Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

Minutes of the meeting held on 14th November 2019 at 8.30am, CCG Conference Room, South Plaza, Bristol.

Minutes

Present			
Kirsty	Alexander	Clinical Lead for Children's and Maternity, BNCCG CCG	KA
Sara	Blackmore	Director of Public Health, South Gloucestershire Council	SB
Alison	Bolam	Clinical Commissioning Area Lead for Bristol, BNSSG CCG	AB
Colin	Bradbury	Area Director for North Somerset, BNSSG CCG	CB
Peter	Brindle	Medical Director, Clinical Effectiveness, BNSSG CCG	PB
Terry	Dafter	Director for Adult Social Care, Bristol City Council	TD
Jon	Evans	Clinical Commissioning Area Lead for South Gloucestershire, BNSSG CCG	JE
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
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
Martin	Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJ
Jeremy	Maynard	Clinical Lead	JM
Justine	Rawlings	Area Director for Bristol, BNSSG CCG	JRa
Julia	Ross	Chief Executive, BNSSG CCG	JR
Rosi	Shepherd	Associate Director of Nursing, BNSSG CCG	RS
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Sarah	Truelove	Director of Finance, BNSSG CCG	ST

Present			
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
Anne	Clarke	Director for Adult Social Services, South Gloucestershire Council	AC
Deborah	El Sayed	Director of Transformation, BNSSG CCG	DES
Kate	Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
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
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
Julie	Thallon	Director of Nursing & Quality, BNSSG CCG	JT
In attendance			
Rachel	Anthwal	Head of Contracts, Non Acute, BNSSG CCG	RA
Gemma	Artz	Head of Performance Improvement, Planned Care, BNSSG CCG	GA
Mary	Backhouse	Nailsea Family Practice	MB
Adam	Brown	NBT, Lead - Emergency Department	ABr
Debbie	Campbell	Deputy Director (Medicines Optimisation), BNSSG CCG	DC
Sarah	Carr	Corporate Secretary, BNSSG CCG	SC
Jane	Guvenir	Head of Children's Complex Care, BNSSG CCG	JG
Mark	Hemmings	Transformation Manager, Children & Maternity, BNSSG CCG	MH
Jacqueline	Holden	Executive PA to Director of Commissioning (Note taker), BNSSG CCG	JHo
Margaret	Kemp	Service Improvement Facilitator, Planned Care, BNSSG CCG	MK
Andy	Newton	Head of Planned Care, BNSSG CCG	AN
Sally	Robinson	Performance Improvement Manager, Planned Care, BNSSG CCG	SR
Kate	Tamlin	Commissioning Policy Development Manager, BNSSG CCG	KT
Adwoa	Webber	Head of Clinical Effectiveness, BNSSG CCG	
Jeremy	Westwood	Programme Manager, Urgent Care, BNSSG CCG	JW
Helen	Wilkinson	Principal Medicines Optimisation Pharmacist, BNSSG CCG	HW

<table>
<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td>01</td><td>Welcome and Apologies
Jon Hayes (JH) Chair welcomed members and attendees to the meeting. Apologies noted as above.</td><td></td></tr>
<tr><td>02</td><td>Declarations of Interest
The following declaration of interests were made:
Kirsty Alexander – general – re RCGP now Co-Chair of Severn Faculty.
Jeremy Maynard – Agenda Item 7 – declared interest – Partnership involved in GP Care Urology Service</td><td></td></tr>
<tr><td>03

04</td><td>Minutes of the meeting and matters arising from 10th October 2019
The minutes of the previous meeting were agreed as a correct record after taking into account the following amendments:

Page 5 – Item 4 - final paragraph - insert “regarding continuity of care levels in Weston”

Action log from 10th October 2019:
<table>
<tr><td>Item 81</td><td>Open</td></tr>
<tr><td>Item 109</td><td>Closed</td></tr>
<tr><td>Item 110</td><td>Closed – see note below</td></tr>
<tr><td>Item 111</td><td>Actioned – Closed</td></tr>
<tr><td>Item 112</td><td>Agenda item - Closed</td></tr>
<tr><td>Item 113</td><td>Agenda item – Closed</td></tr>
<tr><td>Item 114</td><td>Closed</td></tr>
<tr><td>Item 115</td><td>Open</td></tr>
<tr><td>Item 116</td><td>Closed</td></tr>
<tr><td>Item 117</td><td>Closed</td></tr>
</table>

Item 110 - MJ confirmed the outcome; at a meeting on 12 November, it was decided to ensure the same model was in place across BNSSG and that it would be implemented at locality level. There had been wide ranging discussion about validity, need and capacity to meet to discuss the key issues. It had been agreed that Shaba Nabi (SN) from a LMC perspective, UHB & NBT from an acute provider perspective and Jeremy Maynard (JM) from a Datix perspective would meet regularly before coming together as part of a bigger group in January. This was to be discussed with locality leads via the LLG monthly meeting to discuss how to take forward and ensure this was a provider discussion.</td><td></td></tr>
<tr><td>05</td><td>Building Healthier Communities Together
Mary Backhouse (MB) was welcomed to the meeting and Justine Rawlings (JRa) presented the previously circulated paper for review and comment explaining it was aimed at supporting communities by developing a new focus on friends, families and carers working with the</td><td></td></tr>
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	voluntary, community and social enterprise sector. It was also aimed at developing an approach that would build a healthy communities approach into Localities. The resulting proposal had been developed over several months in collaboration with colleagues across all three Local Authorities, the Voluntary, Community and Social Enterprise (VCSE) organisations such as The Care Forum and Voluntary Action Networks (VANs) as well as a number of place based community interest organisations. The resulting feedback had been taken into account when developing the proposal and specification and this had also been reviewed at the Integrated Care Steering Group and formed part of the recent BNSSG Long Term Plan (LTP) submission. JRa highlighted the aim was for BNSSG to work with the VCSE organisations who were able to be: • An equal partner in provider alliance as part of provider board • Aligned to localities • A coordinating organisation for our work with VCSE in localities • An anchor for VCSE who want to and are able to work with us • Support for local communities with their health and wellbeing JRa stressed it was about providing/ensuring a network link into the Locality for the smaller voluntary organisations noting as well as linking into social prescribing and link worker approach it was also intended to build capacity and reach into communities to allow this work to take place. The proposal highlighted the potential to develop the approach of a community anchor VCSE organisation within the wider locality provider alliance so that the alliance is able *jointly* to leverage capacity, assets and resources to co-design solutions and deliver shared outcomes for the local population. JRa advised of some potential sources of future funding which linked with some of the national approaches such as lottery funding. Mary Backhouse (MB) spoke about the benefits and three personal experiences which, whilst relatively minor scenarios, all reflected the understanding, energy and passion that existed in the community. MB stressed the need to harness all the various assets in communities and doing this via communities of interest, ensuring that a system developed which allowed all voices to contribute.	

