Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Clinical Executive Committee (Open)

Minutes of the meeting held on Thursday 11th March 2021 at 10.30am.

Minutes

Present		
Jon Hayes	Clinical Chair, BNSSG CCG	JH
Julia Ross	Chief Executive, BNSSG CCG	JR
Lisa Manson	Director of Commissioning, BNSSG CCG	LM
Rosi Shepherd	Director of Nursing and Quality, BNSSG CCG	RS
Deborah El-Sayed	Director of Transformation, BNSSG CCG	DES
Sarah Truelove	Chief Finance Officer & Deputy Chief Executive, BNSSG CCG	ST
Peter Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Kirsty Alexander	Clinical Lead for Children's and Maternity, BNSSG CCG	KA
Geeta Iyer	Corporate Clinical Lead for Primary Care Provider Development, BNSSG CCG	GI
David Peel	Corporate Clinical Lead for Planned Care, BNSSG CCG	DP
Andrew Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA
David Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Lesley Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Alison Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AW
Kevin Haggerty	Clinical Commissioning Area Lead North Somerset, BNSSG CCG	KH
Shaba Nabi	Clinical Lead for Prescribing, BNSSG CCG	SN
John Evans	Clinical Lead for Governing Body, BNSSG CCG	JE
Hugh Evans	Director Adult Social Care, Bristol City Council	HE
Sheila Smith	Director People & Communities, North Somerset Council	SS
Ann Clarke	Director for Adult Social Care and Housing, South Gloucestershire Council	AC
Apologies		
Michael Jenkins	Clinical Lead for Integrated Care, BNSSG CCG	MJ
Alison Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
David Jarret	Area Director for Bristol & South Gloucestershire, BNSSG CCG	DJ
Colin Bradbury	Area Director for Bristol & South Gloucestershire, BNSSG CCG	CB
In attendance		
Miriam Ainsworth	Clinical Lead for Integrated Care, BNSSG CCG	MA
Sarah Carr	Corporate Secretary, BNSSG CCG	SC
Helena Fuller	Deputy Director of Commissioning (Contracting & Procurement), BNSSG CCG	HF
Sarah Folan	Interim Business Manager, Commissioning BNSSG CCG (notes)	SF

	Item	Action
01	**Welcome and Apologies** John Hayes (JH) welcomed the committee and presenters to the open session of the March 2021 Clinical Executive Committee, attendance and apologies were noted above.	
02	**Declarations of interest** No new declarations of interest were made.	
03	**Minutes of Previous Meeting held on the 11th February 2021** Minutes of the previous meeting were reviewed by Clinical Executive committee and approved with no changes or amendments. JH noted that this meeting will be the last CE for David Soodeen (DS) & Alison Bolam (AB) in current role, also Johnathan Evans (JE) in current role and JE will remain in Governing Body as of this time. The Clinical Executive Committee expressed thanks for all work and commitment to the work of this Committee.	
04	**Actions and Matters Arising** The action log was reviewed and updated. Actions have been updated and detailed in the Action Log, and new actions from this meeting will be added following the meeting.	
05	**C the Signs: GP Support Tool** Alison Wint (AW) presented paper, which was taken as read. AW highlighted this is tool to help Primary Care and the team have developed a specification alongside involvement from Primary Care leads. AW confirmed the final specification will through a procurement process. AW noted that the purpose of this paper is for information, comment and feedback. AW opened to questions on the paper from the committee. Andy Newton (AN) noted the funding and procurement position of circa140k per year which has been allocated from Cancer Transformation funds via STP and Local Alliance. Costs are based on 3-4 year period and if needed to be funded past this point as mentioned the cost would be 140k to the BNSSG system. AN noted after the 3-4 year period the tool was not sufficient, it is possible to withdraw funding and tools. Glenda Beard (GB) joined the meeting	

