



**North
Somerset**
COUNCIL



Joint Health Overview and Scrutiny Committee Agenda

Date: Monday, 23 October 2017

Time: 10.00 am

Venue: The Council Chamber - City Hall, College Green, Bristol, BS1 5TR

Distribution:

Bristol City Council Members

Councillors: Brenda Massey (Chair), Eleanor Combley, Paul Goggin, Tim Kent, Gill Kirk, Celia Phipps and Chris Windows

North Somerset Council Members

Councillors: Roz Willis, Mike Bell, Andy Cole, David Hitchins, Ruth Jacobs, Reyna Knight, Ian Parker

South Gloucestershire Council Members

Councillors: Marian Lewis, Janet Biggin, Keith Burchell, Shirley Holloway, Sue Hope, Sarah Pomfret, Ian Scott

Copies to: John Readman (Strategic Director - People, Bristol City Council), Alison Comley (Strategic Director - Neighbourhoods, Bristol City Council), Becky Pollard (Director - Public Health, Bristol City Council), Shahzia Daya (Service Director – Legal and Democratic Services, Bristol City Council), Sarah Sharland (Legal Officer, Bristol City Council), David Jones (Interim Assistant Director, Adults' Support and Safeguarding, North Somerset Council), Mark Pietroni (Director of Public Health, South Gloucestershire Council), Gill Sinclair (Deputy to the Head of Legal, Governance & Democratic Services, South Gloucestershire Council), (Louise deCordova (Scrutiny Advisor, Bristol City Council), Leo Taylor (Scrutiny Officer, North Somerset Council), Claire Rees (Health & Wellbeing Partnership Support Officer, South Gloucestershire Council)

Issued by: Louise deCordova, Scrutiny Advisor
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Date: Friday, 13 October 2017

Agenda

1. Welcome and Introductions

In December 2016, The Bristol City Council People Scrutiny Commission, North Somerset Health Scrutiny Committee and South Gloucestershire Health Scrutiny Committee held a meeting in common to consider the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (BNSSG STP). (The minutes of the meeting are attached for information purposes.)

(Pages 4 - 29)

Subsequently, a statutory Joint Health Overview and Scrutiny Committee (JHOSC) has been established for the purpose of jointly scrutinising the BNSSG STP.

This is the first meeting of JHOSC.

2. Joint Health Overview and Scrutiny Committee - Business Report

The report sets out the proposed chairing arrangements for future meetings, notes the terms of reference and proposes consideration of stakeholder involvement.

(Pages 30 - 36)

The Joint Committee is asked to consider the recommendations in the report.

3. Apologies for Absence and Substitutions

The Joint Committee to note apologies for absence and substitutions.

4. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to

indicate the relevant agenda item, the nature of the interest and in particular whether it is a disclosable pecuniary interest.

5. Chair's Business

To note any announcements from the Chair.

6. Public Forum

The total time allowed for this item is 30 minutes.

Members of the public and members of council may participate in Public Forum.

The detailed arrangements for so doing are set out in the **Public Information Sheet** at the back of this agenda.

Public Forum items should be emailed to scrutiny@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-

Petitions, Statements and Questions – must be received, no later than, the working day prior to the meeting. For this meeting, your submission must be received in this office, no later than **12.00 noon on Friday, 20 October 2017.**

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

The purpose of this paper is to update the Joint Health Overview & Scrutiny Committee on progress with the BNSSG STP plans.

(Pages 37 - 58)

It covers:

1. Recap of the BNSSG STP
2. Case for change and strategic framework development
3. Developing a single commissioning voice
4. Work Programme
5. STP communications and engagement approach
6. Next steps/ timescales.

8. Healthy Weston

The Joint Committee to note the Healthy Weston update.

(Pages 59 - 61)

Bristol City Council

Minutes of the People Scrutiny Commission Meeting in Common with North Somerset Health Overview and Scrutiny Panel and South Gloucestershire health Scrutiny Committee to discuss the regional Sustainability and Transformation Plan



1 December 2016 at 2.00 pm

Attendance

Present from Bristol City Council:

People Scrutiny commission

Councillors Brenda Massey (Chair), Jos Clark (Vice-Chair), Mark Brain, Eleanor Combley, Gill Kirk, Cleo Lake, Ruth Pickersgill, Celia Phipps, Liz Radford

Other Councillors in attendance

Councillors Clare Champion-Smith (Cabinet Member for People), Fi Hance (Cabinet Member for Health & Wellbeing), Geoff Gollop (Chair of Overview and Scrutiny Management) and Jon Wellington (Neighbourhoods Scrutiny Commission)

Officers in attendance

John Readman (Strategic Director, People and Local Authority Regional Lead for the STP), Mike Hennessey (Service Director Care, Support and Provision – Adults), Nancy Rollason (Legal Officer), Karen Blong (Scrutiny Policy Advisor), Joshua Van Haaren (Democratic Services Officer).

Present from North Somerset Council:

Health overview and Scrutiny Panel

Councillors Roz Willis (Chair), Ruth Jacobs (Vice-Chair) Mike Bell, Sarah Codling, Andy Cole, Bob Garner, Ann Harley, David Hitchins, Reyna Knight, Tom Leimdorfer, Ian Parker, Donald Davies, David Jolley, Dawn Payne, Jill Iles

Officers present: David Jones (Assistant Director Adult Social Services), Leo Taylor (Scrutiny Officer), Julia Parkes (Democratic Services Officer),

Present from South Gloucestershire Council:

Health Scrutiny Committee Councillors

Councillor Toby Savage(Chair), Sue Hope (Lead Member), Ian Scott (Lead Member), April Begley, Janet Biggin, Robert Griffin, Paul Hardwick, Shirley Holloway, Sarah Pomfret, and Erica Williams



Officers in attendance

John Shaw (Head of Commissioning, Partnership and Performance), Claire Rees (Health & Wellbeing Partnership Support).

