# Minutes of the Joint Health Overview and Scrutiny Committee

# Monday, 23 October 2017 at 10.00 am

DISCLAIMER
The attached Minutes are DRAFT. Whilst every effort has been made to ensure the accuracy of the information and statements and decisions recorded in them, their status will remain that of a draft until such time as they are confirmed as a correct record at the subsequent meeting

**Members Present:-**

**Bristol City Council**
**Councillors:** Brenda Massey (Chair), Eleanor Combley, Paul Goggin, Tim Kent, Gill Kirk and Celia Phipps

**North Somerset Council**
**Councillors:** Roz Willis, Charles Cave, Andy Cole, Ruth Jacobs, Reyna Knight, Ian Parker, Deborah Yamanaka

**South Gloucestershire Council**
**Councillors:** Marian Lewis, Janet Biggin, Shirley Holloway, Sue Hope, Ian Scott

**Officers:-**
Louise deCordova (Scrutiny Advisor, Bristol City Council), Leo Taylor (Scrutiny Officer, North Somerset Council)

**STP Representatives:-**
Julia Ross (Chief Executive, BNSSG CCG), Laura Nicholas (BNSSG STP Programme Director), John Readman (Strategic Director, People, Bristol City Council), Prof. Mark Pietroni (Director of Public Health, South Gloucestershire Council), Gemma Morgan (Public Health Registrar, South Gloucestershire), Dr Kate Rush (GP, Member of the BNSSG Clinical Cabinet), Dr Peter Collins (Medical Directory, Weston Area Health NHS Trust)

## 1. Welcome and Introductions

To open the meeting the Joint Committee was asked to confirm the appointment of a Chair (from the host authority).

In response to Councillor Kent's question, it was confirmed that joint Chairing arrangements existed, as set out in the Joint Committees Working Arrangements, meetings would usually be led by each authority on a rotating basis.

**The Joint Committee RESOLVED to appoint Councillor Brenda Massey as Chair.**

The Chair welcomed the attendees to the meeting and led introductions of the Councillors from Bristol, North Somerset and South Gloucestershire and asked health colleagues and local authority officers to introduce themselves.

The Chair confirmed that this was the first formal meeting of the Joint Health Overview and Scrutiny Committee which had been constituted for the purpose of scrutinising the Bristol, North Somerset and South Gloucestershire Sustainability Transformation Plan.

**The Joint Committee NOTED the Minutes of the Meeting in Common, 1 December 2016, which had convened to discuss the Sustainability Transformation Plan.**

## 2. Joint Health Overview and Scrutiny Committee - Business Report

The Chair introduced the business report.

A. Proposed Chairing Arrangements for future meetings

The Joint Committee considered the proposed chairing arrangements for future meetings.

- February 2018 – North Somerset Council
- June 2018 – South Gloucestershire Council

Meeting dates to be confirmed outside of the meeting. **Action: Officers**

The Joint Committee AGREED the proposed chairing arrangements for future meetings

B. Terms of reference and working arrangements

The Joint Committee considered the terms of reference and working arrangements as set out in the appendices.

In response to the Cllr Kent's proposal to amend the Terms of Reference, to include scrutiny of the proposed merger of the regional clinical commissioning groups the following points were noted in discussion:

a. The terms of reference had been agreed at the Full Council of each of the three authorities. The Legal Officer confirmed that any proposed amendments would need to go back to the individual Full Councils of the three authorities.

b. There was concern by councillors that it was not clear that they had the ability to scrutinise the proposed joint CCG and sub regional health body arrangements

c. It was acknowledged that if the proposed merger of CCGs was agreed that the new body would not be formally constituted until April 2018. It was thought that although likely, the outcome shouldn't be taken for granted within the context of this meeting. It was advised that a decision would be taken on 25th October.

d. It was recognised that due to differences in the authorities' committee calendars, there could be timing issues in managing the process to change the terms of reference

e. It was not clear to all members that an amendment was required at this stage prior to the confirmation of the decision to merge.

f. It was not clear to members whether a newly merged CCG would operate outside of the existing Sustainable Transformation Plan. It was confirmed by the Chief Executive, BNSSG CCGs that the organisation(s) welcomed scrutiny holding them to account both in individual and joint form and confirmed that CCGs were core members of the STP and coterminous with the STP. It was noted that any exercise of restriction of treatments for cost savings constituted a change to service but was not part of the STP.

g. The Joint Committee was asked to note that individual authorities were engaged in ongoing dialogue with the CCGs to discuss individual local authority concerns.

The Chair asked the Joint Committee to vote on the proposed amendment to the Joint Committee's Terms of Reference to be passed to individual authorities to progress.

*That the terms of reference add the power to scrutinise the new CCG and other NHS bodies acting together across North Somerset, Bristol and South Gloucestershire.*

Councillor Kent moved the amendment.

Councillor Hope seconded the amendment

Upon being put to the vote,

The Joint Committee RESOLVED that the proposed amendment be referred to individual authorities to progress through their governance processes. (17 members voted in favour with 1 abstention). **Action: Officers**

C. Invitation of co-optees or involvement of other stakeholders

The Joint Committee considered the invitation of co-optees or involvement of other stakeholders.

In discussion the following points were noted:

a. North Somerset had co-opted Healthwatch as an independent voice to the North Somerset Health Overview and Scrutiny Panel and had found this to be a positive working arrangement.

b. The Chair welcomed the role of Healthwatch as an independent voice and considered that a range of appropriate stakeholders with the relevant expertise could be invited to attend future meetings as required.

c. It was acknowledged that as the Joint Committee's membership was already a significant number it may not be appropriate to invite co-optees at this stage.

**The Joint Committee RESOLVED that:**

**A. the proposed chairing arrangements for future meetings be agreed**

**B. the Joint Committee's terms of reference and working arrangements as set out in the appendices be noted and that the proposed amendment be referred to individual authorities to progress through their governance processes.**

**C. relevant expertise and stakeholder involvement be requested when appropriate but not via a co-opted arrangement at this stage.**

**3. Apologies for Absence and Substitutions**

The following apologies for absence were noted:

Bristol City Council
- Councillor Chris Windows

North Somerset Council
- Cllr Mike Bell - Cllr Deborah Yamanaka attended in substitute
- Cllr David Hitchins - Cllr Charles Cave attended in substitute

South Gloucestershire Council
- Councillor Keith Burchell
- Councillor Sarah Pomfret

## 4. Declarations of Interest

Cllr Phipps expressed a declaration of interest, and confirmed being employed by the Southmead Development Trust Social Prescribing Project.

## 5. Chair's Business

There was no Chair's Business.

## 6. Public Forum

The following public forum items were received:

**Statements**

PS 01 Mike Campbell
PS 02 Viran Patel (Additional statement not included in the Public Forum pack)

Mr Campbell's representative (Protect Our NHS) presented his statement. Mr Patel was not in attendance.

**The Joint Committee RESOLVED that the statements be noted.**

**Questions**

PQ 01 Ms Daphne Havercroft
PQ 02 Mr Shaun Murphy
PQ 03 Mr Viran Patel

Shaun Murphy presented his questions. Ms Havercroft and Mr Patel were not in attendance.

It was noted that a written response would be provided to the questioners as per the Joint Committee's working arrangements. (attached at Appendix B)

**The Joint Committee RESOLVED that the questions be noted.**

In response to a member's question in respect of statements that had been submitted in respect of the Condon family, the Chair confirmed that the statements would go to the meeting of Bristol's Overview and Scrutiny Management Board Wednesday, 1 November 2017.

## 7. Sustainability & Transformation Plan (STP) for Bristol, North Somerset and South Gloucestershire

The Joint Committee considered the Sustainability Transformation Plan update report and presentations, (attached to these minutes at Appendix A) for information and discussion.

Julia Ross, Chief Executive, BNSSG CCG introduced the context for the presentations that followed and advised that the Sustainability and Transformation Partnership (previously the Sustainability and Transformation Plan) was the framework for how members organisations worked together in a more integrated way.

A. Recap on the BNSSG STP

Laura Nicholas, BNSSG STP Programme Director presented a recap of the progress to date of the BNSSG STP and shared examples of work that was being done differently as well as the plans for future engagement with councillors as the approach was developed.

In response to the presentation the following points were raised:

a. **Cllr Kirk** sought clarification over whether there was a statutory or legal framework that underpinned the STPs and Accountable Care Systems and sought to understand where the democratic accountability lay with reference to this. In addition, there was a question over whether these had been debated in Parliament and whether any legislation had been passed. It was confirmed that the STP did not have statutory or legal status but was a vehicle for members in health and local authorities to plan together over a larger footprint, and in a strategic way for their populations. Each individual organisation was still statutorily accountable for its own business and the local authority was a partner to the STP as it current stood.

b. It was important not to conflate Accountable care systems with STPs which were something different and about delivering a service in a different way which could only be done with a set of underpinning legal arrangements and the BNSSG CCG were not currently seeking to establish this type of arrangement although it could be an option for the future. The Chief Executive, BNSSG CCG suggested that a written reply would be appropriate to respond to these questions in more detail. **Action: BNSSG CCG**

c. Further, it was suggested that an informal seminar could be arranged for councillors, to provide some background knowledge on these subjects. The Chair agreed that this would be a useful approach. **Action: BNSSG CCG**

d. **Cllr Yamanaka** commented that whilst it was known that NHS funding would not be cut locally over the next five years, asked whether the funding was in real terms taking into account inflation or irrespective of inflation. The Programme Director BNSSG STP advised that a written answer

would be provided, to detail how the inflation calculations were worked through as different inflation rates could be applied. **Action: BNSSG CCG**

e. It was noted that future allocations would be determined by spending reviews that would be decided at a national level. It was noted however, that the rate of spending was currently increasing faster than the rates of inflation. The Chief Executive, BNSSG CCG confirmed that as a tax funded organisation, the focus was now to change delivery to a more appropriate model to service populations and to operate within the resources provided.

