NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 9th April 2020 at 9:30am, MS Teams

Minutes

Present			
Kirsty	Alexander	Clinical Lead for Children's and Maternity, BNCCG CCG	KA
Andrew	Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA
Alison	Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Becca	Dunn	Deputy Director of Transformation, BNSSG CCG	BD
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	MJ
Jon	Lund	Deputy Director of Finance, BNSSG CCG	JL
Lisa	Manson	Director of Commissioning, BNSSG CCG	LM
Shaba	Nabi	Clinical Lead, Prescribing	SN
David	Peel	Clinical Corporate Lead for Planned Care, BNSSG CCG	DP
Julia	Ross	Chief Executive, BNSSG CCG	JR
Rosi	Shepherd	Director of Nursing & Quality, BNSSG CCG	RS
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS

Lesley	Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Alison	Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AJW
Apologies			
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Colin	Bradbury	Area Director for North Somerset, BNSSG CCG	CB
Anne	Clarke	Director for Adult Social Services, South Gloucestershire Council	AC
Terry	Dafter	Director for Adult Social Care, Bristol City Council	TD
Deborah	El Sayed	Director of Transformation, BNSSG CCG	DES
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
Sarah	Truelove	Director of Finance, BNSSG CCG	ST
In attendance			
James	Dunn	Healthier Together Programme Manager	JD
Kate	Lavington	Head of Transformation, Integrated and Planned Care, BNSSG CCG	KL
David	Wynick	Director of Research NBT and UHB Trusts	DW
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker), BNSSG CCG	JHo

<table>
<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td>01</td><td>Welcome and Apologies
Jon Hayes (JH) Chair welcomed members and attendees to the meeting. Apologies noted as above.</td><td></td></tr>
<tr><td>02</td><td>Declarations of Interest
No conflicts of interest were declared.</td><td></td></tr>
<tr><td>03</td><td>Minutes of the meeting of 12th March 2020
It was agreed that the minutes of the previous meeting were a correct record.</td><td></td></tr>
<tr><td>04</td><td>Actions arising from previous meetings:
<table>
<tr><td>Item</td><td>Outcome</td><td>Item</td><td>Outcome</td></tr>
<tr><td>118</td><td>Updated, review May</td><td>148</td><td>Deferred to May</td></tr>
<tr><td>119</td><td>Updated, review May</td><td>149</td><td>Open</td></tr>
<tr><td>125</td><td>Updated, review June</td><td>150</td><td>Open</td></tr>
<tr><td>138</td><td>Updated, review June</td><td>151</td><td>Open</td></tr>
</table></td><td></td></tr>
</table>

	Item	Action
	139 | Updated, review June | 152 | Open 147 | Updated, review June | |	
05	**ED and MIU proposed changes** Kate Lavington (KL) was and Lesley Ward (LW) gave a brief summary of the updates and developments of the proposed changes to ED and MIU. LW advised that due to COVID-19 priorities the planned changes had progressed at a quicker pace than originally envisaged and were now in place and summarised as follows: • Emergency Departments had chosen not to close completely to minor injuries or walk in patients due to anticipating the need to step up quickly when required. • The closure of the MIU site in Broadmead due to the COVID-19 had resulted in the proposal that staff be redeployed to bolster the walk in centre and minor injuries unit as well as the homeless teams based at the Broadmead site. • The NBT and UHBristol orthopaedic and radiology teams decision to bolster support currently offered to MIUs enabled virtual management of fractures in real-time thus reducing outpatient appointments. As a result, Orthopaedic surgeons have promoted and escalated these different ways of real time working. • Reviewed 111 dispositions on the directory of services and for a number of conditions have switched off the ED disposition in view of walk in centres being open from 8am-8pm. This went live on Friday 3rd April and being evaluated on daily basis for impact. Over the first 3 days there were 66 dispositions to MIUs and UCC and 13 the ED for minor injuries. • Bolstered the improved outcome for pharmacy on 111 • No changes had been made to the disposition of services for children. KL advised of: • the excellent support received from the Communication Team in the development and roll-out of the public communications campaign which had been highlighted on Points West and was soon to be used on bus stops. KL noted some concern raised by the clinicians at Bristol Children's Hospital due to late presentation of non-COVID children and advised that this had	

