Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 12th September 2019 at 8.30am, CCG Conference Room, South Plaza, Bristol.

Minutes

Present			
Kirsty	Alexander	Clinical Lead for Children's and Maternity, BNCCG CCG	KA
Janet	Baptiste-Grant	Interim Director of Nursing & Quality, BNSSG CCG	JBG
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Alison	Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Jon	Hayes (CHAIR)	Clinical Chair, BNSSG CCG	JH
Geeta	Iyer	Clinical Corporate Lead for Primary Care Provider Development, BNSSG CCG	GI
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
Lisa	Manson	Director of Commissioning, BNSSG CCG	LM
Jeremy	Maynard	Clinical Lead	JM
Shaba	Nabi	Clinical Corporate Lead for Prescribing, BNSSG CCG	SN
Julia	Ross	Chief Executive, BNSSG CCG	JR
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Sarah	Truelove	Director of Finance, BNSSG CCG	ST
Lesley	Ward	Clinical Care Pathway Lead for Unplanned Care, BNSSG CCG	LW
Alison	Wint	Clinical Care Pathway Lead for Specialised Care, BNSSG CCG	AJW

Apologies			
Andrew	Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA

Colin	Bradbury	Area Director for North Somerset, BNSSG CCG	CB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Anne	Clarke	Director for Adult Social Services, South Gloucestershire Council	AC
Terry	Dafter	Director for Adult Social Care, Bristol City Council	TD
Deborah	El Sayed	Director of Transformation, BNSSG CCG	DES
Jon	Evans	Clinical Commissioning Area Lead for South Gloucestershire, BNSSG CCG	JE
Kevin	Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Martin	Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJ
Kate	Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
David	Peel	Clinical Corporate Lead for Planned Care, BNSSG CCG	DP
Justine	Rawlings	Area Director for Bristol, BNSSG CCG	JRa
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
In attendance			
Adam	Brown	NBT	AB
Julia	Chappell	Snr Contract Manager, (MH & LD), BNSSG CCG	JC
Lisa	Collard	Commissioning Policy Development Manager, BNSSG CCG	LC
Leilah	Dare	NBT	LD
Rebecca	Dunn	Healthy Weston Programme Director, BNSSG	RD
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker)	JHo
Gerald	Hunt	Assistant Director of Commissioning – Adult Care, North Somerset Council	GH
Emma	Moody	Head of Contracts (MH & LD), BNSSG CCG	EM
Greg	Penlington	Head of Locality Planning (Bristol), BNSSG CCG	GP
Claire	Thompson	Deputy Director of Commissioning (Planning & Performance), 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** The following declaration of interest were made: • Kirsty Alexander –indirect CoI were noted – COI to be updated to reflect declaration.	
03	**Minutes of the meeting and matters arising from 8th August 2019**	

<table>
<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td>03.1</td><td>The minutes of the previous meeting were agreed as a correct record.

Action log from 08th August 2019:
<table>
<tr><td>Item 81</td><td>Deferred to October</td></tr>
<tr><td>Item 97</td><td>Closed</td></tr>
<tr><td>Item 106</td><td>Closed</td></tr>
<tr><td>Item 109</td><td>Open</td></tr>
<tr><td>Item 110</td><td>Open</td></tr>
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<tr><td>04</td><td>Closed item</td><td></td></tr>
<tr><td>05</td><td>Weston Crisis Café (for information)
LM gave a brief final update on the Weston Crisis Café. LM informed the Committee that the service that had gone out for procurement had received two bids following which the contract was to be awarded to Second Steps supported by Somewhere to Go.

KA asked, for those considering the Crisis Café in future models of care, if the Weston Crisis Café model should be assumed a reasonable starting point for precedence.

LM advised the Weston contract was a two plus one year contract and the service would be evaluated.

Commissioning Executive Committee noted the report.</td><td></td></tr>
<tr><td>06</td><td>Item deferred</td><td></td></tr>
<tr><td>07</td><td>Item deferred</td><td></td></tr>
<tr><td>08</td><td>Integrated Frailty Service – proposed model
Greg Penlington (GP) was welcomed the meeting to present the proposed Integrated Frailty Service model. Michael Jenkins (MJ) introduced the proposal and gave an overview of the background to the proposed model, explaining the locality focus that supported the work of Healthy Weston and North Somerset.

MJ explained that the proposal to mobilise resource across the system was a first step in developing an Investment Business Case (IBS) for a BNSSG-wide integrated frailty service model delivered through the localities.