f. **Cllr Willis** reminded the Joint Committee that the minutes of the Meeting in Common on this issue had been changed to reflect the Committees decision to 'note' rather than 'accept' the STP, but agreed that the STP was a vehicle to work together to deliver services and that 'Healthy Weston' was a good example of how this process was working.

g. **Cllr Hope** stated that it was not clear what the current position was as Councillors had not been party to the work that had taken place and therefore did not have sight of the whole plan. For example, it was not clear what had happened to delayed transfers of care and the work to progress single point of access. It was difficult to understand the consequences of the changes and therefore difficult to scrutinise. Further, clarification was sought as to whether the STP had to go to Southwest Senate for quality assurance. It was confirmed that the presentations that followed would outline what had been achieved. For example, a real impact had been seen in delayed transfers as the Local Authorities and CCGs had been working very carefully with the community providers on this. In addition, Single Point of Contact had already been implemented across the CCGs.

h. In progressing the STP there was a definite need for the change in terminology from plan to partnership, which was necessary as the STP was not a unified plan but was a collection of organisations trying to bring a partnership together to make better use of resources. The STP was initially envisaged as a plan and they had been moving on with these things. All organisations were spending more than they had. The goal was to be clearer about partnership priorities. There appeared to be misunderstanding about the role of the Senate. It was confirmed that, proposed clinical service changes would need to be taken through the senate. For example, some specific areas of the Healthy Weston redesign were required to go through the Senate process to be approved. However other areas would need to go through NHS England or through Scrutiny.

i. **Cllr Goggin** raised concern regarding the level of involvement Members had had in relation to the proposed BNSSG CCG merger and the low ranking that had been received from NHS England in respect of the STP. It was confirmed that a link could be provided to the published NHS England report. It was confirmed that each of the Local Authorities had received individual briefing sessions on the proposed merger and submitted feedback which had been included with the application to NHS England. [Link to be included here]

j. **Cllr Biggin** queried whether a merged CCG would result in improved or better purchasing power. It was believed that this would result in better economies of scale in negotiations with providers.

k. **Cllr Biggin** stated that in the move to increasingly digital forms of engagement it should be ensured that those without access to digital platforms were not left behind.

l. **Cllr Scott** queried the future of community hospitals at Cossham or Frenchay hospital in light of the positive benefits a proposed merger could offer. It was confirmed that a merged CCG could offer better strategic planning and use of resources in respect of the future of community hospitals including minor injuries at Cossham and the future community hospital at Frenchay. It was confirmed that the South Gloucestershire HOSC would be receiving an item regarding this at its next meeting.

B. Case for Change and Strategic Framework Development

Dr Gemma Morgan, Public Health Clinical Lecturer & Specialty Registrar presented the developing case for change and strategic framework development including the work to jointly assess health needs and associated data.

*The Chair adjourned the meeting of the Joint Committee for a 10 minute comfort break*

C. Key drivers for change

Dr Kate Rush, GP & Member of the BNSSG Clinical Cabinet presented the key drivers for change to improve the patient experience and quality of care to improve outcomes and the opportunity to improve efficiency by working differently to meet the needs of the population and reduce expenditure.

*The Chair requested that further questions be taken at the end of the presentations*

D. Communications and engagement approach

The Chief Executive, BNSSG CCGs presented the Communications and engagement approach, to build public confidence and trust through the STP and reflect the needs and aspirations of local people in prioritisation and decision making.

In response to the presentations the following points were made:

a. **Cllr Kirk** remarked that it was important that the financial recovery plan was shared and presented to the public, in light of the scale and the speed of the cuts that need to be made this year. It was noted that there was a projected residual risk of £22.5m which had not yet been included as part of the current savings proposals and the sum of £17m which was planned for a future surplus. Further it was noted that the idea of control centres had been presented to councillors but it was important that the public were made aware of these. It was confirmed that the BNSSG CCGs were

still in process of finalising the savings plans with some areas still being out for consultation and were working with NHS England regarding what savings could be delivered this year and in subsequent years. It was important to note that as a democratically tax funded system it was it was the role of the STP to work to redesign, deliver and pay for services in a different way within the existing budget allocation of £350m. As the detailed financial plan was developed the BNSSG CCG would bring back to next meeting for discussion. **Action: BNSSG CCG**

b. It was confirmed that Control centres were a CCG invention to focus on different areas of care and explore the potential changes that could be made. The Joint Committee was asked to note that the existing proposals had been published and that public engagement on the financial recovery plan had taken place with each of the Local Authority Scrutiny Committees.

c. **John Readman, Strategic Director for People, Bristol City Council** advised that there was a lot of work and joint dialogue taking place in Local Authorities and in partnership with CCG colleagues both at Cabinet member level, officer level and with Julia Ross meeting with the Local Authority Chief Executives in order to meet the tough challenges and avoid the risk of cost shunting.

d. **Cllr Phipps** noted that many of the elements of prevention proposals would need to be delivered or supported by Local Authorities such as MSK, the Great Weight Debate and Sugar Smart and asked whether it would be possible for projects to be linked and coordinated with a process for Members to feed into the outcomes?

e. **Mark Petroni, Director Public Health, South Gloucestershire** confirmed that a lot of prevention work was being delivered through public health departments, with formal and informal mechanisms to ensure the work is joined up. The informal mechanism means the lead consultant of public health in each of the local authorities takes account of the issues in each of the local authority areas. There is a formal monthly meeting of the West of England Public Health Partnership which includes BANES which is minuted and presents annually to the Chief Executives of the Local Authorities and the action plan is published on council websites.

f. **Cllr Biggins** remarked that a tightening up of repeat prescriptions was required to ensure that patients' needs reflected their ongoing health; and noted that education could help people change lifestyle choices. It was confirmed that the medicines management programme was focused on the right medication for the right things, to ensure that they are used and taken effectively and that repeat prescriptions were regular reviewed.

g. **Cllr Hope** remarked that it would be important for Members to have access to monitor the ongoing outcomes of service redesign work such as MSK and Respiratory programmes. It was noted that there had been a press release which reported that people were dying of respiratory problems. There may be a role for Members to support clean air as a public health initiative issue in order to look at the issue as a whole and make an impact on this.

h. The Director of Public Health, South Gloucestershire advised that the West of England Public Health Partnership had coordinated public health input into the Joint Spatial Plan and Public Health Strategy. There had been positive achievements around health inputs into the plan. Air quality still needed to be addressed by Local Authorities through their transport mechanisms but it was noted that Bristol and South Gloucestershire continued to work in partnership in this issue.

i. **Cllr Hope** reiterated the importance of the need for a robust response to these issues. It was noted that BNSSG CCGs welcomed the Local Authorities ability to tackle some of the wider determinants of health issues.

j. **Cllr Knight** asked that public communications were tested with lay people of all ages before being published. There was a concern that some of the terminology and acronyms used would not be easily understood by the target audience. It was agreed that this was valuable feedback and would be actioned. **Action: BNSSG CCG**

k. **Cllr Combley** queried what performance indicators existed that would illustrate the success of the redesigned programmes, and requested confirmation of how Members could help to scrutinise them. It was confirmed that performance indicators were currently being designed. Information would be provided at the next meeting to clarify the work being undertaken to produce health improvement plans for improved health outcomes for different patient groups. **Action: BNSSG CCG**

l. The Director Public Health, South Gloucestershire advised that a BNSSG prevention plan was being drafted to look at how to reduce ill health alongside the promotion of good health and will have outcome measures attached to it.

## 8. Healthy Weston

The Joint Committee considered the report and verbal update on the Healthy Weston programme.

The Chief Executive, BNSSG CCG provided the context and an outline of the programme known as 'Healthy Weston' before handing over to Dr Peter Collins, Medical Directory, Weston Area Health NHS Trust.

The following key points were noted:

a. Weston area health trust had been a challenged hospital for some time, second smallest hospital in the country trying to provide a wide range of general hospital services which was difficult to make sustainable both from a financial perspective and from a health care workforce perspective. A lot of work had been carried out to look at Weston as a place, with all of the health and social care providers working together to deliver services in a way that better use could be made of the resources available.

b. Significant work had taken place to align the work of providers, commissioners and primary community services into a cohesive vision to meet the needs of their populations and could start to demonstrate real change.

c. The decision to implement temporary overnight closures at Weston Hospital, due to safety concerns, had gone well due to the ability to call on health partners to take care of patients. It had also acted as a catalyst for work being done to look for different models of care and start a healthy debate with the public regarding the provision of the best care possible within the resources available.

In response to the summary report, the following points were raised:

a. **Cllr Willis** confirmed that the North Somerset Council's Health Overview and Scrutiny Committee would be discussing the Healthy Weston Programme at its next meeting. A huge amount of work had been done by North Somerset and North Somerset Councillors were very much engaged in the process.

b. **Cllr Biggin** commented that there may not have been sufficient communication with local residents to explain the safety issues related to staffing that resulted in the decision to implement temporary overnight closure. Work had been carried out to spread the message that this is a collection of different services that could be provided in a different way. There was a responsibility to ensure that patients that attended Weston could be treated safely and if that was not possible to find alternative ways of treating them. The education piece had been all about the staffing difficulties and it would take time to communicate that effectively.

c. **Cllr Holloway** recognised that the situation was complicated and queried how close they were to receiving a list of targets and timescales.It was advised that in respect of the wider work programme a detailed plan was expected at the end of the financial year.

