Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Clinical Executive Committee (Open)

Minutes of the meeting held on Thursday 12th November at 10.15am.

Minutes

Present		
Jon Hayes	Clinical Chair, BNSSG CCG (chair)	JH
Julia Ross	Chief Executive, BNSSG CCG	JR
Lisa Manson	Director of Commissioning, BNSSG CCG	LM
Peter Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
David Jarret	Area Director for Bristol & South Gloucestershire, BNSSG CCG	DJ
Colin Bradbury	Area Director for North Somerset, BNSSG CCG	CB
Rosi Shepherd	Director of Nursing and Quality, BNSSG CCG	RS
Sarah Truelove	Chief Finance Officer & Deputy Chief Executive, BNSSG CCG	ST
Helena Fuller	Deputy Director of Commissioning (Contracting & Procurement), BNSSG CCG	HF
Michael Richardson	Deputy Director of Nursing & Quality, BNSSG CCG	MR
Shaba Nabi	Clinical Lead for Prescribing, BNSSG CCG	SN
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
Alison Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Kevin Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Jon Evans	Clinical Commissioning Area Lead for South Gloucestershire, BNSSG CCG	JE
Sheila Smith	Director People & Communities, North Somerset Council	SS
Deborah El-Sayed	Director of Transformation, BNSSG CCG	DES
Apologies		
Liz Perry		LP
In attendance		
Sarah Carr	Corporate Secretary, BNSSG CCG	SC
Sarah Folan	BNSSG CCG (note taker)	SF
Kirsty Corns	Wellspring	KC
Justine Keeble	Service User, Safe Haven	JK
Kate Davis	BNSSG CCG	KD

Sasha Beresford	BNSSG CCG	SB
Elizabeth Williams	Transformation Manager, BNSSG CCG	EW
Caroline Roper	NBT	CR
Gemma Artz	BNSSG CCG	GA

	Item	Action
01	**Welcome and Apologies** Jon Hayes (JH) welcomed all to the meeting, and apologies were noted as above.	
02	**Declarations of interest** No declarations of interest were declared.	
03	**Minutes of Previous Meeting held on 8th October** Minutes of the previous meeting were approved as an accurate record; this was done at the close of the meeting due to time constraints.	
04	**Actions and Matters Arising** JH and LM to review actions and update action log outside of meeting to be circulated to committee. It was noted this is to aid with time management of this meeting.	
05	**Safe Haven Centre Update** JH introduced item and asked presenters to introduce themselves to the committee and provide an overview of what is being asked today. Kirsty Corns introduced herself and Justine Keeble a service user and member of the project team. KC continued to highlight that both herself and JK are here today to ask for committee approval of the recommendation to transition the AWP COVID-19 response and continue with mobilisation of resource to N.Somerset and JK will talk in detail about why this is important for service users. KC outlined this is vital at this time due to winter and higher prevalence of MH service users in N.Somerset at this time. The project aims to create a safe alternative to ED and Primary care support. KC also noted Police and ambulance colleges support this work. KC also noted that currently 20% of calls by police are MH related, with a far higher demand in Weston and figures are based in information from public consultation, as part of the consultation it was noted that the Healthy Living	

