Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 10th October 2019 at 8.30am, CCG Conference Room, South Plaza, Bristol.

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
Colin	Bradbury	Area Director for North Somerset, BNSSG CCG	CB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Cecily	Cook	Deputy Director of Nursing & Quality, BNSSG CCG	CC
Deborah	El Sayed	Director of Transformation, BNSSG CCG	DES
Kevin	Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Vivienne	Harrison	Public Heath Consultant, South Glos Council	VH
Jon	Hayes (CHAIR)	Clinical Chair, BNSSG CCG	JH
Geeta	Iyer	Clinical Corporate Lead for Primary Care Provider Development, BNSSG CCG	GI
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
Martin	Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJ
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
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
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
Alison	Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AJW

Apologies			
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Anne	Clarke	Director for Adult Social Services, South Gloucestershire Council	AC
Terry	Dafter	Director for Adult Social Care, Bristol City Council	TD
Jon	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
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
In attendance			
Gemma	Artz	Head of Performance Improvement, Planned Care, BNSSG CCG	GA
Sarah	Carr	Corporate Secretary, BNSSG CCG	SC
Andrea	Dickens	Public Health, South Glos Council	AD
James	Gold	Head of Contracts (Interim), BNSSG CCG	JG
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker)	JHo
Margaret	Kemp	Service Improvement Facilitator, Planned Care, BNSSG CCG	MK
Hannah	Layton	Programme Manager, Healthier Together, BNSSG	HL
Niall	Mitchell	Head of Exceptional Funding, BNSSG CCG	NM
Andy	Newton	Head of Planned Care, BNSSG CCG	AN
Greg	Penlington	Head of Locality Planning (Bristol), BNSSG CCG	GP
Hayley	Richards	Healthier Together, BNSSG	HR
Sally	Robinson	Performance Improvement Manager, Planned Care, BNSSG CCG	SR
Carol	Slater	Head of Mental Health & LD, BNSSG CCG	CS

	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** No declarations of interest were made.	

	Item	Action
03	**Minutes of the meeting and matters arising from 12th September 2019** The minutes of the previous meeting were agreed as a correct record after taking into account the following amendments: Page 4 – Item 8 • SN comments - update wording to reflect removal of CGA and insertion of over treatment on third bullet point • JR comments - Insert "only" on full bullet point Page 5 – Item 8 – 1st line – insert word "people" after JR Page 11 – Item 13 – amend Leilah Davey to Leilah Dare Page 14 – Item 13 – amend Shabi to Shaba Page 23 – Item 18 - amend Contact to Contract **Action log from 12th September 2019:**	
03.1	Item 81 – Open Item 109 – Open Item 110 – Open	
04	**Primary Care Strategy – first draft review** Geeta Iyer (GI) introduced the revised draft Primary Care Strategy coming back to Commissioning Executive Committee for comments and feedback. GI noted that since the paper was discussed in May 2019 at Commissioning Executive and had been further reviewed elsewhere both within the CCG and the system. GI noted the following key points: • extensive engagement across the system undertaken • refinement of the priorities developing quadrants • further work to identify where Integrated Care Partnerships should sit • better articulation of where practices, PCNs and localities within the system whilst outlining the direction of travel to PCPs GI confirmed the first version of the draft strategy had been updated with feedback following the September session of Primary Care Commissioning Committee (PCCC). This second version would be updated following comments and feedback required by 18th October before going back to PCCC and then Governing Body in November. Key points to note was a long list of NHSE requirements and assurance processes to go through, the Long Term Plan (LTP) submission tie in, areas to revise notably investment and Mental Health and Urgent Care links are included. The draft strategy had been shared with the membership and feedback was currently awaited. The strategy will be taken to the next Integrated Steering Group (ISG) meeting to ensure their strategy and this are read in conjunction and aligned.	

	Item	Action
	David Peel (DP) raised a concern that the link between the Primary Care Strategy and that of Planned Care needed to be stronger.. GI advised she had already noted this and it was agreed that DP and GI would work together to strengthen the link.. Shaba Nabi (SN) commented the Strategy was a good comprehensive document and noted several queries around the workforce resilience and sustainability thread that ran through the strategy: • Consultations/appointments - there appeared no aspiration for 15 minute appointment periods as a minimum • Online consultations - saved time for patients however not for GPs who would still need to perform the same tasks • Capacity - the risk of burnout if continuously working at the top of your licence • GP Leadership – the reference to GP leadership on Page 15 of the Strategy did not currently include the work of GP partners • Continuity – the narrative spoke of continuity being important however, the strategy currently did not clearly identify how to achieve continuity. • Movement of hospital based staff into the community – would like to see more on how this will be achieved. • Estates – no mention of the impact on those practices that will experience 20% increased service costs Jon Hayes (JH) advised that it was the individual organisation's decision as to how they wanted to distribute their resources and if working to the top of their licence the may also decide on 40 minute consultations. JH stressed that there was a clear need to articulate in the Strategy the scale of the ambition to pull services into the community as much as possible whilst ensuring that structures were properly robust enough to deal with workforce and sustainability issues and service the population's needs. A discussion took place around GPs working at the top of their licence and the importance of GPs being able to work in conditions that would allow them to do that and still see the people they needed to see in the time required. It was noted that these conditions could be best achieved through GPs working with the multi disciplinary teams (MDT) around them, as well as others able to support, to see those people the GP was not able to. SN agreed that the concern was about having the time to see the people the GP should be seeing but not having enough time to complete the post appointment tasks.	

