Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 13th June 2019 at 8.30am, CCG Conference Room, South Plaza, Bristol.

Minutes

Present			
Kirstie	Alexander	Clinical Lead for Children's and Maternity, BNCCG CCG	KA
Andrew	Appleton	Corporate Clinical Lead for Digital, BNSSG CCG	AA
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Alison	Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Kevin	Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Jon	Hayes (CHAIR)	Clinical Chair, BNSSG CCG	JH
Geeta	Iyer	Clinical Corporate Lead for Primary Care Provider Development, BNSSG CCG	GI
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Martin	Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJ
Lisa	Manson	Director of Commissioning, BNSSG CCG	LM
Shaba	Nabi	Clinical Corporate Lead for Prescribing, BNSSG CCG	SN
David	Peel	Clinical Corporate Lead for Planned Care, BNSSG CCG	DP
Justine	Rawlings	Area Director for Bristol, BNSSG CCG	JRa
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			
Janet	Baptiste-Grant	Interim Director of Nursing & Quality, BNSSG CCG	JBG
Colin	Bradbury	Area Director for North Somerset, BNSSG CCG	CB
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
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJ
Kate	Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
Jeremy	Maynard	Clinical Lead	JM
Julia	Ross	Chief Executive, BNSSG CCG	JR
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
In attendance			
Sarah	Carr	Corporate Secretary, BNSSG CCG	SC
Helena	Fuller	Deputy Director of Commissioning (Contracting & Procurement), BNSSG CCG	HF
Vivienne	Harrison	Public Health, South Glos. Council	VH
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker)	JHo
Julie	Kell	Head of Performance Improvement, Integrated Care, BNSSG CCG	JK
Andy	Newton	Head of Planned Care, BNSSG CCG	AN
Fiona	Reid	Contract Support Office, Non Acute, BNSSG CCG	FR
Inge	Shepherd	Snr Contract Manager, (Non Acute) BNSSG CCG	IS
Sarah	Swift	Head of Contracts (Acute), BNSSG CCG	SS
Claire	Thompson	Deputy Director of Commissioning (Planning & Performance Improvement), BNSSG CCG	CT
Elizabeth	Willliams	Transformation Manager for Planned Care, BNSSG CCG	EW

	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**	

<table>
<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>G Iyer declared an interest in relation to Item 10. It was noted this item was for discussion only and any decision would occur outside Commissioning Executive Committee therefore no further action was required.</td><td></td></tr>
<tr><td>03

03.1</td><td>Minutes of the meeting and matters arising from 9th May 2019
The minutes were agreed as a correct record with the following corrections:
Alison Wint to be added to list of apologies
Sect. 4 Page 3 Prof Geraldine Strathdee, NHSE National Clinical Director for Mental Health added
Sect 4 Page 6 Para 5 replace “questioned” with “highlighted”.
Sect 9 Page17 corrected spelling of Egton Medical Information Systems (EMIS) and Local Medical Committee (LMC)
Sect 9 Page 21 2nd Action - wording amended to Chief Information Officers (CIOs).
Action log from 9th May 2019:<table><tr><td>Item 61 – deferred to July</td><td>Item 97 – deferred to July</td></tr><tr><td>Item 77 – closed</td><td>Item 98 – on agenda - closed</td></tr><tr><td>Item 79 – deferred to July</td><td>Item 100 – completed, closed</td></tr><tr><td>Item 80 – closed</td><td>Item 101 – ongoing - open</td></tr><tr><td>Item 81 – deferred to July</td><td>Item 102 – open</td></tr></table></td><td></td></tr>
<tr><td>04</td><td>New Safeguarding Children’s Arrangements
It was noted the paper had been to Governing Body where it had been approved and was coming to Commissioning Executive for information purposes. The paper will be published on the BNSSG website w/c 17 June 2019.</td><td></td></tr>
<tr><td>05</td><td>Commissioning Planned Care Strategy
Elizabeth Williams (EW) and Andy Newton (AN) were welcomed to the meeting to present the item. David Jarrett (DJ) gave a brief overview of the Commissioning Planned Care Strategy paper developed further from previous discussions at Commissioning Executive.

DJ reported that D Peel (DP), EW and AN had since worked together extensively on developing the planned care strategy document and they sought approval from Commissioning Executive and support for the implementation of the joint priorities and work plan.