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	Centre worked well before COVID. KC invited JK to provide an overview of her own and other service user's experiences of phone and face to face services. JK commented that service users feedback that face to face is preferable in many situations as body language can be read and understood, and support for the service user can be seen, when face to face options are lacking, there can be potential for relatives overhearing a call and dark and cold evenings can limit private space JK also noted that many users lack use of mobile phones and credit. JK did note that video calls were said by many to be beneficial and service noted the importance of this option needing to continue to include access for those who may be shielding. Hence the hybrid model being proposed. JH thanked presenters and asked for questions from the committee: ST asked if the rental costs are included in the budget and KC confirmed all costs are included in the budget. LM confirmed that the budget included rent, and that implementing this would cause the current underspend to cease. The VitaHealth phone line is also in place and is BNSSG wide and CAMHS line if effective across system and so therefore believes it timely that this service with a face to face component is stood up. DS confirmed support for the proposal and noted the need for balance between face to face and phone lines will address the issue that MH services have been predominantly phone line based during the COVID response. JR agreed with DS comments and understands the need for face to face appointments for MH service users, but posed the question of how to ensure peoples behaviours in the hub does not increase the risk of COVID-19 transmission. KC responded to comment the team have been working with other areas services most notably Gloucester service which has not had to close due to behaviour or outbreaks and noted the team have engaged with IPC to ensure safety of all users and staff. The current provision would be 4 staff and 4 service users at any one time and the use of wipe clean furniture is being explored with Second Step. KC noted the risk based approach is proportionate to the level of engagement. JE commented to highlight that there are currently many hybrid models of healthcare and this might provide further opportunity to do some work on all models and all modes of service delivery which might prove positive outcomes this could lead to best mode and model discovered.	

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	KC responded to JE to note that the research and evidence team have been looking at this, and have an evaluation plan, which has been refreshed. SN noted support for proposal, and declared an interest as has written blog on this issue. SN highlighted that a decision making SOP or similar could be useful, for COVID face to face and this work leads to a bigger piece of work. For example using remote triage not consultation, which would be dependent on level of tech knowledge by the user. JK agreed with SN assessment and noted that the variety of Safe Haven services will be one of its strengths AB pledged support and recognised the real difference this proposal could make for both the user, and service provider, in the long term. AB gave examples from her own practice of different types of engagement needed at different points MH patient journey and highlighted that often initial face to face contact is important. JH thanked committee for valuable feedback and comments and asked the committee to approve the ratification of the Safe Haven service. Committee agreed and approved unanimously.	
06	**Diabetes Technology Pathway** PB introduced the paper along with presenters Kate Davis (KD) and Sasha Beresford (SB) PB highlighted the paper is asking for agreement to move an area of the pathway to a technological the pathway for diabetes patients. KA commented that this is an area of real interest and glad to recognise that this exists and is being utilised, KA recognised the expense and KA is aware that the industry is still clearly learning and refining, but happy to support as this will aid in getting blood sugar stable and be a more straightforward process for patients in the longer term. JH noted the operational advantages of tight blood sugar control in terms of patient management. JE noted full support for this pathway and commented that the next step would be to create an artificial pancreas for the patient and would like to see some outcome measures if the two devices could be brought together simultaneously to provide a full technology based solution for patients. AA commented that this work is overdue and offered full support, AA noted his own patients have achieved real empowerment through this technology and it provides great opportunity.	

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	KD noted that there has been a new update to Libra2 Freestyle with added advantages for customised alarms system and same price as Libra1. KH this could non medicalise diabetes rather than consultant and doctors we could end with coaches instead guiding patients to achieve better management and outcomes for themselves. SB noted the good outcome data Libra1 and suggested if this continues to be monitored in this way there is a hope for further supporting data with Libra2. JH asked the Clinical Executive Committee to confirm their approval of this pathway. Clinical Executive unanimously approved.	
07	**Musculoskeletal Update including a BNSSG Early Inflammatory Arthritis (EIA) pathway and a draft clinical model for one Trauma and Orthopaedic (T&O) service for BNSSG** Liz Williams (EW) Transformation manager planned care and Caroline Roper (CR) from NBT. <u>MSK Programme</u> MSK programme has 12 deliverables lots at start of pathway. 1st part is dedicated to 'keeping people healthy'. LE updated to confirm funding from NHSX for an MSK self-management app 'GetUBetter' was successful and will be rolled out shortly. 2nd part of MSK programme focuses on structural change, Sirona are implementing this work to align pain services and step up a community based pain service. 3rd part of programme would be to align IT systems to collect outcomes from clinicians and patients so as to adjust MSK work accordingly. <u>Early inflammatory arthritis pathway for Primary Care</u> GP's must use EIA pro-forma on Remedy and as part of consultation must ask where patient would like to be seen, the GP must then send the EIA referral straight to the chosen hospital and not to the referral service. If GP's send and EIA referral to the referral service it will be returned. Once the referral is complete the GP should then arrange for any blood work to be carried out. LE continued to note that NBT have this system in place Weston General and BRI are nearly ready to go live with this work.	

