Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG Commissioning Executive Committee

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

Minutes

Present			
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
David	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
Kevin	Haggerty	Clinical Commissioning Area Lead for North Somerset, BNSSG CCG	KH
Jon	Hayes (CHAIR)	Clinical Chair, BNSSG CCG	JHa
David	Jarrett	Area Director for South Gloucestershire, BNSSG CCG	DJ
Michael	Jenkins	Clinical Care Pathway Lead for Integrated Care, BNSSG CCG	MJe
Lisa	Manson	Director of Commissioning, BNSSG CCG	LM
Jeremy	Maynard	Clinical Lead	JM
Shaba	Nabi	Clinical Corporate Lead for Prescribing, BNSSG CCG	SN
David	Peel	Clinical Corporate Lead for Planned Care, BNSSG CCG	DP
Justine	Rawlings	Area Director for Bristol, BNSSG CCG	JRa
Julia	Ross	Chief Executive, BNSSG CCG	JR
Kate	Rush	Clinical Leadership Development, BNSSG CCG	KR
David	Soodeen	Clinical Care Pathway Lead for Mental Health, BNSSG CCG	DS
Sarah	Truelove	Director of Finance, BNSSG CCG	STr
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	KM
Jon	Evans	Clinical Commissioning Area Lead for South Gloucestershire, BNSSG CCG	JE
Geeta	Iyer	Clinical Corporate Lead for Primary Care Provider Development, BNSSG CCG	GI
Martin	Jones	Medical Director, Commissioning and Primary Care, BNSSG CCG	MJo
Kate	Mansfield	Clinical Care Pathway Lead for Children's and Maternity, BNSSG CCG	KM
Sheila	Smith	Director, People and Communities, North Somerset Council	SS
In attendance			
Gemma	Artz	Head of Performance Improvement, Planned Cared, BNSSG CCG	GA
Debbie	Campbell	Deputy Director, Meds Optimisation, BNSSG CCG	DC
Lisa	Collard	Commissioning Policy Development Manager, BNSSG CCG	LC
Jacqueline	Holden	Exec PA to Lisa Manson, Director of Commissioning, BNSSG CCG (Note taker)	JHo
Natalie	Huggins	Contracts Manager, Mental Health & LD, BNSSG CCG	NH
Richard	Lyle	Assoc. Director of Service Redesign, Transformation, BNSSG CCG	RL
Emma	Moody	Head of Contracts, Mental Health & LD, BNSSG CCG	EM
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	AW

	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** **02a. To consider any changes to attendee interests since the last meeting** None declared **02b. To consider any conflicts of interest arising from this agenda** None declared	
03	**Minutes of the meeting and matters arising from 14th February 2019** The minutes were agreed as a true and correct subject to the following amendments:	

	Item	Action
	• Page 8 Item 9 Commissioning Policies – amend recommendation outcome to include wording "In relation to the Hydrocele Policy a Financial Impact Assessment be carried out". • Page 11 Item 12 Evaluation of current D2A Pathways – 4th para. replace "North Somerset" with "Bed Light" model"	
03.1	**Action log from 14th February 2019:** Item 45 – Closed Item 52 – Deferred to April meeting Item 61 – Deferred to April meeting Item 68 - Deferred to April meeting Item 83 - Closed Item 85 – Closed Item 86 – Deferred to April meeting Item 87 – Closed Item 88 – Closed Item 90 – Closed Item 91 - Closed	
04	**Annual Review of Committee Effectiveness** Jacqui Holden (JH) presented the results of the Annual Review of Committee Effectiveness survey completed by members and which would feed into GB along with the TOR review and Annual Committee Report due in April. JH confirmed the 34% completion rate and highlighted the key themes areas: • Focus – Statement 1.2 • Team Working –Statement 2.4 • Effectiveness – Statement 3.5, 3.6, 3.7 • Engagement – Statement 4.3 • Leadership – Statement 5.5 SN asked for a more robust and detailed summary paper template which should include references to supplementary papers members could access if further clarification was required. Submitted papers should include clear distinction as to whether the committee is being asked to make the final decision or a recommendation to Governing Body is being requested. SN asked about the action items going forward. JHa confirmed he would go through the report, reflect on feedback with Executives, identifying items relevant to Commissioning Executive Committee. JR raised the challenges experienced by the Committee around the timeliness issue of action items.	

