Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 11th April 2019 at 8.30am, CCG Conference Room, South Plaza, Bristol.

Minutes

Present			
Andrew	Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA
Alison	Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
David	Clarke	Director for Adult Social Services, South Gloucestershire Council	DC
Terry	Dafter	Director for Adult Social Care, Bristol City Council	TD
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
Shaba	Nabi	Clinical Corporate Lead for Prescribing, BNSSG CCG	SN
Justine	Rawlings	Area Director for Bristol, BNSSG CCG	JRa
Julia	Ross	Chief Executive, BNSSG CCG	JR
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Lesley	Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Apologies			
Janet	Baptiste-Grant	Interim Director of Nursing & Quality, BNSSG CCG	JBG
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Deborah	El Sayed	Director of Transformation, BNSSG CCG	DES
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
Jeremy	Maynard	Clinical Lead	JM
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
David	Peel	Clinical Corporate Lead for Planned Care, BNSSG CCG	DP
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
Sarah	Truelove	Director of Finance, BNSSG CCG	ST
Alison	Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AJW
In attendance			
Gemma	Artz	Head of Performance Improvement, Planned Cared, BNSSG CCG	GA
Rob	Ayerst	Head of Finance (Primary & Community Care)	RA
Matthew	Bazeley	Associate Director of Integrated Care, NBT	MB
Debbie	Campbell	Deputy Director, Meds Optimisation, BNSSG CCG	DCa
Kirstie	Corns	Head of Locality Planning, North Somerset, BNSSG CCG	KC
Marie	Davies	Associate Director Quality, BNSSG CCG	MD
Mark	Dewick	Head of Unplanned and Integrated Care, BNSSG CCG	MDe
David	Evans	Programme Manager, West of England Academic Health Science Network (AHSN)	DE
Helena	Fuller	Deputy Director of Commissioning (Contracting & Procurement), BNSSG CCG	HF
Jon	Lund	STP Financial Lead, BNSSG STP	JL
Andy	Newton	Head of Planned Care, BNSSG CCG	AN
Claire	Thompson	Deputy Director of Commissioning (Planning & Performance Improvement), BNSSG CCG	CT

	Item	Action
01	**Welcome and Apologies** Jon Hayes (JH) Chair welcomed members and attendees to the meeting. Apologies were noted as above.	
02	**Declarations of Interest** **02a. To consider any changes to attendee interests since the last meeting** None declared **02b. To consider any conflicts of interest arising from this agenda** J Hayes (JH), L Ward (LW) and A Appleton noted an interest in Item 11. JH in relation to the current model, and LW and AA in relation to the new model due to commence on 1 May 2019. LM advised the item was an update only, the decision having been already made, therefore it was considered that there was no conflict of interest with regards to discussing agenda item 11.	
03	**Minutes of the meeting and matters arising from 14th March 2019**	

	Item	Action
03.1	The minutes were agreed as a true and correct subject to the following amendment: Page 7, 3rd para. amend wording to "P Brindle (PB) asked are we confident about the baseline to help us measure the future impact of actions taken". **Action log from 14th March 2019:** Item 52 – Closed Item 61 – Deferred to May Item 68 – Closed Item 77 – Deferred to May Item 79 – Deferred to May Item 80 – Deferred to May Item 81 – Deferred to May Item 86 – Closed Item 89 – Closed Item 92 – Closed Item 93 - Closed Item 94 – Deferred to May Item 95 – Closed Item 96 - Deferred to May Item 97 – Open Item 98 – Closed	
04	**Review of Terms of Reference** Jon Hayes (JH) presented the Terms of Reference (TOR) which had been reviewed and circulated to members for their consideration. LM advised of changes made to Version 6 circulated to members and the further changes made around membership of the two Chairs of the Strategic Finance and Quality Committee. It was agreed: • The two Chairs of Strategic Finance and Quality Committees would not be invited to attend but would receive copies of meeting papers for information. • Following advice from S Nabi (SN) the Reporting Arrangements to be amended to reflect current governance of prescribing meetings in that the Drugs and Therapeutics Committee (DTC) was now called Area Prescribing Medicines Optimisation Committee (AMOC) and the Formulary Groups now reported into AMOC not directly to Commissioning Executive. SN queried whether the style of papers for Commissioning Executive should form part of the TOR. JH advised these would not form part of the TOR but would be reviewed as part of the continuing organisational development by the Executive Team. A discussion took place around paper templates and member involvement in the development of such. In addition, PB and LM noted the current Exec Team priority of developing a template for an internal gateway process which ensured any items taken forward were aligned with the organisational priorities and key standards, delivery organisational priorities and system and financial benefits. CB noted the need for Directorates to own projects prior to commencement to ensure successful alignment.	
05	**1. Single System Plan 19/20 - following system feedback** **2. Financial Position and Savings Plan 19/20**	