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	JE noted concerns of pro forma and the possible rejection of a form by the referral service adding the comms would need to be very clear and right tone to avoid bounce back and possible further delays. JE also noted the current inequity in the S. Glos area and asked how these initiatives are going to affect this inequity going forward. EW responded that EIA pro forma has been in use for a year as a trial and during this time the referrals service have been sending on to hospitals with a note back to the practice explaining the new process so there has been time allowed to get used to this change and embed this practice. EW addressed the equality and inequity question by highlighting that now many of these options are a self-refer service and noted that Sirona have been working to equal out waiting list with a longer term being that there will be one integrated physio service across the whole of BNSSG. JE can we have trajectory and plan on when and how we get to this one integrated service? EW noted this comment and will include in further work. JR commented that this is good and very detailed work. JR questioned the use of the minor injuries unit to defer away from A&E during COVID asking if it would be possible to do this as part of a longer term arrangement for MSK work rather than just as a COVID-19 response. JR asked if the impact of covid-19 on waiting lists has been considered and would like piece added to this work. EW responded to note the minor injuries unit really accelerated during wave one of COVID-19 and is continuing EW noted a small slip during beginning stages surge 2 however this is still considered 'green' as this work has picked back up to operational levels and has data to support this and share with A&E departments if needed. EW noted that the Elective works cancellation is being discussed at the next MSK programme board to ensure as much of this work continues as possible. LM commented that all this plays part of 111First and COVID the response as ability to refer to this service via 111First. DS noted that it is great the EIA is on remedy but noted what is needed is a self-populating form in EMIS to compliment and designed correctly. DS also noted that this would also insinuate a lack of choice, and are we ok with this? EW confirmed that the form is on EMIS, and EW referred to the comment on lack of choice to note that this is urgent service the choice issue is much more relevant if a on waiting list, the 3 week list across each of the providers would aim to remedy this. To ensure choice would be the patients rather than on the size of the list.	

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	DS highlighted that this is currently not the case. EW agreed that this is true currently, however this should be very soon, with audits to monitor to this and with process fully embedded and extra slots will aim to alleviate this wait list pressure. JH noted the South Glos wider footprint which would also include RUH Bath. SN noted the escape pain programme and suggested that there should be parity of esteem medical/non-medical interventions which would mean reviewing fees associated with non-medical interventions and more wider look at the general concept of moving away from medication based treatment if there is evidence to support this. SN requested a Decision Support Tool be developed to help GP's and aid blood test. Which believes would aid the pro-forma and referral service to embed further. SN noted concerns on the referral going back to GP if incorrect as if GP is away this could impact on the 3 week wait time. EW noted whilst the system is being embedded programme will continue current practice of sending the referral form onto hospitals with a note back to the GP and look to educate Primary Care staff to ensure that this new system will become a norm. EW addressed the "escape pain" fees and noted that when gymnasiums re-open after the current lockdown the programme will look for funding to ensure that this option is available to all patients regardless of financial status. JH suggested that if the referral service notices some organisations, practices or GP's continue to send forms to the referral management service some targeted education could be focused on these specific providers. <u>Draft clinical model for one Trauma and Orthopaedic (T&O) service for BNSSG</u> Carolyn Roper (CR) shared presentation to feedback emerging clinical model. CR noted this has been based on 6 workshops with over 70 people attending from across the pathway including different providers and variety of roles within it. CR confirmed proposal has also taken learning from other areas and other systems to further aid and inform design. However this is still very much a draft and the group would continue to work through before further presentation at ACC and other Boards. CR mentioned highlights from the model: **Service Vision & Clinical Principles** • Standardised BNSSG wide clinical protocols and processes • Excellent and timely diagnostics and outpatient care • Elective orthopaedic centre(s) • Focus on excellent patient education and rehabilitation • Specialist centre for the most complex patients • Improvement in delivery of local trauma services • Improvement in staff experience • Appropriate commissioning framework	