*Cllr Knight left the meeting*

d. **Cllr Scott** commented that Police and Education Services were publicly lobbying central government for an increased allocation in the forthcoming budget and queried whether there was a risk of the NHS falling behind if they just accepted the settlement. It was noted that the head of NHS England was exercising his role to speak about extra funding nationally and the challenges on the health service. Locally the role of the BNSSG CCG was to operate within its means.

e. **Cllr Combley** queried whether there was any evidence that the impact of the Weston Hospital closure had led to better outcomes and what impact the closure had had on other hospitals picking up the work. It was confirmed that there was a weekly meeting of those services involved in overnight care and the impact on the other acute services at Musgrove Park, Southmead Hospital and UHB was being carefully monitored. In addition there was careful monitoring of whether there was any adverse impact on patients that would normally have attended Weston. It

was noted that detailed planning with partners as part of the STP process in advance of the temporary closure modelled what would happen and things had gone according to plan. On average 9 patients overnight are transferred to various hospitals in the region with more going to Taunton than North Bristol.

f. In terms of outcomes it has been safer. Providing effective car for people but some people have to travel further. The alternative models being looked at aim to make the most impact as quickly as possible. In addition, no incidents had been reported nor negative feedback received. Many of the more complex services were already being provided by partners elsewhere that a small hospital could not be expected to provide, although this may not be widely understood.

g. **Cllr Willis** suggested that it might be useful to share the Weston Hospital data with members of the Joint Committee. **Action: BNSSG CCG**

The Chair thanked all present for their contributions and noted that the next meeting would be held in North Somerset.

**9. Appendix A: Sustainability and Transformation Plan Update Presentation**

Presentation delivered at the meeting to update on progress with the Sustainability and Transformation Plans.

**10. Appendix B: Response to Public Forum Questions**

Attached are the responses to Public Forum Questions submitted to the meeting of the Joint Health Overview and Scrutiny Committee held on 23 October 2017.

a. Response to PS 01 Mr Mike Campbell

b. Response to PQ 01 Ms Daphne Havercroft

c. Response to PQ 02 Mr Shaun Murphy

d. Response to PQ 03 Mr Viran Patel

Meeting ended at 1.00 pm

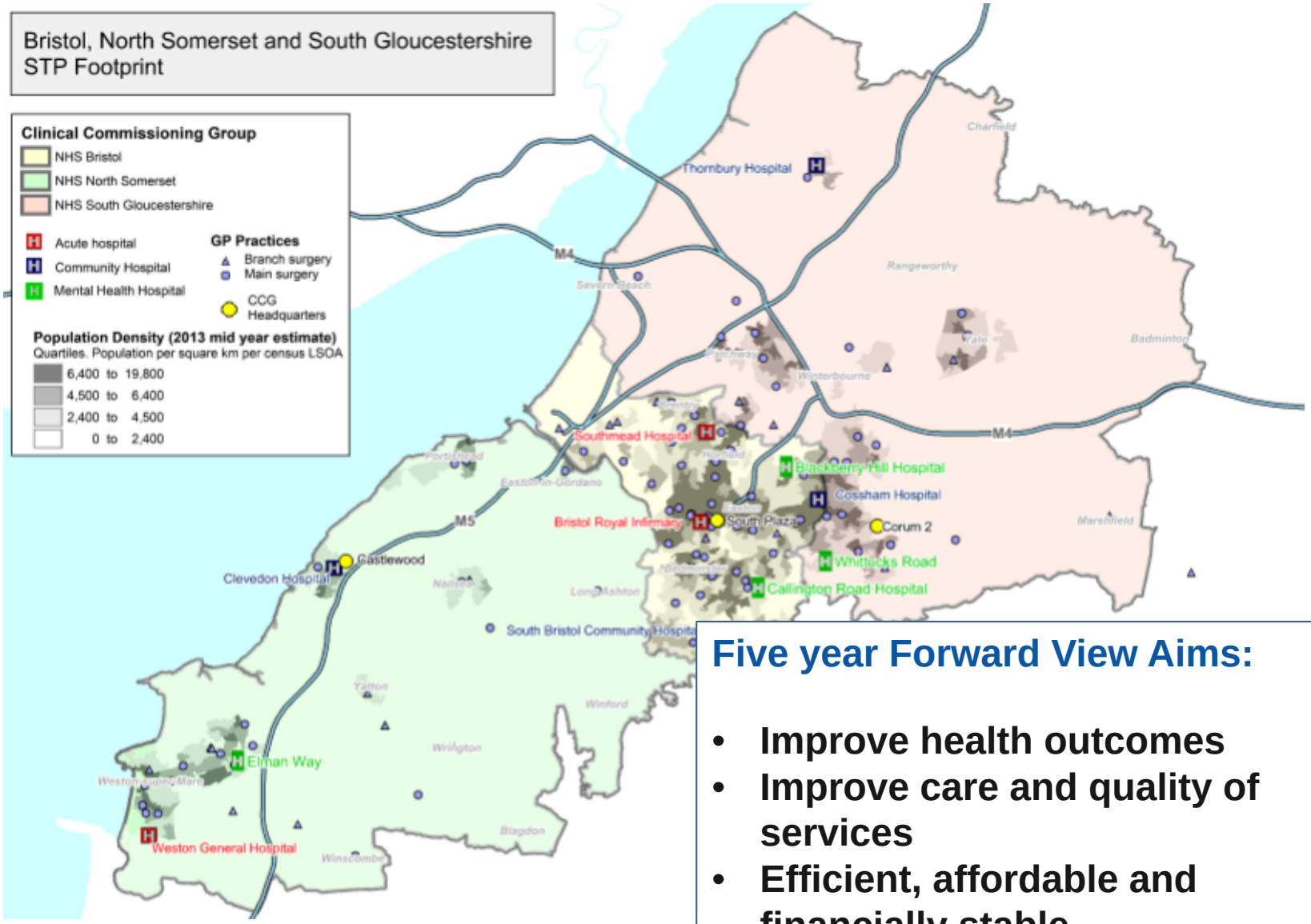
**CHAIR _____**

2017

# Recap of the BNSSG STP

Laura Nicholas,
STP Programme Director
**23 October 2017**

# Bristol, N. Somerset & S. Gloucestershire STP




## Five year Forward View Aims:

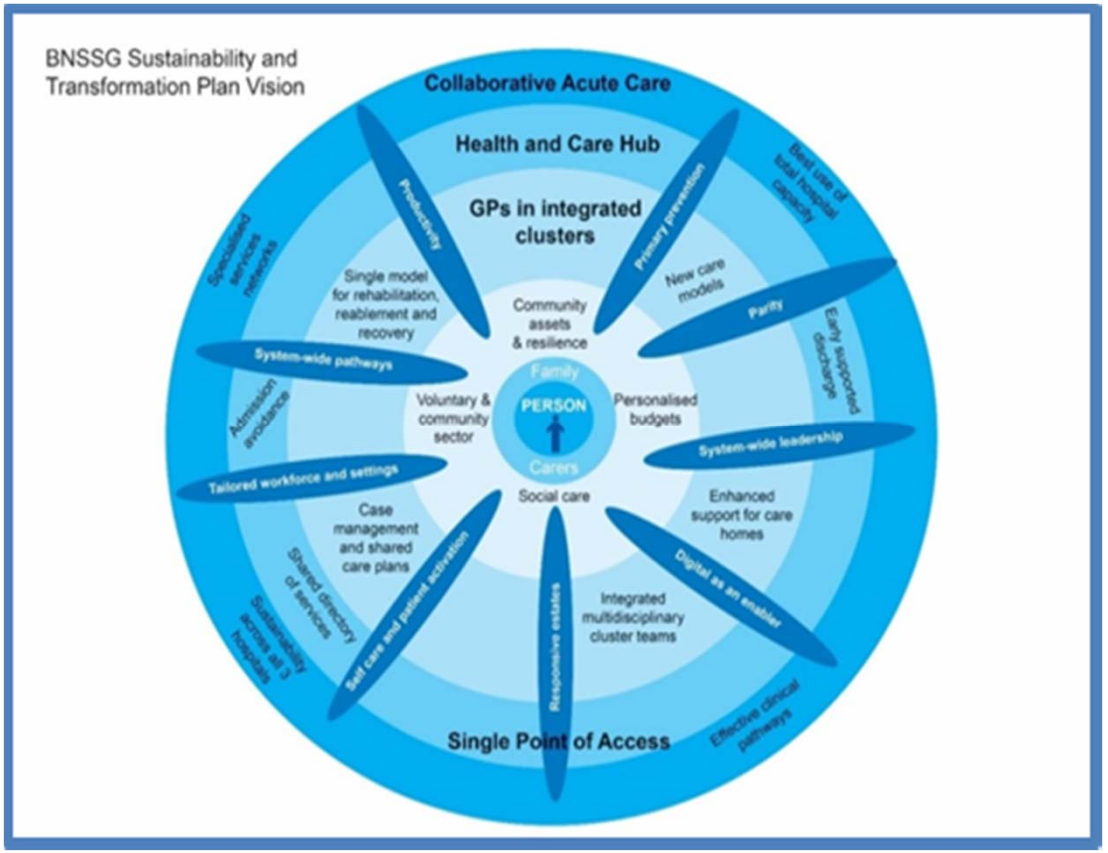
- **Improve health outcomes**
- **Improve care and quality of services**
- **Efficient, affordable and financially stable**