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	JRa advised the need for Commissioning Executive to be aware of the work being done by the Area teams as a lot of BNSSG long term plans, in particular, the Mental Health Strategy were reliant on this being in place. Terry Dafter (TD) advised that BCC had been working closely with JRa and were moving in the same direction, devolving to local communities as appropriate and matching the locality model being created by BNSSG. TD considered the work linked well with social prescribing and working with small to medium enterprises and anticipated it would fill some of the capacity gaps in the system. Kirsty Alexander (KA) noted the paper contained some negative comments about GPs not being engaged and made reference to the involvement of MB in writing the booklet and MB and other GP's involvement over the years. JRa advised this was feedback received from an event and was dependent on the individual experience of those voluntary organisations. JRa felt this was likely to reflect the medical model vs social model that people sometimes don't feel heard in the different ways of working. KA considered that through the social prescribing that most GPs would welcome the opportunity to refer to someone who can then find the best fit solution for that person Julia Ross (JR) considered that the feedback reflected that some of the Voluntary Sector did not feel connected with practices and this must be recognised, as there was a need to be open to the fact that it could be quite hard for some of the voluntary sector to engage with and break into health. Jon Hayes (JH) reflected on his experience at a recent Voluntary Aided AGM in South Glos where one other GP had been in attendance. JH considered this event had raised his awareness of the wide range of VA activity and resources. JH advised that the VA organisation had struggled to engage with practices despite offering to visit and speak. Jon Evans (JE) stressed the need for GPs to use the resources offered by the Voluntary Sector and gave an example of successfully using this resource, empowering and enabling patients, and had not resulted in a cost to the system. Sara Blackmore (SB) considered it important that the enabling of those VA organisations that already existed took place in order to ensure a joined up approach and that everyone was on the same page in terms of what this was whilst enabling conversations.	

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	Mike Jenkins (MJ) highlighted the potentially oppressive nature that governance could have on the smaller VA organisations and raised the question of the point at which being regulated might come into play. JR considered part of the proposed approach was to help organisations be compliant concerning governance whilst enabling them to carry on providing what they are good at doing. JR advised that feedback from a number of small organisations in the voluntary sector had noted the need to be careful not to overlay too much governance on them. Colin Bradbury (CB) asked if best use was being made of the self-help and mutual aid groups which were a huge resource in addition to the formally constituted third sector. JH asked how this work would be promoted to general practices. JRa noted not all practices were convinced of the benefits to be gained by working with the voluntary sector, having herself recently visited a practice to promote the benefits of having a link worker. JRa agreed that what the voluntary sector offered and what was qualitatively different in how they worked with people and communities needed better communicating to general practices. JE stressed the importance of involving the voluntary sector in the MDTs. David Soodeen (DS) considered the potential increase in workload was seen as a negative in primary care and something that needed to be worked through in order to achieve a mutual benefit between general practice and the Voluntary Sector. KA stressed the benefits gained through general practice employing a link worker who focussed on social prescribing elements. KA asked about the current position regarding Well Aware in Bristol and the possibility of having a similar service offer across BNSSG. JRa advised South Glos had a similar service and that through the current work being done this would ensure a consistent cohesive approach and equity of access to social prescribing across BNSSG was achieved. JE stressed that there was still much to gain through the learning points derived from the Age UK work in South Gloucestershire.	

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	David Jarrett (DJ) queried if there was clarity regarding the differences between the anchor infrastructure vs the anchor provider organisations in the paper. JRa confirmed this was detailed in Page 14 of the document and considered it important to note that not all infrastructure organisations had developed this sector quite in the same way as the BNSSG approach intended, which was to work in health and care in a more applied, systematic and structured way. MB stressed the importance of achieving this prescribing social model and the likely impact on general practice should this not be achieved. JR considered: • this was a great project, both innovative and creative, and would make a great impact • the idea of having an organisation as a formal equal member of the Locality Partnership Board and, in time, the Integrated Care Partnership was a very strong action to take, with the response to this from voluntary organisations being extremely positive to the extent that they were now leading the project and saw the value in it. • the clear message to organisations not to rely on statutory funding and to identify alternative funding had been taken on board by the sector, resulting in those organisations with strong expertise in this area sharing this knowledge and expertise to the benefit of all the voluntary sector organisations. • the paper to be excellent, exciting and thanked JRa and MB for their work on this, commended it stressing this was exactly what BNSSG wanted to achieve in the future, mobilising the community itself to provide a much more systematic and structured input which allowed the statutory service to do those things the statutory service should be doing. • Commissioning Executive Committee should sponsor this work and it should return to the Committee for further review/updates on progress with all members supporting and to driving this work forward within their individual organisations. JRa agreed that there was great benefit gained by the CCG working alongside the Local Authorities and learning from each other and generating the maximum benefit. Jon Hayes asked when the update would be delivered to Commissioning Executive. JRa confirmed it would return to Commissioning Executive Committee in January with an update. It was noted that the project would go live in April and that it would also continue go through the Local Authority Strategic Group.	

	Item	Action
	Commissioning Executive Committee noted the report and that there would be a further update at the January 2020 meeting.	
06	**Commissioning of Faecal Immunological Test (FIT) for symptomatic patients from April 2020.** Andy Newton (AN) and Margaret Kemp (MK) were welcomed to the meeting to present the paper. Peter Brindle updated the Committee on the background to the FIT pilot that had been running since 2018. PB considered the paper gave a robust evaluation of the pilot and the likely impact in terms of outpatients, colonoscopy and patient outcomes in relation to what was a considered a small contingency investment in the service. MK discussed the evaluation results and savings noting that the pilot had been running for 18mths, was well received by both patients and GPs and was funded via the Cancer Transformation Fund until March 2020. The evaluation undertaken by Exeter University covered two alliances in the South West and was ongoing focussing on following up those negative FIT patients not referred in to verify if any cancer diagnosis were missed. The savings profiled in the paper were based on the audit results of the 450 patients followed up over a 7mth period. MK noted the cost of the FIT test highlighting that based on a 12mth period there was a potential first outpatient appointment saving of £75k and, in addition, assuming 90% of patients had gone on to undergo colonoscopies, there would be a further saving of £330k. MK advised that if the FIT test costs increased from £6.50 to £13.00 there would still be savings made in terms of the first outpatient appointment. Jon Hayes (JH) asked for any questions: Alison Wint (AW) advised she had been on the steering group of SWAG for this project and considered: • it had proved that lower risk patients had been referred in • that the relatively low cost FIT test could prevent low risk patients being referred • the pilot to be a good thing to continue Jon Evans (JE) asked about the risk element around the accuracy of the assessment about risk and what tools and training was in place to assure this. AW advised that the final evaluation would focus on those patients with a negative result looking at 12-18mths further on to assess how many of those patients develop colorectal cancer. With regards to the	