GP advised that this was a gateway document seeking approval of the direction taken before proceeding to an investment level business case ready for the next bidding round. GP considered that the approach undertaken to date had been very robust in particular with regards to the evidence and research element of the programme. With regards to</td><td></td></tr>
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	Item	Action
	the financial case GP advised that this was currently only at an indicative stage and therefore several caveats had been applied with the ambition being to draw together various sources of funding for use in an integrated way. It was recognised that more work on integration was required given the focus had previously been on the accelerated design work completed with clinical colleagues. Shaba Nabi (SN) considered the document to be an excellent piece of work, in particular the extent of the evidence based work and rigorous evaluation undertaken. SN considered the document would benefit from: • inclusion of additional Mental Health input • replacement of the stop start tool with the new BNSSG Primary Care Medication Review tool • inclusion in the technical section of the negative impact of over treatment and CGA's in addition to the positive already included • being more explicit around how the needs of those of the population who become frail under the age of 75 will be addressed Kirsty Alexander (KA) echoed the previous comments on the quality of the paper. KA referred to the preventative elements of frailty and asked that: • alternative preventative measures/strategies to avoid getting to this point be included • seat based weight training for over 80's be strengthened • consideration of more flexible alternatives to the standard risk register be considered • support for care staff be provided through provision of training and recruitment of additional staff • an alternative be used to the current measure ie attendance at ED Julia Ross (JR) advised that: • a case finding model should not only be a scientific model • the cohort of interest was be the second set down as opposed to the top level • a considerable amount of thinking was required around who was the cohort, how this was identified and joining up and integrating the service. • frailty become a community based speciality led and managed by the localities and community hospitals Sara Blackmore (SB) advised that the close working that had occurred with Local Authorities was considered to be a real positive and from a South Gloucestershire LA perspective supported the shift from acute to community based services for Adult Social Care. SB considered there was room to further improve these links and more work required to shift the work from the second to third tier.	

	Item	Action
	JR commented that people considered the word frail a negative and should cease to be used, rather the challenge being to persuade people prevention was the right approach in avoiding frailty. Alison Bolam (AB) referred to a recent Membership meeting where positive and key messages around the future frailty programme in the community had been delivered by the Community Service provider, noting these had been well received. JR considered this forum to be a key driver of integration. David Soodeen (DS) referred to: • the previously discussed age for frailty and highlighted a significant proportion of the BNSSG population (in the 000's) were unsure of their date of birth • packages of care which often broke down as the social care needs increased and asked if integration would address this issue • nursing homes as a historically forgotten area of the system and their staff training needs which were currently not aligned with those in hospitals or primary care. Lisa Manson (LM) clarified that, in the modelling of the 155 beds included within the Community Services Procurement, Sirona in their bid had put in place step up beds for when: • social care packages broke down resulting in the need for a social admission • a step up admission was needed to give additional support LM advised that whilst currently all beds focussed on people being discharged from hospital, going forward there would be a structure in the beds going forward that improved admission prevention and offered a stabilising arrangement which covered both social and medical needs. Kate Rush (KR) advised whilst a national specification was due out next year for care home support, this also formed part of the new BNSSG community services specification. JR referred to the Long Term Plan and advised of the need: • for a consistent response and same ambition of ensuring people were able to stay in situ with the necessary support • to be proactive in supporting people to maintain their health • to optimise the infrastructure that enables this	

	Item	Action
	Alison Wint (AW) flagged an overlap with a developing project in the cancer STP were there would be an opportunity for MDT working, utilisation of estates and staff. Gerald Hunt (GH) considered this was an opportunity to address and develop resolutions to some of the existing issues around technology. SN considered there was much more to do in the marketing of areas such as end of life process. JR asked how the proposal would be taken forward after taking into consideration the feedback given at the meeting. MJ referred to the timeline in the proposal, noting very little of what had been said had come as a surprise and that next steps would be to: • embark on a PPI programme, exploring patient outcomes and hold further conversations with the people of Weston • obtain more detail around the financial modelling • hold further conversations to better understand the levels of frailty • arrange a discussions with the community services provider and to outline what the community side of the offer will look like • draft and develop specifications for the pathway • review work to date to ensure the vision of an integrated service AW highlighted the need for development of care plans. JR considered clarity was needed to identify how this model would operate to drive a proactive, consistent, continuity based service that a patient could access in one place. It was considered currently the proposal remained too acute focussed rather than reflecting a community model of care with the community driving it forward with the ambition that this become a community based specialty. It required more articulation to reflect that someone in a cohort would stay in the cohort in terms of proactive recall, services received and access to different areas including mental health, dementia clinics accessed via the hubs. **Commissioning Executive Committee approved the proposal to develop an Investment Business Case for a BNSSG wide integrated frailty service delivered through localities.**	
09	**Acute General Practice Team (AGPT) development** Claire Thompson (CT) presented the paper on the future contracting arrangements of the Acute General Practice Team (AGPT) service provided by BrisDoc.	