	Item	Action
	Acute Provision • Elective Orthopaedic Centres – to consolidate routine and complex/specialist elective orthopaedic inpatient care from 6 sites to 3 centres. Each centre would have a dedicated orthopaedic surgical centre separated from existing emergency departments and co-located within HDU. • Local NHS Hospitals – Orthopaedic trauma unit and routine day cases, outpatient care and rehab provided at these sites with option for teams to deliver pre and post-operative outpatient clinics in local community locations alongside advanced practitioners. **Proposed Configuration** • Supports building a sustainable T&O service at Weston Hospital • Supports sustainable local trauma provision • Supports elective centres able to deliver orthopaedic care to patients with medical complexity and provide training for surgical trainees and theatre staff • Supports the continuation of a specialist orthopaedic centre at Southmead **Service Enablers** • Workforce – further integration • IMT – clear and robust meaningful activity • Infrastructure • Diagnostics Services • Therapy Services **Proposed Governance: Trauma & Orthopaedic network across BNSSG** • Provide oversight of elective orthopaedic and trauma service pathways • Chair will act as clinical leader and network will include membership from clinical teams across the pathway and providers • The network will: 1. Foster culture of openness and transparency, shared learning clinical audit, research service developments and quality improvement between all organisations. 2. Work to improve MDT team working across patient pathway and between providers 3. Ensure a focus on continuous quality improvement as the network grows • The network will work to an agreed programme, seeking to reduce unwarranted variation and set up standardised protocols based on best practice. **Clinical Network Group – Proposed workstreams:** • Standardising elective pathways (including GRIFT 6 pathways)	

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	• Optimising BNSSG #NOF pathway and capacity • Community/acute provider integration in outpatient delivery (pre and post op) • Early Supported Discharge (elective and trauma patients) • Establish sub speciality MDT networks • Improve pathway information capture and sharing **Contracting One BNSSG T&O Service** Contracting of T&O services may need to change to support delivery of the clinical model. Contracting options that support the delivery of the clinical model need to be explored during stage 2 and could include: 1. Continue with current contracting arrangements 2. Contracting – Prime Provider contract 3. Strategic alliance – shared leadership and federated models 4. Full merger of all T&O services **One BNSSG T&O Service – Stage 2 Proposal & Objectives** • Fully scope the resource requirements of the proposed clinical model – including required workforce • Cost up current (baseline) and proposed clinical model • Identifying contracting arrangements to support the delivery of the proposed clinical model • Embed BNSSG T&O Clinical Network Group. CR thanked the committee and asked for questions and feedback. JH commented that one of the challenges would be after surgery there is often a post op lag and delay possible little to no physio support and therefore important to be aware on how this would addressed through the pathway. JR questioned as the proposed model is 3 centres but not necessarily buildings therefore would like further information on the change and in terms in productivity and efficiency? CR responded that this would be fully scoped out in stage 2, noting one of the key elements highlighted by the work so far is 30% is currently IS Sector work, predominantly medically well and simpler cases, a view to get this work back to NHS theatres to increase productivity and training. CR also noted the consolidation into 3 sites would also increase productivity as supported by GIRFT metrics and theory. JR noted that the sites are proposed at BRI, NBT & WGH which already have these services in place and questioned if this would be any real change? CR noted that most of the Bristol work is centralised at NBT, with much work going to the independent sector and the model looks at how to readdress and change provider landscape.	