	Item	Action
	Kirsty Alexander (KA) advised this issue had also been discussed at the General Practitioner Council (GPC). JR considered it was about ensuring GPs were able to do the more complex tasks that only they could do with the people around them focussing on the other areas/tasks. Martin Jones (MJ) advised of various strategies to accomplish this. KK stressed the importance of ensuring online consultations be well implemented in the right population area with high quality triaging occurring where this was not possible. Peter Brindle (PB) referred to the three graphs contained in the Health inequalities section on Page 20 of the Strategy paper noting there was currently nothing about what particular drivers in the Primary Care Strategy (PCS) could do to improve the situation. GI advised that Charlie Kenwood (CK) was reviewing that area again in order to get a clearer message out. *(Jeremy Maynard joined the meeting at 8:50am)* JR noted that any difficulties would be around the implementation stage of the strategy. Jon Hayes (JH) considered that should the outcome be a nice clinical experience with enough time to see people then this would create a better clinical involvement. Kevin Haggerty (KH) commented on the good evidence of continuity of care and inequalities element within the document and stressed the need to promote key high quality care to those less affluent communities where the gap had widened considerably. A discussion took place around the importance of tracking and evidencing the quality of care received in Primary Care in order to identify whether patients in deprived communities were getting a much lower level of service. KH reported that there had been a 5-fold difference in the Patient Survey regarding continuity of care levels in Weston between deprived communities and more affluent communities, and it was considered that the high ratio of locums to partner GPs working in some practices could potentially impact on the standard of care received.	

	Item	Action
	Commissioning Executive accepted the report.	
05	**Mental Health Strategy - update** The Committee welcomed Carol Slater (CS), Hayley Richards (HR) and Hannah Layton (HL) to the meeting. Deborah El Sayed (DES) introduced the paper and gave an overview of the work completed since the draft strategy had been discussed at the May 2019 Commissioning Executive, advising that the aim had been to develop an STP wide all age Mental Health and Wellbeing strategy. The draft strategy had been developed in collaboration with Healthier Together partners including the three Local Authorities, providers and commissioners, as well as incorporating feedback from the wider population from engagement events and consultations involving over 1,450 people. DES advised that once comments from Commissioning Executive Committee incorporated the draft strategy would then be presented to STP partner organisations before being going to Governing Body in December 2019. The draft strategy focus was around the following themes: • Promoting mental wellbeing and preventing ill health • Access • Integration • Sustainability • Development of a Primary Care Mental Health service Carol Slater (CS) presented the item stating that the Strategy, co-produced with STP and Healthier Together partners, was a move to more responsive care. The latter stages had been developed in parallel with the Long Term Plan (LTP) responses, ensuring matrix working was fully aligned. CS advised there was further work required on the updated strategy but that it was with Commissioning Executive to obtain member's views and further comments before a final draft was circulated to partner organisations. DES advised the draft strategy was focussed on what matters to people and asked for feedback on any areas missed, advising it was recognised there was still more work to do around the Crisis pathway, and asked if Commissioning Executive considered the strategy to be good enough and clear enough for people to commit to.	

	Item	Action
	Andrew Appleton (AA) as the Digital Lead welcomed the use of digital technology but advised that awareness around the use of data sharing needed to increase. DES agreed and referred AA to the Annex in the Strategy under Embedding Digital Practice suggesting that there may be a need for a Digital MH Strategy as a way for these areas to come together. Kirsty Alexander (KA) referred to the MH elements of the STP strands and asked if this included the children's work stream around CAMHS. DES advised the draft Strategy would remain unchanged, however in terms of delivery the ownership would sit with CAMHS. DES went on to say the Strategy was an all age strategy and CAMHS currently were able to see only 15% of referrals therefore 85% had been taken into account within the MH Strategy to address areas such as transitioning into adult services. Julia Ross (JR) noted the following: • it would be helpful to have a summary of deliverables • once signed off, an implementation plan • clarity on use of investment in core MH services • the need to be clear about what "robustly challenge physical and mental health providers" on page 99 meant • Carers and what attention the Strategy gave to Learning Difficulties (LD) and Autism as it was not appropriate to say LD was not MH • transitioning from children's to adult services should not have an age limit attached Cecily Cook (CC) noted that safeguarding was not explicit in the document and given staff needed to be skilled in this area suggested bringing the Safety team in to advise. DES accepted this offer. Michael Jenkins (MJ) queried how much engagement had taken place regarding Dementia noting that the Frailty Team had been eager to contribute to the Strategy. DES and MJ to meet to discuss further. Lesley Ward (LW) asked whether the cohort with both drink and substance abuse with Dementia had been considered. Shaba Nabi (SN) referred to substance abuse and the issue of prescription drug dependence as an area to include.	