# Our Vision – Where we started

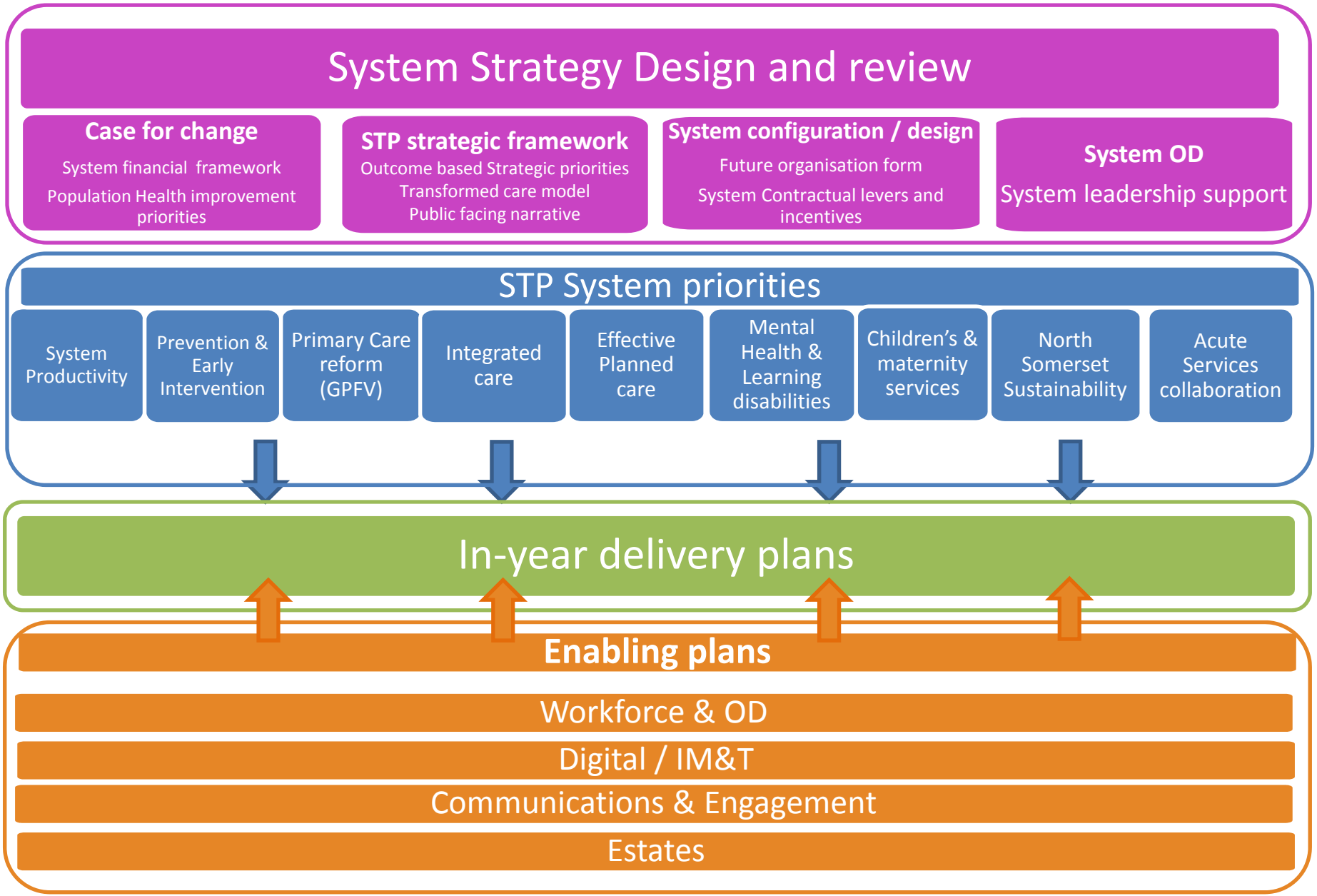
***Health is made at home; hospitals are for repairs***
***(African proverb)***

**Our vision of care starts with people in families and communities**:

- Maintaining independence
- Improving prevention and self care
- Integrated care and services focused on the individual's needs
- Delivered as close to home as possible
- Straight forward access to more specialist care when needed

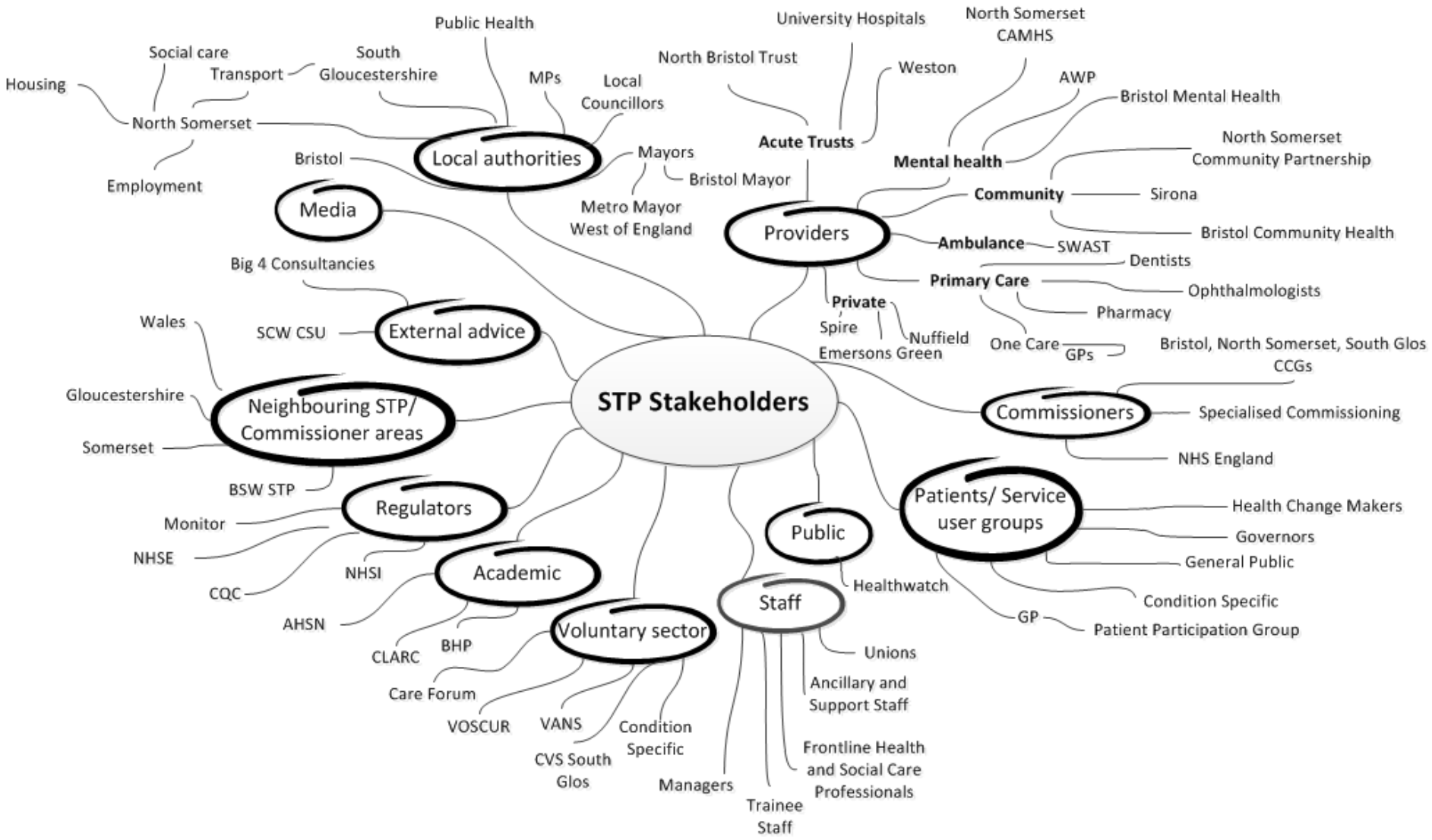


# A refreshed, refocused work programme



# ‘I’ Statements (draft)

# Who's involved



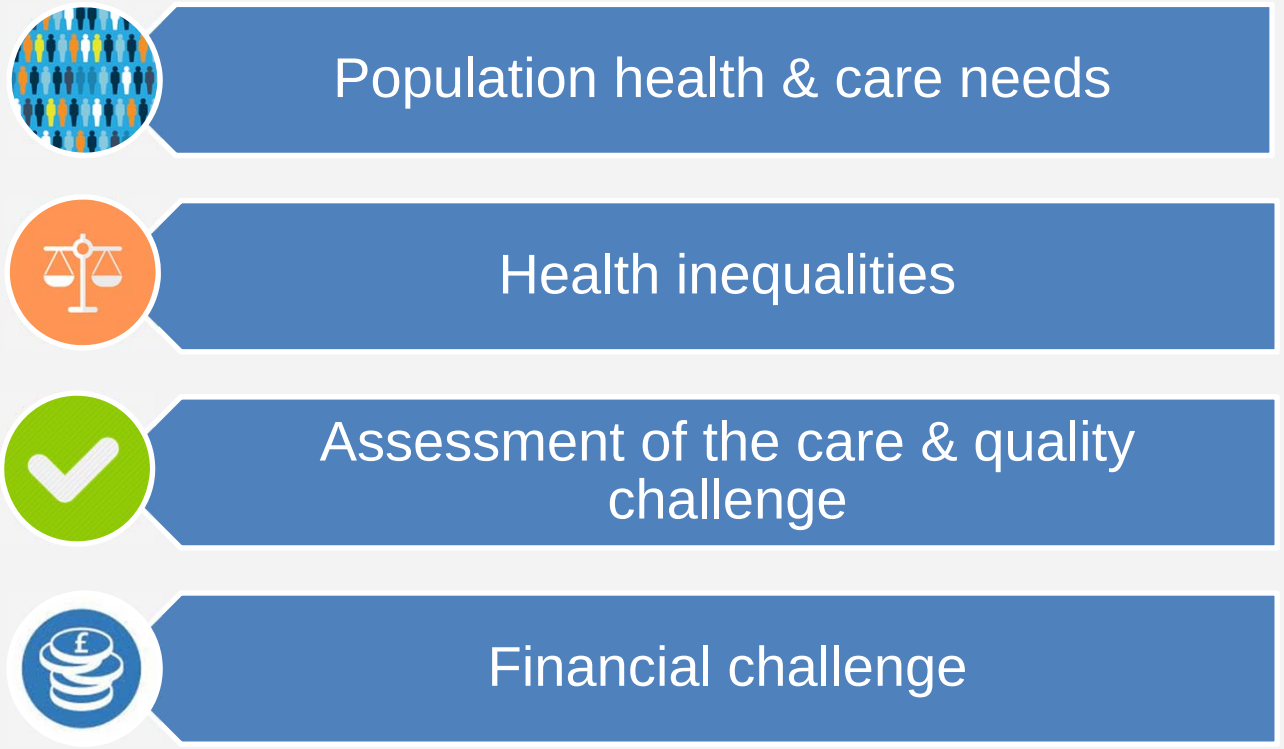
2017

# BNSSG STP Case for Change

Dr Gemma Morgan,
Public Health Clinical Lecturer
& Specialty Registrar

# Developing the case for change

Provides evidence base around BNSSG-wide:




- Builds on assessment made in our October 2016 submission, but provides a greater level of detail on specific challenges and potential opportunities

- The first time such a detailed and consolidated view across the BNSSG area has taken place.