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	JE commented and asked that is this is being considered as system response the clinical network and TOR will reflect this to include representation from primary care and the MSK service. CR affirmed that the network includes GP representation, system Therapy representation, system Nursing representation, patient, trainees from across the system who also train across the Severn network, & acute lead surgical representation CR will confirm final list for comment at a later date. LM noted that this presentation has been helpful to understand the progress that has so far been made, and asked from a performance perspective, what progress has been made to move towards a single list, and a single set of outpatients, as currently there are a challenges when patients are registered at BRI and go to NBT for surgery and back to BRI which can increase wait times. LM asked how the work will aim to smooth these issues out. CR agreed that there are currently performance issues due to challenges as noted by LM and looking at a Prime provider type contract, and also looking at providing patients very clear information about the entire pathway. With the aim of re-channelling this work be more nimble and to progress work more effectively. GA noted that Orthopaedics is currently looking into a system Patient Tracking List (PTL), and will link in with CR and EW to look to shared PTL and has spoken with the Business Information team to ensure whilst this work is waiting to be stood up we can ensure patients will be treated in the correct order. DS commented that a clinical network is a great idea and asked that team incorporate social care teams into these discussions as often patients have limited mobility after surgery and a good aim would be to link in with social care to offer wrap around service to all patients to increase chances of successful post op care. Clinical Executive Committee supported the EIA pathway & T&O direction of travel. JH noted the next steps: EIA – referral service work and communications to be continued to ensure all GP's and Primary Care staff are fully aware and understand the new process for referring T&O - Full service draft to be completed and CR noted that these will be presented to ACC in Dec, and will return to Clinical Executive Committee once this has taken place.	
08	**52ww Performance Briefing** Gemma Artz (GA) shared presentation which was circulated with papers.	

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	GA noted the growth in 52 ww and position in BNSSG with COVID causing an impact and will continue to do so in the coming weeks and months. GA noted that unfortunately in the last two weeks further cancelling of elective surgery (p3 and p4) and this will have a further impact on these figures with certain specialities will be affected more including those that were already challenged. GA noted that now starting to produce 78 week and 104 day wait data is now being submitted to both regional and national teams and this data will be included in future governing body reports for partners awareness. GA continued to note that despite this outlook several mitigations are currently in place including: • Adapt and adopt programme and significant Phase 3 investment to improve theatre capacity, scheduling efficiency, weekend working and waiting list initiatives. • Currently using IS sector capacity available (via national contracts) which has led to an ongoing increase in capacity towards pre-COVID levels. When this national arrangement ends in November will work quickly to ensure local arrangements are in place to continue this work within the new framework provided. • Communications to staff and public • Clinical validation work LM added and flagged categorisation of waiting lists, with the first 4 categories being defined by the Royal College of Surgeon's guidance released on 11th April 2020. The two new categories P5 and P6 are patients choosing not to attend scheduled operations either due to COVID concerns or patient choice, for example a paediatric patient choosing to have an operation in the school holidays to avoid missing education time. LM noted these are now been monitored and does not excuse the current numbers but is helpful to note. JR asked if it would be possible to see the data by classification to note the breakdown **ACTION:** GA and LM to provide 52ww data by classification, including new P5 and P6 to CE. JR noted the mitigations that are in place but would like to further understand the impact of mitigations to further inform and future decisions; JR also questioned what the current net position and asked are the system confident we have gone is as far as we could, is there anything else that could and can be implemented? GA responded to confirm that the current projections do include phase 3 planning mitigations and therefore the impact they will have. GA agreed that the	