	Item	Action
	Action: Following discussion, it was agreed that Executive Team would review the areas highlighted and come back to the Committee for further discussion.	92
05	**IAPT Contract Awards** Emma Moody (EM) and Natalie Huggins (NH) were welcomed to the meeting to present the update on the IAPT contract award. EM informed the committee that EM, NH and DS had been supported through the process by CSU, the main authors of the report. DES and AJW had also been involved in the process. EM highlighted the main risk area which occurred as a result of extending the evaluation period resulting in 1 month less on mobilisation. EM recommended that the mobilisation period be reduced from 6 to 5 months in order not to destabilise the existing service. D Peel (DP) asked for clarity around the transition arrangements for patients already in the system and it was confirmed this was part of the mobilisation plan which would be defined by the end of April following which monthly and 2 weekly catch-ups with providers would take place. JHa asked about current staff and TUPE arrangements. NH advised that CSU had advised TUPE arrangements would be the responsibility of the two organisations not the CCG. LM advised of the AQP for IAPT and the possibility that some existing providers may want to remain as stand-alone. JR asked about the balance of the risks in relation to the true position and queried the appropriateness of anonymity in services providers, assurances that a 5-month mobilisation was achievable, the weight of risk of people leaving during the transition period and if the current provider would resist a 1-month reduction or not. NH explained current providers had re-assured that staff stability was what it needed to be to deliver the service but could not guarantee that level of certainty going forward if there were any further changes. There had been anxiety around current AQP model and further changes to this could result in an extension of the mobilisation period. EM spoke about the mitigation of the risks which would be clearer once GB had made the formal decision on the contract award and meetings could commence with the provider. DS advised of past issues around contract awards regardless of the mobilisation period and noted it would be a difficult period in particular with the risk of staff leaving and potential waiting list issues.	

	Item	Action
	JR recommendation to the Committee would be to approve subject to the caveat that an absolute assurance that the mobilisation period was sufficient was given. **Recommendation to Governing Body:** The Commissioning Executive recommends to Governing Body: • Award of the BNSSG wide IAPT contract to Vita Health for 10 years • A reduction in the mobilisation period of the new service by 1 month in order to ensure a planned start date of 1st September 2019 subject to assurances being obtained from the provider that a 5 month mobilisation period is achievable.	
06	**Sexual Violence Therapies Service Procurement Outcome and Recommendations** Emma Moody/Natalie Huggins presented the item. EM confirmed only one bid for the area (BANES and Somerset) had been received. A meeting with the bidder had taken place for clarification purposes and to gain additional assurances around their bid and the outcome from this dialogue gave assurances required. EM identified the risk of a potential TUPE requirement affecting three staff noting this was not a CCG issue but it was a risk in terms of procurement. EM recommended the CCG consult NHS England regarding the cost pressure impact of a possible TUPE risk. ST confirmed that cost pressures had already been discussed with NHSE and it was understood that BNSSG CCG would only be in a position to take on the service if there were no financial risks. DS expressed concern raised following meetings involving NHSE the costs might be far greater than initially indicated and the £40k additional funding for children's services may not cover the anticipated costs of counselling going forward. JR advised this could only be approved if assurances on funding were received from NHSE and asked that this be raised formally with NHSE by ST. JHa made the recommendation that the Committee approve from a clinical aspect subject to financial approval from the Strategic Finance Committee with regards to the associated funding/financial risks. **Action:** ST to clarify with NHSE regarding cost/financial risk and future funding before BNSSG takes on the service. **Decision:** The Commissioning Executive Committee approved the following subject to Strategic Finance Committee receiving NHSE assurance on funding and financial risks as noted above.	93