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	assessment tool, NG12 AW advised there was an online facility on the website to feedback any issues. Alison Bolam (AB) noted an error on the flow chart on page 5 Sect 6.1 and it was noted by AN and MK that this would amended following the meeting. Kirsty Alexander (KA) advised that the FIT test had a different threshold than the national screening programme and that made it much more sensitive and less likely to be a problem. KA noted that the bulk were negative despite the sensitivity but even so 22% of the 77% negative were still referred so the ability to refer remained. Sara Blackmore (SB) asked how age played into the programme as it was aimed at 50 plus. AW advised that the project had taken the decision to follow the NG12 guidance that was over the age of 50. AW advised since this decision, the DG30 was issued and this did not have an age cut off and AW understood that some areas did carry out FIT tests on all ages however; a pragmatic decision was made to stay with the NG12. AW considered that for patients younger than 50 there were other investigations that could be carried out and those patients. Jon Hayes (JH) asked how non-invasive diagnostic testing could be promoted to the wider community, as there was still a significant number of patients that presented late because they didn't want to undergo invasive testing. A discussion took place around the various strategies to promote the test such as radio, public health and the need for this to become a national campaign. It was recognised for many people it was a mixture of the fear of the investigation and/or the embarrassment factor that delayed them undergoing the invasive procedures. SB advised that there was the opportunity to consider some of the results from the pilot and broadening it for a wider audience. DS spoke about certain communities of minority populations where rectal or vaginal examinations were often refused sometimes with fatal consequences. DS stressed the need to involve community leaders in the promotion of the test to ensure success in uptake	

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	Claire Thompson (CT) asked about the savings profile and, when taking into account the background of increasing demand, whether there was evidence that this had actually had an impact? Andy Newton (AN) advised this project was similar to another piece of work carried out around changing thresholds around patients with bowel disease or symptoms and therefore some assumptions had been made on the new pathway based on the information held. AN advised that from that they had made assumptions around the further costs that would have occurred around colonoscopy had we not brought this new pathway in. MK advised that one of the risks that we had when the project started was that concerns from those undertaking colonoscopies that this would really increase their workload and that feedback had not occurred. Sarah Truelove (ST) queried why the FIT cost was anticipated to double and what was driving that cost increase? MK advised the cost was based on the whole area and the number of tests carried out and the efficiencies made because of this. The assumption was that all involved in the SWAG Alliance would continue to commission the test from the same source however if commissioners decided to make alternative arrangements then this would impact on the cost. Commissioning Executive was asked to approve the commissioning of FIT in patients with "low risk but not no risk" of colorectal cancer in accordance with NICE Guidance (NG12) within BNSSG through Severn Pathology as part of the NBT contract. **Commissioning Executive Committee approved the recommendation for the commissioning of FIT as above.**	
07	**Urology proposal from the Outpatients Transformation Programme** Andy Newton (AN) presented the report and David Jarrett (DJ) gave some background to the report. DJ explained this was the third time at Commissioning Executive, with the original mandate and discussion on this took place in December with an update on progress given to the June 2019 Commissioning Executive. DJ advised that the team had worked across the urology pathway to further develop the proposal and asked Andy Newton present the new model of care and explain on how this could be taken forward into the commissioning cycle. AN presented the item, explaining the proposal had been built on the work carried out in South Gloucestershire and the North Somerset in	

	Item	Action
	past years. AN advised the proposal sat as part of the STP outpatient transformation programme and was intended to deliver a service that had the potential to move care from acute trusts and embed into locality working by delivering more integrated care between primary and secondary care. This would involve reducing the number of face to face outpatient appointments in secondary care and commissioning services that made sense for patients, in particular more joined up care, one stop community based services, and less unnecessary journeys for patients and finally the contract would increasingly focus on outcomes and measuring those outcomes as opposed to measuring the inter-activity. The model aimed to improve the knowledge and skills of clinicians working in primary and community care and if successful will capture valuable learning and data for the development of new models of care in other specialities, developing services which are contracted to deliver value rather than activity. Following discussions with the Exec Team around the recommended procurement option it was proposed to explore further an alliance contacting model which will allow us to build in a potentially a more collaborative approach between current providers of this service. The Commissioning Executive is asked to support this proposal to go to Strategic Finance Committee and Governing Body initially focused on developing an alliance based approach, with a 5 year contract with the option to extend for a further 3 years. Jon Evans (JE) spoke about the PSA remote monitoring tracker used by BANES CCG and asked if there was an opportunity here for improved interface between primary and secondary care. AW advised this was a separate piece of work, investing in a digital platform for a remote access. AN advised the paper mentioned the development of electronic and remote monitoring systems and there was a separate piece of work being carried out with the Cancer Alliance. JE suggested that consideration be given to linking in with this piece of work. David Soodeen (DS) raised queries on the future model workings around: • Locality GPs AN advised the way in which the Specialist Community Urology Service worked with localities, noting this would form part of the exploration of this piece of work going forward and develop through the learning achieved by putting it out initially at a high level and then working with providers to define how it is best delivered. AN advised although it may look different in each	

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	locality there would be an allocation of a named Urologist to each group of practices included in the specification. • Provision of catheters AD advised the pathway linked to the bladder and bowel service. • Urodynamics AD advised there was work to be done around Urodynamics due partly to inconsistency in its use across the BNSSG areas. DS considered that Urodynamics was not good use of resource for the most part. Julia Ross (JR) questioned how this was known and a conversation took place around the use of Urodynamics. Peter Brindle advised that GPs were unable to refer for this investigation and it required a specialist to refer however, there was some concern that there might be some unnecessary referrals. JR asked that a proper evaluation be undertaken in order to identify whether the Urodynamic test was being used appropriately for the right patients and asked that this be built into this piece of work. Martin Jones (MJ) commented on: • Urodynamics – MJ advised there were existing guidelines on the use of Urodynamics which would be beneficial to the pathway • App - MJ highlighted this was a sensitive area in some communities around its use with blood tests and stressed the need to give this more consideration. • Proper advice – MJ supported this element, considered that it would make a big difference to primary care support and noted by tying it in with secondary care becoming one part of one service would simplify matters. Jeremy Maynard (JM) asked if community nurses who were managing catheters be able to access the service direct or via GPs. AN advised the community nurses would be able to access the service directly. Kirsty Alexander (KA) questioned whether the assumption in the service specification on the involvement of locality GPs was slightly optimistic considering GP capacity noting that ideally this would be the case. AN agreed that it would depend on the locality and whether there was interest so potentially the model would look slightly different in the localities dependent on the level of GP interest.	

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<tr><th></th><th>Item</th><th>Action</th></tr>
<tr><td></td><td>Alison Bolam (AB) supported the paper and asked for more clarification around the differences between the first two bullet points relating to 2ww referrals listed under the key elements section on page 7 of the paper.
AN advised that more clarity would be given in the document.

JR considered this was a fabulous model that was moving towards the transformation desired in the way care was delivered. In light of this JR asked, whilst appreciating that there might not be a better way, that the proposed contract model type of cost and volume be reviewed establish if there was a better more innovative way of contracting.

