Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 11th July 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
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
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
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
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
Sarah	Truelove	Director of Finance, BNSSG CCG	ST
Lesley	Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Sara	Weld	Public Health Consultant, South Gloucestershire Council	SW

Apologies			
Janet	Baptiste-Grant	Interim Director of Nursing & Quality, BNSSG CCG	JBG
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
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
Kate	Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
Julia	Ross	Chief Executive, BNSSG CCG	JR
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Alison	Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AJW
In attendance			
Sasha	Beresford	BNSSG CCG	SB
Debbie	Campbell	BNSSG CCG	DC
Lisa	Collard	BNSSG CCG	LC
Cecily	Cook	Deputy Director of Nursing & Quality, BNSSG CCG	CC
Helena	Fuller	Deputy Director of Commissioning (Contracting & Procurement), BNSSG CCG	HF
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker)	JHo
Simon	Jones	BNSSG CCG	SJ
Margaret	Kemp	BNSSG CCG	MK
Jackie	Mathers	Head of Safeguarding Children, BNSSG CCG	JM
Andy	Newton	Head of Planned Care, BNSSG CCG	AN
Matthew	Nye	BNSSG CCG	MN
Sally	Robinson	BNSSG CCG	SR
Kate	Tamlin	BNSSG CCG	KT

	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** Item 4 was noted as a conflict of interest for those Clinical Leads who were also LLG members: After consideration, it was noted by the Chair that the item was for discussion only therefore the conflict would be managed by allowing	

<table>
<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>LLG members participation in the discussion but not recommendations on the way forward.</td><td></td></tr>
<tr><td>03

03.1</td><td>Minutes of the meeting and matters arising from 13th June 2019
The minutes were agreed as a correct record with the following corrections:
Page 15 – amend Health & Equalities to read Health Inequalities
Page 19 – penultimate para. amend transposed letters to show KA
Page 20 – final para. amend typo to read “disappointment”
Page 22 – amend to correct spelling of J Hayes

Action log from 13th June 2019:
<table>
<tr><td>Item 61 – deferred to August</td><td>Item 97 – deferred to August</td></tr>
<tr><td>Item 79 – deferred to August</td><td>Item 102 – completed, closed</td></tr>
<tr><td>Item 79 – deferred to July</td><td>Item 103 - Open</td></tr>
<tr><td>Item 81 – deferred to October</td><td>Item 104 – completed, closed</td></tr>
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<tr><td>04</td><td>Clinical Leadership Review
Commissioning Locality Leadership Groups (LLGs) Review:
Joe Poole (JP) was welcomed to the meeting to present the paper on Commissioning Locality Leadership Groups (LLGs) Review.

Justine Rawlings (JRa) introduced the background to the paper which offered recommendations on the future role and structure of LLGs following a review of the existing arrangements across Bristol, North Somerset and South Gloucestershire (BNSSG) in line with a longstanding agreement to review the CCG’s wider clinical leadership structure after 12 months and in light of local and national development since being established.

JRa explained that due to the changes over the last 12 months such as the creation of Primary Care Networks and development of the BNSSG Locality Provider Vehicles (LPVs) that it was important the LLGs remained fit for purpose. It was evident that there needed to be a slimming down of the current LLGs and place more emphasis in the wider area role.
JP presented the paper highlighting the progress towards maturity that had been made by the BNSSG Locality Provider Boards and their partnerships with other community based provider which had shifted the emphasis away from the Commissioning LLGs.

The report outlined the crucial elements of the LLG role which remained and which should be strengthened:
• Fostering of good relationships with medical colleagues and other healthcare professionals across the locality</td><td></td></tr>
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	Item	Action
	• Building knowledge and understanding of the local population's health needs into the BNSSG plans • Networking widely to improve communications with local GPs, primary care teams and others in the wider locality such as LA colleagues The proposed restructuring of the LLGs would entail: • One lead GP per locality working for two sessions per week with an additional session for Governing Body. The exception to this being for South Gloucestershire where there was a requirement to have two Clinical Leads in line with the constitution. • One lead Practice Manager per locality working one session per week. This would lead to a strengthened North Somerset and Bristol Area Leadership Group (ALG); South Gloucestershire's single LLG equivalent to the ALG in Bristol and North Somerset areas. The financial impact of the proposed re-structuring would result in an estimated annual saving of £296,956. Jon Hayes (JH) asked how the number of sessions had calculated and JP advised that it had been evident that the practice manager sessions had been less than originally planned. The Locality Leads were asked for their comments and feedback: Alison Bolam (AB) commented that in light of the feedback from the membership: • in the main there was agreement of the need to slim down the LLG • re-assurance was sought on how the CCG will support providers locality vehicle • did not want to lose experienced people in this process • did not want the Clinical representation to be bare minimum • impact on nurse representation Jon Evans (JE) agreed with the points raised by AB; expressed concern around: • where the potential savings were intended to be allocated • slight differences between locality and area responsibilities • the fact that we have to be very prescriptive • that the Terms of Reference would need to be reviewed Kevin Haggerty (KH) considered the direction of travel was correct and advised the following needed to be taken into consideration: • meetings occurred all over the BNSSG area making two people in the role beneficial • there was a need to ensure the fundamentals of the role	