	Item	Action
	Matthew Bazeley, (MB) Associate Director for Integrated Care, NHS North Bristol Trust, invited to attend for this item by LM, was welcomed to the meeting by the Chair and introductions made. LM explained the intention and reasons for covering the Single System Plan, the Financial Plan submission, the Change Initiatives paper (submitted as part of the Action Log Item 03.2.1) and the Primary Care and Secondary Care Interface Model Development as one item highlighting the £15M deficit and need to put into context discussions around some of the changes and system ownership within the Plans. LM presented the Single System Plan to the committee highlighting the 3 key challenges put forward to address in 19/20 as improving urgent care, addressing workforce constraints and improving the financial position. **Urgent Care:** LM highlighted the growth in demand over recent years resulting in 7% investment in urgent care in the current year (national average 2.5%) and the significant changes in Urgent Care performance which had necessitated this ie NBT re ambulance changes, BRI re ED walk ins and WAHT re attendances which Is now back at the same level as it was pre overnight closure. Some of the steps undertaken in response to these challenges/urgent care blockers were the Integrated Care Bureau aimed at reducing discharge delays, a single UHB referral form, Rapid REACT, Urgent Treatment Centre in South Bristol, launch of the IUC CAS process and development of Community Frailty projects and Home First, implementation of Core 24 across BNSSG and a review of Psychiatric Liaison Service. The aim was to reduce ED attendances, non-elective admissions and continue the 25% reduction of stranded patients up to 40%. However, the key risks continue to be workforce and financial. **Financial Recovery:** LM outlined the challenges in working towards a system financial recovery, the actions contained in the plan required to achieve this and highlighted the £15m deficit within the plan submitted by the CCG, the main 4 statutory providers had also submitted commitments to delivering their control totals, resulting in £15m from our Control Total requirement in 19/20 which includes £8m of unmitigated risk in the plan. **Workforce:** LM highlighted the challenges in relation to Workforce surrounding the demand for staff, recruitment and retention in the right proportions and	

	Item	Action
	areas, formal training needs and excessive costs resulting from agency usage and the actions required by the system to resolve these issues. A priority was to recruit additional new health sector workforce members following identification that the recruitment gap was partially caused by the movement of existing workforce across BNSSG resulting in the workforce remaining at 21k despite having increased establishment requirements to 25k. **Current Financial Position and actions to close financial gap:** LM advised of the discussion with regulators on 18 March and the resulting statement that the deficit and controls stated in the Plan were did not meet the requirements. Jon Lund (JL) presented Appendix 5.2 Actions to close the financial gap and noted the current financial gap to meeting Control Totals across the system highlighting that across the system the deficit was anticipated to be in the region of £21.5m. JL and LM asked if the Commissioning Executive, recognising having completed the planning cycle there remained a financial deficit, did Commissioning Executive support the principles and ideas shown to close the financial gap or were there other more radical actions which could be looked at across the system to make a more substantial difference and LM used as an example an establishment of community urgent care. JL spoke about the key actions proposed to deliver current plan assumptions and assumptions in CCG net risks and mitigations: LM advised the proposed solutions were about BNSSG starting to make some of the key challenges which could be accomplished readily and asked the Committee what options would add a benefit to the system. DJ asked for clarification around the proposed high impact changes in the operation plans, whether these are already included in the Operating Plan and whether the service redesign priorities were already within plan. JL confirmed this was correct, the assumption was that everything within the CCG QUIPP and provider CIP plans was included. JR asked if there had been a clinical review of REACT to evaluate if the pathway could be delivered differently? LM confirmed this to be the case and described how the Rapid and REACT currently worked and associated costs followed by how a	