	Item	Action
	CT advised that the current AGPT service was split into two contract elements namely Stream 1 and Stream 3. Stream 1 involved telephone calls from local GPs considering admission or specialist assessment of medical patients with Stream 3 being the face-to-face element of the AGPT service. CT advised that there was benefit in the Stream 1 service and recommended that this service transfer into the CAS. CT advised that the Stream 3 face to face element of the service at NBT was indivisible from the acute ambulatory care service and BNSSG was unable to see the benefit from it in terms of avoided admissions. CT advised that the expected benefit was that patients were turned around and not admitted however, because of coding and practice issues, that benefit was not visible therefore there was an overall cost to the commissioner. Alternative measure had been considered such as re-locating the service into localities, coding the activity differently however the reality was that practically and operationally, the practice was hospital activity and there is no benefit to be gained in running the activity in this way. Commissioning Executive was asked to approve the following recommendation: • Transfer Stream 1 to the main IUC CAS contract for all BNSSG activity including expansion of the service to Weston, supporting primary care risk and training which would include the development of a primary care referral dashboard, and • Terminate Stream 3 giving notice the service will terminate on 31st March 2020, using the next 6 months to agree exit arrangements Jon Hayes (JH) asked for clarification around the term no benefit asking if this translated into no cost reduction. CT explained that there was a benefit in the patients being seen by experienced clinicians but they operated off acute positions. JR asked what do the professionals in the service say and think about the AGPT service. Kirsty Alexander (KA) commented that she used the service frequently, sending all her admissions via this system, the patients were never refused but did get sucked into the hospital system. KA considered that	

	Item	Action
	once the locality system was up and running, those patients who were ambulatory could clearly obtain the same somewhere else without the CCG incurring a double charge. KA supported the proposals. David Soodeen (DS) advised that the GPST started at the BRI where it was a revolutionary service by diverting people and offering people better care however the service at NBT had never achieved the same results. Lesley Ward (LW) explained that the service had been set-up very differently at each acute. David Jarrett (DJ) referred to the original set up at NBT advising that when the service was first implemented there was already an established ambulatory care service at NBT and was a very well embedded model with good clinical leadership, which resulted in the IUC service becoming completely embedded in the existing AUC service. DJ further advised : • All activity carried out by this service was recorded as zero length of stay admissions thereby resulting in double payment • In discussing locality development and managing this activity in a different way in a community setting, the AGPT team had not been receptive to that dialogue considering the service to be part of the acute services which reinforced that fact that they are part of the ambulatory care team JH asked: if clinicians referring into the service would see any difference and asked there was a risk on impact on ED performance. CT absolutely a risk that the workforce would leave and the proposal was seeking to mitigate that by not issuing notice to terminate the contract at the end of September. Essentially that would cause AUC to have a large workforce gap at NBT and that would be a major problem. LW reasoned there was an argument to place IUC CAS in other areas of the South West for people with GPs who validate ambulance calls as a decrease in conveyances in categories 3 and 4, which might result in a reduction in A&E attendance. CT flagged a further risk identified being that staff working in NBT A&E rotating through doing the phone calls did not just want to sit behind a desk answering phone calls.	

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<tr><td></td><td>JR expressed disappointment that the staff were not interested in working in the community as there was a need for that skillset to be firmly in the community to avoid people entering hospital.

AW advised of the need to make a very clear positive communication to GP members in order that they fully understand the impact and that patients will not suffer in any way.

Shaba Nabi agreed that it was essential that the communications around this were robust and clear.

JH agreed that no assumptions about GP awareness of the scheme be made and that clear communication was essential.

DJ confirmed that the access route for GPs would not change.

CT considered the proposal would ensure Stream 1 became a more strong and robust BNSSG wide service noting that, as was mentioned in the paper, that facility was not currently available in Weston. The ambition being this would strengthen the IUC and allow it to become a springboard to ensure consistent services to GPs across BNSSG.