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	LM asked if the team are asking CE to approve specification. The broad principles of what the tool would be able to do and be capable of. AN confirmed although noted a full detailed specification has not been included with this paper. AW confirmed Macmillan GPs have looked at scope, and fed back to developers a list of 'essential' requirements and 'nice to have' and IT teams and developers have come back with improved versions of the tools for the team to review again. AW noted that the team have spoken to other CCG's that use similar tools and does align with DES and QAF. JE thanked the team, and questioned a point on the paper referring to 'some of the CCG's will only be interested in some elements of the tool' JE asked for clarification on how this arrangement may work with regards to funding. JE also queried if there was there an options appraisal for a BNSSG only basis AN confirmed that this is not completely clear at this stage, AN did note that currently at least BNSSG and Somerset would look to full functionality therefore these procurements may run in parallel. GB added in support of AN comments that both Somerset and Gloucestershire CCG are both very keen, BSW less keen as use already currently use a different tool: Ardens and Ardens support network. JE thanked presenters and noted that in this case the main challenge would be consensus. AW agreed and noted this is main risk that has been identified by the team. Andrew Appleton (AA) noted that consistency is real challenge with this work, and therefore requires strong messaging. AA noted that this will still result in not all practices up taking the offer, but from this there is an ability to try and assess the impacts. AA noted this will require resource and ongoing education and support across 80+ organisations. SN voiced support of the project and noted that this is the desirable thing to do. SN continued to note that would have liked to see more evidence in paper, as currently not convinced of there is a robust evidence base for this tool. SN noted that there also less palatable things that can happen with early diagnosis like over diagnosis, and would like to see more consideration given to these factors in future presentations of this work. SN also noted that 'pop up fatigue' is a risk, given the amount and of potential 'pop ups' are being dealt with on a daily basis with tools such as script switch and ardens. SN highlighted that can lead to a bigger risk which is rejecting a pop up that may have medico/legal implementations.	

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	SN questioned how much additional workload will be placed in general practice, by implementing this and is there capacity to do this? SN noted that these tools are being reviewed by the GPC, IT, and Clinical policy groups. AW thanked SN for points raised and affirmed all are valid points. AW confirmed that in terms of evidence there are two levels, in the first instance to make the identification and referral of patients easier for practitioners. AW noted the safety netting function of the tool which would aid current safety netting process in place. AW suggested that longer term evidence will be around the early diagnosis of cancer which does create a certain amount of anxiety but will go some way to lowering thresholds and referring patients with identified correct cancers rather than over diagnosing cancers. GB commented that from a medico / legal perspective, the support tools that are being looked at are for patients that would meet 2ww criteria and require diagnostics. GB noted that if these patients were not referred at this point the GP's would be as vulnerable as if this had been pointed out and made a decision not to refer. PB highlighted that agrees with points made by SN, and voiced uncertainty as previous experience with other clinical support tools that have not worked well and have possible unintended consequences. PB noted that SWAG as a collective are keen to do this and it would be a good idea to join in. PB repeated that there are concerns but if there is involvement then BNSSG can influence. KA questioned if the tool has modelled effect on the demand for further investigations as a result of this? AN responded that team had planned to do this pre-Covid, AN confirmed that the expectation is it would increase activity as this would hit the early diagnosis targets. As required by the long term plan MR commented that much has been said that would fully support, MR noted that the specification in the paper is 3-in-1 that are being asked for. Diagnostics/referrals/outcomes tracker. This is important as currently outcomes are not tracked sufficiently. MR asked for confirmation that if GP's are working with the tool they would not need to duplicate work elsewhere in EMIS or similar. GB noted that originally tool was a standalone app, team have feedback to developers and now tool is embedded within EMIS and all patient info leaflets all embedded in Tool with range of languages and. MR commented that the possibility of tracking of outcomes is very exciting. GB agreed and noted that if this could be BNSG wide, recognising the current	