Expert Witnesses

Ellen Devine – Healthwatch Bristol

Georgie Bigg – Healthwatch North Somerset

Morgan Daly – Healthwatch

Health Partners in attendance

- Robert Woolley (Chief Executive University Hospital Trust Bristol (UHB) and Senior Responsible Officers for the local STP)
- Julia Clark (Chief Executive at Bristol Community Health)
- Andrea Young (Chief Executive, North Bristol Trust)
- Tony Jones (Bristol Clinical Commissioning Group))
- Rebecca Rafiyah Findlay (Weston Area Health NHS Trust)
- Colin Bradbury (North Somerset Clinical Commissioning Group))
- John Dyer (South Western Ambulance Services)
- Ben Bennett (Director of Strategic Projects, Clinical Commissioning Group)

1. Welcome, Introductions and Chairing Arrangements

In accordance with previously agreed arrangements, Councillor Brenda Massey would act as Chair for the duration of the Meeting and Councillor Toby Savage, Chair of the South Gloucestershire Health Scrutiny Committee and Councillor Roz Willis, Chair North Somerset Health Overview and Scrutiny Panel, acted as joint Vice-Chairs.

The Chair welcomed attendees to the meeting and outlined the following procedural information:

- The meeting had been arranged as a ‘meeting in common’ between the Bristol City Council People Scrutiny Commission, the North Somerset Health Overview and Scrutiny Panel and the South Gloucestershire Health Scrutiny Committee.
- The meeting has been arranged to consider the Bristol, North Somerset & South Gloucestershire (BNSSG) Sustainability and Transformation (STP) Plan. This was an informal arrangement and each Committee remained independently constituted.



- It was not the remit or role of the meeting in common to accept or reject the STP. The meeting had been arranged to receive the first iteration and to pave the way for further scrutiny and consultation.
- The People Scrutiny Commission would be responsible for the health scrutiny function in Bristol but the Neighbourhood Directorate has responsibility for Public Health. Therefore the Neighbourhoods Scrutiny Councillors were also invited to participate in the discussion.
- Colleagues from HealthWatch had been invited to attend and contribute to the meeting as expert witnesses.

The Chair welcomed Health colleagues in attendance.

The Chair outlined the meeting approach:

- Public Forum – questions, statements and petitions
- Supplementary questions (if any)
- Substantive item – presentation on the STP (aprox 20 mins) followed by questions from Councillors and expert witnesses.

2. Apologies for Absence and Substitutions

The following apologies for absence were noted:

Bristol City Council

- Councillors Lesley Alexander, Martin Fodor, Carole Johnson and Anna Keen
- Alison Comley (Strategic Director, Neighbourhoods)
- Becky Pollard (Director of Public Health).

North Somerset Council

- Councillors Liz Wells, Sarah Codling (substituted by Tom Leimdorfer), Andy Cole (substituted by Donald Davies), Ann Harley, David Hitchins, Ruth Jacobs, Reyna Knight, Liz Wells (substituted by David Jolley)
- Sheila Smith (Director, People and Communities)

South Gloucestershire Council

- Councillors Kaye Barrett, Robert Griffin (substituted by Councillor Ben Stokes), Marian Lewis
- Mark Pietroni (Sara Blackmore, Deputy Director of Public Health attended as a substitute)

Health Colleagues

- Jane Gibbs (Chief Officer, Clinical Commissioning Group)
- Jon Hayes (Clinical Chair, Clinical Commissioning Group)
- Claire Thompson (Bristol, North Somerset and South Gloucestershire Delivery Director)



3. Declarations of Interest

None received.

4. Chair's Business

The Chair highlighted the importance of the STP for health and social care and citizens across all three of the Local Authorities. Councillors understood the importance and recognised the opportunities and challenges.

5. Public Forum

The following public forum items were received:

Questions

PQ01- Helen Thornton –Equalities Impact Assessment

PQ02- Steve Timmis – Weston Sustainability

PQ03 - Daphne Havercroft – Data Proposals

PQ04 - Mavis Zutshi - Capability & Capacity

PQ05- Mike Campbell – Regional Consultation

PQ06 -Emma Foote – Staffing Levels

PQ07 - Viran Patel – Health Service Consultation

PQ08 – Shaun Murphy (permitted by chair on the day)

Statements

PS01 -Kate Bower -Protect Our NHS

PS02 -Ben Glatt –BNSSG STP Public Stakeholder Group

PS03 -Barbara Harris –Local Healthcare Concerns

PS04 -Bristol City Councillors Gill Kirk, Ruth Pickersgill, Celia Phipps and Brenda Massey –Social Care Funding

PS05 -Pamela Trevithick –Mental Health



PS06 -Sid Ryan –Save the NHS

PS07 - Mike Campbell (Additional statement not included in the Public Forum pack)

Petition

PP01 -Charlotte Paterson –Protect Our NHS

Nancy Rollason, Bristol City Council Legal officer advised that petitions presented to a Committee must relate to the role and responsibilities of that Committee and information in the petition must be factually accurate. The wording in the petition presented asked the Committee to ‘reject the STP’. The three Local Authorities would not have the power to reject the STP so the wording presented in the petition would not be considered factually accurate. A petition with the same wording had been submitted on the BCC e-petition web page but had not been accepted until the wording had been altered to be factually correct.

The Legal Officer advised that the Committee could accept the petition as presented but asked Members to note that the legal advice provided.