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	current projections are still not favourable, When the national framework for the IS sector is confirmed will be able to provide much more detail on what can be contracted to the IS sector for the remainder of 20-21 and into 21-22. GA noted that there is a meeting is taking place as the framework is released to plan next steps in terms of possible local contracting arrangements with the IS sector. JR also asked if green sites were being looked into. LM responded to confirm this is something the system teams are still working through. Looking at a possible move to green specialities in a specific site location within a hospital. JR asked if this work could be speeded through noting the current data is shockingly depressing and is aware this is felt across the system, JR asked can we make those speedy and challenging decisions. LM responded to note that teams are trying to accelerate this work and is a priority, whilst noting often colleagues are working operationally dealing with daily challenges whilst also trying to look at redesign work. GA agreed with points being made by JR and LM and noted the position is a quite a crossroads in terms of how best to use the IS sector. However GA noted that some patients on these lists would not be able to be transferred to the IS sector due to have co-morbidity. GA referenced points made by CR in the earlier presentation and the relation as to how to best use T&O capacity in the IS sector and how to best use NHS resource to balance risk with the more complex patients. JR agreed but questioned the balance of risk LM commented that this is one of the many challenges in terms of the scale of risk in each part of the system, noting the narrow risk at sites such as Emerson's Green and to a degree Spire, and would like to continue further discussion on what could be done if the position was slightly flexed further explored. JR agreed with LM and noted it would now be the point to begin asking: what is relative risk? And noted that people and patients would need to be involved in these risk based decisions. GA confirmed that NBT have started to have these conversations with Emerson's green quite recently and is aware that NBT are also having conversations with IS sector providers on the possibility of providing post op care on separate site to NBT. KA commented to note that is in agreement with and supports JR comments on 'have we done everything' noting it is time to look at if operations could be done slightly differently under a different anaesthetic which could decrease wait times and lists.	

	Item	Action
	AB questioned if the system or organisations are now receiving punitive fines due to breaching 52ww? GA responded to confirm all fines are paused as part of the Covid-19 response as nationally mandated. JH thanked GA for presentation and update.	
09	**ADHD Working Group Update** LM welcomed Alex Ward-Booth and asked him to provide highlights from report. AWB confirmed that the documentation developed by the group was positively received in terms of locally enhanced service model and plans for waiting list initiative. AWB noted that clear broader issues identified whilst working with group around current communications from the service which will need to be addressed as part of any new specification that would go into place so group are keen for working group to remain directly involved with AWP as the project progresses. AWB noted that the report was an update and noted several actions have moved forward namely: 1. LES rollout documents co-designed with the groups are now finalised and are in process of translating these ready to move onto GP systems and working with Primary Care Team to ensure these go live. Next step would be for AWP to identify cohorts of patients to transfer to annual review and reduce the pressure on Primary Care. 2. Waiting list initiative: AWP are in process of developing a scorecard against list, will be done at a Contract Review Meeting in partnership with BSW to centralise monitoring and have added an additional piece of work to include service user feedback so any decrease in waiting list size does not comprise quality and experience of service by user. 3. Specification: are confirming times with AWP, and ensuring working group involvement in this specification review and to ensure that this is implemented in the right way JR commented that this is a great piece of work, and congratulated AWB and team. JR noted that one item in the Themes section: The variation in Primary Care with people with ADHD. JR asked if this also needs to be an issue that needs to be explored further. AWB noted that this is something that came through from the webinar, and the varying levels of confidence of GPs with working with and managing ADHD patients, AWB confirmed that part of co-design process was to speak with GP's	

	Item	Action
	and talk about possible documents for development to aid with confidence and agreed this can be included in further work undertaken by group. JR agreed and noted therefore there is further work to be done, JR questioned if a form would be sufficient or if a separate approach may need to be taken to deal with the confidence issue. AB commented that webinar was not terribly well attended with 22 participants. The webinar has been recorded and is available as another resource, AB noted that Ditmar -Lead ADHD Consultant- will be available via phone for any questions GPs may have or further discussion on a particular issue. AB noted that the Group of practices signing up to the LES there will be an improvement in the service as it is embedded and the working group will look to produce FAQ's and other standard documents if similar issues are being experienced by a number of GP's. AB also noted that the working group is aware this is learning process for GPs and will continue to monitor and offer solutions as this service matures. JR agreed that AB's points did answer some of the concerns whilst noting the user feedback cited variable pathways to referral, therefore highlighted that clarity on a pathway to referral would be needed and as noted further work on patient experience and primary care pathway. AWB noted that this is slightly nuanced in terms of variation and most of the variation comes from the service itself, and the way in which the service is communicating to individuals. AWB highlighted that from the groups he has been working with a limited amount of stress and anxiety arose from primary care and far more was focused on the vacuum once engaged, therefore this work should enact the largest change in patient experience. AB noted that there will also be variance if GPs refer to private providers such as Psych UK. JR suggested that further work on pathway and more detail on Remedy including help and support around the management of this cohort. JE (asked in reference to wk1 data) data suggests at this point the annual review was not seen as a good option by patients, therefore was the 'do nothing' option explored in wk1 or in subsequent weeks and the implication of this? AWB commented that it is worth mentioning that much of the week 1 negative feedback came from those members of the group that had been diagnosed relatively recently, and in most cases these users had a long period of time from their initial GP referral to get access to this service and had not undertaken an annual review within the service, therefore working group conducted follow ups with several users who had partaken in several annual reviews and this view was much more balanced and patients felt fully engaged with GP and service to e seen as much more than there ADHD and were able to comment more fairly o a range of experiences that they may have whilst engaging.	

