on the system and evaluation of data analysis the proposal was the service be expanded for an additional session per week. The session would allow review of an additional 3 ‘new’ face to face patients and 3 ‘follow up’ virtual patient reviews.	

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	SS highlighted that 20% of the patients had an emergency admission within 90 days of the appointment, rising to 28% if those patients admitted after 90 days were included. Approximately 68% of patients had an admission prevented as a result of being seen by the service. It was considered that the 9-month extension of the RACOP service would support the South West Bristol Frailty hub whilst it was being developed. SS informed the meeting that the requested funding related to the cost of GP input into the clinic based on an additional session (4hours) to be staffed by a GP and referred to the costings details in the report. The anticipated savings based on a 70% admission avoidance would result in £206k saving in admission costs. LW explained how the clinic would work and the new virtual clinic which was considered would add 3 additional patients to the MDT meeting held at the end of each clinic in addition to the shared learning gained between secondary and primary professionals. The service had been discussed at the provider frailty meetings and developed alongside the providers and was intended an interim arrangement until South Bristol made a decision regarding their Frailty hub. KA queried what were the benefits of a GP sitting in clinic given the time and cost of their involvement and what would they be doing. LW explained that the GP and consultant would work alongside one another each seeing patients. JR also queried the sustainability of having two expensive professionals and asked that requirement be evaluated to ascertain if, as in other models, the role could be managed by a nurse practitioner, community matron or therapist. LW confirmed a nurse would be responsible for dementia assessments, screening, bloods and sets of observations and that the benefit of the GP would be to upskill and educate them. JR agreed that GPs needed to be aligned with frailty hubs but the balance of the model needed to be right and asked that an evaluation identify the value added, the right mix of workforce and the right role for each of the professionals. JRa spoke about the locality frailty hubs currently being developed in Bristol and the Frailty Programme Board raising the concern that the drifting timeline of the RACOP model might result in it colliding with the	

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	Frailty Programme Board business case highline and the roll out of the Weston frailty model which had a detailed pathway and breakdown of workforce roles with potentially. JRa asked that this be reviewed to ensure it was linked in with the workforce development model as part of the frailty programme of work across all localities, linked to detailed pathways and linked to a slightly different skill mix. LW was in agreement that it should link in. J Evans (JE) challenged the criteria on cohorts and emphasising a matched cohort should be used going forward; considered sustainability and cost to be an issue and advised that MDT communications back to the practices regarding outcomes/decisions made was key. S Truelove (ST) questioned whether this was the right thing to do given the current £21.5m deficit position of the CCG and highlighted that Acute Trust support of this pathway was required through the blended tariff discussion and currently that was not place and would not be possible to fund without a source. . JR queried the level of savings detailed in the report indicating these should not be net of expenditure and asked for more clarity as the scheme should be funded as part of the blended tariff. JR requested a more robust answer as to how the savings will be delivered and whether a GP was essential to the scheme was needed. A discussion took place around the cost pressures experienced due to the current financial position and it was acknowledged that the Acute Trust would need to commit to the £206k savings to back the fact it will reduce costs and that these discussions should go through the control centre. K Haggerty (KH) raised a concern that it appeared BNSSG would pay twice; once through the blended tariff and again by providing a GP. JR noted that BNSSG would be taking all of the risk as indicated previously by ST flagging that currently providers were taking no risk on any schemes intended to reduce the amount of non-elective care. KH queried the rate of payment to GPs noting the shortage of GPs and the pressure this may put on general practice coming into the winter months.	