	Item	Action
	• what was being done was much more than just the meetings and outside of the role was more important • the need to apply resource and support to Primary Care Networks (PCNs) to ensure we are building clinical leadership *Jeremy Maynard (JM) joined the meeting at 9:00am* JRa advised that PCNs were a resource via contract and in terms of supporting locality providers the whole organisation need to support locality providers. Sarah Truelove (ST) commented this was an important point raised. JRa advised that Nurse representation was dealt with sometime ago. David Jarret (DJ) advised that South Gloucestershire was run as one area and locality and the number of meetings required formed part of the constitution and that ensuring strong clinical input in supporting the Health and Wellbeing Board was key. Currently the Constitution allowed for two GPs on the board. Colin Bradbury (CB) advised that North Somerset was in effect split into two distinct areas and stressed the need to ensure consistency and being true to local need was paramount. Jon Hayes asked for questions and comments from the Committee: Kirsty Alexander (KA) commented that when re-clarifying the function of LLGs note should be taken that some areas such as South Glos had always worked well compared to Bristol so there was a need to be mindful of this. Shaba Nabi (SN) asked how the proposed structure for the clinical leadership compared with that of other CCGs. JRa explained that there was no statutory requirement for CCGs to have LLGs. SN referred to the differences in population sizes across the BNSSG and that due to Bristol's denser population it would make sense to have two Clinical Leads instead of one. David Peel (DP) highlighted: • if all Locality Leads were lost in his area that would leave only him to manage the function • the PCN played a crucial role in driving change • the number of sessions given to Practice Managers and asked how support for these would be ensured • the need to understand how that blend would work when transitioning	

	Item	Action
	• the risk of anxiety driving the transitional phase JRa responded to the concerns raised regarding the Practice Manager sessions advising that of the two sessions being resourced only one was held in the locality. AB asked if consultation with the full membership was required on the proposed re-structuring. JH advised that the Constitution did not require this on the decision. CB advised that there was a requirement to consult on the process. **Action:** JH advised that JRa and JP would review the paper in light of the comments and feedback. (Action Log 105) **Clinical Leadership Review:** Lisa Manson (LM) gave the background to the discussion, and reminded the Commissioning Executive the position agreed in the Phase 1 of the review. In setting out the roles there were 3 identifiable areas: • Elected Clinical Leaders – to the Governing Body/Locality Leadership Groups (LLG) (Office Holder Contract) • Appointed Clinical Leaders – leading on clinical priorities and pathways of care (Office Holder Contract) • Operational Clinical Leaders – those providing functions associated with statutory or core roles of the CCG (Employment Contract) 5 operational Clinical Leader posts as part of the consultation. There is now a need to consider in the development of PCNs and the Long Term Plan (LTP). Need to bring into one area. The purpose is to support the conversation about the clinical leadership review and align with the Long Term Plan particularly in pathway roles. AB considered it was not clear who was doing what in planned care. LM advised that the work on the long term plan had started to identify gaps in programme areas e.g. in Mental Health & LD and Autism. DES advised the way in which Clinical Leads have worked has been different and it would be both helpful and important to ensure roles are identified where clinical leads add value and reshape to ensure the right clinical focus in areas where work is needed.	105