DP presented the slides to the Committee which identified the strategic drivers and ambitions which included promoting self-care and healthy lifestyles, providing timely and appropriate access to specialist expertise, prioritising person-centred decision making, offering the right treatment or solution relative to the patient’s circumstances, patients</td><td></td></tr>
</table>

	Item	Action
	receiving the right planned care service through a system which is simple for patients, carers and staff. EW spoke about the needs assessment process which had been undertaken and informed the strategy having involved extensive interviews, two evidence reviews, a clinician's survey, two workshops and service user involvement via the Citizen's Panel. Public Health had also produced a needs assessment. Working closely with the Business Intelligence team the strategy had also been reviewed regularly by the Planned Care Programme Board, the Acute Care Collaboration Steering Group and by NHSE. J Hayes (JH) asked what the balance was between primary and secondary care clinicians in the survey. EW explained it had been approximately 50/50 split between the two sectors. DP spoke about the strategy's priority work stream areas; Cardiology, Dermatology, Ophthalmology, Urology and MSK and how the planned care strategy would impact on these. EW spoke about the comprehensive prioritisation process carried out with the Acute Care Collaboration which had resulted in the 19/20 priorities listed below: • focus on outpatients transformation including advice and guidance, using Urology and Ophthalmology to test a new model • continue work on an eye care strategy • re-establish work on MSK particularly around shared decision making, pre-operative health optimisation and improving diagnostics. K Alexander (KA) asked what level of engagement with secondary care colleagues had been undertaken in securing their commitment to achieve value based outcomes within a programme budget. DP explained as the value programme was patient focussed the expectation was the secondary care focus would shift from the current financial focus to a patient and value to patient focus. EW considered that the programme budgeting could be a huge game changer, noted this had been discussed previously and queried whether the system would be open to this approach. S Truelove (ST) thought re-introducing this element was worth considering as part of the value programme in particular with regards to the eye care strategy and assessing the relative value of expenditure in the different areas. A discussion took place around the current accessibility with regards to the eye hospital and urgent care and AN advised there were proposals	

	Item	Action
	being developed around this which were expected to be completed within the next few months. J Hayes (JH) asked around advice and guidance if there were plans to move towards a standard mechanism across the system to replace the existing mechanisms, both variable and awkward, between hospitals and departments. DP explained this was currently in the process of being rolled out, with the aim of secondary care teams gaining an understanding that the same advice is not required to be applied all the time and for them to develop other tools such as Frequently Asked Questions (FAQs). - *J Rawlings (JRa) joined the meeting at 9am* S Nabi (SN) commented on the high standard of papers presented. SN raised a point on the shared decision making process highlighting that this should not be done in isolation in planned care and important that a strategy on how it will be used centrally be developed. SN was meeting with NHSE to discuss shared decision making as part of the networking group. EW informed the Committee that the Planned Care team had applied and been successful in becoming part of the Shared Decision Making Acceleration Programme from which BNSSG would receive an increased measure of support from NHSE to move this work forward. A Bolam (AB) commented that the decision to go forward with the Urology work fitted well with that of the Phlebotomy work. AB referred to the Pre-operative health optimisation element of the strategy in particular smoking cessation noting that Bristol City Council were decommissioning their Primary Care smoking cessation to focus on specific target groups such as pregnant women and people with MH. A Newton (AN) advised this was a challenge and discussions were being held with the LA at the moment to identify opportunities such as adding alongside other work such as smoking cessation and physiotherapy work, targeting patients who are on orthopaedic pathways for surgery. S Blackmore (SB) commented it was re-assuring that the health optimisation pre-opt work linked into the prevention work through the Strategic Transformation Plan (STP) and that stressed the importance of continuing with these links around the prevention work stream. G Iyer (GI) asked DP to ensure that the Planned Care Strategy also linked into the Primary Care Strategy.	

	Item	Action
	MJ advised that Andrew Burnet DPH at N Somerset Local Authority, was very keen to be involved in the development of this strategy as he had under taken similar work in a previous role. AW advised that the paper did not fully reflect the sizeable amount of work which the Planned Care team had undertaken to produce the paper and commended the team on the quality of research, surveys and workshops which had been carried out in a short period of time as well as the evidence and level of detail in compiling the document. AW recommended that the Committee should have no hesitation in supporting the proposed strategy. P Brindle (PB) reiterated AW's comments commenting on the high standard of the document and its contents in particular the way the document framed the case for change around the personalized care, technical value, the striking information from the Citizens' Panel and the evidence this produced to support the shared decision making. JH summarised that the Commissioning Executive Committee was universally impressed with the quality of the paper and messages contained within the document and noted the vigorous support for this from the clinicians of the Committee. **Commissioning Executive Committee approved the Planned Care Strategy and supported the joint work with the Strategic Transformation Plan.**	
06	**Healthier Together Outpatient Transformation Programme** Andy Newton (AN) introduced the item to the Committee which was an update from the Outpatients Transformation Programme on the progress to date for review and discussion. AN advised that the current model in place since the 1940's was considered to be old fashioned and out of date, unsatisfactory for both patients and staff, was wasteful and had a high carbon footprint with the number of outpatient appointments nationally having doubled over the last 10 years. AN advised that the current system was largely organised and based around the benefit of the organisation and not that of the patient. Patients with multiple physical and MH needs were placed on long queues to a pathway with a specialist consultant for one need who would often then refer them to another specialist for their other needs with the patient experiencing long delays before being seen each time,	