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	JR indicated the pathway was absolutely the right direction of travel with work on frailty but that it required further work and needed to be done on a much greater scale. JRa indicated she would work with LW to build on the good work done in the South and also work with the Acute Trust to sign up to frailty work at scale through the work of the programme board and the localities relevant to them. JH asked about the next steps: JRa asked that it be brought into the frailty programme approach with some test and learns in the localities with a view to bringing this work alongside the work already underway. JR confirmed the expectation would be that in light of a £15m deficit position and size of the contract that there was an expectation that £206k savings would be delivered by the team. JRa advised that in order to achieve this it should be linked to the work of urgent care control centres on frailty. **Actions:** LW to link with JRa ensure it was linked in with the workforce development model as part of the frailty programme of work across all localities, linked to detailed pathways and slightly different skill mix. JRa to link with Urgent Care Control Centres regarding work in frailty.	
08	**Severe Weather Plan** Janette Midda (JM) was welcomed to the meeting to present the item. L Manson (LM) introduced the background to the internal policy for severe weather planning which formed part of the review of the BNSSG Emergency Planning Resilience and Response process. JM explained the purpose of the plan was to ensure that there were systems in place both internally and across the system that ensured a BNSSG CCG organisational response, and co-ordination of the system, when responding to severe weather conditions. JM went on to explain the four alerts levels issued by the Met Office and the associated actions that BNSSG CCG would be required to implement for each level. JM confirmed that the plan linked into the local Resilience Forum and Resilience Response ensuring a strong link into the multi-agency response to severe weather conditions. LM advised of the annual	

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	EPRR assurance process noting that this year's annual assurance deep dive focus would be severe weather. EM advised that the plan had been implemented in January 2019 following approval by the internal EPRR group. The plan was a dynamic plan which is added to and amended as necessary. Decisions made in the event of severe adverse weather conditions arising will be based around ensuring patient care and the safety of staff at work is not compromised and business continuity for essential services. Commissioning Executive Committee was asked to approve the Severe Weather Plan. JH asked if BNSSG CCG held severe weather plans for the member practices. LM advised EPRR currently did not have a primary care and incidents in relation to primary care were currently managed via the community providers. LM explained this now formed part of a programme of work being undertaken this year to ensure BNSSG CCG integrated with primary care in relation to EPRR, business continuity PEP plans and robustness in terms of response. **Decision:** Commissioning Executive Committee adopted the Severe Weather Plan.	
09	**Secondary Care Initiated Phlebotomy** Geeta Iyer (GI) and Alison Bolam (AB) presented the item for discussion on the approach to ensuring equity of access to phlebotomy services in general practice, specifically around secondary care initiated phlebotomy. GI thanked David Moss (DM), Head of Contracts for Primary Care who had worked with GI and AB to review the service in response to the apparent inconsistency of offer across BNSSG. GI gave a summary of the report which recognised the value to both the system and patient in having care delivered in the community avoiding unnecessary hospital attendances. GI outlined the proposed approach to resolve the inequity of access and which would ensure visibility of the ICE requests across BNSSG, facilitate the phlebotomy and ensure results would be received by the requesting clinician. L	

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	The proposals were that: • Secondary care clinicians request investigations on the ICE system to allow results to be returned directly to them for appropriate action • Primary care continues to carry out the actual phlebotomy, whilst localities or the CCG identify a long-term sustainable solution. • BNSSG clinical leads clearly define cohorts of blood tests and time frame for moving to a long-term solution. • BNSSG consider supporting practices to undertake phlebotomy by funding the additional ICE licences required to undertake the phlebotomy (Estimated cost £28k). D Soodeen (DS) asked if agreement had been received from secondary care on the proposed approach and if there was capacity to accommodate this. GI advised initial conversations had taken place with some secondary care clinicians who had agreed in principle the approach outlined and it was intended that this become a wider conversation. DS highlighted the need for practices to be informed when patients are coming into their facilities for blood tests and the need for communication around that. JH asked A Appleton (AA) if there was a mechanism on Egton Medical Information Systems (EMIS) where automatic periodic repeats of a tests could be created. AA confirmed this was currently not possible on EMIS, that it was a matter of ensuring the phlebotomist was aware of the ICE blood tests. With regards to software being updated to incorporate this feature, from experience, the software provider would have difficulty in providing this within a reasonable timeframe. S Nabi (SN) considered this was an excellent piece of work to try to connect all the systems and secondary and primary care ICE. SN's main concerns: • the lack of a simultaneous roll out of an enhanced service to fund the increase capacity required to carry out the work • the massive increase in ICE referrals to primary care and resilience of the phlebotomists carrying out this work • unlikely to be acceptable by GPs at forums and also by the Local Medical Committee (LMC) without an additional commissioning pathway simultaneously GI advised the proposed approach was not yet at this point and would be very specific about what would be entailed and assess how much workload that would create. GI went on to explain the difficulty in	