	Item	Action
	Jon Evans asked if restructuring was in the new model were we sure that within the Clinical Leadership we had shown there was enough capacity to fill the gaps? JRa considered that was an anomaly in the number of Locality Leads supporting. ST advised of the need to reduce the size of the LLG but that there was also a need to look at the whole of the Clinical Leadership. PB advised that clinical leads on pathways did not need to be GPs. PB stressed that Clinical Leads were key to the role in driving change forward but that a flexible approach was needed in order to identify the best Clinical Lead for future priorities. JE advised on the importance of retaining organisational memory/intelligence within the Clinical Leadership. Kevin Haggerty considered the review could result in a mixture of posts and budgets so there was a need to Identify the clinical lead element required for each priority. KA considered it was more important not to ignore non-prioritisation and noted there appeared a quantity of other work that had not been prioritised particularly, work around children being one of these. LM advised that across the system the Long Term Plan would prioritise the work the system did to serve the population. ST advised that work in this area was part of the Long Term Plan which had identified more work on children's needed to be done. LM following the discussions above to process a paper on how the Clinical Leadership Review can be developed further and would be brought back in September.	106
05	**New Safeguarding Children's Arrangements:** Jackie Mathers (JM) was welcomed by the Committee to present the Report on the changes to the Safeguarding Children's systems across NHS England and the impact of those changes on Bristol, North Somerset and South Gloucestershire (BNSSG) CCG. JM advised that as a result of the Wood Review recommendation that the LAs no longer be the lead agency all parties, LA, Police and Health were now equal partners in safeguarding of children. The proposed	

	Item	Action
	plans had been required to be published by 29th June 2019 and JM advised the BNSSG plans had been published on time with implementation due to commence 29th September 2019 and a "Go Live" date of 1 April 2020. JM advised the CCG will lead for the Child Death Overview Panel (CDOP) arrangements and work in partnership with Baines and Devon CCGs and LAs. Each local area setting information had been outlined for implementation. JM highlighted the following: • Equal and accountable partnerships under the new arrangements (previously the LA had lead responsibility) • Financial implications: There were agreed 19/20 funding arrangements between BNSSG CCG and LAs partners and these would remain the same 18/19. However, there was a financial risk to the CCG from 20/21 if the future agreement was to match LA funding allocation a potential additional cost pressure of £112K could arise. • Across BNSSG CCG the spend on safeguarding across the three localities was not equitable. • The regulatory work streams required independent scrutiny and the Police Service partner had donated a .5 staff member to act as a scrutineer however the CCG will be contributing via resources. JM noted this as a risk area in relation to capacity within the Directorate. Sara Weld (SW) confirmed arrangements were in place with South Gloucestershire Council. JM suggested that arrangements might be changed to address the safeguarding and to meet the needs of our population. Kirsty Alexander (KA) had significant concerns on how this and the work would be undertaken and where it would be reported. Alison Bolam (AB) advised that the Safeguarding Boards reported into the Health & Wellbeing Boards. However, it was noted that there was no Health & Wellbeing Board in North Somerset and that the 3 localities have differing arrangements which made it difficult for JM as Lead to co-ordinate. JM advised as a result of the relaxing of the statutory requirement for the Safeguarding Boards to have the same name, this would make it difficult for members of the public to contact and/or identify them	

	Item	Action
	Commissioning Executive noted the report.	
06	**Eye Care Commissioning Strategy Update** Andy Newton (AN) and Margaret Kemp (MK) were welcomed to the meeting to present the report. David Jarrett (DJ) explained that in September 2018 Commissioning Executive had received the initial paper seeking a mandate to develop a BNSSG eye care commissioning strategy. The resulting draft strategy had been supported at the June 2019 Commissioning Executive and was on the Agenda this month to give an update on progress and to seek approval for the continuation of the work. Andy Newton (AN) advised that the resulting draft strategy had highlight on two elements namely routine care and urgent care. 1. Routine Care As a result of the work undertaken the team had identified care that could be delivered outside of hospital through an integrated community services model which would deliver a greater range of care than locally enhanced services (LES) and included managing some patients in the community without the need for any hospital care. This model would have 3 tiers of service which patients would move between as their symptoms and needs changed. Patients who could not be managed in primary care or self-manage would be referred via the referral service and would be clinically triaged. If required, the community optometrists could refer direct to the referral service rather than the referral having to come via the GP. 2. Urgent Care In the proposed model Urgent Care would be available in the community through primary eye care services and enhanced services. Patients would access these via a telephone helpline or an urgent referral to Hospital Eye Services (HES) where the patient would be triaged and directed to the most appropriate place. It was noted that on average there were 60-70 walk in patients per day in the single emergency care acute provider Bristol Eye Hospital many of which were not emergencies and the bulk of which could make use of urgent outpatient care. Shaba Nabi asked if there was an indication of the number of non-medical prescribers within Optometry required to cover this work and noted the possible risk of there not being enough training courses to enable them to become independent prescribers.	