	Item	Action
	different approach and assessment of need would both serve the population and reduce risk and costs. A discussion took place around the Rapid and REACT service. KH spoke about diagnosing what is driving the increased activity to identify the trigger, ie tariffs, risk averseness or whether it could be related to softer, cultural and environmental issues that may impact on activity. SN referred to the Urgent Care data which detailed the 20-40 age group and asked if this was the fastest growing cohort nationally. LM Explained data on cohort growth was not available nationally but what could be seen was the relative BNSSG position against other systems in terms of urgent care growth. LM went on to explain that despite thorough and detailed analysis of urgent care performance throughout the year there had been no clear reason for the 7% growth compared to the 2.5% national provision nor why this was so varied between the BNSSG providers. LM stressed the need to not to lose sight of the £15m deficit in 19/20 and the need to build on recurrent savings going forward when considering the choices and decisions on provision. JL identified potential savings in relation to Core 24 with regards to funds previously earmarked for expansion in that service. LM confirmed that as no staff had been recruited to NBT and UHB staff were via agency and bank there was a £800k benefit. JL presented a suite of high impact changes with financial values: **Reduce Outpatient Follow-ups:** LM advised that compared to national benchmarks BNSSG was not within the top quartile in terms of follow-up benchmarks and this would give an estimated £2m benefit if BNSSG moved to national quartile performance. DJ asked as well as follow-up activity were providers looking at their benchmarking of other referrals and JL confirmed that was the case. **Reduce Planned Care:** Benefit to be gained by removal of growth from contracts except Cancer and 52weeks; managing waiting lists thoughtfully in the context of the challenges faced.	

	Item	Action
	There was a discussion about options and LM confirmed that all the proposed solutions had been discussed with both NHS Improvement (NHSI) and NHS England (NHSE). **Deferral of other MHIS investments in Perinatal MH and IAPT:** A discussion took place on the potential benefit in identifying those MH projects that have yet to be deployed. **Key Service Initiatives - Integrated Localities:** JRa asked about investments in relation to UHB in frailty programmes and JR emphasised that these were invest to save initiatives. LM confirmed that the CCG would not be investing in the UHB initiative. JR explained that the initiatives were about achieving up and running community based systematic/structured pathways to treat people most effectively in the community and recognised the challenge was to keep aligned with the cost of healthcare. JR stressed that changes were required now in order to gain financial benefit in the future. **Enhanced Financial Controls via SDOG approval:** JL spoke about: • shared ownership of financial control and escalating financial spending decisions • transparency in decision making across the system • shared governance and shared decision making. • Clarity when defining care pathways ensuring financial implications across the whole system are recognised **Benchmarking Priorities:** JL spoke about the identified priority areas and implementing a systematic approach to understanding benchmarking and delivering assurances of the opportunities in priority areas to enable benefits. LM asked the Committee if there was anything missing from the proposals or any area they considered should not be taken further before moving on to the Urgent Care paper under Item 6. KH asked for more clinical input into the causes of the rise in admissions referring to the young cohort of 0 day admissions and asked if some audits could be carried out on those patients. SN queried the over-investigation of MSK conditions and it was acknowledged this was the way secondary care operated and would only change if moved from secondary to community based care.	

	Item	Action
	SN raised concerns around the Perinatal MH being subject to no additional investment and it was agreed that it was essential to understand the impact of actions undertaken. LM advised that the working up of impact assessments on each of the identified areas would be the next step and noted with regards to Core 24 an impact assessment had completed in terms of the service and this was currently with the Acute Trusts for comment. PB spoke about the Reduced Planned Care option and the need to take into account the possible risks ie more practice attendances and more prescribing costs which might mean parts of the projected savings could be deferred elsewhere. DJ advised the model done previously was still to maintain the RTT contractual standard but to level It across all pathways and providers. JR asked the meeting if the issue around Perinatal MH was something the committee felt strongly about. MJ considered more work around the Perinatal MH pathway would be helpful to understand the impact. PB felt more information around the implications of not increasing our investment in perinatal was needed. SW raised the long term effects of any disinvestment in services as a preventive measure and the possibility that this could create a whole much longer term problem. JR reflected all agreed there was further work to be done on the decision to not make additional investments through the MH Investment Standard but it was acknowledged that the need to address the financial challenges could be resolved by not applying discretionary spend. AB required further understanding of what was being added to the current Perinatal MH before being able to comment on the proposal. LM indicated the Perinatal MH service was for the highly complex 5% who were often already known and in receipt of MH services. DJ asked JL about what opportunities were available in relation to benchmarking around the planned care and if the figures noted included specialised spending also. JL confirmed this was possible and the figures did include specialised spending.	