	Item	Action
	Vivienne Harrison (VH) commented that from a prevention perspective the need to maximise should run all the way through noting employment could be transformative to MH sufferers. Kevin Haggerty (KH) asked for targeted resources/assets to address the disadvantaged inequalities in Mental Health. **Commissioning Executive noted the report.**	
06	**Outpatient Transformation Plan Proposals** David Peel (DP) presented the report in the absence of James Dunn, Healthier Together, who was unable to attend on this occasion. DP advised the purpose of the paper was to seek support to proceed with two 9-mth evaluation pilot projects that had been recommended by the Healthier Together Outpatient Programme Board these being: • new lung nodule pathway • new advice and guidance proposal for lipid service **Lung nodule pathway** DP advised that the new lung nodule pathway was intended to redirect 2ww referrals following a CT scan by a radiologist from the current face to face MDT discussion to virtual clinics unless clinically necessary. This would deliver increased efficiency of MDT meetings by ensuring only those patients who required full MDT input attended and a reduction in unnecessary outpatient attendances, as patients will not need to journey to hospital. *Sarah Truelove (ST) arrived at 9:30am* Lisa Manson (LM) advised that the proposals were being presented to Commissioning Executive for clinical review purposes to ensure there was no risk to the clinical pathway; and the contractual position was outside the remit of the Commissioning Executive Committee. Jon Hayes (JH) asked what would be the impact of external radiology reporting. DP advised that both acute providers currently outsourced radiology and that the pathway ensured that a pharisaic radiologist would see all patients. Lesley Ward (LW) asked if there was adequate capacity. DP confirmed that was the case. Martin Jones (MJ) considered there did not appear to be a natural flow in the pathway and advised that there needed to be clarity around this so both the patient and the GP understood the process. Peter Brindle (PB) asked if the pathway had been assured for any potential issues.	

	Item	Action
	DP advised he would raise this with the trust. Alison Wint (AW) agreed that pilot was good idea but expressed some disappointment in not having been previously involved or consulted on the paper. David Soodeen (DS) referred to x-rays and the confusion over past work being mistaken for new and asked whether this issue would be resolved. Jeremy Maynard (JM) asked for clarity around instances of GP's still receiving reports and whether transport issues had been considered. **Lipid Clinic – Advice and Guidance Service** AW considered that the pilot was aligned with Cancer AA considered that the pilot was also aligned with Digital Julia Ross (JR) thanked DP for the opportunity for the Commissioning Executive to feed into proposals for the out patients transformation programme. JR considered the ambition should be to stop referrals altogether and redesign how they managed into something more appropriate. The pilot was helpful but was not in itself transformation. DP advised there had been support from the Acute Care Collaboration (ACC) and was currently working with the Outpatients Board, which had been more challenging due to this being a relatively new group. It was agreed it would be helpful if, as the new Chair of the Outpatients Board, Mark Smith was invited to attend the December Commissioning Executive Committee meeting to give an overall summary and update of the Outpatient Transformation Programme. David Jarrett (DJ) informed the committee there would be a locality and overall transition of outpatients coming to the November Commissioning Executive meeting. **Commissioning Executive Committee accepted the reports.**	
07	**ADHD service model proposal – update** Gemma Artz (GA) and Sally Robinson (SR) were welcomed to the meeting to present the update paper to the Committee on the progress made to date.	

	Item	Action
	GA advised that following the issue of the unacceptable long waiting times for Adult Attention Deficit Hyperactivity Disorder (ADHD) services first presented to Commissioning Executive in January 2019 and latterly in July 2019, the CCG had written to the provider setting out the required next steps. AWP had since undertaken further discussions at both Executive and clinical level with an understanding that AWP would work to achieve a 90 minute assessment time. On 9th October AWP changed their stance and confirmed that their proposed new model would: • resolve the ongoing demand only • not impact on or reduce the backlog • involve an assessment time of 3.5 hrs in total which still included 90 minutes with a nurse (currently 85% of assessments were put through to see a consultant) In view of the sudden change in stance and lack of progress made with AWP GA considered the only way forward was to bring a full options appraisal for a remodelled ADHD service for decision to the next Commissioning Executive Committee. Julia Ross (JR) stressed that whilst supportive of AWP a ready to go options appraisal was now critical and urgent and any issues with the provider should be taken through escalation alongside carrying out the options appraisal. JR asked for formal notification of the outcome of the recent meetings in order to escalate this with AWP. **Commissioning Executive requested a Options Appraisal and Specification ready to commence procurement to be presented in November for decision.**	