	Item	Action
	David Peel (DP) advised that this would be done within the community using independent prescribers. Lisa Manson (LM) advised that BNSSG were not the first CCG to go through some of these changes so it would be possible to learn from those CCGs experience. Deborah El Sayed (DES) reflected it was good to see pathways with numbers included so that planning could happen; noted the model had started to talk about telephone triage and recommended that the focus should avoid multi-access. Jon Evans (JE) asked if this model was likely to go through the referral services. AN advised that the Planned Care Policy was not to use a referral service. JE asked what would happen those patients who were rejected. AN advised the Minor Eye Care Scheme (MECS) supported that it goes back to the Optometrist who first referred the patient. Geeta Iyer (GI) advised that she had discussed the work with Margaret Kemp to ensure it added value, tied in with the Primary Care Strategy and ensured the pathway avoided the patient having to be seen multiple times within it, for example - seen by optician, referred to GP/BEH and then redirected back to optician, avoiding inappropriate workload transfer. Peter Brindle (PB) considered the strategy to be good. PB asked what proportion of cataract cases with side effects referred by Optometrists needed clinical assessment and advised this need should be factored in. DES highlighted the internal resources this piece of work would require from across the system, in particular the Transformation Planned Care Team and asked if Commissioning Executive considered this work to be a priority and if the Planned Care Team should continue to focus on this given there may be other priority areas developing such as Trauma and Orthopaedics. DES asked the committee for a consensus as to whether this remained a priority. David Jarrett (DJ) confirmed that having set this piece of work out as a key priority for the Planned Care Team, on that basis, he would want to continue. Jon Hayes (JH) asked for a show of support from the Committee and it was agreed that the Planned Care Team should proceed with next steps.	

	Item	Action
	Commissioning Executive Committee noted the report and it was agreed to proceed with the next steps.	
07	**STP Digital Design Authority Partnership Agreement** Matthew Nye (MN) was welcomed to the meeting to present the paper on STP Digital Design Authority Partnership Agreement. Deborah El Sayed (DES) gave a brief overview of the paper which had been brought to Commissioning Executive Committee to ensure the paper and the Terms of Reference reflected what was considered a supportive and beneficial process. It was noted that the Partnership Agreement was not legally binding but rather reflected an agreed way of working that benefited whole of the system. MN advised that the agreement had been co-produced over a 9-month period by all STP partners. NBT, UHB, SGC and AWP had all signed up the partnership agreement. The purpose of the agreement was to gain a commitment for all partners to support the development of technical foundations, principle and standards, working towards an Integrated Care System. This would enable staff to work seamlessly across the system, reduce duplication, deliver long term efficiency and sustainability and add value for the future. Andrew Appleton (AA) advised that this had been tested across the system by all the Partners and strongly endorsed the signing of the agreement. Jon Hayes (JH) asked if this agreement would help to bring a single ICE system closer. AA advised that it would but it would not be a quick solution. David Peel (DP) asked in relation to Primary Care whether this responsibility would sit with One Care. AA explained that One Care as a facilitator would not be responsible for decision making, that would sit with the CCG. Sara Weld noted there was no reference to Public Health Management within the document and asked that this be taken into account. DES noted this and confirmed that Public Health Management would be added to the Terms of Reference. (Action Log 107) Jon Hayes asked that the Committee indicate their support of the Partnership Agreement and Terms of Reference.	107

	Item	Action
	The Commissioning Executive agreed to support the "STP Digital Design Authority Partnership Agreement" and use of the "Request Form For Endorsement" for all future digital requirements.	
08	**Health & Social Care Network (H&SCN) Update** Simon Jones (SJ) was welcomed to the meeting to present the briefing report on the Health & Social Care Network (H&SCN). Andrew Appleton (AA) advised the purpose of the update was to provide recommendations on set-up, implementation and service operation of the H&SCN which replaced the previous N3 network arrangements in March 2017. The report highlighted additional financial implications for the CCG in relation to the total contract costs which CCG funding would not cover and the report sought approval for mitigations recommended in the report. AA advised a request for further funding had been made to NHSE in the form of match funding additional to the ETTF and accelerator funding received in 19/20. AA advised the expected total costs to implement H&SCN in 19/20 was expected to be £1,266k which included the set-up costs. The total spend to maintain H&SCN service for the remaining contract life (3 years) was £397k per annum. AA advised that the Commissioning Executive Committee was asked to provide authority to mitigate expected costs using existing digital revenue budgets: • application to NHS England for match funding to support implementation (£100k) • approval to fund the additional project resourcing requirement (£200k) in 2019/2020 • approval to fund remediation for internal (£120k) and external works (est. £200k) • approval to fund the increased cost (£483k) for phasing from N3 to HSCN during 2019 / 2020 • approval to fund the increased costs of operational service for remaining years of the contract (additional £119k on-top of baseline allocation) A discussion took place around area of spend indicated against commutations rooms which identified a cost pressure of £120k in 19/20 and the reasons for this. AA advised that technically practices were responsible for their own communication rooms and associated costs; however he considered the change from N3 to H&SCN was strategic	