ST advised that the Executive Team had agreed that Option 3 would require some further review and work around modelling.

ACTION; AN to amend report in light of comments.

Commissioning Executive supported the report subject to amendments in light of comments.</td><td>AN</td></tr>
<tr><td>08</td><td>BNSSG CCG Commissioning Policies
Kate Tamlin (KT) was welcomed to the meeting and Peter Brindle introduced the paper that was intended to enable Commissioning Executive to consider a number of Commissioning Policies for approval and therefore adoption by the CCG.

As part of the agreed commissioning policy development process, Commissioning Policy Review Group (CPRG) has considered the latest set of reviewed policies. CPRG had made recommendations on each of the 7 reviewed policies:

<table>
<tr><th>Policy</th><th>Reason for review</th><th>Recommendation to Commissioning Executive</th><th>Outcome</th></tr>
<tr><td>Open MRI Scanner at Cobalt Health Cheltenham</td><td>Three year review</td><td>No change to policy.
Recommend to Commissioning Executive.</td><td>Approved</td></tr>
<tr><td>Cosmetic Contact Lenses</td><td>Three year review</td><td>No change to policy.
Recommend to Commissioning Executive.</td><td>Approved</td></tr>
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	Item	Action

Ectropion and Entropion surgery	Three year review	No change to policy. Recommend to Commissioning Executive.	Approved
Laser Eye Surgery for Refractive Error	Three year review	No change to policy. Recommend to Commissioning Executive.	Approved
Multi-focal (non-accommodative) Intraocular Lenses in treatments of patients with Cataracts	Three year review	Wording has been updated to show the policy covers all patients. Recommend to Commissioning Executive	Approved
Vitreous Floaters	Three year review	Clarification of criteria wording but no change to clinical criteria. Recommend to Commissioning Executive.	Approved
Raised Intraocular Pressure	Three year review	Policy criteria amended as per NICE guidance. Recommend to Commissioning Executive.	Approved
Cataract Surgery	Admin Change	Statement added to clarify all referrals need to go through the Referral Service	Approved

Commissioning Executive approved the 7 commissioning policies as above for adoption by the CCG.

09

Community Pharmacy Supporting Urgent and Emergency Care: Patient Group Directions

Debbie Campbell (DC) and Helen Wilkinson (HW) were welcomed to the meeting. Peter Brindle (PB) gave an overview of the proposal to commission Community Pharmacy Patient Group Directions (PGDs) to enable supplies of prescription only medicines (POMs) by community pharmacists, meaning that referrals to GP practices or out of hours providers are avoided.

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	The purpose was to ensure patients, when appropriate, could be supplied with a POM without the need to consult a prescriber in their GP practice, integrated urgent care (IUC) or A& E. A PGD service would support the urgent care system for patients attending pharmacy directly, or being referred via NHS 111 or their GP. It was proposed that initially the following medicines be made available through the PGD service: • Chloramphenicol for bacterial eye infections in patients aged 1 month to 2 years old (available to buy OTC for patients older than 2 years) • Nitrofurantoin (or Trimethoprim) for the treatment of uncomplicated urinary tract infections in females aged between 16 and 65 years in line with BNSSG antimicrobial guidelines • Hydrocortisone 1% cream for use on the face (available to buy OTC for other parts of the body) • Treatment for Impetigo in line with BNSSG antimicrobial guidelines • Penicillin V for treatment of sore throat, in line with BNSSG antimicrobial guidelines (including use of FEVERPAIN scoring) Julia Ross (JR) asked if there was the ability to widen the range of medicines in particular considering entering the winter period. PB advised the above were the initial medicines identified as appropriate to be made available through the PGD service, however it was envisaged should no particular issues develop then the range could potentially be extended. JR considered there was a need to think laterally about how to ensure good use was made of pharmacies in this area. Michael Jenkins (MJ) spoke about the risk of over medicalising things and commented the most important thing clinicians could do sometimes was nothing; and it was a matter of how clinicians could empower pharmacists to do the same when dealing with a condition that would improve without medication. David Soodeen (DS) considered referral to physiotherapy might also be another prescription area to consider. Alison Bolam (AB) asked if there was an age limit with regards to Impetigo. Debbie Campbell (DC) advised that under 1 years were excluded and that all would be in line with national guidelines. Geeta Iyer (GI) asked if other areas were doing something similar. DC advised that Somerset were doing something similar.	

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	DC advised that they had spoken with the local pharmaceutical board in order to gain an understanding of their educational/learning needs. This had proved to be beneficial and had resulted in a broader scope on what they consider their needs to be and they had understood the need to be consistent in the way any other clinician in the system would take this consultation forward. Claire Thompson (CT) asked what level of confidence we had about the provision of consistent advice, eg 111 for unregistered dental patients, from pharmacies. DC advised that support from CT would be welcomed to ensure this was appropriately accounted for and noted that her team was working with the DOS team and practices to update protocols and support appropriate referrals. DC advised that there had been a clear message there was no expectation the level of antibiotic prescribing should increase, as pharmacists would need to comply in the same way as clinicians. JH considered that community pharmacists were much more likely to follow a protocol of assessment than GPs and subsequently people were less likely to obtain a prescription than a GP. JH advised that the purpose was to relieve the winter pressure on the system and identify solutions to relieve the system pressure and enable GPs to see those higher risk patients. Additional suggested conditions for future inclusion were: • Dental abscesses • Nappy rash • Contraceptive pill • Cellulitis • Fungal skin infection • Gastroenteritis • Mastitis • Pregnancy and vaginal thrush • Asthma • Back pain JR agreed that this move would require robust governance and monitoring to assure the service. JRa asked if it was planned to link the community pharmacists up with those clinical pharmacists employed within PCNs.	

	Item	Action
	DC advised that the Pharmacy contract provided for a PCN lead community pharmacist who would link into that network as well as the secondary care and community pharmacy teams as well. JRa considered that this would strengthen the governance through to the practices and across the whole system. Commissioning Executive was asked to agree the proposal and discuss the training requirements and scope of the Patient Group Directions and provide feedback on how the service would be best rolled out (should certain areas be targeted?) Helen Wilkinson (HW) advised that there would be initial evening training sessions provided, focussing on areas already identified by the pharmacists, and attended by a pharmacist representative from each participating pharmacy in order to accredit the pharmacy to provide the service. This training would be further supported by web-based training for those pharmacists unable to attend the evening sessions and also the locum population of pharmacists to enable them to be competent to deliver the service. The training would cover: • The role of community pharmacy in supporting the urgent care system and self-care of minor ailments • Antimicrobial resistance and appropriate use of antibiotics (delivered by a local microbiology consultant or antibiotic specialist pharmacist) • Patient Group Directions (PGDs) and their use in practice • Red flags, safety netting and sepsis awareness • Referral mechanisms to prescribing services • Pharmacy and Pharmacist accreditation requirements • Governance and Safeguarding • Service reporting requirements • Patient feedback and participation in service evaluation All those operating under the PGD would need to show competency and show they have received training. Therefore, in addition to pharmacy accreditation, pharmacists will be required to complete a Declaration of Competence in order to be able to deliver the PGD service and reaccredit every 2 years. The Declaration of Competence (DoC) system had been developed to help registered pharmacy professionals (pharmacists and pharmacy technicians) to deliver sustainable quality pharmacy services to patients.	