	Item	Action
	The Committee noted the report	
06	**Primary & Secondary Care Interface Model Development** Mark Dewick was welcomed to the meeting and David Jarret introduced the item relating to Same Day Emergency Care. DJ introduced the paper developed by Claire Thompson (CT) and the Urgent Care Team and shared with Community Chief Executives, Brisdoc and the Locality Provider Leads prior to this meeting. Its purpose had been to start a conversation around service system initiatives around same day emergency care in the community and develop a different response from the community to support the urgent care system. DJ noted it was apparent that nationally when discussing Same Day Emergency Care NSI and NSE are focussed on the acute sector emergency care ie ambulatory emergency care units, assessment units with little mention of community assistance. DJ referred to the new urgent and emergency care (UEC) model developed through the 11/12 December through our system around how to develop the urgent care system in BNSSG of which 75% sat outside of the acute sector. Initial conversations with Locality and Community Leads had focussed on how this system could be brought together incorporating a consistent safety net to prevent patients moving into the red quadrant and which element of the red quadrant could come back out into community settings to stop the ever increasing flow to acute providers. DJ highlighted the huge increase in 0-1 day stays within NBT showing an increase of 24% this year, 5% at UHB, a decrease in the longer length of stay but a continued surge in ambulatory admissions and a particular drive around children's' activity at UHBristol. DJ spoke about the case mix and highlighted the surge in emergency admissions which identified a much younger age group accessing services and the key conditions being cardiac disorders and digestive system and disorders. DJ advised that the pack of information was being further broke down to locality level, locality and age level, time of day level and practice level. DJ confirmed it was possible to include deprivation level at a later stage. Another key piece to be included is around the knowledge held within the GPS and GPSU teams around the case mix, practice and locality usage of those services. In addition will be looking at a possible shift and different scale of services and the impact of this would mean in terms of an indicative budget for the localities, what would be the spend for these areas and how funds might be used in a different way before setting out to	

	Item	Action
	localities and elements that would be primary care and primary care streaming. LW introduced the paper on the Primary Care ED Streaming Pilot with NBT and the next steps of the clinical model of the phase 2 pilot. Phase 1 evaluation had taken place with clinical references points to developed to enable clear and consistent pathways. Phase 2 would involve developing a Business Case for longer term solutions which would involve a senior experienced clinician from primary care in NBT working along sessional GPs based on 15 hrs per week. NBT had offered an honorary contract and the GP would work under NBT clinical governance. LW advised that a bid to NHSE to fund the pilot had been declined therefore BNSSG CCG was asked to fund a future test and learn model using UEC Transformation funding. LM referred to clinical risk appetite and queries the number of steps identified in Fig 2 that sit with NBT before the GP became involved. LW acknowledged the steps were current practice but going forward the model would be further developed with NBT however the focus had been on developing the safest and most effective model. JR commended LW on the exemplary work done to date in achieving the completion of phase 1 with NBT and a discussion took place on the pilot and the necessary reduction in steps involved in the clinical model. Matthew Bazeley (MB) confirmed the project group and NBT as a provider agreed on the principle the need to make the pilot as streamlined as possible. MB noted that it would have been useful for the signed up clinical guidelines, agreed as a system for primary care, to have been circulated as this would help the committee to understand the basis for the number of steps and serve as a reminder of the shared clinical leadership. MB also agreed the principle that patients needed to be seen in the primary or community care as opposed to the ED route and informed the Committee he would take back the comments to review the steps needed. JR also challenged the number of steps in the model and it was agreed that the ambition in terms of output and productivity needed to increase very quickly. Following further discussion around the clinical model LM confirmed that the funding was available for phase 2 of the pilot. JH summarised that with regards to Phase 2 there was general support in principle notwithstanding a desire to see a greater degree of speed where possible and focus on the development of pathway to ensure it was a workable model.	