	Item	Action
	decision and had not been asked for by the practices. AA asked how much was the CCG willing to support practices to ensure resilience is built in. AA considered there were lot of costs related to bolstering the infrastructure in practices and that NHSE had offered to match fund £100k. AA proposed funding could come from the Digital Transformation Budget. AA advised that if not implemented there was the potential that practices could lose access to M3 Sarah Truelove (ST) raised the following issues and stressed the need to ensure awareness of: • the reduced flexibility in available funds for use in other areas that this proposal would cause • funding of practice communication rooms could be seen as setting a precedence for future years • cost was re-occurring, updates would be required every 3 years • fundamentally the practice is responsible for the costs of the communication room It was also noted that this had the potential to discriminate those practices which had already financed their communication rooms by financing those practices which had refused to prioritise the upgrade. Martin Jones (MJ) asked what the resilience option available was. Simon Jones (SJ) advised this would be diverse route into practices through copper which would service the need of 1% usage required for back-up. Lisa Manson (LM) asked that in terms of the requirement for practices to fund their communications rooms were the CCG then setting a president for the future? AA considered this was not the case as it was a one off situation/event. LM considered it was not a clear rationale to fund something that the CCG required practices to fund to deliver their business functions. Deborah El Sayed (DES) asked what the implications would be if the CCG maintained their previous approach of not funding communication rooms. ST advised the provider would need to account for service fees unless this issue was resolved. SJ advised that the provider required a minimum standard of communication rooms in place and there was a need to ensure this happened.	

	Item	Action
	ST commented that communication rooms need replacing every 3 years so the proposal that the CCG fund those not updated would set a precedence. DES asked if practices could be mandated to meet the minimum standard. SJ advised that there was a chance this would delay the process. AA stressed this was a time critical project, if not completed, the resulting NHSE charges would be more than the implementation costs. ST recommended that an approach was taken that ensured that this could not be considered as setting a precedent. Jon Hayes (JH) reinforced this to ensure that the CCG was protected against future risk of recurring costs. **Commissioning Executive Committee, subject to the two caveats as per DES and LM above, approved the following:** • **application to NHS England for match funding to support implementation (£100k)** • **to fund the additional project resourcing requirement (£200k) in 2019/2020** • **to fund remediation for internal (£120k) and external works (est. £200k)** • **to fund the increased cost (£483k) for phasing from N3 to HSCN during 2019 / 2020** **to fund the increased costs of operational service for remaining years of the contract (additional £119k on-top of baseline allocation)**	
09	**Commissioning Policies for approval** Kate Tamlin (KT) and Lisa Collard (LC) were welcomed to the meeting to present the Commissioning Policies for approval. LC advised as part of the agreed commissioning policy development process the Commissioning Policy Review Group (CPRG) had considered the 26 commissioning policies now submitted to Commissioning Executive for approval. LC advised the policies had been reviewed in light of: • The three-year review date was due • NHSE's Evidence Based Intervention Guidance for CCGs (NHSE EBI) • Removal of criteria considered to be Significant Functional Impairment (SFI)	

	Item	Action
	Jon Hayes (JH) noted a number of the policies reviewed had resulted in no change being made and would be approved. JH asked the meeting to focus on the policies where there had been a change to criteria and clinical indication listed below: • **Breast Reconstruction post-Cancer : Approved** • **Knee Arthroscopy : Approved** LM queried if change would impact on activity. LC advised there would be no impact • **Blepharoplasty : Approved** • **Cataract Surgery :Approved** • ST queried if change would impact on activity. • LC advised no increase but may result in a reduction • **Dupuytren's Contracture Release in Adults: Approved** • LC advised SFI change would not reduce activity however it was expected to see a reduction due to the coding. • **Surgical Referral for Children under 12yrs with Persistent Otitis Media with Effusion (Insertion of Grommets) : Approved** KT advised the change in criteria had been adjusted to meet National Standards. • **Surgical Referral for Patients over 12yrs with Persistent Otitis Media with Effusion (Insertion of Grommets) : Approved** • KT advised the change in criteria had been adjusted to meet National Standards. • **Shoulder Impingement Surgery for Sub acromial Pain: Approved** • **Surgical Correction for Trigger Finger in Adults: Approved** • **Tonsillectomy – Referral for Assessment : Approved** • **Knee Replacement Surgery : Approved** • **Open or Arthroscopic Femoro-Acetabular Surgery for Hip Pain including Impingement : Approved** • **Hip Replacement Surgery (including Referral for Surgical Assessment of Osteoarthritis) : Approved**	