	Item	Action
	It was considered that the current approach was reactive as opposed to preventative, clinical narrow not holistic and individualistic rather than having a population approach. AN advised that the revised approach was supported by the Royal College of Physicians and went on to present the 5 key work areas planned for 19/20: 1. Rolling out of CCG Referral Management Service across BNSSG. 2. Roll of standardised Advice and Guidance services 3. Reducing new to follow up ratios 4. Non face to face follow ups achieving minimum target 5. New model of integrated, locality delivered outpatient care D Jarrett (DJ) advised the RMS Service was undergoing a consultation process and would come back with proposal for the development of the RMS and potential roll-out of the services to the next Commissioning Executive. E Williams (EW) spoke about the proposed improvements to the pathways which would include a Tier 3 integrated specialist service providing patients with treatment in the community. D Peel (DP) commented the new model reflected UH Bristol's own strategy (UH Bristol's 2020/25 vision) and therefore an opportunity for providers to demonstrate their intentions to reform the way they work. K Alexander (KA) noted the climate change element within the paper and recommended that a climate change section be incorporated within the header papers alongside the financial, legal and risk implications to properly assess the sustainability of programmes. KA noted specifically some patients did physically need to be seen, whilst acknowledging the telephone worked well for some, a visual approach was important in some areas such as MSK. D Soodeen (DS) asked that: • dermatology be considered as a future area to be moved to specialist community services • support be given to staff and clinical leadership who are delivering the planned care • awareness of the potential consequence regarding non face2face proposals might be that work is simply shifted somewhere else such as general practice.	

	Item	Action
	DP advised that one of the key principle of the model was that specialist input would move into primary care and integrate itself with the localities therefore being based around localities and increasing the ability of the locality to deliver healthcare to its population by the implanting specialist support local to people. DP noted this was a radical transformation requiring surgeries to work with their community services in a very new way. S Nabi (SN) asked: • that the advice and guidance might require some prelimary work in practice and had the additional work been accounted for separate from the locality work. • was the RMS shown to be cost effective • queried the consistency of referral and outpatient letters asking if this should be both ways DP advised: • the consistency of referral and outpatient letters was more about relationships and that moving forward in this model general practices would know who the consultant was linked to the locality. • the referral service was showing effectiveness, with consistent return rates; it was about contractual leverage around reducing activity and showing this on a value based system. • Indicated there was data around this and EW advised that membership meetings had been consulted and there had been strong support for the model and it had been noted one main area of concern was what would happen if rolling out to other specialisms. A Wint (AW) noted that not all patients could be re-assured in primary care and needed to be referred for re-assurance and queried the use of secondary care Physicians' time and would this work. DP advised it was about integration and that leaders from the locality together with the consultant will develop that service locally as opposed to a consultant just arriving at a surgery to deliver a clinic. P Brindle (PB) supported the move of Urology into the community and suggested that this was an area where rapid and good progress could be used as an exemplar for other community based services such as the follow up and active monitoring of prostate cancer, and an opportunity to use a web based platform that did that in an efficient way. PB encouraged thought be given to Prostate cancer and the tools which were already available to do that. PB referred to the New to follow up ratio:	

	Item	Action
	• considered this as a somewhat blunt tool, stressing the need to understand the value of the outpatient appointments and not just the measure. • noted some follow ups were really important in cases of some chronic diseases such as glaucoma where it could be detrimental to the patient and value would suffer if stopped. • Referred to previous experience when people have been discharged only to be re-referred and the possibility that it might miss the point about what is best for the patient and the need to be aware of the unintended consequences DP Advised this was a mandated measure. J Rawlings (JRa) suggested reviewing the ordering of the roll-out of the integrated model cautioning that if redesigning how care was delivered to take into consideration those specialist pathways for which, due to the small volume of activity, it would not be possible to construct an integrated service in the locality S Truelove (ST) considered the strategy was based on evidence of what was actually happening elsewhere and the specialities that lent themselves to the integrated MD approach and advised that it would not be possible to transfer out existing services into localities that would cost more and that there had to be ways of having a completely different model for such cases. DS referred to health related anxiety previously mentioned by AW. DS considered this should be addressed through IAPT noting that although lots of work going on in liaison psychiatry across the acute providers currently this was not particularly co-ordinated and recommended that the MH Strategy link with the Planned Care Strategy around this. AA asked about the approach to patient initiated follow-up which was not specifically mentioned in the document. DP advised there was an outpatient workshop coming up and that would form part of that workshop. AN advised that the team had collated information from across the Trusts including PIFU and other methods of non-face to face contact which would inform the process. DJ advised they had been successful in securing national funding from NHSE for outpatient transformation which will supplement the work. JH thanked the team for the update. **Commissioning Executive Committee noted the report.**	