	Item	Action
	been responded to and there was a targeted campaign for children's which would reinforce the message that if it was an emergency and there was concern about a child the hospital was still open for business. • Although in the early stages of the implementation of the changes the first 4 day comparison with the previous week shows a reduction in all EDs with the exception of Weston Hospital and increases at all 3 UTCs/MIUs. • With regards to the clinical pathway process KL advised contractually no changes had been made and the money flow would continue for the closed site in accordance with the contract. Jon Hayes (JH) clarified that the proposal had been to Clinical Cabinet and the Primary Care Cell, and that it was with Commissioning Executive for approval, retrospectively due to going live early in order to react to COVID-19 priorities. Julia Ross (JR) commended the work done by the communications team with the public and asked this be continued through both passive and active media reinforcement. JR asked what steps had been taken to ensure progress made on new ways of working were maintained post-COVID-19. LW advised that feedback from orthopaedic surgeons had been extremely positive on the new ways of working. KL advised consideration on how to formalise the processes around Broadmead was in hand and that although these formed part of the LTP public engagement on co-design would be required post COVID-19. Kirsty Alexander commented on the low level of attendance at the Children's Hospital and asked what work was being done with the hospital and the wider system to ensure in the next phase this was maintained. A discussion took place around the activity in the Children's Hospital and walk in centres. David Soodeen (DS) asked for clarification on whether the whole of Boots in Broadmead would close, advising that this currently remained open and if closed would have a major impact on attendance at the GP Practice (11,000 patients) and the pharmacy housed on site. LW advised that currently the both the practice and the pharmacy were remaining open. KL advised that	

	Item	Action
	BrisDoc were concerned about ongoing access as the corporate view from Boots was whilst the Broadmead site remained open, that given the dramatic drop in footfall in the city centre and increased footfall in the suburbs, they were unsure how long this could be maintained. Shaba Nabi queried: • the MIU based at NBT Southmead site remaining open. KL advised the NBT were in the process of removing the information about the MIU from their website. Lisa Manson (LM) advised that the Southmead MIU formed part of the ED commissioned from NBT for children under 16 and that this could be managed by either removing from DOS or putting as red rated on the DOS to re-direct attendances but generally it was only signalled through 111. The alternative action would be to de-commission the service. **ACTION:** LM to link with KL and LW to agree best course of action re DOS arrangements for children under 16 **ACTION:** LW to work with Mark Bradford, who is responsible for changes to DOS, to implement changes following decision. • the need to be aware of the significant non-COVID fatality from children either not presenting or waiting for 111 or 999 for extended periods. LW advised this was known and that planned targeted communications for children's were in place. Peter Brindle (PB) asked if there had been any learning from London hospitals in terms of overall ED busyness. LW agreed to contact the EDs and ask what their learning had been from London. **ACTION:** LW to contact EDs to identify what learning had been gained from London hospitals Alison Bolam (AB) asked for urgent clarification of the changes to Southmead MIU and also whether consideration had been given to the geographical issues for those local patients who would have attended Southmead now needing to travel elsewhere for minor injuries. **ACTION:** LW to clarify the situation regarding Southmead MIU and resulting geographical gap for patients.	153 154 155 156

	Item	Action
	Commissioning Executive Committee approved the proposal.	
06	**Outpatients interim arrangement proposal** James Dunn (JD) was welcomed to the meeting to present the item. David Peel (DP) gave brief summary of the proposed interim outpatient arrangements and took the paper has read. DP advised the paper detailed the principles on how the BNSSG system would manage the outpatient services during the COVID response period. The proposed changes would maintain continuity in vital areas and negotiate an avenue for advice to support frontline GPs in managing patients throughout the crisis. DP updated as follows: • Communication - all updates accessible via REMEDY COVID-19 page and updated daily • Cancer 2ww pathways remain open • Hot clinics remain open – some moved to the front door • Negotiated all Trust departments will provide an advice and guidance service covering all specialities although will be through differing methods including ERS, REMEDY, telecon • Urgent referrals to continue – those accepted and booked by Trust will be held by Trust and Trust will communicate with patient by letter – any change in patient situation patient advised to contact GP to seek advice and guidance • Post-COVID-19 looking a alternatives to provision and new models of care • Suggestion is GPs hold referrals and risk share with patients. **Non-COVID-19 work update:** Peter Brindle (PB) updated the meeting on the current non-COVID work taking place as part of a complimentary piece of work to the outpatient work. PB advised the system had worked very hard to stop non-critical work so as to reduce the spread of the virus and ensure enough critical care capacity was available. Some short-term under-use of resulting critical care capacity had been identified and in response to this PB was developing a process to identify the broad based/balanced risks associated with stopping activity and re-starting albeit services would be provided under a different approach than done previously. PB asked whether there was a way in which specialities and primary care could consider what	