	Item	Action
	Commissioning Executive Committee approved the 26 Commissioning Policies.	
10	**Approval for use of Botulinum Toxin A in ten indications** Debbie Campbell (DC) and Sasha Beresford (SB) were welcomed to the meeting to present the paper seeking financial approval for the commissioning of Botulinum Tox A (BTX-A) use for ten clinical indications that had been approved by the Joint Formulary Group. This follows a review of all BTX-A use in order to make formal evidence based commissioning decisions using a clear set of criteria for each indication to facilitate the management of this PbR excluded high cost drug. DC advised that this would allow: • proper tracking of future costs • the monitoring of indications of use • process how patient benefit Andrew Appleton (AA) advised there were 11 indications and therefore an extra indication to the added to the list of applications and indications. ST considered that should no reductions be seen nor no visible impact made then this should be reviewed further. Shaba Nabi (SN) advised that there was good evidence supporting it worked well. David Jarrett (DJ) asked if engagement with secondary care clinicians had taken place regarding the potential savings. Jeremy Maynard (JM) considered that if used as a last ditch attempt that would limit the potential for savings. DC advised this had not been previously funded. Lisa Manson (LM) asked: • would the CCG be charged for an outpatients? • in agreeing the pathway with each GP, will this then be charged as an outpatients? Sasha Beresford (SB) advised that the Specification would dictate how this would be managed and charged noting that this varied between output and facilities. DC advised she would pick up on this query. LM advised this should be translated into the contract plan so the reduction can be monitored.	

	Item	Action
	Commissioning Executive approved the ten plus one (11) indications with the caveat that the outcomes would be checked and monitored.	
11	**Avastin Options Appraisal** Debbie Campbell (DC) introduced the paper on Avastin options appraisal for use in the treatment of wet Age-related Macular Degeneration (AMD). DC gave a summary of the background to the appraisal advising that Avastin had been shown to be effective but was not yet licenced for use in the treatment of AMD. If solely focusing on cost-effectiveness of the product, bevacizumab (Avastin®) was considered appropriate to be included into the AMD treatment pathway; Option 2 was recommended for the following reasons: • Greatest opportunity for savings • Lower risk for estate and staffing capacity • Ophthalmologists have put this option forward since it has minimal impact on staffing, capacity and frequency of injection attendances. • NICE guideline committee's view that there is equivalent clinical effectiveness and safety of different anti-VEGF agents, comparable regimens will be more cost effective if the agent has lower net acquisition, administration and monitoring costs[1]. • New patients are within the remit of the judgement. • Patients will still be given an informed choice of treatments where bevacizumab (Avastin) is an option. DC highlighted the risks of introducing Avastin locally in the treatment pathway and the impact on resources, safety and legality which had been identified as a risk with potential legal challenges from the manufacturers of licensed AMD treatments. NHSE position was not supportive of the use of Avastin. DC recommended that in light of the legal issues and risks highlighted no decision should be taken until legal judgement on the appeal brought by the manufacturer was heard in November 2019. Sara Truelove (ST) considered it important to: • Ensure we continue to do the work so that we can proceed in November • Ensure that we continue evaluate? Peter Brindle (PB) considered it Important to measure outcomes	