	Item	Action
	• Award of the Sexual Violence Therapies service contract to Somerset and Avon Rape and Sexual Abuse Support (SARSAS) working as a consortium in association with Womankind and The Green House for 3 years	
07	**BNSSG 19/20 Planning Submission** Lisa Manson (LM) presented the draft System Plan Summary slides as part of the 19/20 Planning Submission which would go to Governing Body, Health & Wellbeing Boards and other organisational boards in draft form for comment before the final submission on 11th April. LM talked through the slides which consolidated the core three system challenges in 19/20 of urgent care achieving financial balance and how these then underpin the work undertaken. It was noted that some key items identified by the System were not explicitly identified in the Plan those being Routing, Triage and Localities. ST spoke about the cost pressures experienced across the system and the control totals for the next year which providers were struggling to meet and linked to the workforce issues around agency and locum staff. ST spoke about the challenging time working with providers, working through how the system could achieve control totals; 2 out of 4 providers had rejected their control totals. ST highlighted the huge financial risk in the system advising allocation was mostly growth related. It was agreed non-elective demand growth had to be addressed and the element of work carried out by acute trusts that need not occur should be routed into community services before arriving at Acute trusts not after. JR emphasised the costs incurred when re-routing occurred after attendance at an Acute and stressed the BNSSG ambition, particularly in the localities, must be any non-elective attendance/admission be into Community. It was noted that this could only be achieved if the pathways were assured. LM went on to explain the challenges in relation to the workforce identifying workforce numbers currently held across Health & Social Care as 21,000 staff for the 27,000 existing posts. LM noted demand for staff was increasing without a commensurate growth in the supply pipeline resulting in difficulties in recruiting and retaining staff, including registered nursing, social care, and key medical specialties including GPs. Premium agency usage resulting in avoidable staffing costs.	

	Item	Action
	DP asked whether education links with UWE and other Universities had been established. LM confirmed that since the achievement of a robust workforce data source, there was now a concrete data source to develop a portfolio to be shared with UWE and other Universities to identify future schemes/conversion courses. LM spoke about working collaboratively with others in the system to develop a portfolio career that at end point individuals are offered a nursing role within BNSSG that may rotate across acute trusts and community service providers. P Brindle (PB) asked if we were confident about the baseline to help us measure the future impact of actions taken. ST spoke about work currently being done across the system on developing performance standards using examples from elsewhere and looking at measures which could go across these things so it might be proxy measures. JR asked how formal feedback from partners was being managed. LM confirmed that the draft slides had been sent out to all Exec Leads for Planning for comments before going to each organisation's Governing Bodies and Sponsoring Board for comments back prior to the submission on the 11th April. **The Committee noted the report.**	
08	**BNSSG 19/20 Savings Plan** Steve Rae (SR) was welcomed to the meeting by Sarah Truelove who introduced the 19/20 Savings Plan which Steve Rea presented to the Committee. 18/19: SR advised that the report previously circulated was based on Month 10 figures and the Month 11 figures were now available indicating that the current year's delivery of savings showing as £23.7m to date had increased to £29.3 in Month 11 and was anticipated in a position to achieve the year-end target figure of £37m savings. 19/20: The CCG submitted a financial plan to NHS England on 12th February which included £21.5m of identified QIPP savings. However, an additional 'unidentified savings' line was also included to reach the CCG's breakeven 2019/20 Control Total; in order to deliver the CCG Control Total commissioner savings (QIPP) of £42m will be required.	

	Item	Action
	SR highlighted the significant challenge in the required delivery of £42m savings to make the breakeven control total and identified that approximately 50% of savings had been identified to date. SR advised that across the South West region all CCGs had recently seen some analysis from NHSE which indicated that the level of unidentified savings as a percentage of revenue resource limit, level of identified QIPP plans from other organisations and, more recently, the headline titles for each of the savings plans for all of the CCGs across the South West. SR was currently doing a piece of work to identify if there were any opportunity areas for further savings. SR explained that work continued with Control Centres to identify tangible milestones for each of the projects and they were continuing to embed some good project methodology behind each of the projects. DS referred to the 19/20 Plan and queried why the £7.9m for Medicines Optimisation savings which had been anticipated to be removed this year remained in 19/20. ST advised that this had formed part of the planning process and this was included in the baseline prescribing budget. JR asked about the CHC and End of Life budget spend. LM identified that CHC was £74m. ST advised that the planning guidance issued contained an assumed level which was used as a benchmark. **The Committee noted the report.**	
09	**BNSSG Commissioning Policies Review Group (CPRG) –Terms of Reference** Adwoa Webber was welcomed to the meeting and Peter Brindle gave the overview for the Commissioning Policies Review Group – Terms of Reference which were returning to the Committee for approval following the requested amendments which had been taken into account, primarily around widening the membership to include a greater range of clinicians. JR commented on the first line of the Terms of Reference and asked that this be re-worded in a more positive and pro-active way. **Decision:** The Commissioning Executive, subject to the revised wording of the first line of text, approved the Commissioning Policy Review Group - Terms of Reference.	
10	**BNSSG Commissioning Policies:**	