	Item	Action
	JH asked what methods would be used to advertise the service to the wider community. HW confirmed that the BNSSG Communications Team were already working with them to supporting this and it would be included in the Newsletters. JR asked how this service would be monitored to assure it is being done properly and appropriately. DC advised that a web-based computer system PharmOutcomes currently used within community pharmacies would be the mechanism for retrieving real time audit information. It was noted that additional evaluation might need to take place concerning reviewing patient outcomes and system benefit. JR emphasised that in addition to assuring the impact of the service it was important to assure the clinical governance of the service and in the setting up of this service what would be the process. **ACTION:** PB to provide assurance of clinical governance of the service to Commissioning Executive Committee. **Commissioning Executive approved the proposal.**	PB
10	**NBT ED Streaming Pilot Q3 update** Claire Thompson (CT) introduced the item to give a Q3 update on the Primary Care streaming project progress. Jon Hayes (JH) welcomed Adam Brown (ABr) to the meeting. ABr went on to brief the meeting on the current status and impact of the ED Streaming Pilot as the NBT Clinical Lead for the ED Streaming Pilot around: • ED performance had improved when a GP was present • Increased productivity trend continued to improve - eg 25 patients seen over a 10 hr shift • Appropriate demand • Benefit to patients • Risks – resilience, recruitment, resources CT referred to her point raised on the initial paper around the issue of productivity level, noting the need to recognise that this was not the same as that expected in primary care, and the impact of a GP presence on our ability to perform and redirect. Lesley Ward (LW) added the pilot was still being bedded in and the existing GP was currently also giving support to the other GPs that were working at NBT. ABr considered that people were being asked to do the same job in an entirely new environment and that was the challenge as the concern	

	Item	Action
	was it was a different job, different patients but they are the same just in a different place. Julia Ross (JR) thanked ABr for the presentation and asked the following questions regarding the productivity issue: • How many patients could this apply to and does 25 per day enough and how do we get to the next stage which was that patients did not arrive in ED at all. ABr considered there was no evidence or single strategy that proved it was possible to stop people attending ED. ABr considered that people would always attend ED if that's what they want to do. ABr considered it was due to it fitting their lifestyle or their perception of their problem, when they think they are going to get things sorted out there and then. There needed to be national messaging about this but locally NBT were seeing a 8% increase per annum on major presentation and 2.4% on minor presentations. ABr advised the aspiration was 84-90 clinical hours per week, but this might become 10 hr shift 7 days per week. On a quiet day attendance is around 240 attendances, on average is 285 and high is 350. 2.5 patients per hour is used as a minimum figure. • Returning to JR's key question of how many of those people attending could be seen by a GP service, what was the optimal number and how far might we push that? ABr considered the optimal number to be around 20% would be primary care JR noted that the 20% meant that the service would need to double the current in order to get close to the optimal number that might decongest the ED. LW advised that many of the really simple GP attendances were seen by ANP. ABr advised that a significant number of attendances re-directed from the ED streaming service because they should not be there. JR clarified that in terms of what was an optimal GP in ED service: • what would the productivity be • what would the service be required to provide • optimally to decongest the ED, what would it provide when working at full stretch, both in terms of the people being seen and how long would it take; therefore optimally how many people would be required to run this service?	

	Item	Action
	ABr advised the data was not with them currently but could be provided. Kirsty Alexander (KA) welcomed the pilot; spoke about the difference in volume of daily primary and secondary care cases, whilst considering a more aspirational/robust message to attendees be developed to reinforce attendance at ED should only occur after other options had been accessed. KA spoke about cost effectiveness of a GP in practice compared to a GP in an acute setting and questioned where this cost should it as whilst benefiting the whole system, it did in fact particularly benefited the acute part of the system. ABr advised that the general message needed to be that ED could diagnose and rule out serious illness quickly in ED but the question is that acceptable to a patient when done at less speed and potentially in a different system. David Jarrett referred to a previous presentation had included a patient journey flowchart of the ED streaming pilot noting that through the work being done within localities there was a willingness to work with the service on a redirection and direct booking service back into localities. DJ anticipated this would enhance the productivity of the service. ABr supported this and expressed interest in understanding exactly what that interface localities would be with NBT and recognised that this was about system change and a move to interface medicine. David Soodeen (DS) referred to the Appropriate Demand chart shown on page 2 of the presentation and queried the numbers showing for no GP appointments, 111 advised and no MH shown. Jeremy Maynard (JM) challenged the assumption that the set of patients seen in the ED streaming pilot were an identical cohort to that seen in general practice. Sarah Truelove (ST) considered it was value question around whether the level of productivity using GPs was the right thing to be doing with what was a constrained workforce and was this getting best value from them since GPs in primary care or an IUC CAS environment might impact more patients. Kevin Haggetty (KH) expressed concern about: • the workforce issue given the shortage of GPs • the productivity issue • putting more primary care resource into secondary care at a time when strategically trying to move people out of hospital settings KH considered that patients would only chose to go to ED if it was easier, quicker and better than primary care therefore if more resources	

	Item	Action
	were primary care focussed this would make primary care the place to go not ED. If more resources were put into secondary care there was a risk of making this more difficult. ABr agreed that strengthening primary care was an important way to manage excess ED demand. Colin Bradbury (CB) asked if consultant support for the pilot varied and how was this managed? ABr considered it was an awareness issue so the scoping exercise took the first 4-6 months but once it becomes a full service there would be a consultant in ambulatory care who would be responsible for supporting the GP and reviewing the patients that are streamed. Peter Brindle (PB) asked a value question in that should the system have £60-70k available a quarter to attempt to resolve the problem was ABr completely convinced that this was the best place be to put that investment rather than doing more activity in the community. ABr considered that in terms of current alternatives there would still be a workload. ABr considered that this was the best use of a GP in ED and also order to preserve senior ED decision makers to not to have to turn large volumes of people away. Jon Hayes thanked ABr for his time and presentation. ABr left the meeting. ***The meeting broke for a break at 10:35am reconvening at 10:40am*** It was noted that the Commissioning Executive Committee was asked to : • Note progress to date with the Primary Care streaming project • Agree a financial option to continue the project through Q4 (Winter 19/20) • Update regarding the potential longer term future of the service CT referred to the various options detailed in the joint report. ST considered a significant contribution had been made by the CCG in the funding of the pilot, and noted that this project was in effect replacing a workforce that the acute trust would otherwise have had in place. Commissioning Executive considered that the streaming service was a great service and supported NBT in their continuing it and funding it whilst the focus of the CCG would be to ensure that community services were available and able to respond to the NBT provided service.	