Commissioning Executive approved the recommendations.</td><td></td></tr>
<tr><td>10</td><td>Commissioning Policies – for approval
Lisa Collard (LC) was welcomed to the meeting to present the Commissioning Policies for approval.

LC explained the paper was to enable the Commissioning Executive to consider a number of Commissioning Policies for approval and adoption by the CCG. A number of changes had been made as a result of the policy review process.

Of the ten policies reviewed, the following had been updated and/or amended and following discussion were approved.

<table>
<tr><th>Policy</th><th>Reason</th><th>Decision</th></tr>
<tr><td>External Ear Surgery</td><td>3 year review and merger of two policies, namely External Ear (Pinna) and Lobe Repair Policy</td><td>Approved</td></tr>
<tr><td>Tongue Tie Division</td><td>Three year review and pathway details</td><td>Approved</td></tr>
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	Item	Action

	updated to include Cleft Palate team	
Elective Surgical Referral for Children under 19 years with recurrent acute Otitis Media	NHSE EBI and three year review. Policy criteria and wording brought in line with NICE	Approved
Microsuction for Ear Wax, Discharge or Debris removal	Changes in GP LES contract and clinical review	Approved but requires further clarification in policy
Paediatric Speech and Language Therapy for children with voice disorders in Secondary Care	Pathway changes made to align service provision across BNSSG	Approved
Funding for Post Clinical Trial or Innovation Treatment	Three year review and scope widened to include innovation treatments	Approved
Carpal Tunnel Syndrome Surgery	NHSE EBI, Three year review; change to criteria and removal of SFI	Approved

Commissioning Executive approved the policies subject to the changes requested in relation to the Microsuction for Ear Wax, Discharge or Debris Removal and clarification which practices delivered are delivering the commissioned service.

11	**Item deferred**	
12	**Primary Care Diagnostic Profiles – for approval** Jeremy Maynard introduced the paper for approval by the Committee and gave a summary of the work carried out to standardise the Primary Care Diagnostic testing profiles to enable profiles to be loaded onto the three acute hospital ICE Test Requesting Systems in BNSSG to support adoption across the system. The Commissioning Executive was asked to approve the standardised Diagnostic Testing profiles. Jon Hayes (JH) considered the standardisation of the profiles an excellent step as this would avoid unnecessary testing and deliver some uniformity in practice. David Jarrett (DJ) advised that this had been well engaged with membership and was wholeheartedly supported.	

	Item	Action
	Shaba Nabi requested references be added to the report to allow further research if desired. Kirsty Alexander (KA) noted the standardisation did not stop clinicians choosing to do an extra test should they consider it clinically appropriate. **Commissioning Executive approved the recommendation.**	
13	**NBT Primary Care Streaming** Leilah Dare (LD) NBT, Adam Brown (AB) NBT, Will Kenyon (WK), Jeremy Westwood (JW) were welcomed to the meeting to present the paper NBT Primary Care Streaming alongside Claire Thompson (CT). CT advised the report, which followed up on the previous briefings to Commissioning Executive, was a proposal to continue the joint service model of the referral to Primary Care service within ED at NBT. CT noted the immediate concern was to ensure that service provision be secured for the remainder of 2019/20 with a view to a sustainable model being in place and appropriately funded/resourced from 20/21 onwards. CT advised of the excellent work done together by the project team, both operationally and clinically, in bringing an agreed clinical model together noting the need to get to a final service model both as a mandated and desired part of BNSSG front door services. CT stressed the clinical model developed at NBT was not a UTC at the front door which risked increasing demand rather a model that managed and discouraged complex primary care patients attending ED. Therefore a slim primary care function and one that could, in time, link to locality models; an option that it was intended to be explored following stabilisation of the service. The Commissioning Executive Committee is asked to: • Note progress to date with the Primary Care streaming project • Support a Q3 solution • Approve a risk share solution for Q4. Assuming that above 1-3 agreed, mandate the project team to: • Finalise the preferred service model • Address the ongoing support internally at NBT through the emerging medicine workforce development business case and the 2020/21 planning round.	