# Population overview

- Almost 1million people live in BNSSG – 90% live in urban areas
- BNSSG is a relatively affluent area, but there are significant areas of deprivation – nearly one in ten are living in some of the most deprived areas
- We are a culturally diverse area – 9.8% of the population have black or Asian ethnicity
- 18% of the population is aged 0 to 14 years, 8% are over 75 years and 41.8% of the population is in the 15 to 44 years age group (significantly more compared to the average of other STP areas)
- The population is estimated to grow by 4% in four years

# The emerging BNSSG case for change

Overall **mortality** rates good compared to England, but Bristol one of the worst

**Smoking** amongst 15 year olds is worse than England

**Binge drinking** rate is greater than England

Emergency admissions comparable to England average

- **Self harm** admissions (esp females) rate is worse
- **Injury** admission rate in 0-4 and 15-24 is worse
- **Alcohol**-related admissions are greater than SW or England

Struggling to meet NHS Constitution standards for **access to care**, such as A&E treatments, elective and cancer treatment **waiting times**

86% of the population rate the overall experience of **GP surgeries** as very good or fairly good; however the range across practices is from 51% to 98%

Currently **£92.8m overspent** and this will rise to **£324.8m in 4 years time** if nothing changes

# Key conditions

Overall premature mortality rates are good compared to England, but Bristol population is amongst worst in England for prem. Mortality

Key conditions

- **Cancer (lung and colorectal)**
- **Heart disease and stroke**
- **Liver disease**
- **Lung disease**
- **Injuries**

Source: PHE healthier lives

| Disease | Bristol | | South Glos | | North Somerset | |
|---|---|---|---|---|---|---|
| | Rate | Rank in 150 LA | Rate | Rank in 150 LA | Rate | Rank in 150 LA |
| All premature deaths | 384 | 103rd | 272 | 14th | 305 | 45th |
| Cancer | 153 | 107th | 119 | 15th | 133 | 53rd |
| Lung Cancer | 62 | 78th | 46 | 18th | 47 | 28th |
| Breast Cancer | 19 | 32nd | 17 | 18th | 21 | 77th |
| Colorectal Cancer | 14 | 130th | 11 | 47th | 12 | 79th |
| Heart Disease and Stroke | 82 | 83rd | 60 | 17th | 60 | 18th |
| Heart Disease | 41 | 68th | 33 | 29th | 28 | 8th |
| Stroke | 16 | 103rd | 10 | 17th | 12 | 37th |
| Lung Disease | 40 | 96th | 23 | 12th | 27 | 36th |
| Liver Disease | 20 | 89th | 13 | 15th | 15 | 34th |
| Injuries | 16 | 127th | 8 | 19th | 13 | 83rd |

Premature mortality outcomes: worst | worse than average | better than average | best

Age standardised= rate per 100 000 and rank among all 150 Local Authorities in England, 2013-2015

# Risk factors

Common risk factors include:

- Alcohol
- Smoking
- Diet/obesity
- Cholesterol
- Hypertension
- Atrial fibrillation

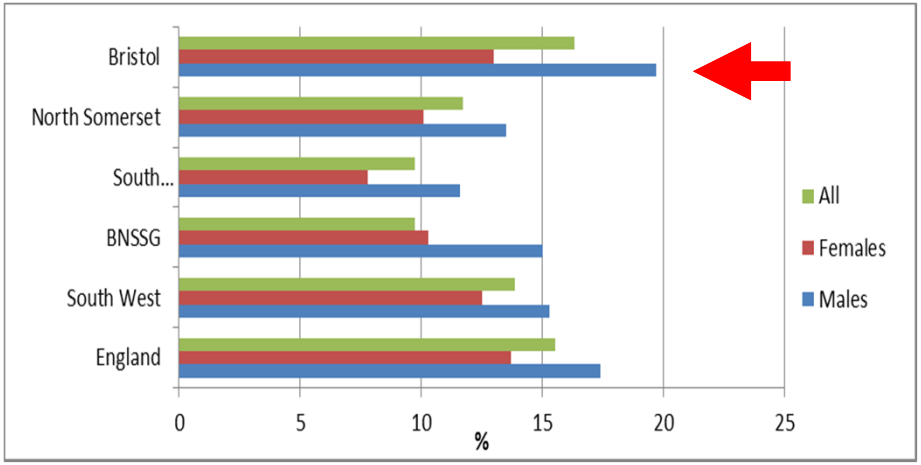
Under-recognised - lower % on GP register compared to SW / England

- Hypertension
- AF (only ~75% recognised)
- Diabetes
- COPD

Binge drinking rate in BNSSG is greater than England

BNSSG smoking rates are comparable to England but

- Bristol (M) smoking rate worse than SW and England




Smoking amongst **15 year olds** across all BNSSG is worse than England

# Health service use across BNSSG

Emergency admissions

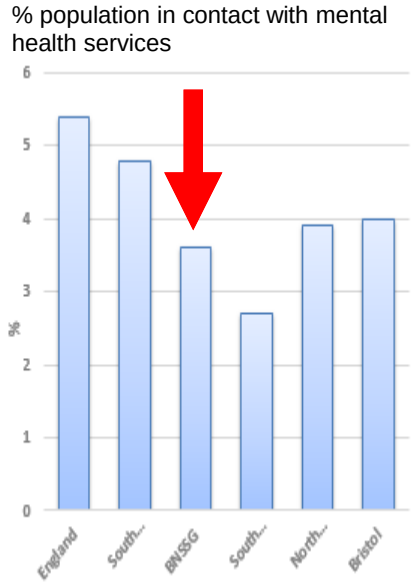
- Overall are comparable to England average
- **Self harm** admissions (esp females) rate is worse than England
- **Injury** admission rate in 0-4 and 15-24 is worse than England
- **Alcohol**-related admissions are greater than SW or England

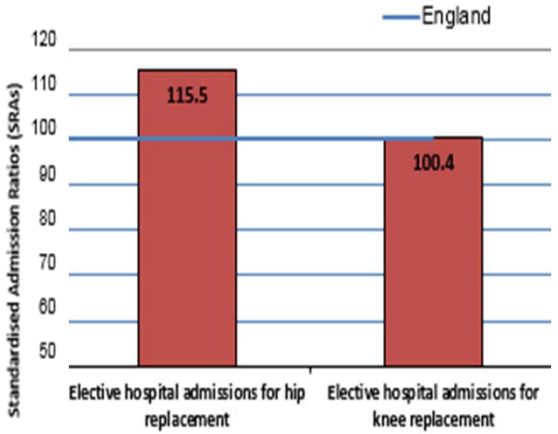
Mental health

- Adults in contact with MH services in BNSSG lower than SW and England

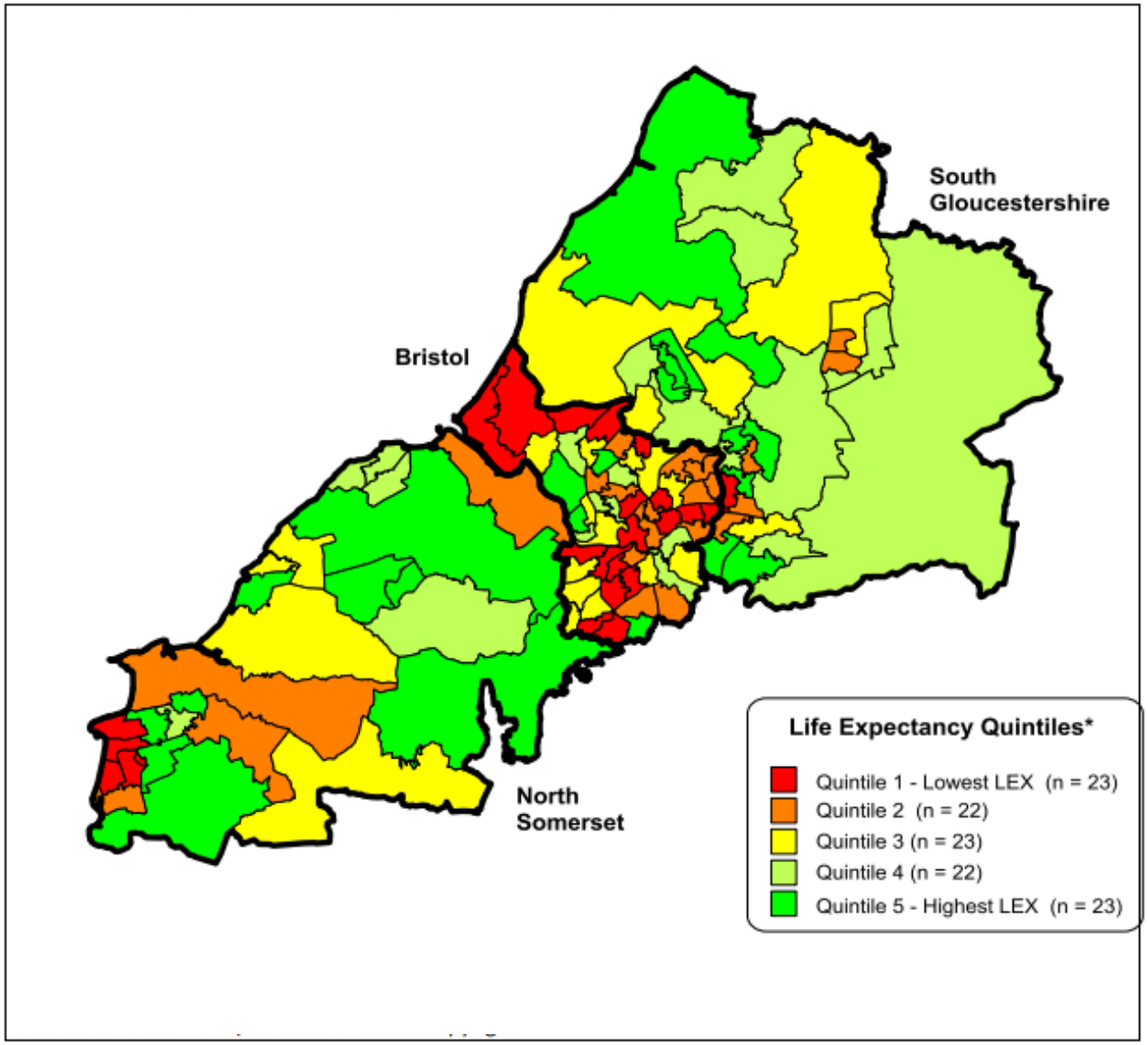
Elective admissions

- **Elective hip replacement** admissions greater than England
  - GP-recorded arthritis diagnoses are greater tha England



# Inequality in life expectancy



# Thank you…

Any questions?