	Item	Action
	The consensus of the Commissioning Executive was in support of continuing to progress the phase 2 pilot and recognition of the immense challenges that had been overcome and positive relationships built. **ACTION:** It was agreed that monthly updates throughout Phase 2 of the ED Streaming Pilot should be provided to Commissioning Executive.	LW
07	**Weston Crisis Café** Kirstie Corns (KC) was welcomed to the meeting to present the item. Colin Bradbury (CB) gave an overview of the paper and updated the meeting on the following points: 1. Market Sector was complete and results detailed on page 3 of the paper 2. Service User Engagement and PPI involvement had taken place 3. The blended model work with non statutory and MH teams working together; market testing had taken place but had proved there was no interest from providers in doing this. 4. Agreement with AWP in principle had been made that the Crisis Café provider would have access to RIO. RIO incurred a smaller recurrent cost in addition to some start-up costs within the first year of the proposed programme. On the basis Commissioning Executive was supportive of proceeding with the Crisis Café as set out, CB noted there was more detail to cover with AWP regarding the IT element and asked for delegated authority to proceed on behalf of the CE. 5. Start-up Costs: Assumed costs for year one were quiet high however the refurbishment costs for the successful bidder were not yet known it was felt these would be covered. KC spoke about the recommendation for using the slippage was the market testing that was that was carried out with the voluntary sector. There was a lot of interest and it was assumed the winning bidder would have access to their own accommodation however it was felt reasonable to support them with some set up costs to ensure the premises are fit for purpose. LM with regards to accommodation set-up costs advised: • caution in offering set-up costs in anything other than exceptional conditions so as not to disadvantage the responders who have sites • ensure properly linked into North Somerset WAL estates • incorporate wording to ensure that bidders must demonstrate they have tried every available public sector option first. JR noted the really helpful and good paper and queried the comparison outcomes.	

	Item	Action
	KC confirmed the comparison outcomes were not hugely detailed and appeared to be very different in what they were measuring. Having spoken with Devon and Aldershot; Devon had just started piloting 3 social model crisis cafes in Devon roughly the same budget for the population and they reported 80% who attendees are completely new to the service whereas Aldershot report about 97% have been in attendance 4 times or more so very different. KC had spoken to service users at length about the different models to get their feel about it and it was very important to service users to know how they get the medical support when needed but liked the idea of it being non medicalised and a feeling like a different space than a statutory provider. JR noted the intention was not to create new demand and it was agreed that more work be done on the BNSSG outcomes to ensure clarity of purpose and ability to demonstrate impact, particularly on other providers. CB considered that although AWP would not be involved in the delivery they would be happy to work alongside the scheme. LM spoke about the additional investment in community services in AWP this year and suggested one of the measure of success should be a reduction in referrals into AWP. **ACTION:** Outcomes to be updated to ensure clarity on purpose and key performance indicators for measuring and demonstrating impact. **Decision:** Commissioning Executive approved the following measures: 1. Proceed with procurement of a stand-alone social model (supported by a contract variation with AWP for provision of RIO). 2. Approve the recommendation to proceed without additional investment for dedicated medical input to the Crisis Café from AWP, making the service more similar to that of other social models (e.g. Bristol Sanctuary, Leeds Well-Bean, and Devon). 3. Approval of additional funding (from slippage) to support the set-up of the service in year 1. 4. Approval of amending the overall financial envelope to £631k (originally £651k) to account for funding the costs associated with RiO support, maintenance and reporting. 5. Proceed with pass / fail finance criteria in the tender documentation. 6. Approval in principle of the tender documentation. Delegation of authorisation for final approval of procurement documentation and	CB

	Item	Action
	procurement launch to the project SROs Colin Bradbury and Lisa Manson to negate the need to return to the Commissioning Executive for final authorisation to proceed to procurement.	
08	**Transfer of Stoma Prescribing to Stoma Care Nurses** Debbie Campbell (DC) and Gillian Down (GD) were welcomed to the meeting to deliver the item. Peter Brindle (PB) introduced the item explaining the aims and purpose of the transfer of Stomas prescribing to Stoma Care nurses and noted that this innovative pathway approach would streamline the supply of stoma items, ensuring better continuity of care for patients and result in a significant saving benefit to BNSSG CCG. DC presented the paper and recommended Option 1 to centralise Stoma services in the Acute Trusts as being the preferred option. JR queried the commercial model and asked for clarification on how the financials would be aligned with the Acute Trusts to guarantee that the indicated savings would be released to the commissioner? DC advised this was yet to be confirmed but had considered: • Option 1 – Budget (net of anticipated savings) to be held by the Acute Trust with the opportunity to explore growth if valid reasons apply or • Option 2 – Acute Trusts to invoice BNSSG JR highlighted approval of the scheme would not be possible unless assurances could be given that costs would not be driven upwards and the risk not left with the Commissioner. A discussion took place around ensuring a robust basis for negotiations with Acute Trusts to ensure the financial risk was mitigated. LM advised of contractual models which could be explored with Acute Trusts that would minimise risk but clarity around the incentive for Acute Trusts to take this service was required. LM noted the preferred commissioner option would be option 2 as this would give more benefit to the patient and be in line with the intent to deliver community based services. Whether the project be carried out as a pilot of one year was discussed. DC explained the Acute Trust had been consulted on the proposal and considered the proposal would give them improved control over the patient journey and ability to better plan workloads. DC advised that from a clinical perspective this was a specialist niche area and the proposal would continue Stoma nurses being community based and give better continuity of care to the patient.	