	Item	Action
	Adam Brown (AB) advised that NBT recognised that a lot of its patients coming in was due to the fact that NBT was an unscheduled healthcare environment; also that a blended workforce was key to success and that included primary care and managing the health and safety of all patients and being essential part of the team. Lesley Ward (LW) commented that most patients visit to ED because they fail to recognise that primary care is where they should be seeking care. The streaming service took complex patients who would normally go through the full ED route whereas out in the community there would be very similar patients who would not have such intense investigation, so it was about changing and managing patient behaviour. Julia Ross (JR) asked what measures were in place to avoid GPs becoming less able to make the primary care decision that a person did not need any further investigation. Leilah Dare (LD) advised from the evidence of attending the GP leader study day it was very evident of being mindful that the GP does not turn into an acute ED clinician. Measure taken to avoid this included the GP working from a separate room, wears own clothes not greens, had separate stream, functions independently with his own equipment with access to radiology and if bloods are required that is done in anticipation of onward referral because it will help the patient not because it must be done. Therefore, it was very clear that the GP functions as a primary care physician and maintains those skills, which was the strength that was wanted from the GPs. LW considered that was reflected in the outcomes with a large percentage of the patients are sent away with advice or a GP appointment. JR raised a concern that this relied on a particular physician, acknowledging the measures had been put in place to ensure the service itself operated that way, but over time with different people coming through the original focus can become lost. Will Kenyon (WK) added that this had been his main concern throughout the process and that it very much came down to ensuring the right person was recruited to the role and that broadly speaking would be an individual who was experienced in primary care, currently working in primary care and community and who was not afraid to make decisions. These needs had been addressed when recruiting individuals.	

	Item	Action
	AB supported the need to have the right GP to do the right test, and re-assured the committee that there was buy in from ED that this was what they wanted too. KA highlighted two areas: • that in order maintain the lines and not default to the environment around you, there was a need for a separate physical space with only the normal kit to be expected in a GP surgery. • that productivity was disappointing; one problem being the interface/triage at the very beginning which appeared too risk averse hence was there any learning going forward that would improve the productivity of the primary care resource in the department. AB considered the ED had taken that on board noting that with such huge numbers of staff rotating through the posts that were important to the streaming, it had taken a while to embed but was confident the culture was now there. LW commented that evidence showed having a GP involved had positive effects on the 4 hour target seeing between 2-4%. Sarah Truelove (ST) questioned the activity level of 1.8 patients per hour. On review of the data over the last six weeks, this had looked to be just over 1 per hour. ST stressed that the health system was massively over committed financially this year therefore when asking for additional money, there needed to be an improvement in productivity before making a decision, as currently it was difficult to see much added value. If however it was considered the service was reaching tipping point then evidence of that would need to be seen at Commissioning Executive before agreeing Quarter 4. JR questioned whether 1.8 patients per hour was high enough. Whilst recognising that the environment was not the same as a GP surgery, an ambition should be set for when the service was working optimally with an indication of the number of patients that would be seen over a period of time, show a trajectory of that ambition which reflected the phases from start up to full productivity. CT advised that the project team would hold the answer and that the optimum number was 2.3 per hour to break even financially with 2.5 per hour in full phase a reasonable expectation. AB noted there would be a season change therefore in winter there would be a slight change in demography, change in presenting complaints and in resources to see and stream patients.	

	Item	Action
	Jeremy Westwood (JW) advised in relation to the 4 weeks that the lead GP had been on leave and that there had been new GPs coming into the service that probably had not had the same level of activity but as the GPs became embedded that level of activity should increase. JR stressed the need for ambition, to give value added and meet the needs of the people we serve and rather than reflect on what was being done consider a different angle around what do we expect it to be and how do we ramp it up to get to that point. LD considered once the service was embedded and there was regularity and knowledge of the staff and hours, this would certainly increase the referrals coming into the service. David Soodeen stressed the importance that those working in the streaming service also should work in primary care as well and also be integrated into other areas of the system such as developing primary care networks and locality hubs; these two things needed to evolve together. Shaba Nabi referred to the 78% of patients being discharged with advice and queried the personal incentives to attend and the advice given and asked if more detail in this area could be given in subsequent papers. JR acknowledged NBT streaming was a good pilot, highlighting the importance that it robustly links with the locality and fits in with the model of future care and shared vision. **Commissioning Executive supported the proposal for Quarter 3 with the caveat that the pilot return in Quarter 3 demonstrating an ambition around the future model and productivity, sit within the financial envelope, and provide evidence of increasing productivity**.	
14	**Procurement plan for Integrated Community Equipment Service (ICES)** Kate Rush (KR) introduced the paper providing an update on the work completed to date in seeking Commissioning Executive Committee support the recommendation to Strategic Finance Committee (SFC) to proceed with the procurement of a BNSSG Integrated Community Equipment Service in conjunction with Its Local Authority partners.	