	Item	Action
	services, including outpatients, could be kept going in the interim period but could also stop without impact when critical care capacity demand increased. PB advised this would require the following: • Critical appraisal of associated risks • Lateral thinking on how services continue to be provided • Identifying if a site reserved for certain activities was required • Keeping a flow of elective activities • Undertaking an inequalities impact assessment • Development of a strong comms message for those people who believe they might have symptons of life threatening conditions to not delay in seeking advice PB advised the work would dovetail into the work around recovery and accelerated transformation but was being reviewed on a daily basis. DP requested that the Outpatient Working Group was kept sighed on that work. **ACTION:** PB to keep DP sighted and to send most recent paper. Alison Wint (AW) advised that the 2ww referral system remained open and if a GP had a patient they considered seriously ill they must refer in; the paitent might receive a video or phone call consultation in place of a face to face but the patient will be held in secondary care and continued to be tracked in secondary care. In addition, AW advised that NBT had turned off the direct referral to colonoscopy to ICE so2ww referrals should go via ERS for triage and secondary care clinicians decision on whether to investigate. Any incidents where there is uncertainty as to whether the patient is a 2ww then discuss with Consultant as to next steps. Jon Lund (JL) queried whether the Outpatients Proposal paper had been reviewed by the independent sector providers and if the independent sector recognised the same with regards to the turning off of referrals and ownership of patients. James Dunn (JD) advised that the Head of Planned Care (Gemma Artz) had been in communication as far as possible and that it was understood that eye, MSK and Somerset Surgical services as well as Prime and CareUK were all informed. JD advised that all were	157

	Item	Action
	working under same expectations and the ongoing responsibility for tracking patients and maintaining their path in the pathway remains with the provider referred to unless not yet seen in which case responsibility remained with the GP. LM advised nationally NHSE&I had negotiated with independent sector providers that had in-bed provision in the acute sector to make available their bed capacity across the system. For BNSSG that involved Nuffield, Spire and Emmerson Treatment Centre. LM advised current agreed arrangements were: • that the ventilators at Nuffield and Spire would transfer to UHB and NBT • the bedded capacity associated with the Nuffield would be available to UHBW and that associated with the Spire would be available to NBT • use of Emersons Green Treatment Centre for urgent cancer surgery would continue in particular to ensure flow through • Diagnostics had not formed part of the initial national contract therefore conversations were underway about what additional diagnostics facilities we could be using on the Emmerson Green site in particular but also the Nuffield and the Spire to support planned care Kirsty Alexander (KA) referred to the care space that sat between urgent and longer term planned care highlighting that consideration needed to be given on how to manage this. PB agreed that this was an example of things that needed to be addressed. Shaba Nabi (SN) raised concerns around: • the current situation where it appeared secondary care dealt with urgent care only and primary care dealt with urgent, semi urgent as well as the huge quantity of planned care previously dealt with by hospitals • the level of risk associated with this and currently held by general practice was significant • the level and range of advice and guidance from Secondary Care needed to be increased to address the level of risk held by practices.	

	Item	Action
	SN asked: • what was the secondary care provision for outpatient phlebotomy to avoid defaulting to the GP • what is the strategy for outpatient prescribing for secondary care • for increased clarity around radiology referral **ACTION:** DP to link into Primary Care cell and LMC regarding the concerns raised on level of risk being held in primary care. DP advised that the Trusts had initially focussed on readying as COVID-19 centres and were now starting to focus more on their urgent and routine cases and managing patient cohort moving forward. DP was in the process of ensuring all Trust departments prioritised their advice and guidance as part of this piece of work. DP indicated that UBT had 140 referral specialist destinations and some would be aggregated up to speciality level so may receive advice and guidance from a non-tertiary specialist and felt this was acceptable as there was a need for a good GDH service from the Trusts. DP advised re the phlebotomy issue that due to ICE restrictions and the requests to prevent results from secondary care going back to primary care, the phlebotomy service for secondary care patients would be put into hubs, 3-6 hubs across patch serviced by Sirona and consideration around shielded patients was needed. DP advised that secondary care patient phlebotomy results would not come into practices at this stage. SN stressed the need for speed in relation to responding to advice and guidance queries particularly around radiology than had been done previously. AW advised that generally the request for routine referrals are deferred if possible otherwise refer and they will be triaged at secondary care and both patient and GP written to regarding what the management would be but with caveat that should the patient's clinical situation change to re-contact the radiology department.	158