For each question received one supplementary question would be permitted. The following supplementary questions were received:

Reference and name	Question	Response
PQ04 Mavis Zutsi	What will be the capacity and capability of social care within STP? Local authorities were responsible for delivery and should only sign it off when there is certainty and less risk that it can be delivered?	Information to be provided as part of the presentation
PQ05 Mike Campbell	What impact will the plan have on residents and patients, and will Cllrs oppose it until there has been a consultation across the region?	The Chair reassured that Councillors will be scrutinising going forward – the meeting in common was the first appraisal.
PQ08 Shaun Murphy	The aim of the STPs nationally is to redesign NHS services to annually cap the spending to £23 billion less than NHS needs to deliver pressurised services currently offered. Will lrs reject this STP and call on the government to increase spending on the National Health Service?	The Chair re-affirmed that the purpose of the meeting in common was not to accept or reject the STP, as this is not within the remit of the respective local authority committees. The meeting had been arranged to receive the

		first iteration and to pave the way for further scrutiny and consultation.
PS07 Mike Campbell	Queried how committees can properly scrutinise such a large document? Asked for timelines on when will this be scrutinised properly and not merely noted. Do not accept the comments and asked where the financial details were for the plans.	The Chair acknowledged the repeated concerns over the density of the document but reassured the public that the councillors had read the documents. Health partners had prepared presentations for the meeting.

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

A report had been provided in the agenda papers which asked the Committee:

- 1) to note the STP in its current stage of development as the basis for further detailed work leading to implementation of specific proposals, and
- 2) to consider the preferred option to receiving further updates as this work is progressed.

Presentation

Mr Robert Woolley (Mr Woolley), Chief Executive University Hospital Trust Bristol (UHB) was in attendance at the meeting as the Senior Responsible Officer for the local STP.

Mr Woolley welcomed the questions and statements received. Health colleagues recognised the emotive nature of the issue and welcomed the opportunity to speak on behalf of the partners who had so far contributed into the work.

Mr Woolley presented the Committee with an overview of the report which outlined the vision of the Sustainability and Transformation Plan (STP). The initial development of the local STP has involved 15 local organisations responsible for planning and providing your health and social care services (see page 5 of the agenda papers for the full list of partners).

The STP in its current stage of development included; a shared assessment of the service and financial challenges facing the local health and care system, a summary of the case for change and our vision for working together and working differently to meet this challenge. Following a 'checkpoint' review by NHS England, the STP would now be progressed leading to the development of specific plans and proposals. Mr Woolley made the following general points:

- The report presented outlined a high level strategy and further work would be required to provide the detailed plans. Mr Woolley apologised that the report could not be published earlier but felt this was at the vanguard of those being released nationally.



- The aim of the STP was to do the best possible with available resources. Mr Woolley referenced the ongoing crisis in health and social, the STP was required because of the ongoing austerity measures introduced by central government.
- The proposals were a result of collaborative work, undertaken with no extra funding which looked at what local people wanted and the challenges that face healthcare now and in the future. The concern raised over proper consultation had been noted and actions had been taken to address this, i.e. initial conversations have already involved HealthWatch patient engagement via existing surveys and feedback.
- Further engagement would take place (which would include the public and Councillors) to assess the impact on communities and different groups with strategies to help people engage going forward. The STP steering group were committed to absolute transparency and honesty and felt it was critical that communities and the public fed into the strategy to make it a workable plan.

The following health colleagues were also present to provide information on their work areas:

- Julia Clark – Chief Executive at Bristol Community Health
- Dr Sara Blackmore – Deputy Director of Public Health at South

Gloucestershire Council (Substituting for Mark Pietroni)

- Andrea Young – Chief Executive – North Bristol Trust

As part of the presentation (appendix A to the minutes) the following salient points were noted:

Slide 2 – A new approach and principal aims

- By empowering residents individuals would know how to find information and resources to look after their health and long term wellbeing.
- Residents across BNSSG should be able to access services across the region based on need and not location.
- Health and social care should be affordable.
- Mental and physical health would be recognised equally – bringing health and care systems together.

Slide 3 – The Case for Change

- The number of people requiring care for life changing diseases such as dementia and diabetes continues to rise was an aging population.
- Sufficient and well organised services allowed individuals to be supported in the community and specialised services in hospital when required. Incorrect services led to admittance to hospital for extended periods which could lead to a loss of independence.



- A substantial deficit was projected within 5 years and Local authority budgets for social care were also reducing. Significant change would be required to address the financial challenge. No action could result in a deficit between -£100 million and -£300 million.

Slide 4 – What people tell us matter to them

- Work has focussed on developing a shared, detailed understanding and agreeing a shared approach.
- Information from existing feedback about local services from previous engagement activities, patient surveys and complaints has been used.
- Specific communication and engagement plans would be used for individual projects.
- Where significant changes to services are proposed formal public consultation would be required.

Slide 6 – Our vision

- **Prevention, self-care and early intervention**

Work to date has identified four core components – Pathways, Healthy lifestyles & wellbeing, Mental health Inequalities. Initial priorities were steered by a stakeholder group drawn from Voluntary and Community groups. Funding for a diabetes prevention programme had been secured directly because of STP and alignment of work.

- **Integrated primary and community care³**

Most people experienced this service area which involved everything outside of the hospital setting.

- **Acute care collaboration**

The following general points were noted:

- The STP aimed to keep the full range of specialist works in Bristol which was seen as vital to keeping the region at the leading edge and to protect the bigger picture.
- John Readman (Strategic Director for People, Bristol City Council and STP Local Authority Lead) noted the appetite to work across the region to deliver better back office savings which could assist to mitigate front line impact. Standardised regional discharge practice focussed on supporting patients back to an appropriate community facility or home more quickly.
- Acute care collaboration plans were outlined which included a more integrated single discharge service for the area to make transition smooth and prevent complications. Acute hospitals working differently would enable GPs to manage and care more effectively. Regional services would need to be standardised to ensure consistency across all hospitals.