	Item	Action
	The paper had been initial discussed at Commissioning Executive in October 2018 with approval given to extend the contract in order to allow further development of a plan to procure a single integrated community equipment service for BNSSG. The paper now returned to Commissioning Executive to give further information on the process and to seek support to proceed to SFC for formal approval to commence the procurement. KT updated the Committee on the process to date: **Current contracts and financial expenditure**: • There were currently three contracts in place in Bristol, North Somerset and South Gloucestershire, with a combined spend of £5.65m. These contract were due end on 30 September 2020 (Bristol and South Gloucestershire) and 30 September 2021 (North Somerset) The total indicative value of the contract across organisations will be in the region of £28.2m. • It was noted it was an activity based contract therefore would be vulnerable to future increased costs however; mitigations had been put in place to address this risk. **Procurement governance**: • A programme board with senior officers from the four commissioning partners was in place. Each of the partners were required to seek approval to proceed with the procurement through their own internal governance routes **Procurement approach:** • Approved by the programme board and will be a competitive procedure with negotiations similar to that of the Community Services approach. **Procurement timeline:** The OJEU notice was due to be issued on 2 October 2019, with the new contract commencing on 1 October 2020 **Proposed contract length, type, commercial model and contract management:** • Approved by the Programme Board the proposed contract length is five years with an option to extend by two years. The contract would operate on an 80% refund model. Contact management would be subject to a Section 75 agreements and Bristol City Council had offered to be the lead commissioner, with strategic support provided by the CCG. In addition to regular contract management, the Programme Board would continue to oversee roles and responsibilities that would be further underpinned by a local authority agreement. **Service specification:**	

	Item	Action
	• The specification incorporated a single catalogue, supported by a single ordering system and single prescriber policies. The requirements within the specification were described in outcome terms wherever possible, to enable bidders to respond with innovative solutions **Evaluation:** • Tenders to be evaluated using a 60% quality and 40% price model **Issues and Risks:** • North Somerset Council (NSC) had raised concerns regarding a requirement to mandate the location of an equipment store within North Somerset; procurement advice had given reasons why this would not be possible and an extraordinary programme board meeting had taken place with all partners to identify a way forward. The current position as that GH would take back to NSC to discuss in preparation for a full response to GB in October for a final decision, following SFC. Gerald Hunt (GH) explained that at this point the exclusion of a mandate for a store in North Somerset was a cause for concern for NSC due to: • Procurement advice appeared to be contrary to the procurement advice received by NSC • In the context of community support, understanding why it was not possible to mandate a location that if not prescribed would have a direct impact on employment in the Weston store which was located in one of the NS disadvantaged wards • Whilst logically clearly wanting to see a service that is consistent and joined up across BNSSG there was concern that this should not be at the expense of the continuation of the local service. Lisa Manson (LM) advised: • the principle was to commission a service based on timeliness of response • feedback received through market engagement event from two of the three interested parties had been that any mandating of location would increase costs. • part of the process was getting to the point where there were outcomes in terms of timeliness and delivery and that fundamentally, it was about achieving that timeliness. • one key advantage of a BNSSG wide service that was not in three separate contracts would mean prescribing staff were not restricted to a postcode location and this in turn would allow the process of what they did and how they achieved it to become consistent.	

	Item	Action
	Julia Ross (JR) agreed that the procurement must be based on outcomes for people and that included deliverability; that contractually the expectation should be that it was as cost effective as possible. JR queried how mandating a location would make that the case and considered that by entering the dialogue process on where bidders would put the equipment stores there would be an opportunity to question and challenge and be clear about what the benefit was. JR considered all parties were interested in delivering the best possible equipment to people as quickly as possible, at the lowest cost possible and recycling and reutilising as much as possible in order to ensure best value for all parties. Alison Bolam (AB) asked that the figures detailed on page 2 of the report be identified as £000's to avoid possible confusion. David Soodeen (DS) asked for clarity of what was actually within scope and if there would be any changes to how the LA historical budgets developed. LM offered to provide DS with a catalogue of the full range of equipment that currently exists within the community equipment service that would be used and predominantly prescribed by social workers and community nurses either to prevent someone being admitted into hospital or another care setting or on discharge. LM advised pricing had been discussed at the Programme Board who had considered getting to the point where all parties agreed to work together across the three BNSSG area and getting to single contract was the main priority. This focus would change as the community teams moved into closer integration of ways of working but at this point in time the priority had needed to be achievement of a single contract. JR asked that the specification be as future proofed as possible in light of over the next 5 years localities becoming strong themes and as part of that equipment would a critical element in keeping people in their homes. JR considered some wider thinking about the specification involving a variety of professionals would help to ensure longevity of the procurement. KR confirmed steps would be taken to ensure the specification was as future proofed as possible.	