	Item	Action
	James Dunn advised that where possible a unified/consistent way of coding was needed and JD and DP would propose something around this. JH asked that Andrew Appleton (AA) be involved in this process. **ACTION:** JD and DP to link with Andrew Appleton on developing a consistent way of coding for referrals and also link into the Primary Care cell JR considered: • the issue of coding and managing risks in primary care should be directed to the Primary Care Cell in particular as the LMC formed part of the cell led by Martin Jones • equitable treatment and access to GPs was important • the Non-COVID patient work led by PB on reviewing those services stopped was important to avoid stopping services that could still potentially run • a good DGH service was important and there was a need to capture what that entailed look like so when entering the next planning and commissioning round there was clarity on what was required • Phlebotomy in secondary care being managed from locality hubs in addition to other services that sat outside of the community contract; JR requested assurances in particular around capacity and identifying who was best placed to deliver services as essential. • the Locality, Primary Care and Workforce cells should all be joined up on the Phlebotomy requirements and this be managed through the Bronze Command Cell by LM. JD advised that there had been recognition from Sirona that they would not have the capacity currently to undertake the Phlebotomy work so currently liaising with the Acutes around resources available to TUPE across to localities. LM recognised the concerns and in terms of Phlebotomy where there had been a drop in service within the trust not currently being utilised and the re-direction of those resources. LM advised that centrally work was being done to enable Sirona to respond and provide the services only they could provide within that arrangement.	159

	Item	Action
	David Soodeen (DS) referred to the frequent response of investigate further following a request for advice and guidance and asked there was an understanding as to what was possible to order in primary care. **ACTION:** DP to obtain clarity from Diagnostic Group about what would be provided given increasing risks carried by primary care could result in a wider range of diagnostic tests being required. Jon Evans (JE) queried the different way of gaining advice and guidance that required a fast response and asked this should be managed. DP advised that apart from the technical solutions there was a need for clinicians to speak to one another in an appropriate modality. DP noted that it would be different for each request however, more complicated queries were better dealt with by conversation where information could be shared. Mandating a method was not considered necessary as flexibility was needed to ensure it worked for all parties to ensure the value of information coming back was not too generalised. **Commissioning Executive Committee approved the interim arrangements subject to the above comments and actions.**	160
07	**Clinical Decision Aid Support for COVID planning:** David Wynick (DW) was welcomes to the meeting to present a paper on an evidenced informed clinical support tool for use in COVID-19 system response planning and assessment. DW briefed the meeting of the rapid developments which had occurred over the last 3 weeks: • an agreement of the score with Clinical Cabinet • current rigorous testing and refinement underway • would be live on Connecting Care by end of day • expectation of the score also being directly pushed into EMIS DW explained the reasoning behind the production of the decision aid being the high mortality rate indicated in the elderly and males and the greatest associated comorbid disease was existing heart disease. Clinical Cabinet had indicated that was required was a pre-coded baseline score that would be available for all 1.2million	

	Item	Action

	people in advance that would assist with two separate but related things:
	• Identifying groups of high risk individuals who would benefit from nuanced discussions concerning their possible treatment options if they should become ill with COVID-19 (ReSPECT and others)
	• Clinical decisions on very ill patients as to whether or not they should be:
	  ○ sending to ED,
	  ○ actively treated within the community
	  ○ placed on an end of life pathway.
	
	DW stressed, this was purely a decision making tool and that in no way or expectation of, nor would anyone be advocating, that this would be a single score that determines what happened to an individual patient. That would never be overridden by the individual clinician/patient discussion that would be nuanced and take everything into account.
	
	Shaba Nabi (SN) queried:
	• the score in relation to the UK demographic data showing average age of death at 60 and asked if the score indicated age of the over 80s was replicated in the UK.
	
	• the immense ethnic differences occurring worldwide noting the high level of mortality in African Amercians in USA >70% which appeared to be replicated in the UK with South East Asians and blacks.
	
	DW advised that currently not enough data was available to understand the conclusively however currently feedback from American physicians was that this was a surrogacy or measure or of comorbidity of existing heart disease. Likewise in Italy in relation to smoking.
	