	Item	Action
	Kate Tamlin & Lisa Collard were welcomed to the meeting and Peter Brindle gave an overview on the BNSSG Commissioning Polices for approval namely the changes applied to the Gall Bladder Removal in Adult Patients and Referral to Secondary Care Pain Service Clinics for Assessment and Treatment. **10.1 Referral to Secondary Care Pain Service Clinics for Assessment and Treatment – Kate Tamlin (KT)** KT clarified the level of the primary care engagement undertaken during the development of the policy. SN referred to the Patient Activation measure detailed in the policy and asked how this could be accessed. It was noted that the Patient Activation Measure was an essential clinical tool in identifying and measuring how engaged and motivated a patient was to look after their own health. JR advised that as the policy was rolled out the Policy Team would ensure that information of this type would be included in the policy together with any necessary links. **10.2 Gall Bladder Removal in Adult Patients – Lisa Collard (LS)** LS updated the Committee of the changes made to the policy specifically around the assessment criteria and management of symptomatic gall stones as detailed on Page 18 of the policy. DS asked for clarification around the number of qualifying episodes. LS confirmed that it was NHSE steer that there must be two documented episodes before the criteria was considered to have been met. **Decision:** Commissioning Executive approved both commissioning policies	
11	**BNSSG Individual Placement and Support (IPS) Secondary MH Employment Service Bid Outcome** Richard Lyle (RL) was welcomed to the meeting to present the item. DES introduced the IPS initiative explaining that the focus of the IPS programme was to assist people with MH needs back into work and to date there was good evidence of success in achieving this outcome. Funding for the scheme totalled £680k over two years however although this linked to the mental health strategy and it was noted that limited IPS provision was limited within BNSSG, the purpose of the paper was to gauge if Commissioning Executive considered this project matched current BNSSG priorities and whether there was capacity to engage in the programme. The intention was to continue only if the benefits were clearly identifiable and quantifiable. RL presented the item to the Commissioning Executive noting that in terms of tracking benefit limited this had yet to be tested within BNSSG and there was a view to use some of the methodologies used in the control centre to test this. RL advised that AWP were the provider of	

	Item	Action
	the service with some 3rd sector support and went on to highlight the identified risks and mitigations in place. DES asked Commissioning Executive if they believed this was something they believed should be taken forward. SB noted the value of joining up with what is already in place and asked if this could be beneficial in maintaining contact with the various communities and campaigns to promote mental health and employment. RL advised that the IPS case load was directly linked to the secondary care case load so was not an open access service. JRo asked for clarification on: 1. capacity costs to the CCG 2. capacity costs to AWP as an additional service to their core services 3. recruitment issues AWP may experience in delivering this service RL advised of direct conversations taking place with AWP including AWP Director level and noted that AWP also had similar reservations around capacity. The assumption was that this would potentially reduce the services in other areas of AWP as the likelihood was the individuals taking part in the programme were likely already on AWP case load so this would provide an additional outlet to treat people. DES noted it was not explicitly identified in the paper as to whether AWP wanted to deliver this service. RL advised operationally people understood the benefit for those patients identified as likely candidates for the programme however there was currently only limited IPS capacity and this programme would be mean a significant increase in numbers. With regards to workforce it was considered a different skillset was required and the workforce could be recruited via the 3rd sector non-typical mental health recruitment groups. ST asked had any evaluation of the current service been undertaken RL advised the evaluation was carried out on a broader service than just IPS therefore he would need to review the data. ST asked how quickly was a decision required, given that the CCG would need to use resources on this programme, verifying the evidence of impact of this service to ensure it met the populations' needs and understanding the strategy of where this programme sat within the MH provision was required in order to make a decision. JR stressed concern around AWP's capacity to deliver this service above the core services. DES considered success would be directly related to AWP's desire to carry out the service and without this the funding could potentially be	