08	**Ophthalmology – Cataract Activity Management** Niall Mitchell (NM) and James Gold (JG) were welcomed to the meeting to present the item on Cataract Activity Management. Lisa Manson (LM) gave the background to the paper, which addressed the concerns raised at the level of activity in cataract surgery within BNSSG. NM advised that: • activity levels and Standardised Admission Ratios [SARS] rates had increased exponentially in the last two years, and • it was apparent that this had been driven by AQP providers increasing activity in an uncontrolled manner and significantly reducing waiting times for patients, whilst fewer patients are being treated at Acute trusts This has increased expenditure at AQPs and overall for cataract surgery. In response to this NM had introduced changes to the pathway working in conjunction with Clinical Effectiveness, Planned Care, Referrals and Transformation and was seeking approval for the following proposal: Commissioning Executive was asked to: • Note the initiatives being undertaken by the CCG to manage current activity levels whilst developing robust mechanisms to support better planning and patient choice in future • Consider whether the trial supporting patients in considering informed consent should proceed at pace or run for a longer period of time and whether, as a consequence, additional resource should be made available to the Referral Service for the period of the trial in order to support that core service • Agree that the Commissioning Policy for Cataract Surgery should be amended to make the Referral Service a compulsory part of the referral pathway for all patient referrals, in order to support the pilot of informed consent, whilst allowing financial challenge to those providers that fail to comply. Jon Hayes (JH) asked if there had been support for the proposed changes from the LMC. NM advised that Elizabeth Williams, Transformation Manager for Planned Care, was in contact with the LMC and that they had indicated their support and would produce a technical letter for their members. Sarah Truelove (ST) asked if the LMC had any control over Optometrists who refused to comply with the request that referrals	

	be processed via the eRS. NM advised that this had formed part of the discussions with the LMC and it was considered that by updating the Commissioning Policy to ensure all referrals went via the Referral Service a proportion of those referrals with incomplete forms or those not meeting the criteria would bounce back to the optometrist. A discussion took place around the increased workload the proposed pathway might place unnecessarily on GPs; the control measures around ensuring optometrists complied with the requirement to process referrals via the referrals service and the issue of retrospective referrals being submitted to GP practice receptions. JR advised that retrospective requests had ceased and the protocol was that any retrospective requests received via a GP practice reception should be re-directed to the referrals service. ST queried the level of confidence in the proposed measures / processes as currently only 30% of referrals were triaged via the Referrals Service and asked how this would be monitored to ensure this anticipated increase occurred. NM advised that the CCG Business Intelligence Team would provide monthly reporting on referral numbers in addition to Referrals carrying out a monthly check and challenge process on data. ST stressed that in light of the CCG's current £12.9m financial deficit evidence of this was required to ensure it fully addressed the issue. LM advised that the main concern was this should not move to a prior approval system. NM agreed noting that the Prior Approval system was a heavy administrative route and that the compromise was a one-stop shop. JR questioned why GP's needed to be involved in the process and noted the issue had arisen due to optometrists sending referrals direct to outpatients without going via the referral service. JR considered the aim should be to manage optometrist behaviour as opposed to increasing the workload of GPs. NM advised that: • there was currently no direct communication with optometrists therefore no way to demand they complete the paperwork correctly	

	• the proposed pilot required an eRS to be uploaded on the system however optometrists did not have access hence the need for this to be done by a GP. JH asked if it was possible to inform optometrists that payment was reliant on receipt of a completed form. JR indicated the issue was with the Commissioning Policy under which the Optometrists operated not GPs. Shaba Nabi (SN) suggested the need to reflect on what was trying to be achieved ie cost savings or a patient making the right decision for them. JR noted the Cataract 2 week waiting time for referral compared to the ADHD waiting time of 2 years was actually driving inappropriate costs. The correct course of action was to have a discussion with the patient so they could make an informed choice however this was clearly not happening and intervention was now required to manage this. MJ asked if all referrals going via the referral service route would be assured. NM referred to the proposed monthly check and challenge on data. Alison Bolam (AB) asked what happened once the forms arrived with the referral team. NM advised these would go through a triage process would result in any incomplete forms being bounced back to the optometrist DP raised the issue of inequalities and the need for 70% not 30% to be triaged; in addition clear communication to GP colleagues outside of Commissioning Executive about the process would be a priority JR requested evidence of abuse of the system be seen by the CCG and stressed that these proposals were not aligned in any way to Exceptional Funding therefore any reference to EFR should be removed from any correspondence. *(HF left the meeting at 9:55am)* ST considered that clarity around the process was needed as it did not appear to be assured.	