	Item	Action
	David Peel (DP) considered the CCG should ensure there was shared decision making with the patient as this would negate risk and would demonstrate a robust process involving patient involvement in the discussion. David Jarrett (DJ) suggested that this be discussed with the Planned Care Team and DJ would invite to the next meeting. Jon Hayes (JH) considered the CCG should be in a position to launch the pathway subject to approval in November 2019 taking into account the need to show value. **Commissioning Executive noted the report.**	
12	**Adult Attention Deficit Hyperactivity Disorder (ADHD) Briefing** Sally Robinson (SR) was welcomed to the meeting to present the item. Lisa Manson (LM) gave a brief overview on the background of the briefing paper which had come to Commissioning Executive for discussion. LM advised that the CCG were working with the current provider to find a solution as of how best address the issue of clearing the waiting list. However due to the complexity of the issue there was a need to return to Commissioning Executive with an update for further discussion and recommendation on next steps. Sally Robinson (SR) advised that since first being presented at the January 2019 Commissioning Executive Committee meeting a Contract Performance Notice (CPN) had been issued on the provider who later presented an alternative service model on 3rd April 2019. A joint action plan was drafted which addressed the conditions set in the CPN and included the possibility of using alternative providers to assess and initiate treatment for the 680 people who had currently been waiting more than 18 weeks on the waiting list. It was noted that 67 of those on the waiting list had been waiting for more than 2 years. The providers current proposed services model (Appendix 1) was received on 21st June 2019 and does not include any of the short term actions suggested by the CCG as part of the CPN process. No services changes have been made by the provider since the January Commissioning Executive meeting other than to introduce a signposting letter now sent to patients upon referral – unfortunately this was found not to exist when evidence of such was requested by the CCG quality team.	

	Item	Action
	The proposed model from the provider whilst containing many very positive aspects would only increase the number of assessments carried out marginally with the predicted waiting list increasing significantly. It was considered that this model would not address the waiting list issue and the provider had made the assumption that the waiting list would be moved to an alternative provider to clear. The additional funding needed for the waiting list initiative work was estimated to be in the region of £476k to £828k. SR reported that alternative providers had been approached with a view to reducing the waiting list and the quickest time to achieve this given had been 9 months. All of the 6 options covered in the paper carried cost pressures but at this point in time there was no clear recommendation and asked the Committee for a recommendation on the next steps. LM advised that the shortfall in the provider offer was an assumption that there was no other option. Martin Jones (MJ) considered there was an opportunity to draw from existing evidence of good practice around the country on element of which had shown that training formed a crucial role in delivery. MJ considered the provider model to be very much top end for a small number of people which created a risk of the service being taken away from the provider completely. Alison Bolam (AB) questioned the value of the 3 hr F2F diagnostic assessment and noted that GPs were making diagnosis. AB asked if the serviced was fined for 52wk waits. LM advised that the expectation was that there would be no fine but this would not resolve the issue for these patients. ST advised if 52wk waits were fined it would be applied to both the provider and the CCG. Shaba Nabi (SN) considered that there was overly long diagnosis in the current and proposed models and referred to the NICE guidance which did not stipulate 3-4 hr assessments. SN considered this would not be sustainable in view of the assumed the anticipated growth. DP suggested that the existing 4 hrs allocated to assessments could be better used by spreading across a period of time to use to help the patient manage their condition.	

	Item	Action
	There followed a discussion around the current and proposed models' processes, the value of an annual review, the increased workload on GP practices and the value to the patients. LM advised what has been derived from the options so far is that from a patient perspective it was not working; the provider model defined what the provided wanted to offer rather than what the patient needed. LM recommend that the Commissioning MH & LD team undertake the mapping out a service that met the needs of the population, which the current provider would be asked to adopt and deliver. Should the current provider be unable to adopt and deliver the model then it would then go out to market. LM asked members to consider what other therapeutic options were available for these patients and which could form part of the model. AB asked about the waiting list initiative but it was agreed that in the current financial difficulties this was not an option for the CCG. **Commissioning Executive noted the report and supported the mapping of a service that met the needs of the population.**	
13	**Urgent Care Activity & Performance Update** Lisa Manson (LM) presented the Urgent Care Activity and Performance Update report to the Committee. Notably there was a first time increase in SWAFT activity and a significant increase in NBT attendances. Sara Truelove (ST) queried the significant increase in admissions for NBT and asked if these may be due to re-admissions. LM considered this might be the case but would clarify data with NBT. **Commissioning Executive noted the report.**	
14	**Contract Performance Update Report – Mental Health & LD** Helena Fuller (HF) presented the Mental Health and LD contract performance update report for June to the Committee. HF advised of the current position in that contracts were now ready for signature, the Weston CAMHS IT solution had been agreed with AWP to incorporate into their IAPTUS system and the North Somerset Crisis Café was out to procurement. The IAPT procurement had been completed and due diligence concluded. However out of area placements continued to deteriorate and AWP had been at OPEL 4 two week prior.	