	Item	Action
	redirected to another system where better use of funds could benefit the population. DS advised there was existing evidence that employment improved people's MH and highlighted an existing model using 3rd sector organisations as recovery navigators that he believed produced better outcomes than the service being considered. JRo asked if there was any evidence that the model worked and PB asked how quickly and where the return indicated by the data for the intervention would be delivered. DES clarified that the data used was external to BNSSG and the outcomes were unlikely to be achieved. RL indicated that the return would likely to be directed back to secondary care. The business case to invest in extending the service provision had yet to be made therefore there were not the services across the country and this was seen to be an opportunity for local Systems to prove/disprove the worth of the investment and a tangible operation with financial benefit. LM asked in terms of the context of everything BNSSG wanted to achieve with MH and, recognising the additional funding came from NHSE, whether this was the biggest priority for BNSSG's population. It was recognised this needed to have a benefit for AWP and currently the benefit to AWP in terms of caseload or intensity of interaction was not known. DES recommended, before going back to NHSE, that it was clarified with AWP what the opportunity would cost and the level of their desire to work on this programme before a final decision was made. ST requested the financial evidence go to Strategic Finance Committee as clinical evidence had been addressed at Commissioning Executive. **Action:** • Liaison with AWP regarding the costs and their desire to work with the programme. (DES) • Financial evidence to go to Strategic Finance Committee (DES)	94
12	**Community Services Procurement Specification Updates** Kate Rush (KR) presented the papers seeking approval from Commissioning Executive of the updates made to the draft contract, service specifications and quality schedule for the Community Services procurement following clarification questions and bidder negotiation meetings resulting. KR summarised to the meeting the key changes made highlighting: • Contractual changes as detailed in Appendix 1 • Primary Care Networks development and BNSSG expectations of how provider should align with these • Social Prescribing – additional statement added	

	Item	Action
	• MSK – following 38 clarification questions an additional paragraph/statement had been inserted to give clarity to providers they should work as a system partner with secondary care with regards to transformation of the service. • Quality Schedule – assessing if data can be available to the provider on outcomes to ensure focus is on making changes and improvements to both their own services and other services in particular in relation to data on emergency admissions for avoidable conditions. • Current and upcoming programmes of work within BNSSG have been identified in a schedule to site within clinical and non-clinical service specifications to ensure provider awareness and to reduce costing and uncertainty. • Community Services schedule produced to clearly show where the specifications align with the Long Term Plan. SN commended the inclusion of Primary Care Networks in the service specifications and suggested that clarification of the type of avoidable admissions should be included. JRo raised a query on Appendix 1 re Schedule 2A - Acute and reactive care specification managing demand 3.11.2; around the removal of wording "Initiation of these processes will be in line with the Activity Management Framework detailed within the Contract". KR confirmed this wording was removed as it was an incorrect descriptor additional to the correct wording. LM clarified the appropriate clause existed within the standard contract. It was agreed that this section of Appendix 1 be updated to reflect this. **Decision:** The Commissioning Executive: • Approved updates to the service specifications and quality schedule taking account of the key changes subject to the clarification and changes noted above. • Noted the process for current pilots, projects and programmes of work that could impact on the community provider • Noted where the community services contract aligns with the NHS Long Term Plan.	
13	**BNSSG Elective Care Access Policy** Gemma Artz and Sally Robinson were welcomed to the Committee and presented the item. SR advised of these were relatively minor updates to the Elective Care Access Policy subsequent to the system led review in 2016. SR highlighted the key areas and proposed changes to the Policy noting that although feedback had been received via GP Forum meetings patient feedback had still to be initiated. SR advised of proposed clinical reviews would occur when patients made multiple cancellations or did not attend with an addendum that the Acute hospitals correspond with GP practices to seek clarification on reasons for non-attendance.	