	JR reinforced the message that good communications with GPs was required and it was agreed that PB/MJ/DP would cover this element. JM agreed to raise this at the Quality Forum. LM asked if Commissioning Executive would approve the amendment to the Commissioning Policy and the mapping out of the pathway with the localities in order to go to the next CPRG meeting. *"All referrals to secondary care must be processed via eRS in order to allow the patient access to support to make informed consent to the procedure and provider*." **Commissioning Executive noted the report and approved the pilot and the insertion of the above additional wording in the Commissioning Policy.**	
09	**Rapid Diagnostic Service – update** Margaret Kemp (MK) was welcomed to the meeting to present the update on the development of a pilot Cancer Rapid Diagnostic Service. Alison Wint (AW) introduced the item and gave a brief summary of the background to the work undertaken. AW advised that subject to submission of a successful business case to Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance by 1st November 2019, there would be a transfer of funds from the Cancer Transformation Fund to develop the service in line with the Long Term Plan (LTP). AW explained the service was for those patients who did not meet the criteria for the 2ww pathway yet displayed vague non-specific symptoms the GP considered merited further investigation. There was no age limit applied but the pilot to date had shown most patients were found to be in their 60-70's. JH asked for any questions or comments. David Soodeen (DS) spoke about the implications about health and equalities noting that this service would benefit those people with vague symptoms who did not speak English as a first language. Lesley Ward (LW) asked for clarification on the initial diagnostic tests that the GP could request be carried out. AW advised that the pathway had changed slightly from that originally presented due to what was considered an emerging demand and potentially increasing activity on what was a scarce diagnostic resource.	

	Martin Jones (MJ) was mindful of undermining the ability of Primary Care to investigate appropriately people with vague symptoms and considered that to send all people with “sort of, could be” cancer somewhere where people did not know them would not work. AW realised that diagnostics would be one of the challenges in the pathway and getting secondary colleagues to complete the investigations in a timely way was one of the key elements. Julia Ross (JR) referred to the reference on page 5 that the service would link closely with frailty services and noted that as not all the people using the service would be frail there was a different way of achieving this through the localities without aligning it to frailty. AW part of reason was to utilise similar resources, particularly around estates and access to clinics, given the projected number of patients per week (20) across BNSSG. JR advised that aligning to the locality hub would be more appropriate. AW agreed that this could be done. Alison Bolam (AB) referred to page 10 and challenged the statement that there was currently no access to urgent CT at North Bristol Trust. Margaret Kemp (MK) understood this to refer to 2ww requests only Following discussion it was confirmed by AB and other members that a CT could be requested at NBT and it was merely the process that differed. AW advised that for referrals to be looked at, for them to be a patient navigator to help the patients, to ensure they access the appointment on time etc., and for the clinic to be staffed with a secondary care consultant GP who would discuss the case at the end of the appointment, so a type of mini MDT. Sarah Truelove (ST) asked about the financial implications and clarity on the number of patients likely to go through the service and the associated costs. MK advised this was not yet known however part of the next steps was the completion of the Business Case, which, following the revision of the pathway that week, would go out to trusts requesting they return costings. AW confirmed that there had been an Expression of Interest submitted to SWAG to develop a business case and this paper formed part of that process. Mike Jenkins (MJ) noted there were risks around investigations and expressed concern that the paper was not very specific about what the non-specific symptoms might be. AW confirmed that the symptoms had typically been unexplained weight loss, vague abdominal pain, off legs etc. AW advised that part of the	

	reason for having a longer MDT type of appointment was to enable a conversation with elderly patients and their carers as to the value of further investigation. Kevin Haggerty considered this part of mainstream general practice. Shaba Nabi agreed noting day-to-day work of general practice was managing uncertainty, diagnosing normal when it was normal and identifying the wood from the trees, with continuity of care being essential to do that properly. David Peel (DP) advised that National Guidance was move to better Stage 1/Stage 2 diagnostic rate in the UK and questioned whether this was this the correct tool and was there more specific things that as a community could be done. AW advised that without a specific pathway it restricted what a GP could do about those patients who did not meet the 2ww criteria. Lisa Manson (LM) expressed concern about the workforce implications of the pathway in terms of how this mapped against the overall workforce arrangements. LM explained that the radiographers were employed by the Trusts so it would be a matter of how this would be aligned in the business case. AW confirmed that would be addressed. Peter Brindle (PB) advised that the service fell under the STP work programme and that one of the governance routes was the Acute Care Collaboration (ACC) and workforce implications had been an item there and across the board. PB explained that it was recognised there were uncertainties about this approach but early diagnosis was generally not as good as it could be and this was a national attempt to improve that and the pathway would be monitored to identify whether this particular approach was working and feasible. Kevin Haggerty (KH) considered he was unable to give his support to the pilot due to the workforce issues in particular GPs in Weston and the lack of evidence of value to the patient. AW advised she would ensure these were included in the risks. ST stressed the need to be very clear that the money was a resource allocation and heeded caution about assumptions on slippage in the financial recovery plan that Commissioning Executive had signed off at the start of the year. A discussion took place around the funding restrictions and it was established as the business case progressed it must be explicit that	