	Item	Action
07	**Locality Transformation Scheme19/20** David Jarrett (DJ) introduced the paper on the Locality Transformation Scheme 19/20 which focussed on delivering two core programmes within localities, Frailty and Community Based Same Day Emergency Care (SDEC). DJ advised the paper had been trialled at the June GB seminar where there had been discussion on elements of the paper. DJ summarised the journey of development of locality transformation in the continuing development of the localities in the context of primary care network establishment, the urgent emergency care strategy, the primary care strategy, changes in the movement in urgent care demand and the recent developed urgent and emergency model of care (UEC) and community procurement all of which had been developed alongside and aligned with locality development. DJ went on to explain the next steps for development of the Integrated Community Localities and delivery of the UEC model of care and the two core programmes for localities in 19/20. This would be funded from previous year funds carried over and amounted to £0.50 per patient being released to fund delivery of the frailty model of care existing plans; a second £0.50 which has to be trialled with locality providers to fundamentally change the delivery of urgent care within the localities. DJ noted the need to identify a small amount of recurring funding for localities. DJ asked the Commissioning Executives to approve: **Delivery of LTS Phase 2 Programmes** £0.50 per head of population released to support delivery of BNSSG Frailty model and continued engagement in Mental Health strategy development **Development of Locality Based Urgent Care Services** £0.50 per head of population released July 2019 for development of proposals and delivery of Locality Based Urgent Care Services **Shared Incentive Scheme** Shared incentive scheme to be developed and implemented **Locality Infrastructure Support** Funding to recurrently support locality leadership (Funding allocation to be confirmed through alternative route). The Locality and PCNs will then be asked through the PCN Development Plan to identify from this collective resource locality clinical leadership in the following areas: • Locality Development	

	Item	Action
	• Urgent Care • Frailty • Mental Health CCG Area Teams to provide dedicated and direct support through Locality Development Managers to enable delivery of Frailty, Mental Health and UEC Service Delivery Proposals K Alexander (KA) referred to the locality urgent care services, queried the evidence that allowing easier access to urgent care via the Primary Care Networks would improve the situation and cautioned about setting unrealistic goals or ambitions. S Truelove (ST) suggested that it might be about giving people an instant response as opposed to service; with the action being carried out in a time appropriate way. G Iyer (GI) explained that surgeries were already trying to appropriately clinically triage people but there was a group of people for whom this was not acceptable. C Thompson (CT) considered there was a growing view that having the same response wherever patients arrived was important and there had been work done with NBT around re-direction and the opportunity for direct booking. CT considered the Locality Hubs should not be considered to be additional access but a replacement with the activity being re-directed. P Brindle (PB) advised that there was evidence that one key reason why walk-ins attend ED because they find GP appointment systems confusing and difficult. PB considered there was a good case for trying to make a good response, provide re-assurance for those that need it or appropriate guidance and was keen to have good access 24/7 but not necessarily the service. PB referred to the pathway work, commenting it was very important that to understand why the three pathways were chosen, what it was within those three groups of individuals that we could do something about and if there was a significant number of people to warrant such a change. S Nabi (SN) queried the current restrictions around the 111 service and duty doctors for patients seeking advice; the overflow hubs which she considered had a significant impact on the continuity of care and queried how £0.50 per patient would cover 24/7 care. DJ advised that the £0.50 is not for the service, this was for practices working with BNSSG to develop the model.	

	Item	Action
	DJ advised that the key element of the new improved access service specification will be integration with IUC and having the ability to book through 111 which is not currently available. CT advised that at least 50% of those patients were receiving further validation by a GP under a different model. K Haggerty (KH) considered there were 3 cohorts of people who were accessing urgent care who did not need to and stressed the focus should be on the population not solutions in order not to reduce continuity which is a key component on balancing all those cohorts. S Truelove (ST) clarified the purpose of the £0.50 per patient was about developing a plan, opposed to the draft incentive scheme about to be discussed. ST spoke about how this plan would need to link with the BNSSG Financial Recovery Plan expectation regarding resources and the stipulated 2:1 return on investment. DJ explained the context for the draft proposal for a SDEC incentive scheme which was based on 2018-19 outturn activity. The scheme was intended to incentivise Locality provider teams to develop solutions to reduce demand for Urgent & Emergency Care. Three areas for opportunity had been identified: • Reduce A&E attendances for no investigation and no treatment • Better utilisation of existing out of hospital and direct access pathways • Develop more cost effective care models DJ explained the draft proposed sliding scale payment scheme and indicative budget per practise JH asked how would the incentive for continued good performance be maintained? ST advised that the non-recurring £0.50 per patient paid to practices was simply to develop a plan. Following the development of a plan this would then need to be resourced and this funding would be additional to the £0.50 non-recurring payment to practices. ST highlighted the £11M of growth built into urgent care this year and the commitment to reduce that by £3M in year; therefore, based on the required 2:1 return on investments, there had been put aside £1.5M to spend on the alternatives that could deliver this £3M reduction. With regards to continued good performance there would be a bonus payment on top of the service delivery cost to localities to re-invest in the next phase of the development of the locality hubs on a more industrial scale.	