	Item	Action
	JM asked that wording be inserted specifically to identify Did Not Attend and asked for clarification around non GP referrals between specialities. GA advised this related to instances where there was a similar problem i.e. a clear pathway such as a pain clinic etc. and in cases where it was clearly a different problem the expectation would be discharge for re-assessment in primary care. JM noted the need for GP awareness of the policy and SR advised the three Acute providers had offered to provide a workshop with GPs to answer any questions and this would go via the GP Locality Managers. LM advised the policy would continue to be refined as outpatient reconfiguration continued in order to reflect non face to face patient admission and follow-ups and other changes made to some of the more defined pathways. DP spoke about direct access numbers for the practices being available to Acute providers to enable liaison on DNAs. LM noted this could be addressed by way of insertion of an Annex to the policy. AJW spoke about the need to ensure patients referred on 2-week wait be made aware of the importance of attending and the reason for the urgency of the appointment. GA advised that work was currently being carried out to identify ways of getting the message across effectively to patients of the reasons for the 2 week wait referral and the importance of their attending the appointment. DES advised of the ERS programme and existing information resources which could be drawn down and used for patient awareness. A discussion took place around consultant referrals and GA advised there was clarity on this in the policy and it was agreed this should be followed. **Decision:** • Commissioning Executive approved the refreshed BNSSG Elective Care Access Policy to be added to the contracts for the 2019-20 financial year. • Commissioning Executive recommended a PPI review of this policy take place during the 2019 calendar year.	
14	**BNSSG Area Prescribing and Medicines Optimisation Committee - Terms of Reference** Debbie Campbell was welcomed to the meeting to present the item. DC gave background information as to the reasons for the revised Committee name and proposed changes to the Terms of Reference	

	Item	Action
	including how much decision making would be acceptable at this committee before escalating to Commissioning Executive. A discussion took place around the proposed membership: DS asked for clarification was to where the GP Clinical Lead representation was being sought. • It was agreed that an additional volunteer GP Clinical Lead would be sought from Commissioning Executive. JHa asked for clarification around GP Provider representation. • It was agreed GP Clinical Leads were able to provide this function without further cost implications. The frequency of meetings was discussed and it was noted that it was intended to meet every two months on variable days. Decision making responsibilities were discussed as per Appendix 1: • It was agreed that decisions around investments and with cost implications could not be made at APMOC and these should be directed to Commissioning Executive or appropriate committee. • It was agreed the APMOC aims should include a clear reference to reducing costs with wording around the drive for value for money more definite and explicit. • Clinical guidelines and Formulary decisions should be referred back to Commissioning Executive for ratification when major changes were involved. **Decision:** The APMOC Terms of Reference were approved subject to the above required changes.	
15	**Item deferred**	
16	**BNSSG Prescribing Quality Scheme for GP Practices** Debbie Campbell presented the item for Prescribing Quality Scheme for GP Practices advising the scheme paper was with Commissioning Executive for consultation and check prior to submission to PCCC for sign off. The scheme had been through a consultation process and through the membership before bringing the finalised scheme to the Commissioning Executive. JRo noted that CPMs would receive additional funding through this scheme and the need to ensure BNSSG is aware of the need to obtain best value out of resources and avoidance of duplication. **Decision:** Commissioning Executive supported the recommendation to Primary Care Commissioning Committee that the attached scheme is approved so that it can be offered to all BNSSG GP practices for 2019/20.	
17	**GP Care Urology Service 19/20 – Briefing Paper**	