	going forward the Trusts would need to provide for this service within their existing funds. It was agreed that the pilot would go ahead and that this would then be evaluated and reported back to Commissioning Executive. MK flagged that the pilot needed to be trialled and evaluated however raised a concern that the format needed to comply with the National Team directive. LM advised it was appropriate as the objectives set by the National Team had been met and the reason for the proposed model was that it was the best fit for our local circumstances. **Commissioning Executive supported the further development of the pilot, business case and evaluation.**	
10	**Integrated Frailty Service – 19/20 MDT Business Case** Greg Penlington was welcomed to the meeting to present the item MDT Business Case for the Integrated Frailty Service. Justine Rawlings (JRa) gave a brief background to the item advising this Business Case had transpired from the last Commissioning Executive meeting where there had been a request to understand what might be fast-tracked in year around frailty and other related areas involving the mixed of incumbent of community providers, Sirona and the local authorities. JRa advised this was still in the process of negotiation with the various parties and that this was an investment that was likely to be offset by the anticipated reduced admissions and therefore worth pursuing. No other means of investment had been identified. Jon Hayes (JH) asked the Committee for questions. Peter Brindle (PB) commented on the 1% cohort, noting that having identified the 1% there remained more to do to understand what that cohort represented and stressed further analysis was essential. PB asked that contact be made with analysists and that GP drive the conversation forward in order to inform this work. Greg Penlington (GP) confirmed this process had already begun. Deborah El Sayed (DES) spoke about the development of the evaluation model and offered assistance in ensuring there was a link-up with some of Insight's work around what matters most to people as they are experiencing the change. JRa confirmed the link-up was in place.	

	Alison Bolam (AB) queried the November 2019 recruitment date given for the MDT co-ordinator role. GP advised that it was anticipated this could be achieved due to a significant number of at risk staff able to move into the role very quickly. Kirsty Alexander (KA) supported the direction of travel and having spoken with local practices, advised they equally supported the direction of travel given most practices already had some sort of MDT meeting; what they did not want was to have something that was completely separate. GP advised he was currently working with both community providers to understand what existing meetings might be replaced by this approach but did not believe they could service both so it would be about rationalising and that was currently being worked through. KA asked if practices had flexibility without the need to be too prescriptive. JRa explained that whilst not wanting to be too prescriptive it was about following the Sirona model around MDT working, not continuing the existing MDT work sitting within practices currently. JRa stressed that the intention was to avoid being so flexible that effectively the same model continued and therefore no additional impact derived. Sarah Truelove (ST) asked for clarification around the financial impact referring to the investment of £160k and projected savings of £749k; specifically the sensitivity of analysis and risk the CCG would be taking on this decision, given that this would occur 6mths after the MDT the majority of the savings would only be realised 20/21. ST stressed the need for confidence, that the pathway at least cover costs this year and give benefit next year. GP explained that the figures in the sensitivity analysis related to the whole impact of the scheme so was not sensitive to 19/20 or 20/21 so the same apportionment of 29% this year and 71% next should be assumed. GP went on to explained that within that there were three variables in the sensitivity analysis: • 1% Cohort - did this allow the highest impact individuals to be case reviewed and actioned planned by the MDT • Quantified impact of MDT working – on a sliding scale have taken 65% from Camden MDT intervention benefit • Slippage – have allowed 4 mths delivery resulting in 23% as a whole Julia Ross (JR) considered MDTs to be a good idea however considered there was a lack of evidence that they saved costs elsewhere in the system.	

JR asked members to consider the steps required to achieve a systematic joined up frailty service that proactively helped keep people well and independent, and had a 24/7 reactive model.

JR understood the need to provide this year but considered the business case:

- Too generic – not sufficiently focussed or targeted to give confidence that it would make a difference.

  JR noted within the 1% cohort who were the specific people on who we could have some real confidence of making an impact. Suggesting this could be the 6% within the 1% that reside in Care Homes or those in deprived communities, which might be targeted.

- Lacked evidence – not enough of the evidence base contained within the document nor of the risk stratification having a massive impact.

  JR noted this not attuned or specific enough and would rather a smaller return and greater confidence in the service, that is required targeting and focussing on the most difference could be made.

- MDTs – there was a need to ask what would happen after the mini MDT occurred; was there confidence that sufficient support was in place after the mini MDT had happened?

  JR suggested non-professional qualitied care co-ordinators who had regular contact the patient dependent on their needs would give them the opportunity to talk through things and avoid tipping into services. This would potentially give more benefit than a professional approach.

- Costs – re-alignment of staff by providers should occur without incurring additional staffing costs.
  JR heeded caution on double fronting staffing costs for staff already employed with providers that could clearly be utilised without paying again for those people.

JRa confirmed:

- BCH had been challenged on staff costs and noted it might be beneficial to go through another route to challenge that process.
- Care co-ordinators, in particular in Bristol, were already in place in practices as well as a good social care prescribing offer and would link with that.
- Understanding of the Community Services element of the follow on from MDTs also formed part of the ongoing conversations.