2017

# STP work programme

Dr Kate Rush,
GP & Member of the BNSSG Clinical Cabinet

# Key drivers for change

- Improve the patient experience
- Improve the quality of care
- Improve outcomes
- Reduce / contain expenditure

# Our priorities

Current priorities include:

- Prevention and early intervention
- Integrated care
- Primary care
- Mental health and learning disabilities
- Healthy Weston
- Acute care collaboration
- System productivity

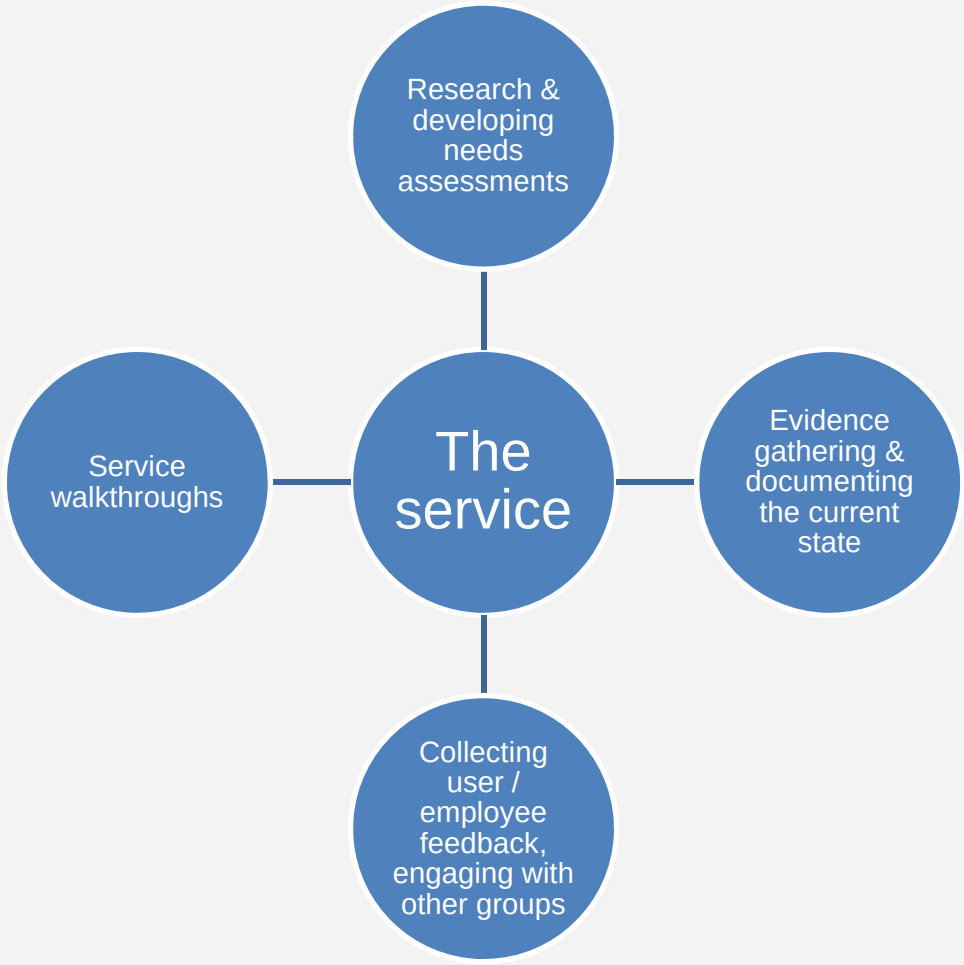
# Our Current Redesign Programmes

Current clinical redesign programmes include:

- Respiratory
- Musculoskeletal
- Diabetes
- Stroke
- Cluster based (integrated working)

# Redesign process overview

In each instance, a systematic BNSSG-wide method has been taken to the redesign process…



# Respiratory care pathway

The ‘respiratory vision’ is:

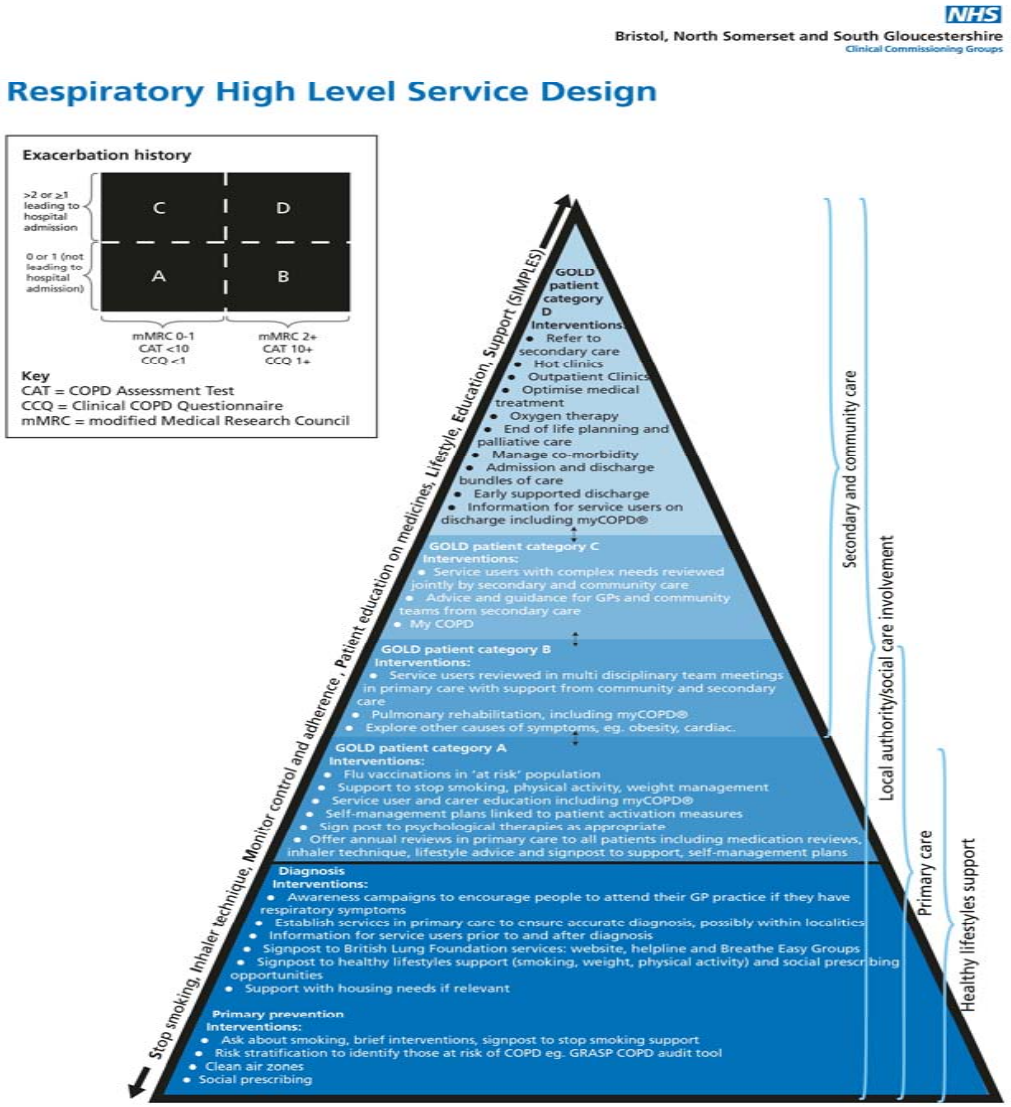
“For primary, community, secondary care and the voluntary sector to provide an integrated respiratory service without walls across BNSSG.”

Focus on COPD in the first instance:

- Work ongoing since February 2017 to develop a new model of care
- Number of workshops held so far with providers and other key stakeholders to help design the pathway
- Patient involvement integral to the process – Breathe Easy Groups, Puffers Group, targeted outpatient questionnaire, Health Change Makers

# Respiratory care pathway

- Focus on primary prevention and diagnosis
- Ensuring patients receive the support they need in the right place by the right person
- Integration of services across settings
- Education across BNSSG for the population and professionals



# Voluntary sector involvement

The British Lung Foundation have played a key part, providing:

- ✓ The voice of the voluntary sector to the Programme Board
- ✓ Support in recruitment of a service user to sit on the Programme Board
- ✓ Engagement support with Breathe Easy Groups
- ✓ Attendance at all four service design workshops
- ✓ Joining the dots with other areas who had already redesigned respiratory services.

" The British Lung Foundation are pleased to be part of the Respiratory Programme, making sure that the patient perspective has been well-represented at all stages of the service design process."