	Item	Action
	ACTION: CT to provide an update on the impact of CE decision not to allocate any further funding. **Commissioning Executive Decision** Commissioning Executive agreed that no further funding would be allocated to support the project and that future funding was the responsibility of NBT to resource. *TD, DJ and JRa left the meeting.*	CT
11	**Effective Suctioning Pilot** Rachel Anthwal (RA) and Jane Guvenir (JG) were welcomed to the meeting to present the paper intended to address the commissioning gap in the provision of paediatric respiratory training for effective suctioning in the community. This involved piloting a 6mth fixed term acute paediatric physiotherapy post to support suction training in the community which would demonstrate significant cost savings, preventing unnecessary prolonged admission and readmissions whilst improving the quality of life for children living with complex health needs. This training would be provided by Bristol Royal Children's Hospital (BRCH). RA advised that this was both a national and regional issue effecting the more complex children requiring deep effective suctioning. Currently there was no specialised commissioning provision for this and the NHSE stance was that it did not extend to training outside of inpatient care. RA advised there were currently 4 complex needs children having suctioning provided by parents and carers and those able to attend school required the use of agency staff at a cost of £58k per annum per child. Kirsty Alexander (KA) advised she was aware that this issue had existed for some years and that whilst BRCH had been training parents to carry out suctioning whilst in hospital so they could perform the suctioning once out of hospital, with regards to schools they were not allowed to provide the training to those who might carry out this function. RA advised nurses could not be delegated to train however physiotherapists, which this pilot was aimed at, could be delegated to train whoever would be performing this service outside of the hospital. Jane Guvenir (JG) advised that nurses had previously done the training up until 2012. Julia Ross (JR) asked for clarification around: • the savings indicated through the spend to save initiative	

	Item	Action
	- the need for a 0.5fte post for 6 mths to support 4 children - what was already in the children's contract and if this was a whole new service or was it a specialised service Sirona would be expected to cover RA advised that: - currently the cost of the 6mth pilot was £15k compared to the cost for one child of £58k due to the agency costs incurred to allow suctioning to take place during school time. - this was a joint proposal with BRCH and BRCH considered they need to go into school, assess and competency training with carers which would take some time and allow for additional training due to a change in carer. Agreement with BRCH that if CCG funded pilot they would look to train others wider than the four mentioned here. - the Sirona contract did not allow for specialist respiratory at this level JR asked RA to consider whether in the future the Sirona contract should include this service; would we require BRCH to do this or would it be possible for a therapist in the community with this expertise to provide this. Sarah Truelove (ST) queried the amount of savings discussed and asked for clarification around the indicated spend to save figures, as it appeared to show as a net cost. RA referred ST to the Section 8 Appendices on Page 7 and confirmed that the £12K plus travel costs for the 6-month pilot would be recovered in full via savings for the one child referenced and then there would additional savings with the other three children. Alison Wint (AW) asked where the decision had been made as to the level of nursing care. JG advised the decision was made via the Children's Continuing Healthcare Panel. AW heeded caution about people being trained to do things they would not do very often, as they would lose those skills so only those people who really needed to do it should be trained. AW queried the modelling of 29hrs in the first year and queried how this equated to a 0.5ftwe. RA referred to page 4 of the paper that indicated a potentially larger cohort that existed as of Aug 2019. AW considered that the basis of setting the costs against 1 child whilst trying to provide a service wider than that was not the right comparison and a difficult calculation to make.	

	Item	Action
	Claire Thompson (CT) considered there was a much bigger opportunity by potentially working with the community provider to provide something more sustainable, more embedded and flexible, therefore whether this was the only option or whether or not there was an alternative. AW noted that evidence around ED did not appear to be in the paper. RA advised the Chartered Society of Physio commissioning tool had been used which had indicated there was a wider business case and there was an opportunity to roll out the service on a regional basis as BRCH was a specialist centre for the region. RA considered whilst there might be an economy of scale again in looking to work potentially at regional level as well as reviewing the community model; this had been an issue for this particular child for the past 18 months who had not been able to attend school with large costs. RA stressed there had been a need to be pragmatic in the here and now whilst currently looking to building a business case and ongoing discussions with Specialised Commissioning to resolve the issue. JR asked if there was a challenge in the period it would take to train someone competently who could be assured of carrying out the role confidently before giving notice to the current agency staff. RA recognised that this was a challenge and noted potentially there would be a period of paying for both the agency staff and the physio whilst training occurred however, this had been factored into the costs. RA advised that BCH were confident that they could commence mobilisation within a month with the family and carers. ST asked for clarification on finances, which showed in 2019/20 there would be a saving of £8k with a cost of £15k that indicated a net cost. RA advised this costing was based on a single child only and due to the reporting timeframe had not been able to quantify what the other impact would be on the wider cohort. JR commented: • she considered this to be an obvious direction of travel; a far better experience for people and families to help them to be self-sufficient in this area and give them the right skills and competencies to do that, as well as special schools who would	

	Item	Action
	have multiple clients who have these kinds of challenges. • however currently it was not clear whether this was a long term sustainable model being offered. RA advised that she considered a pragmatic approach had been been required to address the immediate needs of the 4 children whilst the model was fully tested and a more robust business case developed. AW proposed that more work be done with Specialised Commissioning to develop a clearer and more confident model. Rosi Shepherd (RS) commented on the statutory responsibility to ensure children throughout their education and a responsibility to ensure they support those children with their education, health and care plan. CT commented assuming confidence that the monthly funding currently spent on agency staff would stop in two months' time then this would definitely be a financial in year saving as a spend to save initiative. Commissioning Executive were asked to: • To approve a pilot appointing a 6 month fixed-term acute paediatric physiotherapy post to support suction training in the community • To decide whether this requires CCG or specialised commissioning. **ACTION:** JR suggested and it was agreed that CT work with RA and JG and involve JT as Director responsible and AW for clinical oversight on the basis there was clinical approval from Commissioning Executive members. **Commissioning Executive agreed to delegate the decision to Julie Thallon and Claire Thompson as detailed above.**	CT
12	**ADHD Options Appraisal and Specification** Gemma Artz (GA) and Sally Robinson (SR) were welcomed to the meeting to present the ADHD Options Appraisal and Specification. The paper outlined the options for the future of the ADHD service. SR advised that following the rejection of the initial AWP offer and further communications with AWP from Emma Moody (EM) and Julia Ross (JR) had resulted in a very recent revised offer from AWP. SR advised there remained a number of questions about the model but considered these were not insurmountable and noted:	