	David Peel (DP) queried the lack of reference to dementia in the document and advised this also linked with the care co-ordinator role and asked where Dementia fitted in with the service. JRa confirmed that: • this had been referenced within the overall frailty programme • once the core service was in place it was anticipated there would be further plug ins to the MDT work and Dementia was one of these JR commented the paper assumed the service would take place in Bristol and North Somerset and asked if more value could be derived from the South Gloucestershire way of working recognising it was well embedded. JR considered that even more could be achieved in South Gloucestershire and was unconvinced about the exclusion of South Gloucestershire from the business case. David Jarrett (DJ) considered this could be included in terms of the focus impact assessment. Sheila Smith (SS) advised that historically North Somerset had MDTs when Social Care and NSCP worked as an integrated team so there were MDT co-ordinators from NSCP. Martin Jones (MJ) considered the risk register rating for contractual agreement was key. MJ considered it would be difficult with MDTs and weekly working with people with complex needs given the quality of the system was such that due to capacity it would take only a couple of bad decisions per practice to go into meltdown and likewise a couple of good decisions to go into starvation. MJ stressed the key was how to get the system to work when making acute decisions around acutely ill people, when a little bit more would prevent that admission which would likely turn into a 40 day admission. It was not just about MDT but the wider context and changing the culture on how we work together and share risk. JR noted that it was not just about decisions in practice; it was about what else was available in the system that could support them. JRa indicated that further to the feedback given the business case would be updated to reflect: • A fuller review existing resources to reduce or eliminate workforce costs • Improve the assurance around the impact • Introduce a more targeted approach involving South Gloucestershire	

	It was agreed that more confidence in the financial and risk elements of the paper was required before a decision could be made. Due to the short timescale involved, it was agreed that GP would circulate an updated business case to Commissioning Executive that took into account the above feedback for approval prior to the November Commissioning Executive meeting. **Commissioning Executive noted the report as above.**	
11	**BCC new Stop Smoking Service** Andrea Dickens and Jennifer Davies were welcomed to the meeting. Peter Brindle gave a brief background to the paper written by Dr Viv Harrison (VH) brought to Commissioning Executive for information purposes and to give an understanding of what it might mean for the population of Bristol. Vivienne Harrison (VH) explained the purpose of the paper was to set out the Bristol City Council (BCC) commissioning intentions from April 2020 in relation to smoking cessation in Bristol. VH advised that whilst smoking had declined substantially it remained a major driver of early deaths, disabilities, inequalities and health outcomes, including pregnancy outcomes. VH advised the support to stop services was one component of BCC's wider approach to tobacco control; however the context for support to stop services had changed as across the country there had been a substantial decline in people accessing these services. This was due to methods of quitting having changed resulting in support to stop services being the least used therefore following a review last year of Public Health commissioned services a proposal for a new-targeted support to stop service had been developed which would be a community based opt-out service. Jennifer Davies (JD) and Andrea Dickens (AD) gave an overview of the pregnancy element of the new model that involved a holistic approach which included the whole family throughout the pregnancy and then extended over a 1,000 day period. VH advised that BCC was working the South Gloucestershire and North Somerset as part of the Tobacco Control Implementation Group under the STP and very much so on the Smoking in Pregnancy pathway. VH confirmed that the BCC approach was aligned to that of South Gloucestershire, incentivising and targeting priority groups and promoting a self-care approach using web based resources.	

	Jon Hayes (JH) queried if the 1,000 day support period applied just to the mother or parents. JD advised that it would apply to the whole family. David Soodeen (DS) commented that: • the accuracy of data relating to those with long term conditions and advised that accurate data could be found through various sources. • long term conditions appeared to be focussed towards to hospitals whereas the bulk of people with long term conditions sat within primary care • he would like to have seen MH & LD included in the document • with regards to procurement if there was anyone from the CCG involved in the procurement or had it been purely a BCC process AD noted the absence of MH & LD in the documents advising that BCC were currently in discussions with AWP to identify how they could support AWP to come up with something effective. Conversations had taken place with North Somerset to identify how this could be achieved STP wide. BCC were aware this was a difficult group to provide an effective service for and that the standard treatment was not the most effective way so this would form an ongoing piece of work with partners across BNSSG and AWP to support the problem. Julia Ross (JR) commented: • it was helpful to know the approach towards MH & LD however there appeared to be several exclusions in the document which looked to be waiting for people to become sick before intervening • supported DS's point about the majority of people with long term conditions being in primary care and asked do we have to wait for them to be in hospital before they are picked up • how can we be assured we are doing the preventive element as well as the reactive VH referred to the work taking place within Healthy Schools and Elicit Tobacco etc. in preventative work outside of this particular service advising that it was about identifying where to target with an opt out approach, monitoring and reviewing and then adapting as the programme developed. Alison Wint (AW) raised the concern that on the surface the proposal appeared to be a contraction of the service and considered this to be a slightly negative approach. VH advised of the need to recognise the context had changed and that most people when using something to help quit were using e-cigarettes not the support to stop services. The aim was to promote self-care approaches and if people are able to use web-based resources and buy	