	Item	Action
	locum workforce this can be a safety netting feature. (from chat-bar) SN: don't want to speak again but wanted to highlight 2 areas of importance. 1. The need to not amplify health inequalities 2. The need for accurate GP coding. MJ agreed with SN earlier points on the risks of harm and over diagnosis. MJ referenced a famous graph from BMJ outlining increase of diagnosis cases of thyroid cancer and mortality. AW noted that international benchmarking highlights UK is still lagging in cancer outcomes. AW suggested that thyroid is poor example, in this instance as this tool is for the 'big 4' we need to be better, and we are talking about patients that fit meet the 2ww referrals. SN asked a question about UK cancer outcomes and is this due to measured screening? Compared to USA with annual health checks? AW responded to confirmed that USA is not included in international benchmarking and countries are benchmarked on a like for like basis with similar health service structures and provision so the UK would be compared to countries such as Denmark, Australia and Canada. AW noted that the screening SN is referring to would only pick up less than 10% of cancers. KH suggested that outcomes are very poor also due to lifestyle of the country, which is backed up by a huge evidence base to confirm this. KH would be keen that BNSSG do not pursue wholly medical model. Lifestyle and changes to lifestyle will also improve cancer outcomes. I think the safety netting aspect of the product is very important too, we have seen a number of cases where patients do not follow advice given resulting in a late diagnosis MJ (from chat-bar) I also wanted to say we could pin primary care engagement to the thrombocytosis issue. JH referenced this GB summarised to confirm this Tool is just 1 part of state of diagnosis, and it will take a long time for decent data. Data from tools so far would not stand up. LM asked a point of clarification for procurement process, what is the evaluation of the preferred product? How do we get this engagement as part of procurement process, so we are able to select an appropriate product that practitioners would want to use?	

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	AN clarified that the plan for procurement would have full clinical involvement and BNSSG would be a 'key player' in the procurement process. JH asked do we have full input from BNSSG, and LM asked how would this be ensured. AN noted that there is not a variety on market to make this likely, and BNSSG is going for a 'full spec' approach and if a separate CCG required less there may need to be two procurement processes to ensure each CCG gets what they need. **ACTION:** AN & AW to bring back finalised evaluation of GP Support Tool to Clinical Exec and run past PB team for response to ensure unanimous championing. This may need to be conducted outside of meeting/via email due to timescales. JH asked committee to approve: Committee voted to approve.	
06	**Business Continuity Plan 2021** LM and Janette Midda (JM) presented the paper which included the reviewed and updated Business Continuity plan 2021. JM noted this is a review of the plan as part of a larger piece of work looking at Emergency Planning, Resilience and Response (EPRR). JM outlined the process and previous governance and oversight steps completed ahead of presenting this plans to Clinical Executive noting that all BNSSG CCG directorates completed done Business Continuity Plan exercise and the results have been fed into the updates of this plan and EPRR Operational Delivery Group have reviewed and fed in to this plan and updated it accordingly. JM highlighted that Appendix 7 has received the largest portion of review and biggest changes to the original plans which reflect experiences of COVID-19 and to support further incident responses. JM also noted the addition of extra explanation on how to run concurrent ICC relating to separate events at the same time for example: pandemic and a fire and or flood scenario. JM confirmed that although this document is presented in its entirety for the Clinical Executive Committee to review, operationally the plan will be divided into several parts as user guides fir relevant roles and responsibilities. PB asked a question referring to page 13 section 7.2 quoting: incident director is the first contact? Can this be clarified? LM confirmed that the incident director will be responsible but tactical will receive the first call.	