	Item	Action
	HF advised of a multi-agency event which had taken place to develop an action plan to improve systems. Meanwhile the Mental Health Strategy continued to be developed. Kirsty Alexander asked in relation to IAPT if there had been any change in funding. Lisa Manson (LM) advised there had been significant increase in funding; the specification had been significantly enhanced and, once awarded, the provider would visit localities **Commissioning Executive noted the report.**	
15	**Corporate Risk Register & GB Assurance Framework** Jon Hayes (JH) presented the item in Sarah Carr's absence and noted the new risk added to the register. **Corporate Risk Register:** Sarah Truelove (ST) noted the month 3 position and significant increase in CHC costs. ST advised the planned deep dive in CHC was now happening and once completed would be reported back to Commissioning Executive and Governing Body. **GB Assurance Framework (GBAF):** No questions raised. **Commissioning Executive Noted the report.**	
16	**Nursing & Quality Directorate – Clinical Update** Cecily Cook (CC) was welcomed to the meeting to present the Nursing and Quality Committee Clinical Update intended to provide a summary of the high risk clinical issues. CC highlighted the following: **Never Events:** Item 3.23 Contract Performance Notice (CPN) had now been closed and there had been no further never events since January 2019. **Care Quality Commission visit to WAHT**: A visit to WAHT had been made by the Quality team, the findings supported the CQC findings and an action plan has been put in place by the Trust and monitored at the monthly quality sub group. **Commissioning for Quality and Innovation (CQUIN)**: Two new CQUINS were now in place for Catheter Passport Implementation and Pressure Injuries.	

	Item	Action
	Safeguarding Children and Safeguarding Adults: There was a new named GP for Safeguarding Adults who would be commencing in the role from September 2019. **BNSSG Clinical Safety (Safeguarding Adults) Internal Audit**: There had been a recommendation to improve timelines for provision of assurance reports. **Healthcare Associated Infection End of Year Report**: Performance against the set targets for E.Coli were significantly under target. There had been an unsuccessful funding application via to Design Council. Lisa Manson (LM) asked what progress has been made around Never Events. CC advised the since 2017-19 across BNSSG there had been 19 Never Events since 2017. Of these 2 Weston, 11 UHBristol and 6NBT. Monitoring was via action plans put in place and all Never Events were now on tract barr one. CC advised a joint Summit had taken place involving all partners in order to share learning across BNSSG. From a CCG perspective there would be impromptu visits made to review and ascertain any further action required for the one Never Event still in place. **Commissioning Executive Committee accepted the report.**	
17	**Operational Issues** **AGM:** Jon Hayes (JH) expressed his delight at how well received and supported the first BNSSG AGM had received. A large amount of positive feedback had been received with only a single negative feedback which was regarding the location/venue. JH gave particular thanks to Geeta Iyer and Charlie Kenwood for their excellent presentations. JH considered it would be good if more GP members could attend going forward and thanked all contributors and the BNSSG Comms team for all their hard work. **Significant Incident:** Lisa Manson (LM) advised the city centre of Bristol would be the venue for Extinction Rebellion group who planned to demonstrate, hold slow cycle rallies and camping in public areas throughout the week commencing Monday 15 July 2019 and this could impact on the ability to function of SWAST, community providers and the Acute hospitals.	

	Item	Action
	IAF: Deborah El Sayed (DES) advised that BNSSG CCG had been awarded a green star, equivalent to outstanding, rating for Patient Involvement and Engagement. Sarah Truelove (ST) advised that the overall rating for IAF awarded to BNSSG had been a Good. **Kate Mansfield:** Jon Hayes (JH) advised that this would be Kate Mansfield's (KM) last Commissioning Executive meeting before coming to the end of her term as a Clinical Lead. JH expressed thanks and gratitude to KM for all her expertise, hard work and support given to the CCG. **Action:** Lisa Manson (LM) would write formally to KM to convey the thanks of her CCG colleagues. (Action Log 108)	108
18	**Any Other Business** **Joint Governing Body and Commissioning Executive Seminar:** Lisa Manson (LM) notified the meeting of the forthcoming joint seminar which would take place on Tuesday 1st October in Weston. Invitations would be issued at a later date. **June Agenda Item:** Shaba Nabi referred to an issue in relation to the June Agenda. Jon Hayes (JH) noted he was aware of the misinformation and advised the meeting this was being resolved. Jon Evans (JE) advised he was conflicted due to his role so would not be involved. **Committee Effectiveness:** JH asked for feedback in relation to committee effectiveness and no issues were raised.	
	Date of next meeting: Thursday, 8th August 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