	Item	Action
	M Jones (MJ) noted the probable need for investment at PCN/Locality level of staffing tie-ups/additional staff and the associated costs. ST referred to the 3 elements: • £0.50 per patient paid to practices to develop a plan • £1.5M to resource the service delivery of the plan • Incentivising continued performance L Ward (LW) queried the % reductions and ST explained the projection was £11M more on urgent care would be spent in 19/20 than was spent in 18/19 and are trying to reduce that by £3M to get that down to an £8M increase which was still very significant and beyond what other South West CCGs are planning in the region. SN asked if ST believed that this is a win win situation for everyone concerned, for the commissioners and primary care? ST considered this to be so and felt it was the same for patients too. ST felt the Acute Trusts might not feel the same as they were potentially increasing their resource for urgent care. Given the need to break this cycle the incentive scheme needed to be in place before next year's contracting round began to demonstrate delivery in 19/20 and show the level of plans we haven't been able to this year. Currently there was no confidence that there was an alternative to the Acute providers just recruiting another six A%E consultants. L Manson (LM) noted additionally the issue was about the physical capacity of departments and the impact of overcrowding at peak times and the department's physical ability to function at these times. DJ asked for the support of Commissioning Executive on the three areas of focus in terms of Locality Transformation prior to taking to PCCC and support for the continuing development of the incentive scheme. **Commissioning Executive supported the three areas of focus as outlined above and supported the continuing development of the incentive scheme.**	
08	**Healthcare Public Health Work Programme 19/20** Vivienne Harrison (VH) was welcomed to the meeting to jointly present the item along with Sara Blackmore (SB). The paper set out proposals for the annual shared work programme of healthcare public health across Bristol, North Somerset and South	

	Item	Action
	Gloucestershire (BNSSG) for 2019-20, to be delivered by Public Health teams working with BNSSG CCG. The paper reflected the BNSSG footprint and focussed on principles, priorities work areas and ways of working. The three key areas of work were: • Strategic Leadership • Healthcare public health contribution to addressing priority issues • Public Health input to CCG policy development VH spoke about the three key focus areas: **Strategic Leadership:** Added into the plan for 2019-20 had been joint leadership for the Population Health Management Steering Group and a more explicit link to locality working and community mobilisation. **Healthcare public health contribution to addressing priority issues:** A change of emphasise in this work programme aimed at prioritising the Healthcare public health resource to enable collaborative work across the public health teams and BNSSG CCG to address the strategic issues that are of significant scale and impact across the system. The areas of work will be identified and prioritised through a strategic oversight process with BNSSG CCG to agree major priority issues where Public Health can add value. These will be Public Health consultant led pieces of work underpinned by technical public health skills. VH advised this was a change of emphasise to a more planned, strategic, prioritised delivery against BNSSG CCG system issues where Public Health contribution was desired. **Public Health input to CCG policy development:** Stronger medicines management support had been added into the area prescribing and medicines optimisation work. VH advised the Healthcare Public Health (HCPH) Group would continue to meet on a monthly basis and it was proposed that an extended group meeting was held quarterly to agree priority areas of work for HCPH and oversee delivery against the overall work programme. PB welcomed the way of working and the emphasise on the strategic priority issues and explained that the one of the reasons for this was due to there being less technical support available from Public Health colleagues. PB advised that this might leave the CCG less well	

	Item	Action
	supported on the technical aspects than in previous years and that a work around might be required. S Nabi (SN) commented that the Meds Optimisation teams hugely valued the work done in the plan. C Thompson (CT) asked where the current thinking on clinical governance across the system and the creation of a shared risk between organisations would fit in terms of the priority work streams. SB advised that this was something which could be captured within the work programme, advised clinical governance would be discussed at the next shared DPH meeting and SB would keep CT informed. D Soodeen (DS) noted that the Health Inequalities plan and strategy was not specifically mentioned in the work plan. VH and SB advised that a Public Health colleague had been identified to link with the Health Inequalities work and that this was covered in the long term plan where there was a strong theme of equalities guidance. DS considered there was a gap around sexual health, drugs and alcohol services STP wide and asked what the CCG could do to help fill the gap, suggesting clinical input. SB advised that recent guidance had indicated closer working with CCG was required and considered that clinical input, particularly around sexual health, would be valued. A Wint (AW) highlighted that the Cancer Alliance had a great focus on LD as evidence showed that patients and carers often did not recognise the symptoms and asked where screening sat within the work programme. SB confirmed that screening is an assurance role and explained that within LAs PHE held the responsibility in terms of delivery and monitoring was done via the individual Health Protection Assurance groups through their oversight role. SB confirmed that screening would be included specifically in the work programme as an area to monitor. K Alexander (KA) asked if Public Health England (PHE) had a strong healthcare public health element.	