	Item	Action
	• AWP had made clear that this was their final offer • AWP admitted the model was not transformational • AWP had committed to using their new quality improvement resources to review the service • AWP had shared their caseload by GP surgery – the highest caseload was 22 The options were: • Continue with the AWP contract and final AWP offer • Closing the specialised service but leave funding within AWP to embed ADHD within core services or have a combined secondary and tertiary care model. • Serve notice on the AWP service and explore commissioning a block contract with an alternative provider through a procurement route for BNSSG or the wider patch including Wilshire and B&NES. The paper included the benefits, risks and mitigations of each option. The AWP final offer was included, as was a draft specification that could be used to start the tender process. The paper was with Commissioning Executive to approve the AWP model and offer of further QI work, with no additional funding approved in year, but that non-recurrent funding consideration be included as part of the Contract Negotiations and allocation of Long Term Plan/Mental Health Investment funding for 20/21. Kirsty Alexander (KA) considered: • the final offer was not much better than the first • the 7 page referral form requiring completion by GPs was an issue Julia Ross (JR) questioned the need for this form given currently there was almost a 100% conversation rate from GP referrals to diagnosis. Martin Jones (MJ) advised that quite a lot of information on referral was required in order to reduce the amount of questions AWP raised with the individual. However, MJ considered this information was more about the patient history so it was a case of the patient completing the majority of the form as opposed to the GP. JR considered the 2.5hr assessment time required by AWP specialists still appeared excessive. GA advised that AWP had been challenged on the length of the assessment time and that for how much extra was being asked of primary care the 30-minute reduction was not different enough. Despite	

	Item	Action
	this AWP advised this was how far they were willing to take the model; however Matthew Page had recognised the point made and the offer of QI support was intended to move the model to a more transformational place. David Soodeen (DS) raised the following: • 7 page referral form - suggested a template be used for the required GP information • Caseload – suggested the number of referrals per GP was much higher than the current caseload • Students – considered that there was something specific about ADHD in students (and in particular overseas students) that should be factored into the model • Current advice and guidance on the what the best ADHD therapeutic interventions you can have was not just about drugs it was about alternative interventions SR confirmed that AWP did provide non-medicated options. GA advised of a request made to AWP that some patients on the waiting list be put straight into some of non-medicated interventions but for a number of reasons AWP had not supported this request. JR considered that if Primary Care needed to have these patients on those interventions and considered this needed to happen prior to diagnoses this should be done direct from source, as opposed to sending to AWP for them to do it. JR suggested a pathway was required before referring for formal diagnosis. Martin Jones (MJ) considered: • not getting the diagnosis and delay in commencing treatment was the biggest risk and frustration • that the small numbers of people who needed regular medication to remain stable was not a problem as this could be prescribed by a pharmacist • felt concern around those complex cases involving drugs and alcohol and a mental health complexity and the recovery service • if the decision went ahead for a primary care psychiatry of care he considered there would be an issue of linkage with the recovery services and this required more thought • the purpose was to enable AWP to change and move on and work with primary care in a different way JR asked if the proposed model went far enough, fast enough for the BNSSG population's needs. MJ considered that it would make a big difference and change, would move the service on in a reasonable period, was not the final model but was a much-improved position than 12 months ago.	

	Item	Action
	GA advised that: • without the additional non-recurrent funding progress would not happen very quickly • if non-recurrent funding was available then waiting times would come down much more quickly as described in the paper. • there was an issue with the use of funding with regards to the wait between the initial assessment and treatment commencing • there was scope for further discussion with AWP but noted their reliance on the non-recurrent funding to achieve the above. Alison Bolam (AB) noted AWP was currently delivering 177 assessments per year however the new offer indicated a proposed delivery of 924 which would be without the non-recurrent funding. AB challenged how AWP could accommodate this fourfold increase for a 1 hour less assessment. AW asked if this was due to AWP removing the transition patients. GA advised there was an element of that. JR asked if AWP had modelled the people coming onto the waiting list. GA advised that was why it was non-recurrent funding, AWP had advised that without a waiting list they would have enough capacity with the new model to meet the demand ongoing and possibly a little more. The backlog was the issue. JR referred to the modelling of the waiting list reduction chart in Section 3.5 and asked for clarification around the indicative waiting list number of 200. GA advised AWP considered this to be an accurate indication of the waiting list size for an 18ww. MJ asked if biggest risk was how AWP met the trajectory was there something that would be put in place to test that. JR considered there to be another risk which was the impact on Primary Care. DS questioned if the excessive monitoring currently carried out by AWP was being moved into primary care. SR confirmed that was correct AWP was moving follow-ups to primary care. JR asked MJ what clinical interface with AWP had taken place around this issue.	

	Item	Action
	MJ considered it would involve the stable patients who required prescriptions and had a good and appropriate relationship with their GP. KA asked what proportion of the cohort would be non-complex ADHD. DS advised that approx. 60% of ADHD referrals had underlying mental health causes. JR asked MJ, PB and AB for their level of confidence in AWP being able to resolve the problem (0-10 with 10 being entirely confident). • MJ Level 7 – due to AWP having moved a long way towards solving the problem. Would however like to test the new model over 3-6 months, understand the trajectory and work with the clinicians to try to make a difference. • PB Level 5-6 due to being less confident of other options although recognised this as the best option available. Main priority was to understand how this would land and work properly and carefully in primary care, which would take some time to get right. • AB Level 5-6 due to concerns at the late information and difficulty in understanding the true caseload per practice and the impact of additional work flowing from AWP to primary care and what this would entail. JR advised of other best practice models across the country with 1.5hr assessments and stressed the need to push AWP much harder at every level to achieve the this model. JR asked: • for clarity around the process for how we do this and escalate it, ensuring there is a connection at CEO and CFO level. • what were the conditions that would be put around doing this – noting that these should be explicit in the response to AWP in particular around funding • ask AWP to consider how they are going to manage the waiting list, what they are going to do about it and how they are going to ensure the people on waiting lists are supported and managed • how are we going to effectively monitor this and ensure both corporate and clinical monitoring is retained • decide whether non-recurrent funding should be applied **ACTION:** MJ to provide CE with a summary of how the above would be managed.	MJ

	Item	Action
	Sarah Truelove (ST) advised it would need to be in the context of looking at whether it was within the priorities of the Mental Health Investment Standards. There was investment that would occur next year already therefore a decision was needed as to whether this would be prioritised against something else. ST asked was it feasible to suggest to AWP that the CCG fund a peer review and, assuming there was openness to having an external peer look at their practice, this would support them to think differently about their models of care whilst being an opportunity for CCG learning for primary care. JR asked for a summary of how this would be managed. MJ confirmed that the following would be implemented: • the placement of very robust/explicit conditions, on a weekly basis in terms of reviewing numbers • gain an understanding the impact of the model on primary care • approach revised to ensure expert to expert challenge via peer review ST clarified that the investment standards remained the responsibility of the CCG. JE stressed that there was a 12 month notice period which could be triggered. JR agreed there was a possibility of giving the 12mth notice pending the improvement. It was agreed that AWP needed to work effectively, so BNSSG would work with them to achieve the improvement, but it was imperative that AWP be aware that unless there was massive improvement then the12mth notice period would be enforced. Hence notice given but with a plan to rescind notice on improvement. **ACTION:** MJ Implementation of 12mth notice period to be issued to AWP for ADHD service as detailed above. **Commissioning Executive Committee agreed to test the model with the conditions listed above.**	 MJ
13	**North Somerset Special Educations Needs and Disability (SEND) Joint Commissioning Plan** Mark Hemmings (MH) was welcomed to the meeting to present the item. MH took the report as read and explained the NS SEND Joint Commissioning and Service Alignment Plan was with Commissioning Executive for information and for sign off before going before the North Somerset SEND Programme Board.	