	Item	Action
	Gemma Artz presented the paper on GP Care Urology Service highlighting concerns raised regarding the 2ww pathway offered by GP Care the community provider for BNSSG. GP Care had been unable to offer all elements of the new national prostate pathway resulting in GP Care being unable to manage 2 week waits and as a result more patients had been transferred to NBT for diagnostics risking delayed pathways for prostate cancer. AJW advised this had been discussed at the Cancer Steering Group and the Planned Care Group resulting in a request to modify the commissioned pathways for urology with GP Care and the acute trust. JRo noted the shift in procurement and asked what impact of this shift on the Acute Trust might be and the willingness to make the change. AJW advised the Acute Trust had been involved in the discussions and although not all risks could be eradicated from the existing urology pathway it was felt that the Acute Trust could take the capacity if some of the routine work was re-directed back to GP Care. CT advised in terms of case mix it would be similar as the GP Care service had only ever offered the first part of the pathway so would not be a whole pathway change. LM advised that GP Care was not an NHS provider therefore no automatic alteration of contract was possible and this should be treated as an interim solution only in terms of capacity and would instead be picked up as part of the BNSSG planned care strategy. JHa asked if RUH would be impacted by the proposed changes. GA advised that it would only affect 2 week wait referrals made to GP Care, referrals made to other providers would continue. **Decision:** The Commissioning Executive agreed to endorse the approach supported by the cancer steering group of option 2 with additional discussion and progression as described in section 4.	
18	**Musculoskeletal (MSK) Model implementation options** Gemma Artz presented the item on MSK Model implementation options and highlighted some of the changes and how these would link in with the community services provider. GA spoke about the approach to implementing the Musculoskeletal service model previously agreed by the committee in place of an end to end pathway re-procurement as an interim solution over the next 6 months particularly around orthopaedics and pain. JRo advised the Acute Care Collaborative (ACC) should manage this in a partnership way and not a model for the CCG to procure and should become a priority within the ACC work stream of the STP.	

	Item	Action
	JRo advised that is was not a contractual issue and the dialogue should be between the providers about how they best resource the service although BNSSG would ideally assist the discussions. LM advised that it probably would not have given the desired outcome which could have been achieved through provider negotiation rather than procurement. The challenge that needs to be fed into provider discussion is the amount of TNO work that goes to the independent sector and how this is brought into the system to enable the Acute to own the totality and allowed them to subcontract under tariff. ST referred to discussions with the ACC and highlighted the need to develop awareness of the shared priorities and ownership of MSK. JRo suggested a programme budget for providers to manage this together might be a helpful enabler for providers to take responsibility for the pathway. DS noted lesser focus on Rheumatology and GA explained there had not been the same level of discussion as it had become apparent Rheumatology had experienced less problems than pain and orthopaedics in terms of the pathway. KH referred to pain management services component of the paper and queried if this should be addressed separately as opposed to being part of the larger project. GA had reflected at the ACC that this was a huge programme of work which over time had been broken down into components and this paper is asking for some support in how to obtain the programme resource to move some of the programmes forward. JR advised it was possible to consider moving pain management into a community based programme but that would be a different type of discussion. In terms of creating a tier 3 hub, orthopaedics and rheumatology were suggested, the priority would be to get the providers to drive and lead that change. **Action:** LM recommended a small working group to develop a proposal and paper through to ACC about how to take this forward and with potential financial initiatives that could be used in 19/20.	95
19	**19.1 Urgent Care Activity & Performance Update** Claire Thompson presented the update report and spoke about the January and February performance highlighting the massive variation day to day from Acute Trusts and the work being done to avoid attendances and stream patients differently to avoid admission into hospital. DS asked about if 4 hr waits would continue to be reported. CT advised 4hr waits would continue to be reported and with new standards due to be trialled from June to next spring. Of the new	

	Item	Action
	standards Time to Initial Assessment would be a key measure and then 1hr for those patients who fall in these categories. Although not a pilot site CT would be looking at what could be reported on the new standards in this shadow year. JRo asked for an update on the Stranded position. CT advised this had improved from 2018 however deteriorated in January across the board but had now recovered in most cases. NBT had a good process which was working well keeping the numbers broadly in line with the reduction targets. WAHT and UHB processes were developing to ensure everyone had the right information but have delivered a reduction in the overall stranded position. JRo queried the data issues in WAHT. LM advised this was in the process of being resolved. The issue, which started in month 7, was in relation to how data was being updated particularly around how patients were being discharged. There had been a number of data quality issues with the WAHT data so this was currently being worked through. JRo commented on the Ambitions charts and proposed that Amber rating could be Improvement but no met. **19.2 Contract Performance Update Report – Acute** Helena Fuller presented two reports on the Independent and Acute Sector and highlighted the key areas of focus to the Committee: • Acute - the contract negotiation process to date with regards to getting contract signature of which the date for signing was 21 March 2019 • Acute - CQUINs landed last week therefore in discussions with Quality we are having conversations with providers to ensure we can agree those CQUINs and include them in the contracts. JRo queried the non-elective under performance and ophthalmology over performance detailed in the report specifically around mitigating actions and assurances. HR explained with regards to ophthalmology performance the actions already taken to mitigate risks and a proposal paper currently being developed for discussion with Finance to identify further mitigating actions in relation to demand. JRo asked how the demand had grown so significantly. LM advised the key area had been the reduction in waiting times from the previous 18 week waits. DS referred to previous locality plans/referral service forms used to identify whether a patient wanted cataract surgery and whether this was now being bypassed resulting in surgery being undertaken without patients having been asked their preference or given other options.	