	Item	Action
	VH advised there was a good healthcare public health function in PHE noting that from a medicines optimisation perspective the structures were still evolving. SB considered this to be correct. Commissioning Executive were asked to support the proposed shared work programme of healthcare public health across BNSSG for 2019-20 to be delivered by the Public Health teams working with BNSSG CCG< **Commissioning Executive supported the proposed work plan.**	
09	**Age UK South Gloucestershire – Personalised Integrated Care (PIC) Programme review** Inge Shepherd (IS) and Fiona Reid (FR) were welcomed to the meeting to present the item. L Manson (LM) introduced the background to the paper. LM noted that, as part of the work undertaken to amalgamate the different contracts and arrangements of BNSSG, the pilot with AGE UK Personalised Integrated Care Programme (PIC) working in South Gloucestershire since 2017 had been identified as requiring an evaluation and value for money assessment. FR advised that the scheme was a GP referred social prescribing scheme in the South Gloucestershire locality and that a value for money desk top evaluation of the scheme had been conducted using AGE UK's own data and a study carried out by Aleron management consultancy to identify if there had been any savings in the planned admissions for the cohort of patients in the programme. TFR advised there was no evidence there had been any savings in planned admissions. The costs were high per patient. The conclusion was that the service did not delivery value for money for the CCG and consideration should be given as to whether this should be decommissioned and if so, whether engagement with the LA, GPs and patients was required. A Appleton (AA) considered that the service was greatly valued by the practices and patients with whom it had been working and the manner of evaluation might not have reflected the value to surgeries and impact on services. J Rawlings commented that potentially a lot of what this scheme offered would be wrapped up in the new Community Services going forward and the link role of the PCNs and BNSSG were not currently in a position to have a unique social prescribing scheme sitting outside	

	Item	Action
	those services for frail older people. JRa considered there was a high degree of overlap. LM confirmed there was a high degree of overlap and advised that when the scheme was commissioned it was on the basis that it would reduce activity in the acute sector and that was the premise on which the scheme was constructed so therefore it had been measured and evaluated on the construct of the scheme. KA suggested that there should be some shared learning from the scheme ascertain what was good about this particular scheme and extract the elements which were good and what we are measuring it against. IS agreed the need to share the learning from a contractual perspective with Transformation and service design to enable this to be taken forward in future developments. J Hays (JH) noted that the pilot whilst happening in South Gloucestershire was not universally happening across the whole of South Gloucestershire. D Jarrett (DJ) agreed that was the case, it was not equitable across BNSSG or South Gloucestershire. JH read out a comment from J Evans (JE) regarding an independent review conducted in 2016 which showed evidence of a reduction in non-elective admissions: "Can we highlight the need for PCNs to provide social prescribing and that indeed 3% of the proposed community nursing budget is to be is to be devoted to 3rd sector provision. The fact that as these AGE UK Practitioners are already in place and within many MDTs are seen as a vital resource within the MDT offer would we be essentially losing this resource to re-provide it later on in the process? In South Gloucestershire and the loss of this service and its effect on the MDTs as mentioned is not to be under estimated and if decision is made to decommission this service may I ask that this is communicated to the locality membership in order for locality intelligence is taken into account before going forwards." DJ assured the meeting he would speak with JE further. DJ considered it was an issue of transition and about how do we take the learning and best out of the service into a new service. P Brindle (PB) asked how do we know the new service will be better than the existing?	

	Item	Action
	JRa advised that there was a plan being developed around evidence from the AGE UK scheme amongst others that exist across BNSSG, as well as evidence from social prescribing, GP appointments and quality evidence as well. The frailty element was built into the delivery; the consensus is that we are broadly using this evidence base to inform what that model should look like for frailty. JRa referred to a personalisation agenda within NHSE to which BNSSG were not yet fully aligned and of which social prescribing was one element of that therefore there was a legitimate call for a more strategic approach based on all the evidence and also the Long Term Plan requirements too. A discussion took place around what the scheme had achieved and use of the data captured. The importance of retaining the good elements of the scheme and taking that learning from this forward in order to deliver effective future transformation of services across BNSSG was agreed by all. IS spoke about the timing of the de-commissioning, currently AGE UK had been informed the pilot would continue to be funded until the 30th September 2019 when the budget expired. LM advised it was always made clear to AGE UK that this pilot would only be funded until the end of September 2019 as this was part of a bigger piece of work around the Social Impact Bond. Unless AGE UK could demonstrate success within the pilot BNSSG would not proceed with a bigger piece of work. LM confirmed that the budget only ran to end of September, after which BNSSG would pick up the full costs of this currently jointly funded service. LM recommended to Commissioning Executive that AGE UK be notified the contract was being terminated at the end of September and BNSSG would work through a transition over the next quarter. **Commissioning Executive supported the proposal to de-commission the AGE UK pilot at the end of September 2019.**	
10	**Options for Paediatric Primary Care Clinical Support** Inge Shepherd (IS) introduced the item and asked that Commission Executive recognise the need for an appropriate support service for GPs managing non urgent paediatric primary care outpatient referrals.	