Questions

Following the presentation Councillors and HealthWatch expert witnesses were invited to ask questions. The Chair asked for questions rather than statements to ensure the best of the time allocated. The following was noted as part of the discussion;

- a. Councillors requested ongoing proper public consultation and a reduction in the use of jargon. The size of the document was also questioned as it could hinder engagement. The financial predictions were queried, specifically the projected £500,000,000 (pg49) short fall and the reduction in government funding. It was noted that the “unidentified savings” fall short by £104,000,000. More detail would be needed to understand the scale of the problem faced 4-5 years down the line.
- b. Cllr Roz Willis, North Somerset Council, assured the public that Councillors had read the agenda papers and additional information had been requested. Regardless of the meeting outcomes, North Somerset Council would continue work as part of a steering group which would then feed into further joint committee work.
- c. Comments were made on the scale of the financial crisis and the proposals to address this. South Gloucestershire Councillors noted the loss of Frenchay hospital: the area had experience of going through referrals with government to save facilities. Councillors urged those present to lobby MPs in the local area to highlight this as the number one issue of concern.
- d. Councillors requested an accessible and well planned engagement programme to allow for all groups who use health services to be involved, this included the elderly, disabled, marginalised and ethnic groups.
- e. Further information was requested on unidentified savings. Publicity had been scarce and the public felt it had been difficult for people to provide give meaningful feedback. Health colleagues clarified that the technical submissions (provided for meeting) would not be used for public engagement and more user friendly documents were available. Ben Bennet , Clinical Commissioning Group) was introduced and clarified his position as part of South Gloucestershire CCG (Clinical Commissioning Group) with a dedicated role to lead on development of communications and engagement strategy for the STP. Mr Bennett acknowledged the challenges identified and clarified that the documents submitted for the meeting were used to enable NHS England to plan centrally, hence the technical nature. The CCGs had worked with the Care Forum and engaged with local people at the start of the process. The public and Councillors were encouraged to promote the development of the STP within the communities. The input of local people, service users and carers would be integral to inform this work going forward.
The concern of unidentified savings was acknowledged; some had been identified and information provided in the report but more work would be required to identify these. Engagement plans would include targeted engagement for specific projects.
- f. Information was requested on specific options not included in the document. Mr Woolley confirmed that all information had been provided. Work had taken place across agencies to begin the strategy and reports submitted to central government as requested.
The Chair encouraged Councillors to use the meeting as an opportunity to ask questions and scrutinise the proposals, rather than making statements.
- g. Councillors made the comparison with the health changes introduced 15 years ago and highlighted that funding had further reduced. Reference was made to the Frenchay hospital site – no replacement services had been developed in Yate and Thornbury. The report provided minimal



information about the pressures on social care and how this would be approached. Councillors requested a commitment to openness and transparency.

Health colleagues referred to the current funding crisis which required partners to address the obstacles that have previously stopped similar work. Work would be required across organisational boundaries, switching more resource to Mental Health, Social Care and prevention. These things have long needed to happen but must now be done within tightly strained resources and with greater impetus.

Mr Woolley confirmed that health colleagues believed NHS & Local Authorities (LA) needed to take this forward together, reiterated that both NHS and LA directors attended the steering group meetings. The NHS would continue to draw on Local Government expertise, especially as integrated health and social care would be vital and needs the Council's input. LA input would be required both on the specific plans and as part of engagements plan: reaching out to people and communities via consultation.

h. The Chair introduced Judith Brown (JB) – Older People's Forum. Ms Brown welcomed the discussion related to working together and sustainability. Colleagues should be encouraged to consider how Councillors, organisations and the public could work together to lobby the government to increase percentage of GDP spent on health and social care to 10.6%.

i. Councillors requested a stronger voice for Local Government as the lack of social care has impacted and put pressure on hospital beds which can cause the system to fail. Could the STP be implemented with so little funding to make changes?

John Readman, BCC People Strategic Director and STP lead for LA's highlighted that Directors from each Local Authority area had been involved with the planning but acknowledged the governance concerns highlighted. Proposals to change social care or public health practices within the remit of LAs would be subject to the same governance and scrutiny procedures as normal. The Statutory duty of health bodies to consult the public on significant change was also noted.

j. Discussion was had around resource requirements for engagement – those present agreed that it would need to be thorough. Some projects would be more resource heavy than others.

The Committee meeting was scheduled to end at 4pm. There were a number of outstanding Councillor questions and Councillors resolved to extend the meeting.

k. Councillors requested clarity on the stroke pathway review as services have a big opportunity to improve quality of life and outcomes.

Officers confirmed that staff across BNSSG were looking at how improve acute care and prevention (including standardising treatments) could be improved. A detailed plan would be available by summer 2017. The region was considered good at acute care and provided effective treatment without operations.

The Chair asked one Councillor from each Local Authority / HealthWatch to ask final questions.

k. Was joint commissioning being explored and do the plans involve reducing the "wasteful" process of re-commissioning to market? How would concerns about the pressures facing local authority spend on adult social care, the biggest proportions of LA spend, be addressed?

Health colleagues referred to the suggested combined budget for commissioning which was being explored. Councillors welcomed this proposal as something that could result in an actual saving and free



up money for the front line services. Acknowledgement was given to the statutory requirements but there was hope this strategy could achieve some change.

L. Can future reports or presentations can be acronym and initial free? Councillors had found the report challenging to read - the style could also hinder member engagement with member so the public. Health colleagues re-iterated that the document provided was technical and had been shared to ensure transparency amidst concerns over secrecy. A commitment was made to use a more manageable and transparent style going forward.