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	obtaining the outpatient tariff if a patient went back into hospital to get their phlebotomy. LM advised this depended on whether they been seen in an outpatient clinic or not. Some patients will be seen in a phlebotomy department in terms of open access, some are seen by the service, particularly the cancer unit where they are actually brought back into the department most patients go back into the SN stressed the need to see the process and selection of what is being asked for as this would be crucial in what happened next and whether it was acceptable. LW referred to drop in phlebotomy clinics at providers and if it was known how often they were used – was there a potential de-commissioning of that service releasing funding into primary care. GI there have been some discussions about that and the activity has gone up. LM clarified that BNSSG did not commission the phlebotomy clinics they were provided by the outpatient tariff paid for by the provider. The drop in service was for the provider to use for patients who were currently outpatients. However, when a patient goes back into a clinic and we are charged for that patient when they have bloods then that could be reviewed. D Peel (DP) asked if the Acute Trusts could be encouraged to negotiate with localities? ST considered that this potentially was possible as some of the at scale work on outpatient transformation had identified large cohorts of patients attending outpatients for a simple blood test. JR advised full consideration should be given to how this could be achieved whilst at the same time gaining a system benefit as without which it would just become another cost pressure. MJ advised of an alternative approach by way of decommissioning another physical resource i.e. phlebotomy clinics based in hospitals followed by the relocation of these to locality hubs in primary care. JR challenged who should be responsible for the £28k cost of the proposed approach in this particular model as it looked to be more about supporting secondary care. JH considered it to be about improving services for patients JR advised this needed to be done on a major scale which would likely involve a community based provider rather than general practice.	

	Item	Action
	SD considered the whole safety aspect around phlebotomy services should be reviewed and raised the following points: • safety aspect of blood tests not going back to the person who ordered them. Some blood tests coming back to primary care were related to specialised conditions and there had been cases of blood tests sitting in primary care and not being seen by the specialist who had ordered them. • Some phlebotomy teams were quite small so capacity would be an issue. SD referred to the paper which stated clinical leads needed to clarify which and where blood tests should be carried out and asked if the expectation was that Clinical Leads arrange lists? J Maynard (JM) raised a concern regarding what would be done with the results and the possibility that these might be passed around before landing with someone who could understand them. A discussion took place around co-ordination of the different strands, reviewing of bloods to determine what actually needs to be done and the capacity and resources available. AB re-emphasised the need to achieve equity across the system for all patients whilst aligning with the direction of travel in trying to secure care in the community to avoid travelling to hospital just have bloods drawn. AB asked about the potential to have a single ICE system across BNSSG however AA considered this was not possible in the medium term as until the ICE software was completely rewritten it would not work. LW asked if there would be a requirement to have contracts and payments to the Trusts for certain types of bloods such as chemotherapy. LM advised of a South Bristol pilot for practices to not see the results and that letters had been exchanged around clinical responsibility for taking the bloods. The key concern that triggered this change was around the fact that some patient's bloods were not being reviewed by the consultant hence the pilot to turn off the results to that. Patient attendance at either the drop in clinic at UHB or the bloods clinic was more about how easy it was to take bloods than patient choice. JR asked the members what the consensus of opinion was.	