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	PB noted that on the following page (14) plan quotes meds optimisation, and asked if this could be revised to the teams new name: Medical Effectiveness to be changed and medical effectiveness and research added for completeness. **ACTION:** JM to confirm Medical Directorate listing in Business Continuity Plan. JR asked how much learning has been done during and since the beginning of COVID-19? LM responded to confirm learning events have been run after each phase of the incident and worked through via each directorate and brought into the plan. JR questioned were there significant changes because of this? LM responded affirmatively and noted changes are mainly reflected appendix 7. LM also highlighted this learning is organic and looking at how the structure was conceived and what has happened in reality gave pause to reflect on what would be done differently in any future incidents. (LM on behalf of JH) asked for approval: Committee approved unanimously.	
07	**Risk Register Quarterly Review** LM noted the updated Risk Register and asked committee to consider which risks would require a deep dive, noting that for example cancer risks may be an area that would be appropriate. To test that risks are owned by this committee and that they are accurately described. LM suggested that a Cancer deep dive takes place given the earlier discussion on Cancer risks. To address number of referrals that have dropped off in the last year and also to improve some of the intervention rates. Sarah Carr (SC) joined meeting. JE noted that risk register has not changed for a long time. Some elements have not been updated, JE also noted that given upcoming transitions happening how is this communicated to new teams and this awareness communicated. SC thanked JE and noted a conversation had earlier in the month at the Quality Team away day and that risks are not changing, one of the things that was noted and the conclusion that was made, that there is not level of traction. What is the level a risk can be reduced. 'What does good look like'. SC noted that this is a larger part of work, into the 'right risk' and risk threshold. MR noted the extra field: What does good look like? The Quality team are also suggesting that another or further narrative in this field which would express in detail what needs to be done to achieve full mitigation of the risk as it would be expressed.	

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	JR commented that risks currently are too generic, they would need to be reframed to adequately reflect the actual risk. JR commented on the current Risk appetite, noting the system will never eliminate the risk of XYZ but what is the actual real level of risk and how then is that mitigated. JR noted that currently the system takes a risk adverse approach to risk management, further helpful thinking and consideration of risk management will make it real and tangible document. JR commented that Clinical Executive will need to understand these risks and ask some more challenging questions on how these are mitigated. JH asked the committee to confirm if there are there any missing risks to the register at this time? LM noted that to get better will have to improve at defining the risk attempting to mitigate and also being confident that any mitigations would be effective. For example Urgent Care, which can sometimes feel like any risks mitigated can cause more to appear. Therefore LM suggests a focused seminar session on Risks and looking at gaps in Risks and risk mitigation. **ACTION:** LM and SC to test through all risks on register and add as agenda item on forward planner. CE to convene a focused seminar session on Risk Register.	
08	**Corporate Risk Register and Governing Body Assurance Framework** SC noted updates to the Governing Body Assurance Framework, including updates to Mental Health. Objectives will be updated for 21-22 as priorities this year. LM noted the integrated framework for Children will feed into this framework. LM noted we need to be better are joining GBAF with CRR and CE. To direct people to update as papers are written and will support this document becoming live. SC asked if this could be done via cover sheet, this could make the links, LM noted this would be helpful and agreed it would help the documents being live. **ACTION:** SC to review and update cover sheet document to include work carried out on any current risk and mitigations which links to risk register and also GBAF. **ACTION:** Deep dive into Cancer and cancer risk to be added to a future CE agenda	
09	**Clinical Executive Forward Planner 2021** For noting and reference of future agenda items. Committee members to add items to a future agenda by emailing:	

	Item	Action
	sarah.folan1@nhs.net	
10	**Urgent Care Activity and Performance Update *(For information only)***	

For information.

LM noted the paper and reported that performance remains incredibly challenging. LM highlighted a series of mitigating actions including:

- Further Amber and Green beds which are leading to improved flow going through providers
- Reduced levels of activity being maintained via MIU and 111 first
- Working with providers to unlock specific issues including ambulance handover delays at specific sites.

JH asked what happens to the patient in an ambulance handover delay.
LM commented that clinicians treat patients in the back of ambulance, and noted that this is not considered acceptable.
JH asked if they are also counted as a trolley wait whilst in the ambulance.
LM noted that the patient whilst in an ambulance is not counted as a trolley wait, highlighting that this same patient may then also incur a 12hr trolley breach.

Lesley Ward (LW) noted that has seen much evidence of how primary care are helping with redirection and has spoken with really engaged clinicians who are trying to support system.

MJ added that has also worked in hospitals (during early Covid response) and seen ambulance techs 'nursing' patients, is unsure why this would be.

LW suggested this could be related to legal, safety and contractual obligations, for example: techs can't leave the patient until handover has been completed.

MJ noted that would be good to get SWASFT around the table and involved in conversation and asked to take this conversation offline.