	Item	Action
	IS advised that the current provider had given notice on the contact effective from November 2019 therefore the re-commissioning of this service was time critical. The recommendations to Commissioning Executive were that: • Commissioning Executive recognise the need for an appropriate support service for GPs managing non-urgent paediatric primary care outpatient referrals. • A piece of service evaluation and redesign work be undertaken to agree the most cost effective service model, taking into account both short and long term impact. This should include the options of linking with other CCG initiatives such as advice and guidance tariff or locality hubs • BNSSG CCG accepts the notice given by the current service provider and informs GP Practices and other stakeholders that the service will not be available after 30th November 2019. IS noted there had been some issues with the current model, notably the lack of succession planning by the provider to ensure the model could continue to function. LM advised that this proposal had been discussed at the STP Children's Operational Group and the group would be very willing to support part of a review of the service and how it fitted in with the work of the outpatients' transformation programme. AA noted that this service had been greatly valued by all the GPs that used it and asked that the focus be on providing an alternative model that would be easily accessible and give GPs prompt advice. JH expressed disappointment about the contract notice having been received. The quality of the service that GPs and patients in the South Glos area have received had been excellent, but it was accepted that a more robust and sustainable model would be required in future, if it were to deliver services across the wider BNSSG footprint. LM advised that this should not sit outside the rest of the work being done in outpatient transformation. KA commented that it was a good service despite sustainability being an issue and should be supported to ensure the service was carried out in a community based fashion with only the most complicated cases going to the hospital.	

	Item	Action
	LM proposed a review be undertaken of the service as part of the outpatient transformation. **Commissioning Executive noted the provider's intention to give notice and agreed that a review of the service would be undertaken as part of the outpatient transformation.**	
11	**Integrated Care Bureau and Rapid & React – Future funding** Julie Kell (JK) and Grace Elias (GE) were welcomed to the meeting to present the item**.** **Integrated Care Bureau:** JK informed the Committee that the format of the evaluation undertaken had been from a four-point approach to cover staff and stakeholder surveys, a review of the financials assumptions, a review of the data assumptions and some patient stories. The 5 key aims and objectives used as measures throughout the project were: • Optimal use of capacity • Shared decision making • Return to home • Improving flow • Reducing demand and for each of the different components, the data had been measured back to those. JK advised that the project had been a cultural change for the 9 organisations involved in delivering the ICB. JK asked that the Commissioning Executive: • Agree future funding from non-recurring funding ending in July 2019 to a fully funded service for 2019/20 and performance managed through individual providers Integrated Quality and Performance meetings using the existing performance measures. • That the action plan developed for ongoing system issues is managed through the ICB Task and Finish group reporting into A/E delivery Board for ICB. • That the ICB Phase 1 evaluation is used to inform Phase 2 of ICB and the digitalised solution for further implementation. S Truelove (ST) noted that the Integrated Care Bureau (ICB) had been a real success story; the disappointment had been in getting an agreement on funding going forward and ST considered this to be the important next step. ST asked where the paper had been other than Commissioning Executive in terms of the formal evaluation given the Acute Trusts had also been actively focussed on reducing length of stay	

	Item	Action
	therefore some of what was being attributed to ICS possibly was not. ST asked how do we get the sign off across the system about the outcomes JK advised once a decision was made on what the evaluation might look like, the 6 partners (3 Acute Trusts and 3 Community Providers) had been informed in writing of what the evaluation would look like and what would be contained within it, since then they have received all the evaluation and data within it and they have until 21st June to feed back to the CCG. The evaluation had also been circulated to the A&E Delivery Board (AEDB), Out of Hospital Delivery Group (OOHDG), various Task and Finish groups and next Friday for response, WSOGs to pick up the operational components. ST considered: • the recommendation that the service go from non-recurrent to recurrent funding required the agreement of all plus a clear understanding of the benefits ICB had delivered to the system such as reductions in length of bed stay and a greater benefit of reducing the acute providers' need to open up escalation capacity. • That the ICB service be tested to gauge whether there was a different more cost effective way of delivering the service. CT confirmed after the 21st June deadline for provider feedback it was intended to cover this at UCOB to address as a system. JK considered there were opportunities to update the service to make for a leaner and more efficient service. SB asked if the evaluation had gone to the three Local Authorities Strategic Group and JK confirmed this was the case. CT advised that it had not yet been possible to include the potential impact of long term care costs to LAs. **Rapid & React:** JK advised that the purpose of this paper was to update Commissioning Executive on the progress of the 6-month review of this add-on to an existing service, to update on current performance and to clarify next steps regarding the disinvestment plan. Whilst the service has made progress during the first 6 months it had not delivered the anticipated bed day savings. Neither had the service delivered the required commissioner savings to justify continued investment. Despite an increase in PoA activity, mainly due to the	