	Item	Action
	MH advised the NS SEND Local Area Review took place in May 2018 and one of the areas highlighted was the arrangements for the under developed joint commissioning, the task was to develop a SEND Joint Commissioning Plan which supported the SEND strategy. The Plan must be reviewed at least annually by the Board and was likely to be reviewed on a bi-monthly basis. The NS SEND Strategy was out for consultation and the joint commissioning plan dovetailed with that and particularly with the Parent Charter. The SEND re-inspection would take place in March 2020 and it was important that the Join Commissioning and Service Alignment Plan in place at that time. A similar plan was being developed in South Gloucestershire and would come to Commissioning Executive for sign off. Meanwhile Bristol was not quite as well developed, having recently undergone a SEND inspection joint commissioning was not identified as a real weakness however, a plan was being developed in exactly the same way so all three Local Authorities would have a similar plan over time. Commissioning Executive Committee was asked to agree and approve the NS SEND Joint Commissioning and Service Alignment Plan. Jon Evans (JE) was interested in the transition element of setting up a dedicated transition group and asked if South Glos LLG could be kept appraised of the learning achieved from the SEND transition arrangements. **ACTION:** MH agreed to involve South Glos in those conversations. JR thanked Ali Ford and Mark Hemmings for their work on the process and the thanks received from BCC on their behalf. **Commissioning Executive Committee agreed the report.**	MH
14	**Transition Approach : for people on treatment where commissioning policy has changed** Adwoa Webber was welcomed to the meeting to present the paper. Peter Brindle introduced the item, took the paper as read and explained the Commissioning Policy Development process had been updated to ensure that there is a clear and transparent process for transitioning people from receiving an intervention to no longer receiving it due to a change in commissioning policy. Sarah Truelove (ST) asked PB to clarify the current process.	

	Item	Action
	PB advised the current process was difficult to manage when changes had been made leading to some Exceptional Funding requests and some complaints. The biggest change was that future cohorts and their clinicians would be fully involved in the process and conversations. Jon Evans (JE) considered that whilst sometimes an alternative might not be possible, where relevant evidence based activity going back to clinicians to provide to patients was a positive. Alison Wint (AW) considered ensuring clear information fed back through to the secondary care clinicians was also key. PB advised that all commissioning policies were always developed with the relevant specialist. **Commissioning Executive Committee agreed the report**	
15	**Urgent Care Activity & Performance Update** Claire Thompson (CT) presented the Urgent Care Activity and Performance update report and asked for questions from the Committee. CT referred to a request from Alison Bolan regarding the current content of primary care urgent care activity contained in the report and what urgent care performance reporting would be helpful. The current data was around the Severnside Urgent Care and it was agreed this should be widened to include day to day in hours data across primary care. Kirsty Alexander (KA) suggested it would be easy to report to Alamac on the same day. Julia Ross (JR) suggested that a working group focus on this Sarah Truelove (ST) considered there wasn't enough clarity around the level of urgent care in primary care so its inclusion in the dashboard was essential. David Soodeen (DS) commented that the variable systems used within general practice made it difficult to assess. Jon Hayes (JH) considered that a small think-tank group to consider a way forward would be appropriate. **ACTION:** It was agreed that Jeremy Maynard (JM), Lesley Ward (LW) and Geeta Iyer (GI) would work with CT on the development of primary care urgent care performance reporting.	CT

	Item	Action
	Commissioning Executive noted the report.	
16	**Contract Performance Update Report – Non-Acute MDT** Helena Fuller (HF) presented the Contract Performance update report for the MH and LD sector. It was assumed the report had been read and HF asked if there were any questions. Alison Bolam (AB) advised that the Bristol wide membership meeting and at that meeting it was highlighted one of the risk areas contained in the report mainly the low number of referrals into the community urology and DPV services. Kirsty Alexander asked for information on the implications of the NHSE for Young Peoples Health and Justice Services funding ending in March 2020. **ACTION:** It was agreed that HF would follow this up with KA. **Commissioning Executive noted the report.**	HF
17	**Corporate Risk Register and GB Assurance Framework** Sarah Carr (SC) was welcomed to the meeting to present the item. **GBAF**: SC advised of the work carried out with the Quality team, the Long Term Plan response, updates around the Value Programme, Primary Care Networks and Healthy Weston risk score which was anticipated to reduce to 3. The financial recovery risk was also expected to change. **CRR:** SC advised of the work carried out with the various Directorates on the Corporate Risk Register to review and moderate risk scores. Jon Evans (JE) asked who made the decision on risk bandings. SC advised those reporting in around the score made the assessment and GB made the final decision. JH stressed the importance of all Governing Body sub committees, such as Commissioning Executive Committee, raising any concerns that GB may not be aware. SC confirmed that PCCC was in the process of developing its own risk register. SC confirmed that all COI training had been completed. **Commissioning Executive noted the report.**	
18	**Nursing & Quality Directorate – Clinical Update**	

	Item	Action
	Rosi Shepherd (RS) presented the Nursing and Quality Clinical Update report to the Committee advising that going forward the current report would include system quality and safety risks and the actions that the team were taking mitigate those risks. JH asked for further information on: • Liberty protection safeguard pending changes RS advised that the legislative changes to the Mental Capacity Act and Liberty protection safeguards were due to come into force in October 2020. The Quality Directorate would be carrying out a system impact on what that means for BNSSG with our partners and that will be brought to Commissioning Executive for consideration. RS advised that a working group would be set up for this piece of work and it was expected to continue for approximately 18 months because of the impact it will have and the need to understand the impact on our primary care providers. AB asked if recruitment of a named doctor for safeguarding had been accomplished. RS advised this post was still unfilled however, conversations were taking place with community providers about how we might improve our success in recruitment within the GP community for this role. JH asked if there was a targeted approach to practices promoting the role. RS confirmed that was correct. **Commissioning Executive Committee accepted the report.**	
19	**Minutes of the Area Prescribing Medicines Optimisation Committee (APMOC) (August)** No questions were raised **Commissioning Executive Committed noted the report.**	
20	**Minutes of the Commissioning Policy Review Group (CPRG) October** No questions were raised **Commissioning Executive Committee noted the report.**	
21	**Any Other Business** • Jon Evans noted that LLG members had raised the issue of long waiting times for physiotherapy with times ranges from BCH 10.6 weeks to Sirona 35 weeks. **Action: JH to follow up**	JH
	Committee Effectiveness:	

	Item	Action
	None	
	Date of next meeting: Thursday, 12th December 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