	Item	Action
	LM referred to DPs outpatient work and considered this should form part of the outpatient transformation work where the required elements could be built into that piece of work. DP advised the Outpatient Programme Board would need to understand very clearly what the tariff required trusts to do with regards to bloods. LM advised this should be picked up through the outpatient transformation work. AA advised that the ICE restrictions would affect other services JH asked if everyone could access all three ICE systems. MJ confirmed not although that only results on their own ICE system could be read. JRa highlighted that if South did want to collaborate with UHB in a piece of work around phlebotomy then the big issue would be in the numbers, and pathways and the when why and how. Given that Acute Trusts were struggling were struggling to identify numbers and pathways. JRa stressed that localities would be unable to drive this on their own and supported LM's advice that this should be driven through the outpatient pathway. LM advised if done through the outpatient pathway this would enable a defined pathway and give clarity on how this would be commissioned going forward. AB asked whether the Acute Trusts, having driven change and by default having prevented practices from using their new systems; had given any thought to how they provide ICE licences? DES advised that this had formed part of the discussions at the strategic phlebotomy group. There was still a need to ensure that practices were connected and the licence issue was pervasive to all the conversations at the Strategic Phlebotomy Group. There was a need to mandate Acute Trusts to have a single ICE licence however there was currently no capability for Trusts to do that as a single system so if an intermediate solution was wanted it would be to buy an annual licence. If we want to carry on with some of the mixed economy that we have currently and push that forward for the future in terms of an investment across our Acute Trusts on a system level, then that would be another strategy for consideration. DSE advised that the issue about technology and access remained whether trust or community based.	

	Item	Action
	JR asked what would be the impact if this issue wasn't moved forward? GI considered this impacted on both patients and practices by stopping practices moving forward by doing things differently and getting patients through the system much more quickly. AB advised the current situation was also resulting in some practices considering stopping doing bloods altogether. JR asked if in the immediate term whether it was worth going back to the trusts to say that GPs will carry out this on a small scale but they need these licences are you prepared to pay for them? We need to do a bigger scale thing but in the short term this might be a solution. DES commented that the idea of a trade-off was interesting point as it was clear that the different departments within the Trusts were not connected up. DP commented that with regards to behaviours if clinically under tariff this should be the responsibility of the department in the Acute and we as commissioner should be providing a challenge not solution. DP advised that the outpatients services board was focussed on getting the Acute Trusts to lead with solutions. DES highlighted the issue appeared that they were not connecting up with their own digital teams. JR advised that although as Commissioners we might not offer a solution we should ensure the Trusts are really clear about the problem. DES asked that this be added to the agenda for CIAs to inform and raise awareness prior to going through the outpatient environment. JR asked for clarity regarding the immediate term approach. **Action** • Update report to give clarity on the immediate term approach • Add to agenda for Chief Information Officers (CIOs) • A decision on resourcing via the Outpatient Transformation required and DP and LM to give an update on this at June meeting.	
10	**Living Well With and Beyond Cancer: Programme Overview** Chris Moloney (CM) was welcomed to the meeting to present the item. P Brindle (PB) gave a brief summary of the background of the Living Well With & Beyond Cancer project (LWWBC) which had been funded	

	Item	Action
	for 2 years by the National Cancer Transformation Fund (CTF) and delivered across community, primary and secondary care services. The NHSE funding totalling £1,672,182 over the two-year period was being used to fund staff at Bristol Community Health (BCH), University Hospitals Bristol (UHB), North Bristol Trust (NBT) and Weston hospitals on fixed term contracts/posts most of which would end by March 2020. CM was currently reviewing the outcomes of the investment and once the data was compiled would produce an options appraisal. In light of the current cost pressures within the system, the purpose of the report was to raise awareness of the project with Commissioning Executive and gain feedback on the sorts of information Commissioning Executive might particularly need and value in order to make a decision about the pathway going forward. J Ross (JR) considered this would be a candidate for community mobilisation work and social prescribing work. CM advised that a potential option was a community driven model working with the clinical services manager at BCH and the operational lead that are attached to Living Well. JR considered that the project did not require a health care provider to deliver the service rather that organisations such as McMillan and third sector providers could deliver. J Rawlings (JRa) agreed and recommended that the model did not need to segment care for each speciality and the approach should be the same across the board, tailored to meet the needs of the relevant population. JR did not consider the current model to be the right fit with the current hospital focus. PB noted that a significant amount of cancer leadership and funding appeared to be acute targeted. K Alexander (KA) noted that some of the basics should be automatically part of the current offer and delivered in the community given the number of people living post cancer was increasing. DES asked what people had indicated that mattered to them most? CM advised that question had formed part of the evaluation and the initial feedback was that patient to patient support groups were wanted. PB commented that all the support options being delivered for cancer were applicable to many long term conditions and the learning from these evaluations could be applied across people with similar conditions. JR commended the holistic approach of the pathway. M Jenkins (MJe) referred to the post cancer support patients received and highlighted this was an opportunity to review the value gained from the cancer care review.	