	Item	Action
	Kirsty Alexander (KA) asked for clarity around the in expenditure across the areas and Sarah Truelove confirmed this was due to the population size being similar in each of the three areas. Sarah Truelove asked given the move to integrated localities and thus integrated teams prescribing how the differential funding arrangements currently retained in the contract would develop as models of care and the way in which people worked changed. Was there a plan to have that conversation as a part of the discussions going forward. LM confirmed that in order to achieve a live procurement it had been agreed to leave funding as currently shown however this would form part of future conversations as the parties worked together and achieving consistency and clarity formed part of the programme of work going forward and that any ambiguity around funding sat with the Commissioners not the provider. JR asked whether the specification ensured there was no provision for differential levels across the 3 areas thus ensuring people received the same service and equipment irrelevant of postcode. LM confirmed this was correct. LM spoke about the existing funding arrangements noting these formed parts of the inherited agreements of the historical arrangements between the former 3 CCGs and LAs prior to becoming BNSSG. Noting that any ambiguity arising would be between the commissioners not providers. LM confirmed the basis of the procurement was factored on current costs, creating a more consistent service and not building into the specification any ambiguity about what will be asked of the provider. ST asked for clarification on what would occur if the activity level went over current levels in order to understand where the financial risks sat. After discussion it was agreed further clarification was required and LM would take this away to respond more fully on the financial modelling going forward, the split within the financial envelope should the pathway change. Jon Hayes directed that clarification on the funding arrangements should go to the SFC.	

	Item	Action
	Commissioning Executive supported the procurement plan subject to the further clarification requested above to SFC.	
15	**Integrated Contract & Quality Performance Monitoring (ICQPM) Terms of Reference** Lisa Manson (LM) presented the report Terms of Reference for Key Contract Meetings. LM advised the intention was to standardise the various TOR between Acute, Non-Acute and Mental Health in preparation for the new contract arrangements for next year. The TOR reflected core conditions of the contract in relation to setting out where reports were received, contract performance notices and consistency of offer. LM advised that Vita Health had also been included as the IAPT provider. LM advised that Commissioning Executive was being asked to: • approve the revised Terms of Reference to ensure a clear, effective and unified approach to these meetings by Commissioners and Providers • formally sign off the Vita Health IAPT Contract Quality and Performance Meeting Terms of Reference • undertake a corporate decision not to have Patient/Service User representation on the Access and Performance Meetings across all BNSGS Contract meetings including the voluntary and community sectors contracts Jon Hayes (JH) queried how this would be managed with the individuals currently involved as patient/service user representatives. LM advised that conversation was yet to take place but it was considered that a better patient engagement arrangement could be achieved outside a contractual arrangement. Julia Ross (JR) advised that there needed to be clarity about how this would be done in the report. JR asked how this addressed our ambition to move to peer based performance review and had we done enough to engage the system in this model, and where did this sit in governance terms. LM advised the contract determines the escalation process, so we have a defined escalation service which sits within the contractual terms that ends up with both Chief Execs entering formal arbitration and mediation.	

	Item	Action
	JR asked for clarification on the governance in relation to the performance management process. LM agreed that this required further clarification as she considered it inappropriate for the escalation of performance management to go to Governing Body and that it should form part of the remit of Commissioning Executive. JR asked if the TOR reflected how we as a system, through informal escalation, would hold ourselves to account together in a peer review manner. LM advised the TOR focused on landing the contractual arrangements and clarity with each of the providers to identify the roles and responsibilities within that. LM advised that the CCG had worked in parallel in terms of creating performance and peer review frameworks however, these were not yet dovetailed in due to a lack of maturity in the peer review; and envisaged this would form part of the next refresh as opposed to now. Claire Thompson (CT) considered this would fit as operationally highlight reports on each of these three areas were regularly reviewed by the Committee. JR advised the work of the Commissioning Executive should not become too operational and what should come to the committee should be clinical governance, quality or challenge whereas a management function could manage other elements. Sarah Truelove (ST) considered that Commissioning Executive was in effect being used as a management committee. JR considered the TOR tightened up current arrangements but needed to be worked up to reflect the future models of work. Sara Blackmore (SB) asked about governance sat with co-commissioning with LAs in relation to Sirona and children's services. LM advised that children's services contract has exactly the same structure within it however the ICQPM has all the commissioners involved.	