	Item	Action
	JR stressed the need to secure a commercial and contractual arrangement with the Acute Trusts that would assure the savings indicated and mitigate the financial risk. The committee acknowledged the positive clinical benefit of the proposal. **Decision:** The Commissioning Executive agreed a test and learn pilot for one year based on Option 1 on the proviso that robust commercial and contractual arrangements with the Acute Trusts were agreed.	
09	**Faecal Calprotectin Pathway** David Evans (DE) Programme Manager, West of England Academic Health Science Network (AHSN) was welcomed to the meeting to present the item. Peter Brindle (PB) introduced the paper the aim of which was to promote best practice within a national NHS England collaborative approach based on evidence collected in York. The resulting paper recommended a revised pathway across the STP to assist in the differentiation of Irritable Bowel Syndrome (IBS) and Irritable Bowel Disease (IBD) resulting in unnecessary referrals into secondary care. DE presented the paper to the Committee highlighting that this would offer: • A standardised approach across the STP footprint • Greater guidance for GP's • A reduction in referrals into secondary care for expensive colonoscopy procedures and consultations • Reduced waiting times for patients with serious gastroenterological conditions. DE noted that whilst the data provided for BNSSG was not sufficiently detailed to fully predict the impact and measurable benefits of the revised pathway, modelling from a study at York indicated potential savings in excess of £550,000. A discussion took place around the pathway and it was considered a sensible move and would help reduce patient's anxiety levels. SN asked that the flow chart could be amended to show the inclusion criteria at the top of the flow chart. KH asked if some detail about the duration of the symptoms might be added also. JH and SN asked that the interpretation of the test arrive alongside the results from the pathology laboratory.	

	Item	Action
	DE advised that the implementation plan required minor updating of guidance for GP's including an education video to be funded by the West of England AHSN. This involved: ▪ Updating of the GP referral form ▪ Updating the pathway onto Remedy ▪ Updating guidance from Pathology units ▪ GP education by way of a short video clip (which will have a GP fronting this) and a newsletter article JH relayed an email received from Alison Wint, BNSSG Clinical Lead for Cancer who welcomed the proposal and who thought it would be worth pointing out some safety netting advice if the FC is negative and gave the following points: • Consider carrying out a FIT test if the patient is in the appropriate category: That is non-TWW patients who are - A) Over 50yrs with abdo pain and weight loss B) Under 60yrs with change in bowel habit or iron deficiency C) Over 60yrs with anaemia but without iron deficiency • In women over 40yrs, a new diagnosis of irritable bowel syndrome is very unusual and investigation for Ovarian Cancer should be considered. • Referral for flexible sigmoidoscopy should be considered if rectal bleeding persists, even in young patients or colonoscopy if significant GI symptoms persist, even if the FC is negative, as there is increasing incidence of colorectal cancer under 40yrs, DE advised this could be added to the guidance notes. SN suggested incorporating the elements above into one flowchart for ease of use by GPs. LM asked if the tests would be carried out within the existing budget for direct access. DE advised that in raising the profile there might be some initial additional tests carried out but it was not expected to be more overall. JR referred to the suggested £550k savings in capacity and asked what would happen to that capacity. AA advised it would be quiet difficult to measure and the impact it would need to be measured via the laboratory results. Following further discussion LM advised that as a minimum it was expected that endoscopy numbers would not increase above current	