	Item	Action
	JR considered a non-medical conversation with a peer supporter would perhaps benefit the patient more when starting to prepare not to rely on the hospitals. S Nabi agreed in that this was person centred care which did not require a healthcare professional. T Dafter (TD) considered that this should be done collaboratively as partners as was done with the STP model and locality working to properly consider what the offer should be to people with long term conditions. S Weld (SW) highlighted that whilst agreeing with TD that the community based delivery of services for people with long term conditions was the way forward consideration of how this would be funded was important as the voluntary sector would still require funding. J Evans (JE) asked would this have any effect on the procurement of the community nurse – and it was confirmed not. L Manson (LM) asked: • with regards to the treatment summary if this should, in fact, be part of a pathway for which BNSSG already paid providers for and therefore would form part of tariff. • In terms of the evaluation it appeared some was being funded through tariff and some through allocation. Are we looking at the totality in the evaluation? – CM confirmed this was the case. DP asked if there was a risk of losing current expertise generated by those individuals currently delivering the service? CM advised of one service in particular would be affected which was managed by a physiotherapist with a particular interest in cancer at UHB and who was considered to be a pioneer therefore should the project cease the risk would be that the expertise might not stay locally. **Commissioning Executive noted:** Commissioning Executive would be interested in a return proposal of a different model not dependant on £1.5m in funding and moved the location of this into the community as part of a community mobilisation piece involving LA partners using an asset based community model.	
11	**Integration of NBT and WAHT Breast Services** D Peel (DP) presented the paper on Integration of NBT and WAHT Breast Services and updated the Committee on the background to the reconfiguration of the services. DP explained the purpose of the paper was to notify Commissioning Executive of a service reconfiguration. The main rationale was to	

	Item	Action
	ensure clinical sustainability of breast service provision within North Somerset. WAHT had a number of senior medical staff within their breast service who have indicated that they are close to and intending to take retirement. WAHT had been unsuccessful in recruiting suitable candidates to these roles. It was anticipated that without integrating with NBT, that these services would close over the next 12-18 months. If this was to occur, there would be significant strain on the service at NBT. It was noted that the re-configuration would ensure a more robust service with a better staff base which would be able to offer patients a 'One Stop' assessment service. Further benefits of the proposed service model were: • The development of a multidisciplinary team (MDT) meeting model, which allows for sufficient discussion and has adequate cover arrangements in place for the core membership. • The model improves access and treatment of breast patients within North Somerset. • The model creates a shared Breast Service governance and improvement in clinical outcomes for patients across BNSSG. This would be through the same clinical pathways and resources being available. • Improvement and greater resilience in Breast cancer performance across BNSSG. • Improved efficiency benefits across both sites DP highlighted the following key points: • The proposed model is expected to commence in July. • The service model is built on the indication that the patients local hospital will remain as their front door. • NBT will process all 2 week wait bookings to offer capacity as geographically close to the patient's home address as possible, and will open additional slots. • NBT will undertake operating at WAHT. • GPs will be asked to refer directly to NBT; as slots will not be bookable by WHAT, but will be provided at Weston General Hospital LM confirmed there would potentially be a nominated North Somerset person but the 'One Stop' assessment clinic would be provided by a team to ensure resilience in staffing. DP highlighted that from a CCG perspective there was a need to recognise that, due to the volume of breast patients currently contributing to the 62-day performance denominator number at Weston,	