M. HealthWatch North Somerset, Chair, Georgie Bigg requested the following information:

1. An explanation on the sentence "acknowledge evidence around supply has on a service – bold collaborative decisions unwarranted demand"
2. 2% funding applied for prevention and self-care- commend but what if this if not available?
3. What investigation has been done to see what resource and capacity is available in the voluntary sector?
4. Enabling population to adopt healthy behaviours - what will happen if they don't?

ACTION: Due to time constraints answers to be put into writing with Somerset CCG to follow up. Appendix B.

Councillors were encouraged to submit any further questions in writing via their Scrutiny / Democratic Services Officer.

The Committee members discussed the proposal to 'note' the presented report with some Councillors expressing concerns that noting the report would indicate an acceptance of the proposals. Following a discussion members agreed to amend the wording and 'receive' the report as presented. As suggested in the report, updates on the STP would be provided each quarter in 2017.

ACTION: The Chairs from each Health Scrutiny Committee would meet in January 2017 to discuss options around a formal joint health scrutiny committee.

The Chair thanked all who contributed and apologised to those who didn't get to speak, acknowledging the challenging time frame. The Chair thanked officers, colleagues and health partners for attending.

Resolved:

The Bristol City Council People Scrutiny Committee, the North Somerset Health Overview and Scrutiny Panel and the South Gloucestershire Health Scrutiny Committee agreed:

1. **To receive the report: this would not indicate acceptance of the STP proposals as presented**
2. **To receive updates on a quarterly basis going forward**
3. **To discuss formal joint health scrutiny committee options.**

The meeting closed at 16:30



7. Appendix A

- Presentation delivered at the meeting on “Developing a Sustainability and Transformation Plan”.

Meeting ended at 4.30 pm

CHAIR _____





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Developing a Sustainability and Transformation Plan

Bristol, North Somerset, South Gloucestershire working together.



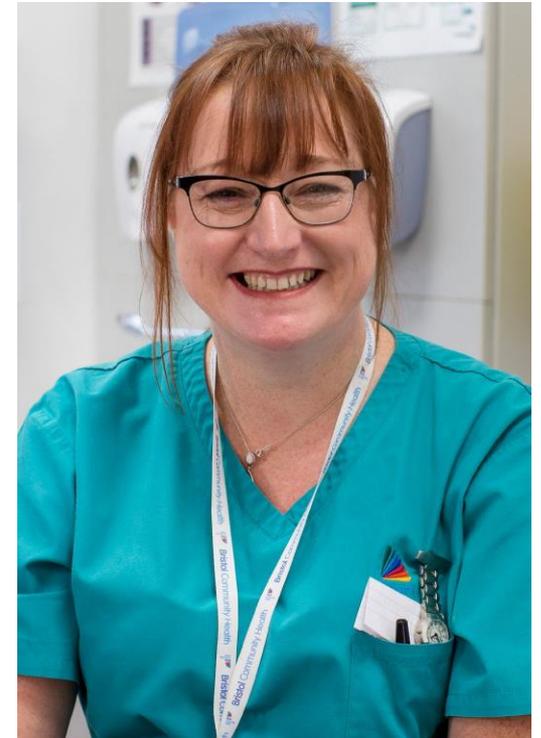
A NEW APPROACH

Sustainability and transformation plans are a new approach to planning health and care services across England over the next 5 years.

Local organisations will work together to develop a shared understanding of the challenges and agree joint plans for addressing them.

Principal aims

- Page 17
- Improve the health and wellbeing of local people
 - Improve the quality of local health and care services
 - Deliver financial stability in order to be able to continue to meet local health needs



THE CASE FOR CHANGE

- Growing and aging population
- Avoidable illness
- Pressure on services
- Organisation of services
- Financial balance

WHAT PEOPLE TELL US MATTERS TO THEM

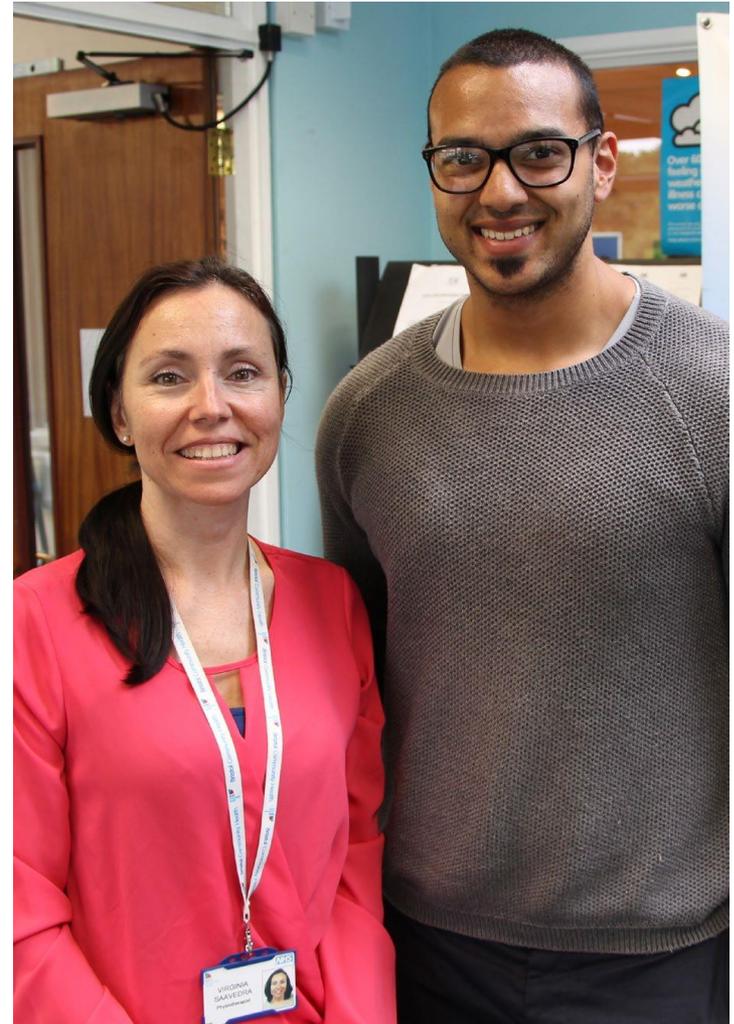
- Understandable information and help navigating the 'system'
 - Having needs assessed multiple times can be frustrating and distressing
 - Care plans arranged around the needs of the individual
 - Families and carers also central to successful care
 - People value locally accessible services and improved access to primary care
 - Transport issues, especially for those living in rural areas and people with disabilities
 - People's experience of discharge from hospital is not consistently good
-