	Item	Action
	ST advised it would be helpful to give feedback that the TOR were accepted but only until 31 March 2020 and because they want some more work now you are asking to have that future model described. JR asked that there be strong clinical engagement in the review of the TOR. **Action:** **LM – further review of TOR by 31 March 2020** **LM – feedback to providers that TOR as above.** **Commissioning Executive approved the TOR until 31 March 2020**	
16	**Mental Health Contract Review – update** Emma Moody (EM) and Julia Chappell (JC) were welcomed to the meeting to present the update on the Mental Health Contact Review. EM explained the purpose of the review was to: • recommend next steps in relation to the six Bristol Mental Health lots which were procured in 2013 and were due to expire in 2021 • review all historic CCG contracts and consider if these provided value for money and were part of the core business of the CCG • make recommendations for prioritising pathways and services future re-modelling or re-procuring. EM explained al contracts had undergone a detailed review to understand and assess the background and service driver, quantitative evidence, access, finances – including value delivered and provider sustainability, recommissioning, remodelling or de-commissioning implications. There had been 350 responses to survey monkey questionnaires, two lived experience events and discussions at all GP locality forums with feedback from all three Local Authorities. Julia Chappell (JC) presented the slides on Bristol Mental Health findings, which identified that statutory services in Bristol broadly appeared under greater pressure and had poorer performance than those in North Somerset and South Gloucestershire. The emerging recommendations were discussed, noting alignment with the emerging Mental Health Strategy: Pathways of care to be re-designed for better outcomes which are not predicated on existing functions/services	

	Item	Action
	Crisis pathway emerging as the initial priority pathway in order to release placement and acute out of area spend for reinvestment in prevention JC spoke about the next steps in the process, which commenced with sharing the draft report at the forthcoming Commissioning Executive and GB seminar. Jon Hayes (JH) highlighted that it was not intended to have a long debate at this point since this would be the focus of the GB seminar and asked if anyone who would not be attending had any questions. Sara Blackmore (SB) confirmed that Public Health would be at the Governing Body discussions and reported that the IAPT service specification had been well received in terms of the joint working with LAs and pathways. Kate Rush (KR) asked for further clarification of MH needs being addressed for those people suffering from substance abuse. David Soodeen (DS) commented on the Voluntary Sector grants and the rationale behind these and how these were monitored and reviewed in order to ensure they remained fit for purpose. DS advised that there was national guidance requirement that whoever ran the Crisis service should also run the inpatient service. JR considered it was a great piece of work. JR considered it should say more about new models of care and localities, and felt the biggest problem in terms of gaps in care, were around Tier 1 and 2 which the LAs had invested in over the years and those people who did not meet the needs of the secondary care service. JR stressed the need for a model of care that started in the community and worked its way up to secondary care services with clarity about what the role of specialist mental health services was and ensure the resource in the localities was a properly fully integrated service. J JR asked this to be included on the slides. Shaba Nabi (SN) spoke about the subject of prescribing, looking at the scale of prescription drugs, looking at people with physical problems that have developed substance misuse through prescribed drugs. Noting that these people did not currently sit anywhere and asked that this area be included in the review.	

	Item	Action
	JR also noted that eating disorders sat in a similar position. LM advised that in terms of the evaluation, the user network have responded by identifying where they see gaps. **Commissioning Executive noted the report.**	
17	**Urgent Care Activity & Performance Update** Claire Thompson (CT) presented the Urgent Care Activity and Performance update report. **Commissioning Executive noted the report.**	
18	**Contract Performance Update Report – Acute** Lisa Manson presented the Contract Performance update report for the Acute sector. **Commissioning Executive noted the report.**	
19	Withdrawn item	
20	**Nursing & Quality Directorate – Clinical Update** Janet Baptiste-Grant presented the Nursing and Quality Clinical Update report to the Committee. **Commissioning Executive Committee accepted the report.**	
21	**Operational Issues** None	
22	**Any Other Business** LM updated the Committee of the EU Exit Plans.	
23	**Committee Effectiveness:** None	
	Date of next meeting: Thursday, 10th October 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