# Musculoskeletal (MSK)

- The South West region has the highest number of MSK related ‘years lived with disability’ in England
- Approx. 150,000 people in BNSSG have an MSK condition
- 44% of work related illness is due to MSK and 11.5% of incapacity claims are for MSK conditions

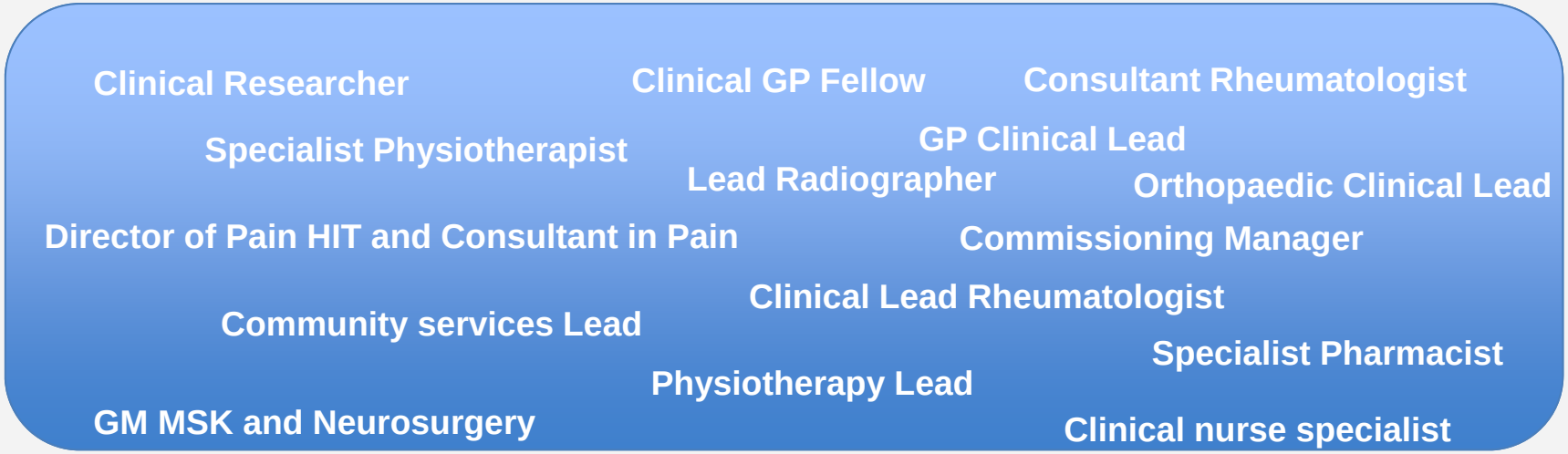
“The aim is to improve the pathway for patients, encouraging a more integrated approach to deliver reduced wait times, improved outcomes and experience within a sustainable budget.”

- The scope includes pain, rheumatology, orthopaedics, physiotherapy and podiatry
- We currently have a complex pathway to access care and want to make this simpler for patients to navigate to get the care they need.

# Musculoskeletal (MSK)

We have clinical leadership and engagement at every level:

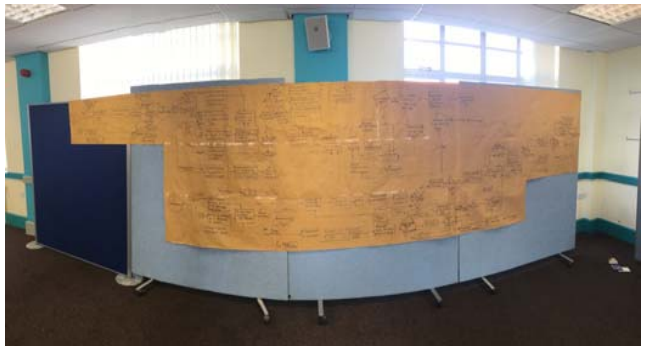
- ✓ **Sponsoring board** – Chair of the Clinical Cabinet is a member
- ✓ **Assurance through clinical cabinet** – A broad range of clinical leaders from across the system involved in reviewing and checking quality, safety, evidence and involvement in programmes and projects
- ✓ **Clinicians leading and engaged in every transformation programme** – Each programme has a clinical leader and clinical engagement involved in the design of the programme and the development of any proposed changes
- ✓ **Patients in-depth feedback** – patient groups across BNSSG



# Musculoskeletal (MSK)

We have been undertaking a thorough review of all services to create a shared understanding:

- Comprehensive needs assessment
- Feedback from clinicians working in the service
- Feedback from patients using services
- Evidence base of integrated MSK services and learning from other areas
- Workshops to identify issues and develop solutions together for each area



# Musculoskeletal (MSK)

Next steps:

- Workshop this month to design the MSK pathway for BNSSG
  - PPI and Equalities leads facilitating
  - Outcome an initial draft model to be finalised by December
- Implement new model April 2019
- CLAHRC undertaking qualitative research on engagement with patients and what self management means to patients and clinicians as part of this programme.
- Feedback can still be made via the following link:
  - https://www.southgloucestershireccg.nhs.uk/get-involved/current-engagements/musculoskeletal-services-your-experiences/

# Diabetes

The ‘Diabetes programme’ vision is:

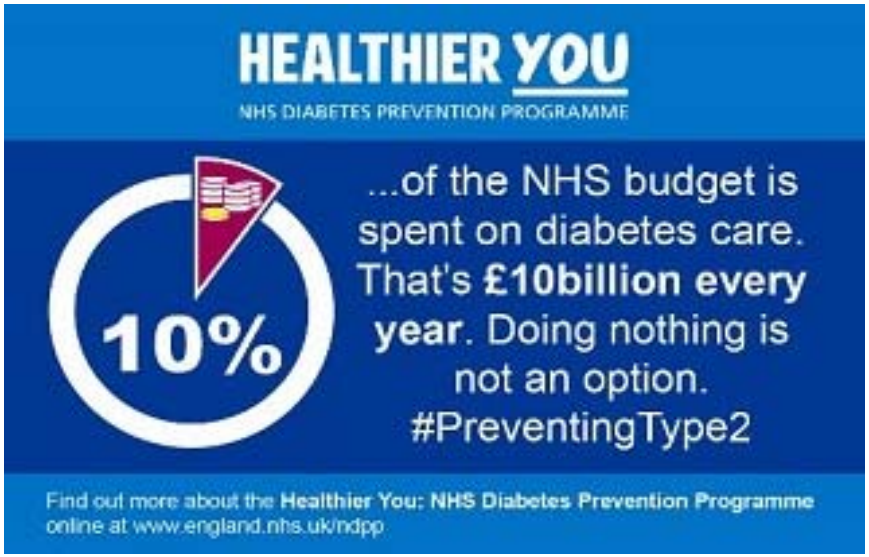
“To develop an integrated diabetes service which wraps around the patient and is focused on this, not limited by organisational boundaries”

- Outcomes based approach
- Workshops and consultations are underway including service users, carers and the public to develop and design the service
- Current projects:
  - National Diabetes Prevention Programme
  - Education – focusing on diagnosis, early management and prevention of complications
  - Prevention of complications – treatment targets and foot care
  - In-patient care

# Diabetes

National Diabetes Prevention Programme:

- Joint programme with Public Health England, NHSE and Diabetes UK
- Focus on identification of those at risk of Type 2 Diabetes
- Receive personalised help
  - Education
  - Help to lose weight
  - Bespoke exercise programmes

# Thank you..

Any questions?

2017

# Communications & Engagement

Julia Ross, BNSSG CCGs
Chief Executive

# Through the STP our aim is to build public confidence and trust

- Reflecting the needs and aspirations of local people in our prioritisation and decision making
- Designing pathways and services that work for the people who use and operate them
- Enabling and empowering people to take control of their own health; and support the friends, families and communities who care for them
- Valuing our stakeholders and keeping people informed and involved in everything we do

# We will achieve this by:

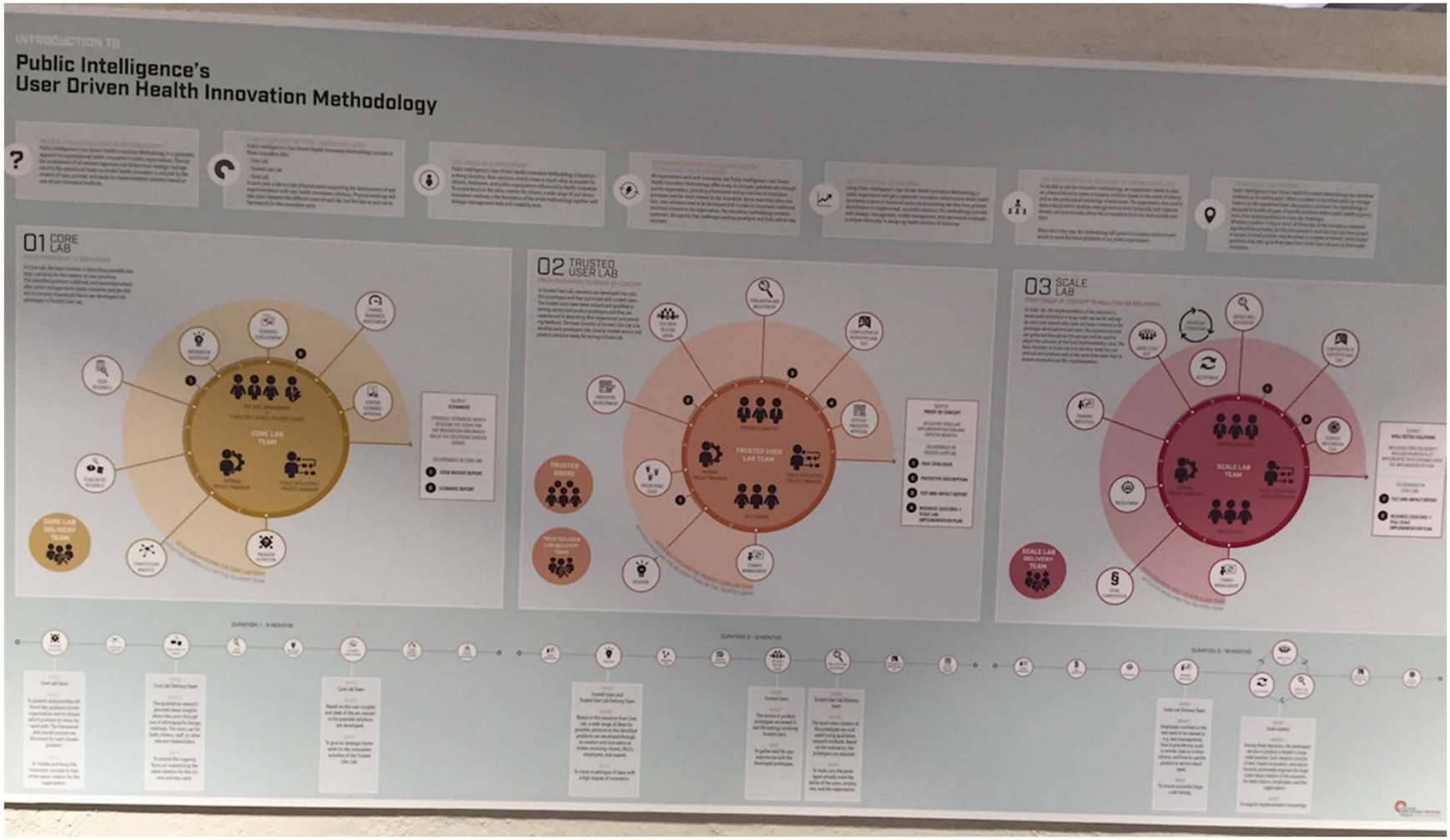
- Commissioning a programme of deliberative research and establishing a citizen's panel
- Designing a systematic, structured and repeatable methodology for user-centred design
- Embedding shared decision making and informed self-care in clinical pathway design
- Providing regular and ongoing communication tools for use by all partners

# 1. Deliberative research

PURPOSE: To uncover the public's informed, considered and collective view on the values and priorities we should apply to STP prioritisation, plans and decision making.