	Item	Action
	there was a risk this could adversely affect Weston's cancer performance for both 2ww and 62 days. DP informed the meeting this had also been discussed at STP and WAHT discussions. DP clarified that all breast clinic services were provided by South Bristol, surgery provided by NBT and oncology provided by UHB. JH asked if there were any differences in quality and outcomes; DP considered not it was really a matter of resilience. LM advised this reconfiguration also gave resilience as one of the key performance challenges with cancer at NBT has been around breast in terms of 2ww performance and the consolidation into a single service model would allow them to recruit to a higher level consultant. DP advised there had been anticipated there would be some public relations work with refers required and this would be done via the various forums. LM emphasised that the intention was that the service offer at Weston would be remain the same and that it would just be provided by NBT at Weston. JH summarised that potentially this would centralise services whilst maintaining activity in Weston. LM advised with regards to performance reporting for 19/20 it was recognised that it could potentially impact on the individual provider's performance reporting but not that of the CCG. **Commissioning Executive noted the report.**	
12	**Approach and Timeline for Developing Primary Care Strategy** (Information only) G Iyer (GI) presented the paper for information noting it had also been presented to Governing Body, Primary Care Operational Group (PCOG) and Primary Care Commissioning Committee (PCCC) to update them on the proposed approach to updating the 2016 Primary Care Strategy (PCS) in the context of Healthier Together and other system wide strategies. It also took into account the national requirements in the General Practice Forward View (GPFV) the NHS Long Term Plan and operational planning guidance and the new GP contract as well as the local picture with community services procurement.	

	Item	Action
	I went on to explain the initial steps taken and timeline referring to the high level priorities described in the quadrants contained in the report. An initial working group meeting had taken place and work had commenced to define who would be required to contribute to the work identified in the quadrants. GI advised of the initial steps of the planned engagement and timeline highlighting a joint seminar with Commissioning Executive and GB in June. S Weld (SW) asked that Public Health be included in the stakeholders for this work. DP asked for input into the Outpatient Transformation element of the report. KA asked that thought be given to the long term strategy with regards to the terminology used when referring to primary and the changing meaning of primary in the light of moving activities from secondary into primary. LM advised that the joint Governing Body and Commissioning Executive seminar would take place on 4th June 2019 at 9-10:30am and invites would be issued in advance. LM asked that any members not part of the Governing Body please notify her accordingly. **Commissioning Executive noted the report.**	
13	**Urgent Care Activity & Performance Update** L Manson (LM) presented the Urgent Care Activity and Performance Update report advising the report related to Month 11 and 12 highlighting the performance remained below national standard and English average in terms of type 1 performance and dipped again in March. LM advised that the April position remained challenging, with some providers' performance below 50% at both BRI and NBT. BNSSG were continuing to work with providers in terms of additional mitigations around how the system managed the service and demand as opposed to flow going forward. LM highlighted that there had been very good success in managing stranded patients with reduced numbers of stranded patients across BNSSG however the front door admission remained challenged particularly on a Sunday and Monday.	