	Item	Action
	year's level and it was agreed to review the trajectory for the current contract and build in the reduction. **Decision:** The proposal was unanimously agreed by Commissioning Executive Committee.	
10	**Business Case - Eye Clinical Triage** Andy Newton (AN) was welcomed to the meeting to present the business case for a 9mth pilot to recruit an optometrist to clinically triage all ophthalmology referrals received by the BNSSG Referral Service. AN advised the BNSSG CCG Referral Management Service received more ophthalmology referrals than any other speciality however these were not clinically triaged due to lack of Ophthalmology specialist knowledge within the GP triage team. In relation to thresholds for surgery referral and questions around value and procedures, referral quality was deemed a priority if consistent application of threshold across the BNSSG system. The expected benefits of this approach were identified as: ▪ Reduction of referrals into secondary care ▪ Reduction in Ophthalmology related CBA procedure activity ▪ Improved patient access to care e.g. right clinic first time ▪ Education and support for GP and Optometrists ▪ Cost savings for Commissioners An evaluation plan had been developed and an evaluation report will be produced to inform the future decision on clinically triage of ophthalmology referrals. AN confirmed that the Local Ophthalmic Committee (LOC) had agreed to support BNSSG in sending referrals back to Optometrists. AN referred to a similar service model running in Wiltshire which had demonstrated improved patient pathways and quality of care. The potential savings were indicated aim is to return to pre-2018/19 levels of cataract activity and 15% reduction in all ophthalmology first appointment activity JH asked about a similar pilot previously run in the South Gloucestershire area and the learning had been derived from the project. AN advised that the issue had been that GPs had not had a single provider for the IFLs so went to multiple destinations. DJ advised that this had been embedded in another step in their referral process and there had not been a close alignment with the LOC at that time.	

	Item	Action
	SN questioned the additional value the Optometrist would bring to the process over and above the administration process of checking referrals against a set template of criteria. AN explained the intention was to commence with an Optometrist to build up the expertise within the Referrals Service and also noted it was about credibility of the person making the decision for the clinician who made the referral. PB asked about: • the level of confidence in the indicative savings shown in Wiltshire scenario being comparative to that of BNSSG • the largely paper based triage: would this make it more difficult to identify referrals that meet the criteria • whether this was a temporary or permanent arrangement • the bulk of the issues – were these related to cataracts AN explained that it was not just about cataracts and in terms of the quality issue, improved referrals would help both patients by being fed into the appropriate clinics and hospitals receiving the right patients. Commissioning Executive Committee was asked to consider: • The investment of approximately £37,440 or £48,640 for a 9-month pilot to recruit an optometrist (0.8 Whole Time Equivalent) to clinically triage all ophthalmology referrals received by the Referral Service. • Option 2 was recommended: use of a provider to provide the Optometrists to the Referral Service (approx. £48,640). **Decision:** It was agreed to support a 9mth pilot staffed by Option 2 above.	
11	**Deep Vein Thrombosis Specialised Service Update** Pippa Stables (PS) was welcomed to the meeting to present the item along with AN: PS explained the purpose of the paper was to update the Commissioning Executive on the plans for the CCG and the Provider to monitor any potential harm to patients following mobilisation of the community based BNSSG DVT service, as requested by the Governing Body on 8th January 2019. The initial 3mth plan for monitoring of potential harm to patients would include: • Monitoring of patients who had waited more than 48 hours for a scan and the reason for that wait. To be further broken	

	Item	Action
	down by those waiting 3 – 5 days and over 5 days, by day scan requested, clinic location and locality. • DNAs • Incidences • Complaints LO advised any issues would be raised through the Quality Committee. JR asked how the reason for the wait would be monitored. AN indicated they would review how this could be monitored. JH raised the issue regarding accessibility for Weston patients and following a discussion, it was noted that patient accessibility would be measured as part of the process. DJ confirmed that patients would have access to the NHS Patient Transport Service. **The Committee noted the report and actions.**	
12	**Psychiatric Liaison Service**	Closed Item
	Meeting interrupted by Fire Alarm at 12 pm – Building Evacuation took place.	
13	**Urgent Care Activity & Performance Update** Any questions to be emailed to LM.	
14	**Contract Performance Update Report – Mental Health** Any questions to be emailed to LM	
15	**Corporate Risk Register & GB Assurance Framework** Any questions to be emailed to LM	
16	**Nursing & Quality Directorate – Clinical Update** Any questions to be emailed to LM	
17	**Operational Issues** None raised.	
18	**Any Other Business** None raised.	
19	**Review of Committee Effectiveness** Due to a fire alarm evacuation of the building the meeting was interrupted and on resumption of the meeting at 12:25pm it was agreed that Items 13 – 19 would be covered by email questions only to LM.	
	Date of next meeting: Thursday, 9th May 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