OUR VISION

A health and care system for Bristol, North Somerset and South Gloucestershire in which:

- Services are responsive to individual needs and relevant to local communities
- Appropriate care and support is available in the right place at the right time
- People are partners in their care
- Mental health is given equal priority to physical health in the way local services are planned and delivered
- There is consistency in the way both hospital and community services work so patients and staff know what to expect and how to use services

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OUR VISION

Our areas of focus

- Prevention, self-care and early intervention
- Integrated primary and community care
- Acute care collaboration

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PREVENTION, EARLY INTERVENTION AND SELF CARE

We know that people's lifestyle choices can have a big impact on their health.

Smoking and being overweight increases the risk of many major diseases such as cancer, COPD, stroke and heart attacks.

We need to make it as easy as possible for people who are health literate to self-serve and provide more support to those who may need help in making changes.



INTEGRATED PRIMARY AND COMMUNITY CARE

A whole-person approach for everyone accessing community and primary care services.

Completely different interface from traditional arrangements in which the GP is almost always the first point of contact.

A dynamic new integrated approach with a multi-disciplinary team extending beyond health professionals.

Also encompassing social care workers, volunteers, counsellors and others.

Able to support a variety of issues and manage whole-person problems – housing, money, loneliness, anxiety and depression, physical conditions.

A focus on improving and maintaining health and wellbeing.



ACUTE CARE COLLABORATION

If people need to go to hospital we need to make sure we provide services in a logical and efficient way.

Many services have evolved over time in response to the needs of patients but the journey often does not make sense to them.

We need to take a step back and design services around patients, not around organisational structures.

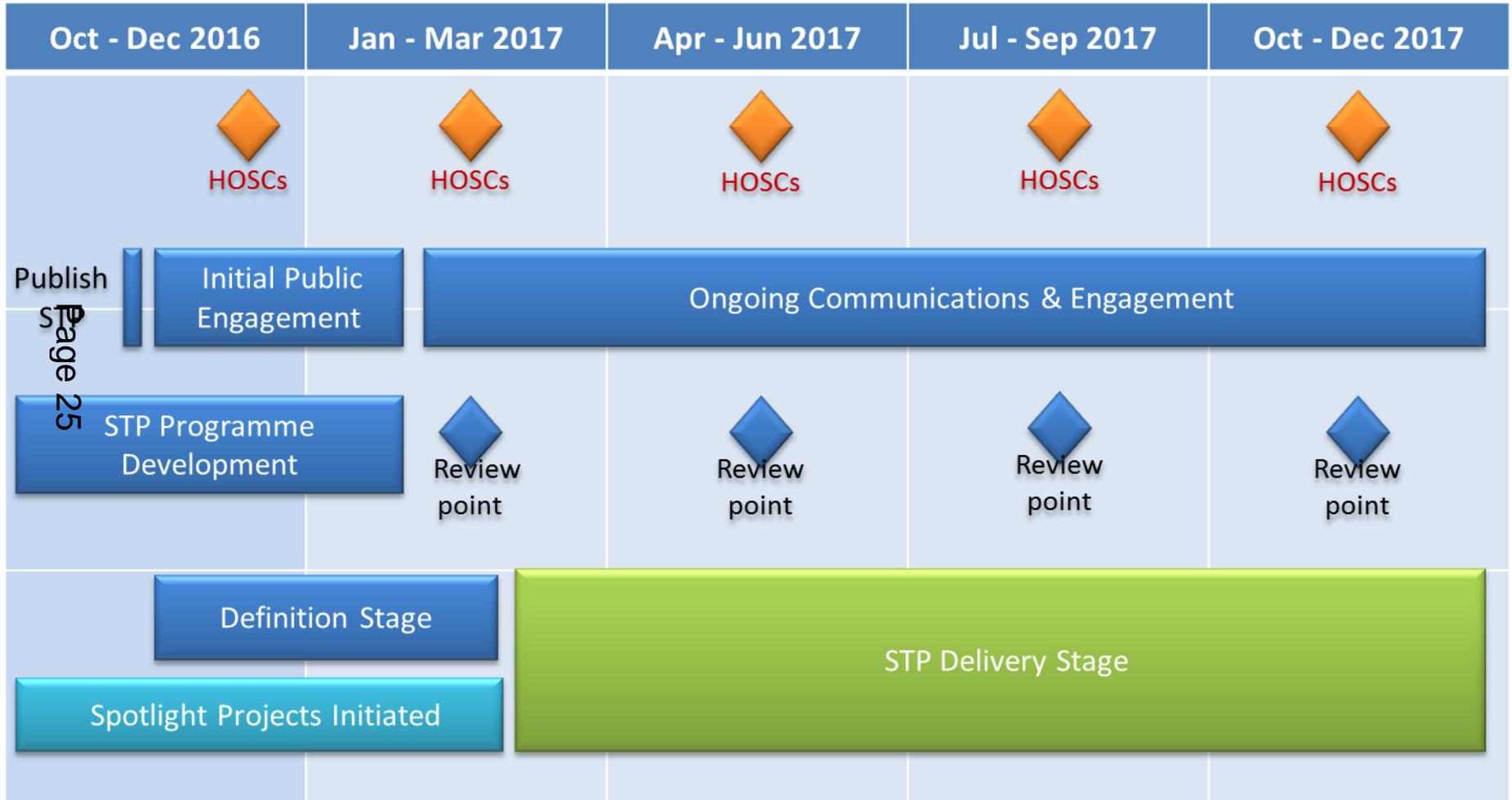
It is right to expect patients to travel for specialist care but we should provide regular, routine services close to where people live.