	Item	Action
	number of staff now in post (89.5% at the end of March 2019) the service failed to deliver the level of activity required to produce the expected savings. Patients were being admitted before receiving a REACT intervention and therefore being charged as an admission by the acute trust and an intervention within the service. Therefore, a decision was made at Healthier Together System Delivery Oversight Group (SDOG) to disinvest in the expansion and the recommendation made to issue notice to the service. LM advised that the existing main Rapid and React service would also be reviewed in order to understand if that was delivering the benefits we were expecting it to deliver. J Hayes (JH) asked what period the 6-month review period covered and JK confirmed it was from 1st October when the pilot commenced. K Alexander (KA) commented whether not doing something for a short time frame was the right thing to do given it would take quite a lot of culture change in a service to get it to work well. Sometimes things are put in place with the expectation they will work quickly and we underestimate the time it will take for the changes to embed. JK advised that in the case of Rapid & Review as it was an existing service some of those things would have happened anyway and would have been embedded. Although the acute providers really wanted the service they struggled to buy in when it came down to payment or changing behaviour on how they undertook the tariff. ST highlighted it was no acceptable as a commissioner to double pay because a patient had been admitted to wait for a Rapid and React assessment. ST noted a slight issue with the Rapid & React was that the data for the 6-month period did not show an increase in trend of patients avoiding admission; had that potential benefit been apparent there would have been a different conversation. JK advised that letters had been sent out to all contracting teams to explain exactly what the review would consist of and again formally with the timescales of the review. D Soodeen (DS) asked, having received about six requests asking what was happening with regards to Rapid and React as well as other issues, what would be the involvement of the BNSSG Communications team when it came to announcing the decommissioning of this service.	

	Item	Action
	G Elias (GE) advised the conversations with the BNSSG Communications team had already taken place about both the message externally and with regards to the staff recruited into the service. GE stressed the need to be mindful of the fact that the core service would continue so following the disinvestment the service would revert back to Monday to Friday 5 days per week as opposed to the existing 7 days per week service. It was agreed that the service had not delivered reduced admissions. JK asked that Commissioning Executive note the decision made at Healthier Together System Delivery Oversight Group (SDOG) and the actions plans around completing the final reviews, reviewing the existing service and components around making QIA and EIS are completed **Commissioning Executive noted the report.**	
12	**Urgent Care Activity & Performance Update** Claire Thompson (CT) presented the urgent care activity and performance update on the April and March 2019 data noting that nationally performance was down but that BNSSG was below that. **NBT Primary Care Streaming Update** A highlight report on the NBT Primary Care Streaming pilot was presented to the meeting. The project run in partnership with NBT and BrisDoc to embed primary care practitioners in ED to see and /or redirect patients to Primary Care and through this work develop an understanding of the opportunity for a future Primary Care Streaming model for the NBT system on behalf of BNSSG with full implementation by 31 October 2019. L Ward (LW) advised that a GP was now in post working with NBT; currently carrying out variable shifts to gain an understanding of when it would be most useful. **Commissioning Executive noted the reports.**	
14	**Contract Performance Update Report – Acute** Sarah Swift (SS) was welcomed to the meeting to present the contract performance update report on Acute. SS advised that the highlight report was based on Month 12 data and the key points to note were: Performance: • NBT below target in all areas – CPNs in place • 52wk wait position will be included on future reports • WAHT had a reduced number of CPNs in place	

	Item	Action
	Quality: • NBT formal enquiry into Rectopexy still ongoing • UHB undergone a CQC inspection – awaiting further information • WAHT under a Warning Notice re CAMHS and Community Paediatrics Finance: • Contracts – All parties instructed by the Regulator not to sign contacts due to the gap in the system control total • ICQPMB TOR to be reviewed and will return as a package to Commissioning Executive for approval SS advised that system and bilateral meetings and actions were in place with the aim of closing plan and contract gap. This included diagnostic on urgent care with appropriate action in place. **Commissioning Executive noted the report.**	
15	**Corporate Risk Register & GB Assurance Framework** **Corporate Risk Register:** Lisa Manson (LM) highlighted a new joint risk between the Commissioning and Finance Directorates around gaining approval of a single budget across BNSSG for 19/20 and how we develop a single plan. LM advised this was a core risk between the two Directorates. **GB Assurance Framework (GBAF):** No questions were raised.	
16	**Nursing & Quality Directorate – Clinical Update** For information only. – Deferred to July meeting.	
17	**Operational Issues** L Manson (LM) advised of two practices in Weston who had been handed back by the current provider with 2 weeks' notice to find a replacement provider. The new provider was Pier Health Group.	
18	**Any Other Business** Paper noted. **Committee Effectiveness:** JH asked for feedback in relation to committee effectiveness in the following areas:	
	Date of next meeting: Thursday, 11th July 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