	DS advised that in terms of average age of death in the UK there were far smaller numbers. Additionally nuanced discussions around end of life care might result in patients not being moved to ED but managed in the community where testing was not currently undertaken. Deaths in community were not included in the published metrics or figures currently.	

	Item	Action
	Kirsty Alexander (KA) commented on the limited impact of the use of the 10-year mortality rate for those patients who had already a much lower mortality rate. DW agreed the importance of the nuanced conversations with individual patients. Jon Hayes (JH) raised a question on behalf of David Peel (DP) related to circulation of an agreed PDF version of the Charlson for reference. MJ advised that MDCalc was an online calculator and DW advised to calculate would take 7-8 minutes per patient, which was why this had been done prospectively via Connecting Care and EMIS for speed and ease of use. Question regarding testing to be discussed in AOB. **Commissioning Executive Committee approved the adoption of the Charlson Comorbidity Index (CCI) has aid to clinical decision making.**	
08	**Stroke Programme update** Jon Hayes (JH) relayed an update from Becca Dunn (BD) on the Stroke Programme: BC asked Commissioning Executive to note the receipt of the Stage 1 Strategic Sense Check assurance letter from NHSE/I on the stroke programme noting that work would be carried out within the programme and with NHSE/I to address all the actions prior to moving to Stage 2, which is approval to go to public consultation. In addition, Clinical Senate Review Panel for Stroke at the end of April had needed to be postponed. The programme timeline was currently uncertain but worked continued to develop the programme where possible, and support the response to COVID-19, throughout this period. Julia Ross (JR) considered it excellent news to have achieved Stage 1 of the assurance process and noted that work would continue albeit on a slower work stream. **Commissioning Executive Committee accepted the update.**	
09	**Any other business** • Question arising:	

	Item	Action
	• David Peel (DP) – Testing. Jon Hayes (JH) informed the meeting that Geeta Iyer had confirmed that testing was being rolled out, GP comms on this had gone out the previous night and capacity was expanding. • Shaba Nabi (SN) - Testing in A&E. SN noted that 30% of tests were false negative and asked what was the policy for negative tests? Lisa Manson (LM) advised she did not recognise the 30% false negatives and this did not match the information that was coming out on patient testing arrangements currently in place so LM would obtain an update from the pathology laboratory. **ACTION:** LM to obtain an update from pathology laboratory on false negative patient testing query. ***Update on Action 161:*** Response received from NBT as circulated on 14th April 2020: The test needs just 2-5 virus particles (and hence the underlying viral RNA) to generate a +ve result. The common causes of a negative test are poor swabbing technique (not a deep throat or deep nasal sample) or the patient happens not be shedding at the time. There is no other confirmatory test. The current test is considered sensitive enough that PHE / NHS E have recently sent around a missive asking providers not to re-swab after first negative (unless doing an endo-tracheal fluid sample) Contact details are: Rommel Ravanan Rommel.Ravanan@nbt.nhs.uk • K Alexander (KA) advised of incorrect advice received from PHE in relation to a request for tests for 4 practice nurses following positive tests being returned for the practice GP. • KA referred to the modelling of COVID-19 and the revised June peak date. KA asked when it would be possible for some routine primary care work to re-commence ie face to face consultations where appropriate. LM suggest that the Primary Care cell could model at what point it would be appropriate to re-commence, where	161 162

	Item	Action
	necessary, face to face patient consultations whilst ensuring patients were seen as appropriately as possible and recognising there may be some key issues going forward. JH considered it was also about Primary Care having a clear understanding where it sat on the curve. Julia Ross (JR) requested that this request be aligned to the piece of work being done by Peter Brindle too ensure only one piece of work was being done not multiple. **ACTION:** LM to feedback to the Primary Care Cell as above. • SN asked about the format and frequency of Commissioning Executive Committee in the current circumstances and whether it ought to meet more frequently. JH advised that the appropriateness of changing the frequency of meetings was gauged on need whilst also taking into account clinical colleagues' availability. JR considered the infrastructure and process around the COVID-19 incident specifically the Primary Care cell and others such routes such as Clinical Cabinet appropriate but there was a need to keep this under review. JR noted that Commissioning Executive was a critical part of the CCG governance process but considered there was currently no need to meet more frequently.	
	Committee Effectiveness: The Chair asked for comments on the meeting's Committee Effectiveness and no comments were given.	
	Date of next meeting: Thursday, 14th May 2020 at 8.30 – 12:00pm MS Teams Meeting	

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