	some LRT then we should do that for those who can and then use the resources we have for those who cannot. Kirsty Alexander (KA) asked: • what percentage of the 11% that are smoking are going to be covered by this approach • about the increasing evidence from the USA about the dangers of vaping and what provision Public Health England was making VH explained this the data was not currently available but could be provided. AD advised with regards to the vaping issues in the USA; essentially there was a lack of regulation of vaping products in the USA, in the UK there was a much tighter heavier regulated market with reputable providers and retailers, and Public Health England advice is that vaping 95% safer than smoking. David Peel (DP) referred to the planned care pathways going through to surgery and those struggling with smoking cessation and asked how they could link in with this service. VH advised it was intended that people on the free optimisation pathway would be included in this service. JR asked if the BCC wider Smoking Cessation Strategy be shared with the Commissioning Executive. AD noted this was in the process of being re-drafted but would share once completed. Shaba Nabi (SN) asked: • whether this way of working offered best value as it appeared to be a duplication of work done in primary care by HCAs in chronic disease clinics • if it would be better use of funds to incentivise Primary Care to do this via clinics • about the inequity between the three local authority areas given the aim was to work as a single system • about the impact on finances given the current system in primary care allowed for the prescribing drug costs to be invoiced back to the Public Health and that cost being approx. £180k per year. VH advised that BCC were in discussions with the CCG about the re-charging of NRT and Champex, however BCC would continue to reimburse costs for prescribed NRT and Champex for the next 6 months until April 2020. After this it would then be a matter of reaching an agreed position on what happened beyond April given BCC would want to see a downward trend in the NRT budget noting that continuing	

	to fund recurrently at the rate BCC had done in the past was no longer feasible. JR recognised that this was similar approach to that of the over the counter prescriptions and flagged: • the need to be careful not to inadvertently have an impact on those people who needed this type of support the most • that the approach should be targeted and tailored to those needs. JH asked that the Strategy be shared with the CCG once completed. JR asked that there be CCG involvement with the Strategy. **Commissioning Executive noted the report.**	
12	**Urgent Care Activity & Performance Update** Lisa Manson (LM) presented the Urgent Care Activity and Performance update report. LM highlighted the current impact in terms of stranded patients due to difficulties in maintaining flow which had resulted in an increased number of 21 day stay patients remaining in hospital. There has been targeted input into all 3 providers but most particularly Weston and the latest data was starting to show an impact at NBT and Weston but not at UHB. Julia Ross (JR) asked if the reason had been identified. LM advised there was no specific reason but that it had been more a matter of understanding the flow through. Alison Bolam (AB) queried if the report was supposed to contain the Primary Care data previously requested. LM confirmed that it was supposed to be in the report and that this would be rectified and circulated. **Commissioning Executive noted the report.**	
13	**Contract Performance Update Report – Mental Health and LD** Lisa Manson presented the Contract Performance update report for the MH and LD sector. **Commissioning Executive noted the report.**	
14	**Corporate Risk Register and GB Assurance Framework** Sarah Carr (SC) was welcomed to the meeting to present the item. SC asked colleagues to reflect on conversations that had taken place during the meeting and give thought to any of risks that might not currently be on the register as well as those that were. SC asked for this to be taken back to the individual Directorates to consider further. SC reminded members of the importance of undertaking the Conflict of Interest training and noted some members were either due or late in carrying out this training. SC advised this training was audited, the	

	compliance rate was required reporting to NHSE, and contributed to the overall rating on the GBAF with NHSE. Jon Hayes (JH) noted it was also a requirement of GMC registration and asked SC to provide him with a list of those whose COI training was outstanding and he would follow this up with the individual members. JH asked if there was anything missing from the risk register following the discussions. JR considered that the impact of the change in the smoking cessation programme could be considered for financial risks and otherwise if a considered to be a genuine risk. It was suggested that Sarah Truelove (ST) review this risk. **ACTION - ST to review and action.** **Commissioning Executive noted the report.**	
15	**Nursing & Quality Directorate – Clinical Update** Cecily Cook presented the Nursing and Quality Clinical Update report to the Committee noting the following: • NBT had received a CQC rating of Good. • UHB had received a CQC rating of Outstanding • Named GP for Safeguarding Children for South Glos and North Somerset – no GP applications to date received • New named Doctor for Adult Safeguarding in place • Notice to enable GP reports to Safeguarding Meetings to be improved **Commissioning Executive Committee accepted the report.**	
17	**Any Other Business** None	
	Committee Effectiveness: None	
	Date of next meeting: Thursday, 12th December 2019 at 8.30 – 12:00pm CCG 4th Floor Conference Room, South Plaza	

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