	Item	Action
	LM advised this issue had been highlighted to the Referral Management Service who were developing mitigating actions such as looking at bringing Optometrists into the cataract referrals process to obtain a different clinical perspective. SN commented it was a mandatory item within the policy to have a robust discussion surrounding shared decision making. LM advised the that within the referral form there was a required conversation around a choice however confirmation this had been done was by way of a tick box completed by the Optometrist and not signed by the patient. LM advised this could be looked at as referral forms came through this system. JRo asked that more detail was required around the main issues. LM advised that the intent of the Contract Performance Update reports was to give a quarterly update on each of the core contract areas to bring a different perspective. JRo asked that an update with regards to the blended tariff be included in the next report. **Action:** • Ophthalmology referral forms to be reviewed for cataract surgery to ensure shared decision on choice was taking place (LM) • An update on the blended tariff be included in the Acute Contract Performance Update report (LM) **19.3 Corporate Risk Register & GB Assurance Framework** The Committee noted no questions had been received for the Corporate Risk Register and the Governing Body Assurance Framework.	96
20	**Nursing & Quality Directorate – Clinical Update** Marie Davies (MD) was welcomed to the Committee to present the item. MD advised the report was a summary of the clinical issues identified as areas of risk and discussed in the Quality Committee in February 2019. MD advised that items included in future reports would be risk rated. JHa asked if the September re-opening date for Cossham Birth Centre would be achievable. MD indicated this was to be reviewed in July and an update would be reported back to Commissioning Executive. JRo questioned whether the clinical model was appropriate and asked for clarity on whether the Trust had got the breakdown of services, pathway and governance right.	

	Item	Action
	MD clarified this was still developing but that having a local birthing centre model was right and the Trust was confident in the model assuming they could get the workforce right. LM stressed the need to plan services based on the workforce that could be recruited to as opposed to what the Trust would like and asked that the Trust be challenged as to what the service offer would be based on this. DJ highlighted that the original staff pulled back from Cossham on its closure should still be available to the Trust and therefore could be released back into Cossham without the need to recruit. JRo stressed the need to ensure the clinical model was right and that the Quality Team assure themselves this was a viable service BNSSG would wish to commission and support. JRo asked that a quality review be undertaken and this was to include questions as to whether this remained a service BNSSG wanted, could support with clarification around clinical supervision etc. to assure themselves this service would be fine. LM Noted changes to the requirements around maternity services from the Better Birth Plan which would start to impact from19/20 and asked that the services be reviewed in the context of that which is part of the LMS Plan in 19/20. JRo raised a question around the Safeguarding Adult Report – WAHT compliance training and asked for assurance a) it was a data cleansing issue and b) that this was being corrected so BNSSG was absolutely assured the training and numbers were correct. JRo raised a question around SWASFT around what assurance was in place around call stacking enhanced patients. MD spoke about the presentation previously given to Governing Body and noted there was a follow-up Quality Surveillance Group (QSG) meeting scheduled later in March. JRo asked that this be noted as a very serious quality/patient safety issue. It was agreed that future reports should include escalation of priority issues with enough detail to ensure Commissioning Executive was assured. **Actions:** • Future reports to include risk rating and escalation of priority issues with enough detail for CE assurance. (JBG)	97

	Item	Action
	• Quality review to be undertake on Cossham Birth Centre in line with Better Birth Plan 19/20 (JBG)	
21	**Any Other Business** Setting System Priorities 19/20: LM updated the Commissioning Exec of a paper setting priorities following a system review of priorities across all of the groups. The paper would be refreshed following the Directors of Finance meeting that day and the whole system meeting the next day following which it would then be circulated.	98
	Date of next meeting: Thursday, 11th April 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

14th March 2019