LW agreed and has previously noted SWASFT found difficult to get to practices

KH raised concerns with the performance figures and data.

SN noted agreement with KH and re-iterated the desperate need for training and advance care planning, highlighting that DNRA order is not declining hospital treatment. SN suggested that as a system currently not honest enough to really investigate and implementation of radical change in the care of patients in the community outside of a hospital setting. SN noted comment includes reference to both health and social care colleagues.

DS commented we are not going back there is a new normal. We tinker at the edges of Urgent Care. DS noted that what is needed is comprehensive investment across the system to tackle this issue.

	Item	Action
	JH asked where and how do we (as a committee) take this forward? Where does the learning go? To aid practices and colleagues. LW confirmed system is starting to look at this and work has been commenced across a variety of services. JR agreed with LW and further extrapolated: this is what the system is looking towards, commenting the current state is frankly shocking and End of Life (EoL) pathway is undesirable . This is the dream for ICP to become a place of care. How the community wraps itself and creates a community system. Resources point is well made and backing ICPs is a way forward. AW suggested that what JR describes is a complete culture change for health services and population as a whole. JR responded to AW to note that; so often this can be used as an excuse to not do something. 'Because it's difficult' JR accepted the scale of the challenge and noted; This is real change and cultural shift. MJ commented to address EoL, and further referencing SN's earlier comments on training. MJ questioned: Who would need further skills to manage these cases and patients. Look at across population and Health and Social Care. Assess frailty and appropriate interventions. Quite far off at the moment. So much further to go (Rockwood Score) to back up mortality discussions. SN commented that there is a need to join the dots, and connect to recovery phase in Primary care. SN questioned: How are we going to get through the current backlog, and highlighted the need to connect two (primary and secondary) and a full system wide approach. AA noted that agreed with earlier points made on care planning and wished to highlight what progress that has been made. AA noted an example: the RESPECT form and digital implementation. AA noted that this piece of work has been nominated for a HSJ award. AA suggested that this type of work must continue across organisations, and could bring great opportunities and the change is on the horizon. KH noted that EoL care is different to palliative care. The focus is concentrated into improvement remainder of a patient's life; KH commented that this could be made clearer for secondary care and ambulance staff. JR asked what do we expect for palliative care, JR suggested that this should be hospice rather than hospital care. GI noted the work being undertaken by Primary Care Leads and the Clinical Leads Forum as a result of coming out of Covid and resetting the expectations to understand where people are. GI noted that Practices quite anxious at the moment as system is 3 months into mass vacs programme and Practices will not be able to keep working with this in the current model, GI also highlighted that practices are aware possibly from as soon as the 1st April could be back to QAF. GI noted work undertaken is review of risk stratification and prioritising	

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	long term conditions/SMI/LD and sort through all other patients. GI affirmed that Queue COVID will help, as can't actually remember last video consultation undertaken. Would need some kind of guide for clinicians to decide which consultation medium is best, but risk threshold for seeing face to face is different for each clinician, and noting that estates are also varied and different across BNSSG. **ACTION:** GI to discuss at Clinical Leads Forum and feedback at the end of the month. LM summarised that the discussion has been extremely helpful and noted we now have the environment to make the changes discussed here.	
11	**Any Other Business** No further business discussed at this time.	
12	**Committee Effectiveness and Annual Survey Responses** The committee provide the following responses to the Committee Effectiveness & Annual Survey questions as detailed below: • Did the meeting run to time - **Yes** • Did the right people attend – **Yes** • Were action items assigned where appropriate to the right people - **Yes** • Were all items given sufficient time to discuss – **Yes** • Were all members able to contribute – **Yes** • Has the meetings business contributed to the organisation's aims and objectives in terms of: • Strategy – **Yes** • Planning - **Yes** • Governance - **Yes** • Were any of the items inappropriate for this committee – **No** • Did the meeting receive the administrative support that it needed – **Yes**	

Sarah Folan
Interim Business Manager – Commissioning Directorate, BNSSG CCG
Thursday 18th March 2021