2024

SUSTAINABILITY & TRANSFORMATION PLAN

NEXT STEPS



The BNSSG local authorities

Established BNSSG Local Authorities Planning Group

- Meeting regularly, to ensure effective and coordinated contribution to STP process and outcomes.
- We are working together, across all STP work streams, on short and long term priorities

Exploring and developing opportunities for collaboration

- Adult social care workforce development: joint efforts to develop social care capacity and integrated teams; 7 day working
- Integrated discharge services/processes: working to support older people's urgent care system
- Care pathway opportunities: e.g. shared working to develop stroke prevention
- Single point of access: a shared understanding
- Shared commissioning where possible, e.g. community equipment

Working towards a single BNSSG health and social care integration plan

- A joint approach to Better Care across BNSSG
- Joint Director of Public Health network and joint Public Health Commissioning



Outstanding questions from HealthWatch North Somerset– Georgie Bigg from the STP scrutiny meeting in common – 1st December

<p>An explanation on the sentence “acknowledge evidence around supply has on a service – bold collaborative decisions unwarranted demand”</p>	<p>Both locally and nationally, demand for services is increasing at a time of ongoing resource constraint. We need to work together and think differently about the way services are provided in order to continue to meet local health needs.</p> <p>The reference on p6 is an acknowledgement that there is evidence that the way in which services are organised can lead to increased demand for a particular service. An example of this evidence can be seen this 2014 report from the Nuffield Institute (see link below)</p> <p>http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/140630_meeting_need_or_fuelling_demand.pdf</p> <p>At this stage in the development of the local STP we are identifying this as one of a number of themes for further consideration; however there are currently no specific proposals.</p> <p>As with all aspects of the STP there will be opportunities for public engagement to inform the development of any specific proposals, and if proposals emerge for significant changes to a particular service there will be formal public consultation.</p>
<p>2% funding applied for prevention and self-care-commend but what if this if not available?</p>	<p>This represents an estimate of the extent of funding required to enable the delivery of prevention, early intervention and self-care at the scale required to impact on the demand for services. It is accepted that investing in prevention is key to reducing the demand on services in the longer term however any increase in spending in one aspect of local services will need to be achieved through a redirection of funding from other aspects but the STP gives us the opportunity to review spending cross the system and across patient pathways.</p>
<p>What investigation has been done to see what resource and capacity is available in the voluntary sector?</p>	<p>Events were held in December to begin a discussion with local voluntary sector organisations about how they can be involved in the further development of the STP and any specific projects or programmes that arise from this and this is expected to lead to further engagement with local voluntary sector organisations both individually and collectively in the weeks and months ahead.</p>

Enabling population to adopt healthy behaviours – what will happen if they don't?

Supporting people to adopt health behaviours is already part of local and national health policy. One of the roles of public health is to ensure services and interventions to support behaviour change are evidence-based and therefore more likely to succeed' In the context of the STP this is one part of a wider set of plans that we expect to develop. All else being equal, if progress is not made the expectation is that the impact of unhealthy lifestyles on people's health this will continue to contribute to increasing demand for health services making it more difficult in relative terms to achieve the progress required towards a sustainable position.



**North
Somerset**
COUNCIL



Joint Health Overview and Scrutiny Committee Public Information Sheet

Petitions, Statements and Questions

Members of the public and members of council, provided they give notice in writing or by electronic mail to the proper officer of the host authority (and include their name and address and details of the wording of the petition, and in the case of a statement or question a copy of the submission), by no later than 12 noon of the working day before the meeting, may present a petition, submit a statement or ask a question at meetings of the committee. The petition, statement or question must relate to the terms of reference and role and responsibility of the committee.

The total time allowed for dealing with petitions, statements and questions at each meeting is thirty minutes.

Statements and written questions, provided they are of reasonable length, will be copied and circulated to all members and will be made available to the public at the meeting

There will be no debate in relation to any petitions, statements and questions raised at the meeting but the committee will resolve;

- (1) "that the petition / statement be noted"; or
- (2) if the content relates to a matter on the agenda for the meeting:
"that the contents of the petition / statement be considered when the item is debated";

Response to Questions

Questions will be directed to the appropriate Director or organisation to provide a written response directly to the questioner. Appropriately redacted copies of responses will be published on the host authority's website within 28 days.

Details of the questions and answers will be included on the following agenda.



**North
Somerset**
COUNCIL



Joint Health Overview and Scrutiny Committee

Monday, 23rd October 2017

Report of: Service Director, Legal and Democratic Services, Bristol City Council

Title: Joint Health Overview and Scrutiny Committee – Business Report

Ward: Citywide

Officer Presenting Report: Louise deCordova, Scrutiny Advisor

Contact Telephone Number: 0117 352 6151

Recommendation

It is recommended that the Joint Health Overview and Scrutiny Committee

1. appoint a chair
2. agree the proposed chairing arrangements for future meetings
3. note the Joint Committee's terms of reference and working arrangements as set out in the appendices.
4. consider the invitation of co-optees or involvement of other stakeholders

Summary

A statutory Joint Health Overview and Scrutiny Committee (JHOSC) has been established for the purpose of jointly scrutinising the Bristol, North Somerset and South Gloucestershire Sustainability Transformation Plans (BNSSG STP). The JHOSC's terms of reference and working arrangements (as set out at Appendices 1 and 2 respectively) were considered by the Chairs of the North Somerset and South Gloucestershire Health Overview and Scrutiny Committees and Bristol People Scrutiny Committee. After consideration of the relevant regulations, it was the view of the Chairs that a new joint committee be established specifically to scrutinise the STP.