	Item	Action
	JE thanked AWB for his explanation of the data and questioned if the 'do nothing option' was explored? LM responded to JE to confirm that this was discussed and discussed in understanding implications this may have on the service including capacity and flow. LM noted that there are individuals that are comfortable meeting with their GP and others that would much prefer to remain with the service. JH asked where pathway work will go further to this meeting. AWB confirmed that all actions will be captured in action plan and form discussion on specification.	
10	**Corporate Risk Register and Governing Body Assurance Framework** Sara Carr presented the paper as circulated with the pack for today's meeting. SC noted that the paper opens reminding of the Committee's responsibility on reviewing and therefore challenging the management of risk by asking what is mitigating the risk. SC noted that many of these risks have been talked through today as part of agenda items (especially ADHD and 52 ww) and actions taken to mitigate as part of this meeting, which will be updated on the corporate risk register. Therefore SC asked for comments on other risks noted in the paper and therefore detailed on register. ST highlighted that the risk noted as BNSSG Commissioning 36 – Diagnostic long waits can be updated to include a mitigation noting SDOG recently signed off the agreement for UK Biobank which will increase capacity for system. JH asked fines applied for 52ww including legacy possible long COVD waits. ST confirmed no fining due to current financial regime LM offered to clinical executive to do deep dive on any items on register. JH noting that is conscious these reviews take place as a later agenda item or at the end of meeting, and questioned is this something to be considered when drafting future agendas? KA responded to LM's comment on possible deep dive into Gynae 52ww is high at NBT is there scope to focus clinicians on these areas? LM noted that in terms of mitigations system have moved gynae to Emerson's green to maintain p2 and happy to test back through and bring back via planned care programme board.	

	Item	Action
	ACTION: LM to conduct deep dive into gynae 52 ww figures via planned care programme board to be presented at next Clinical Executive Committee meeting in December. LM reminded the committee that when and whilst the system is in a significant surge (as experienced as part of the 2nd wave of COVID) these registrars will be pulled back into ED to assist colleagues which will create a backlog in their workload. LM agreed that if as a system there has and continues to be commitment to non covid BAU work, then it will remain a challenging balancing act to ensure there is capacity across the system at all times, which could be further understood by this deep dive work. JE asked for a deep dive on AWP Performance LM agreed to prepare this for next agenda **ACTION:** LM to organise and conduct a deep dive into AWP performance data and bring report and findings to December clinical executive committee meeting for comment and discussion. SC to support LM with this work. JR asked for all board assurance frameworks to be reviewed and explored and added to forward planner. **ACTION:** LM to review all board assurance frameworks and add to forward planner for committee. SC to support LM with this work. JR noted and acknowledged the challenge to achieve the balance between COVID/non COVID activity and noted that as commissioners and as a committee collectively this does need further exploration and consideration to answer the question of addressing the complexity, JR noted we know it exists but need to be able to see this and work on re-addressing the current commissioning stance on enabling this complexity to a place of mitigating and working through issues where they are. JR provided the example of current growth in non-elective activity and asked why this 'tide is not currently being stemmed' and if there is anything else that can be done to aid this current pressure point noting that often given the current circumstance there may not be but would like to feel assured as a commissioner this has been explored fully. JH asked if there any Risks on the current register that SC is proposing to close. SC responded to note there is one risk that will not be closed but transferred to the finance risk register SFC and this has been reviewed. The risk is noted as Commissioning Directorate 3 and is concerned with delivery of required savings. SC asked if Risk Register can be reviewed at the start of the agenda once a quarter (starting in December) with all deep dive items to follow directly after this agenda item.	