- Representative population sample
- Informed deliberation through independently facilitated events
- Outcomes tested through quantitative survey (conjoint analysis)
- Online citizen's panel established for ongoing test and feedback of STP plans

# 2. User-centred design methodology



# 3. Shared Decision Making & Informed Self-Care

All pathways to consider:

- How professionals can support the patient's Choice | Options | Decision throughout the pathway
- Patient and clinician education
- Tools & resources
- New models of care delivery (e.g. group consultations)

# 4. Ongoing stakeholder involvement

- Ongoing PPE Forum facilitated by the core team
- Regular newsletter(s) – public and professional stakeholders
- Common presentations, newsletter articles and other communication collateral for use by all partners
- Communications and engagement professionals embedded through all programmes for tailored support
- Core decision-making meetings in public

# Thank you…

Any questions?

**Joint Health Overview and Scrutiny Committee - 23 October 2017**

**Subject: BNSSG STP**

**Question PS01 submitted by: Mike Campbell**

I am sure that members are mindful of the questions from, and responses to, members of the public at the last JHOSC meeting in December 2016, when this committee resolved "to receive the [STP] report: this would not indicate acceptance of the STP proposals as presented".

I welcome the fact that item 7, Sustainability & Transformation Plan (STP) for Bristol, North Somerset and South Gloucestershire is being presented with the purpose of updating the JHOSC on progress with the BNSSG STP plans. Does this mean that the committee now accepts the plans?

Bristol CCG recently said, "we have a significant gap in our finances across Bristol, North Somerset and South Gloucestershire and we are looking at a number of ways to help us balance our budgets". But the STP report contains no information about how this will be done.

My reading of the STP report is that it is rather selective in what areas it covers. For example, there is no mention of proposed changes to and consultations on reproductive medicine issues, no mention of post-cancer breast reconstruction policy issues, no mention of proposals to reduce the prescribing of 'Over the Counter' medicines and no mention of changes to urgent care provisions.

Are consultations on such matters taking place with elected members?

**Reply from the Joint Health Overview and Scrutiny Committee**

- The Joint Health Overview and Scrutiny Committee first formally met on 23 October 2017 and have not been asked to 'sign off' or accept any plans. The Joint Committee will continue to receive regular updates as the BNSSG Sustainability and Transformation Partnership plans emerge so that the Joint Committee has the opportunity to comment and provide input at the appropriate points.

**Reply from the Chief Executive, BNSSG CCGs**

- The proposed changes referred to which have been subject to recent consultation are part of the work to implement the CCGs' operational plan for 2017/19 and are not directly part of the programme of work relating to the STP. The feedback from each of consultations will inform decisions by the CCG Governing Body about whether to proceed with the proposed changes.

- Details of the CCGs' operational plan are available on each of the CCG websites - this is a combined operational plan for the three current CCGs

- For each of the consultations a 'you said, we did' report will be published summarising the feedback received in each case and the actions being taken in response to this.

- Decisions in relation to the each of the proposals will be taken by the CCG Governing Bodies via the regular public meetings.

- As part of the consultation process briefing material was provided to the members of each of the local authority involved in the overview and scrutiny of health matters.

**Joint Health Overview and Scrutiny Committee - 23 October 2017**

**Subject: Care Needs Assessments**

**Question PQ01 submitted by: Daphne Havercroft**

1. For each council - Bristol, North Somerset and South Gloucestershire, what are the target timescales for carrying out care needs assessments and what are the achievements against the target?

2. For each council - Bristol, North Somerset and South Gloucestershire, what are the target timescales for issuing written decisions following a care needs assessment and what are the achievements against the target? !

3. Are there any national timescales for conducting care needs assessments and issuing written decisions? If so, what are they? (According to Age UK, the Local Government Ombudsman has said that a reasonable time for an assessment should normally be between four and six weeks from the date of the first request).

**Reply from Bristol City Council, North Somerset Council and South Gloucestershire Council**

- There is no target timescale for carrying out an assessment. When we are contacted by someone, a member of our social care team will have an immediate conversation to help identify what sort of help they need and how to access it. If the person requires a more detailed assessment from a Social worker this is passed on to one our area teams who will arrange this with the person. We would prioritise this depending on the circumstances or potential risk.

- We do not have a target timescale for issuing a written decision following a care needs assessment, but we would expect the assessment to be shared quickly, as soon as the assessment is completed.

- The Care Act:
  The Care Act specifies steps that the local authority must take for the purpose of ensuring that the assessment is carried out in an appropriate and proportionate manner;

- Statutory Guidance:
  6.29 An assessment should be carried out over an appropriate and reasonable timescale taking into account the urgency of needs and a consideration of any fluctuation in those needs. Local authorities should inform the individual of an indicative timescale over which their assessment will be conducted and keep the person informed throughout the assessment process.

**Joint Health Overview and Scrutiny Committee - 23 October 2017**

**Subject: STP Financial Savings**

**Question PQ02 submitted by: Shaun Murphy**

The papers before the Committee today do not appear to contain any financial details. Is the immediate financial aim of the STP to make savings of £83million in 2017-18 as reported in a recent article in the Health Service Journal, and does the longer-term aim remain that expenditure in the BNSSG area should be capped by 2020/21 to £305 million less than is required to maintain current services?

Nor do the papers contain details of current proposed cuts to health services such as the fertility service and breast reconstruction procedures after cancer, details of which can be found on the website of Bristol CCG. These and other proposed cuts, and the many which will follow in the coming months, are driven by the aim of capping the local NHS budget at a level at which it is not possible to provide the current level of service.

Will the Scrutiny Committee have a standing item on its agenda starting at the next meeting for which the NHS will provide a current list of proposed cuts to health services and a financial report showing the extent of NHS budget cuts within year in the BNSSG area?

**Reply from BNSSG STP Programme Director**

- Papers submitted to the JHOSC meeting explained the work that is ongoing on our BNSSG case for change. Initial work has been undertaken to understand the finance and efficiency aspects and this will be further developed over the coming months.

- NHS budgets across the UK are determined centrally. It is understood that there is a current financial gap of £92.8m across the BNSSG area which is estimated to reach £324.8m in four years if nothing changes. Overall levels of funding for the NHS in BNSSG will continue to grow (approx. 3% per year) in line with a growing population and to cover some cost increases, but spending is predicted to grow at a faster rate which we cannot afford (approx. 7% per year).

- There are opportunities to provide services in a way that will reduce waste and improve care – for example, more joined up care approaches. Working together we are trying to identify ways to improve care and treatment to make sure it is efficient, high quality and designed around the people who use the services. Proposals are being worked on, based on firm evidence and evaluation to ensure best possible value in terms of outcomes and results for patients as well as financial investment.

**Reply from the Joint Health Overview and Scrutiny Committee**

- The Joint Health Overview and Scrutiny Committee first formally met on 23 October 2017 and will continue to receive regular updates as the BNSSG Sustainability and Transformation Partnership plans emerge, so that Joint Committee has the opportunity to comment and provide input at the appropriate points.

**Joint Health Overview and Scrutiny Committee - 23 October 2017**

**Subject: Sustainable Transformation Plans (STP)**

**Question PQ03 submitted by: Viran Patel**

1) Present unmet need and demand in local services e.g. ADHD waiting list of 18 months and Autism waiting list of 6 months for adults, the figures are not registered anywhere and not included in the STPs plans. Neither are they included in the JSNA.
This goes beyond the 18 weeks promised for Secondary Mental Health Services by NHS England.
What will the Joint Committee do to hold to account the CCGs and Councils, around this matter within the STP plans ?

2) Following on from number 2, there is no inequality information, as shown above on services, under the Equality Act and or Impact study. That highlights the financial underinvestment, in presently commissioned services vs the savings impact likely ?
What will the Joint Committee do to hold to account the CCGs and Councils, around this matter within the STP plans ?

3) The lack of informed patient choice available through the present STP plans based on NICE guidelines evidence based approaches.
What will the Joint Committee do to hold to account the CCGs and Councils, around this matter within the STP plans ?

4) What will the Joint Committee do to hold to account the CCGs, Councils and NHS England, DOH, with patients and service users, both past and present, the issues of lack of services and cuts in services, since they have not been informed ? How do they plan to reject the plans and when with the scrutiny end since the plans are already being implemented ? Therefore is the committee complicit in the below statement ?

**Reply from the Joint Health Overview and Scrutiny Committee**

- The Joint Health Overview and Scrutiny Committee first formally met on 23 October 2017 and will continue to receive regular updates as the BNSSG Sustainability and Transformation Partnership plans emerge, so that the Joint Committee has the opportunity to comment and provide input at the appropriate points.