	Item	Action
	LM advised the IUCCAS had gone live and had experienced a smooth launch; also SBCH launched as an urgent treatment centre and Yate MIU as an 8-8 running 7 days per week. LM highlighted some recent changes in referral behaviour at Weston resulting in a reduced number of patients totalling 90 per month due to the changes happening around Weston. JH asked if Yate now had radiology. LM confirmed this was now available at Yate 8-8, 7 days per week and advised use of these services would be monitored to measure usage to test whether the service was worthwhile. KH queried Slide 13 re 111 activities and noted that over a year there had been a 7% increase in 111 calls but a 16% increase in ambulance dispositions and a 20% increase in A&E dispositions. LM advised of implementation of the Clinical Support Desk in terms of call handlers in April 2018 put in place to address the increased activity and noted work had been done to ensure that all the pathways and interfaces between the services were more robust. LM highlighted concerns relating to SWASFT around conveyances to hospitals which had increased disproportionally to activations and this was being reviewed. A discussion took place around the extend of this issue, the geographical areas affected and what was driving the increase. JR stressed the importance to understanding what was driving the increase to avoid solutions that merely moved activity from one place to another. **Commissioning Executive noted the report.**	
14	**Contract Performance Update Report – Non-Acute** Lisa Manson presented the contract performance update report for the non-acute sector noting the following areas: • the DVT contract which had gone live on 1st May 2019 • work underway on the adult community provider procurement whilst ensuring a robust service offer as BNSSG progress through the remainder of the current year • joint working with our 3 LA partners for the recommissioning of Integrated Community Equipment Contract (ICES) • work underway for Continuing HealthCare (CHC) services expected to take place in September 2019.	

	Item	Action
	• Contract management for Patient Transport Services (PTS), SWASFT and Care UK (NHS 111 via IUC contract) to take place from April 2019. **Commissioning Executive noted the report.**	
15	**Corporate Risk Register & GB Assurance Framework** Sarah Carr (SC) was welcomed to the Committee to present the item. Corporate Risk Register: SC went through the corporate risk register noting no new risks had been added to the register. SC highlighted a core piece of work that would happen shortly and involve BNSSG colleagues in undertaking a refresh of all the assurances, controls and actions. GB Assurance Framework (GBAF): SC advised that the GB had been reviewing the priorities for the organisation looking at a refresh of the eight 2018/19 priorities and looking at what would go forward into 19/20. Once the priorities and risks around the delivery of those priorities are finalised it was expected that the refreshed GBAF would go to Governing Body in June. SC gave assurance of a significant overlap between 18/19 and 19/20 priorities noting one priority which required some further discussion to ensure this was covered within the corporate risk register. J Evans (JE) referred to the gaps and mitigations and asked if there was evaluation of risks which were uncontrollable and/or there was no influence over and those that that could be mitigated. SC noted this was a good point to raise and advised that a conversation about assurances had taken place that week and SC would take the question back to discuss with colleagues and provide a fuller answer. LM advised that this was done by Commissioning Directorate in terms of reflecting on what happened in the previous year in relation to risks such as the EU Exit.	
16	**Nursing & Quality Directorate – Clinical Update**	Closed Item
17	**Operational Issues** **Glenside Manor – Salisbury Unit Closure:** LM advised of the enforced closure of Glenside Unit in Salisbury noting that the transfer of patients was being managed by NHSE as a major incident due to a total of three homes and 150 patients being affected by the closure.	

<table>
<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>LM assured the meeting that BNSSG had one affected patient whose transfer into alternative accommodation was already well underway.

IAPT Procurement:
LM advised it had been announced that Vita Health was the BNSSG preferred provider for IAPT services.
JR advised the Commissioning Executive of some of the inaccurate reporting by the press around the IAPT procurement and Vita Health and one particular piece of reporting that had the potential to cause anxiety to an already vulnerable group of people with mental health issues which the BNSSG were contesting.</td><td></td></tr>
<tr><td>18</td><td>Any Other Business

Committee Effectiveness:
JH asked for feedback in relation to committee effectiveness in the following areas:

<table>
<tr><td>Timing of items</td><td>Yes</td><td>Good</td></tr>
<tr><td>Meeting papers</td><td>Yes</td><td>Improved</td></tr>
<tr><td>Decision making</td><td>Yes</td><td>Good</td></tr>
<tr><td>Other comments:
Chairing of meeting</td><td>
Yes</td><td>
Excellent</td></tr>
</table>
</td><td></td></tr>
<tr><td></td><td>Date of next meeting:
Thursday, 13th June 2019 at 8.30 – 12:00pm
CCG 4th Floor Conference Room, South Plaza</td><td></td></tr>
</table>

Lisa Manson
Director of Commissioning
NHS Bristol, North Somerset and South Gloucestershire CCG