	Item	Action
	ACTION: Risk Register to be noted at the top/start of the Clinical Executive Committee once a quarter and at the start of each quarter as standing agenda items. Clinical Executive admin and chair to ensure this is in place. JE commented that he currently believes the clinical leadership view is a risk in itself. JE asked what the function and structure will be going forward. JH noted that he will give this some thought and respond to JE at the next meeting. **ACTION:** AWP Performance deep dive & Gynae deep dive to be added to top of December Clinical Executive Committee meeting agenda, directly following Risk Register Review item.	
11	**Urgent Care Activity and Performance Update** LM highlighted appendices included in papers for information and consideration. LM provided an update and overview; in terms of urgent care figures remain below national average and national performance, noting that currently in an unusual position compared to the rest of the South West with only BNSSG and Devon seeing high numbers of COVID positive patients. Currently over 200 patients in hospitals across the system that are COVID positive. Maintaining number of attendances and therefore admissions to hospitals and are suffering from significant pressure relating to outbreaks and bed closures which is causing a potential of risk in the system. LM noted the system is very pressured, and are trying to maintain a mix of blue/yellow/green beds yet are in a position where there have been cancelations of p3 and p4 operations to actively maintain p1 and p2 activity which is urgent on the day or within one month. Therefore teams and colleagues have a COVID escalation framework in place, allowing system partners to take a series of actions, some of which are not necessarily the most palatable for example UHBW are in the process of opening an adult ward in children's hospital to maintain and maximise flow across the system. LM noted the Increase of an extra 300 beds in community and looking at adding another 55 to add to this capacity. LM confirmed that therapists have been moved from acute settings to community provision to aid this extra capacity within the community. LM noted that this situation is slightly different to the initial wave 1 activity as currently have more a-symptomatic patients in hospital. LM noted that this will be discussed in further depth in the AOB section by Peter Brindle who will address and explain progress made on the COVID virtual ward. LM highlighted that the mix and different presentation of COVID patients at this time compared to March/April, with around 10% of all patients being admitted to hospital are testing positive for COVID needing ICU and ventilation treatment.	

	Item	Action
	LM asked for questions and feedback. KH noted concerns of pressure on 111, especially with further plans of 111First. KH reported the current long wait to get back to patients, which has clinical; risk but will also add to A&E pressures. Suggested a recruitment drive to support 111, possibly in a virtual way and maybe from as little as 2 hours per evening from clinicians would help with triage based calls. LM confirmed that Severnside are currently undertaking a recruitment drive for both call handlers and clinicians. JH commented that he had not seen this advert or any comms relating to this circulated to Primary Care. **ACTION:** LM to circulate Severnside recruitment info to Commissioning Executive committee and ensure this is circulated to Primary Care bulletin. KH noted that this offer would need a low threshold of commitment to get clinicians to commit without impact on other areas of work and balance.	
12	**Any Other Business** • Dermatology Pathway – not discussed at this time. **ACTION:** Peter Brindle to circulate COVID virtual ward paper for comment and discussion via email. **ACTION:** AB asked to be cc'd into ADHD actions when JH and LM undertake action log review.	
13	**Committee Effectiveness and Annual Survey Responses** Not discussed at this time.	

Sarah Folan
Commissioning admin support, BNSSG
Thursday 12th November