Context

Sustainability and Transformation Plans (STPs)

STPs are a new approach to planning health and care services across England over the next five years. Local organisations are required to work together to develop a shared understanding of the challenges and to agree joint plans for addressing these.

The principal aims are to:

- Improve the health and wellbeing of local people;
- Improve the quality of local health and care services;
- Deliver financial stability and balance throughout the local health care system.

Locally, Bristol, North Somerset and South Gloucestershire (BNSSG) are working together.

Statutory joint health scrutiny arrangements

Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires local authorities to appoint “mandatory” joint committees where a relevant NHS body or health service provider consults more than one local authority’s health scrutiny function about “substantial reconfiguration” proposals. In such circumstances, Regulation 30 sets out the following requirements:

- Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately);
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal;
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service.

Regulation 30 of the Local Authority also provides that local authorities may appoint a “discretionary” joint health overview and scrutiny committee to carry out all or specified health scrutiny functions. Establishing a joint committee of this kind does not prevent individual Councils from separately scrutinising health issues (i.e. non mandatory). There are likely to be occasions when consideration of a non-mandatory item of the STP is best dealt with by a discretionary joint committee.

Proposal

It is recommended that the Joint Health Overview and Scrutiny Committee:

1. Appoint a Chair

The Joint Committee is asked to appoint a Chair from the host authority for the purpose of chairing this meeting.

2. Agree the proposed chairing arrangements for future meetings

The Joint Committee is asked to agree the proposed chairing arrangements for future meetings.

- a. October 2017 – Bristol City Council
- b. February 2018 – North Somerset Council
- c. June 2018 – South Gloucestershire Council

3. Note the Joint Committee’s Terms of Reference and Working Arrangements

The Joint Committee is asked to note the Terms of Reference and Working Arrangements as set out in Appendix 1 and Appendix 2.

4. Consider the invitation of co-optees or involvement of other stakeholders

The Joint Committee is asked to consider the invitation of co-optees as one method of ensuring involvement of key stakeholders with an interest in, or knowledge of, the issue being scrutinised. The Joint Committee is asked to note that this is already a power of overview and scrutiny committees by virtue of the Local Government Act 2000. However, the Guidance also recommends other ways of involving stakeholders by, for example, giving evidence or by acting as advisers to the committee.

5. Appendices :

- Appendix 1 - Terms of Reference
- Appendix 2 - Working Arrangements

**Sustainability and Transformation Plan Joint Health Scrutiny
Committee: Terms of Reference**

- 1) Bristol City Council, North Somerset Council and South Gloucestershire Council to collectively review and scrutinise the Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Plan (STP) pursuant to Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.(Regulation 30)
- 2) To collectively review and scrutinise any proposals within the STP that are a substantial development of the health service or the substantial variation of such service where more than one local authority is consulted by the relevant NHS body pursuant to Regulation 30
- 3) To collectively consider whether a specific proposal within the STP that's is not a substantial development or variation is only relevant for one authority and therefore should be referred to that authority's Health Scrutiny Committee for scrutiny.
- 4) In the event that a participating council considers that it may wish to consider a discretionary matter itself rather than have it dealt with by the joint committee it shall give notice to the other participating councils and the joint committee shall then not take any decision on the discretionary matter (other than a decision which would not affect the council giving notice) until after the next full Council meeting of the council giving notice in order that the council giving notice may have the opportunity to withdraw delegation of powers in respect of that discretionary matter.
- 5) To require the relevant local NHS body to provide information about the proposals under consideration and where appropriate to require the attendance of a representative of the NHS body to answer such questions as appear to it to be necessary for the discharge of its function
- 6) Make reports or recommendations to the relevant health bodies as appropriate and/or the constituent authorities' respective Overview and Scrutiny committees or equivalent
- 7) Each Council to retain the power of referral to the Secretary of State of any proposed "substantial variation" of service, so this power is not delegated to the JHOSC.

**Sustainability and Transformation Plan Joint Health Scrutiny Committee
Working Arrangements**

Membership

The joint committee will be a committee established by Bristol City Council, North Somerset Council and South Gloucestershire Council in accordance with section 101(5) of the Local Government 1972

The membership shall be made up of 7 members from each participating council with each council's membership being politically proportionate. Non-executive councillors will make up the membership.

Substitutions will be accepted if a councillor is not able to attend a meeting of the committee.

Co-options are a possibility and can be considered by the joint committee at its first meeting. The Guidance suggests that co-opting people is one method of ensuring involvement of key stakeholders with an interest in, or knowledge of, the issue being scrutinised. This is already a power of overview and scrutiny committees by virtue of the Local Government Act 2000. However, the Guidance also recommends other ways of involving stakeholders by, for example, giving evidence or by acting as advisers to the committee. A chair (from the host authority) will be appointed by the joint committee at each meeting

Quorum

The quorum for meetings will be 7 members from at least two local Authorities. During any meeting if the chair counts the number of councillors present and declares there is not a quorum present, then the meeting will adjourn immediately. Remaining business will be considered at a time and date fixed by the chair. If a date is not fixed, the remaining business will be considered at the next meeting.

Reporting Arrangements

Prior to the agenda for each meeting of the joint committee being finalised officers will convene a planning / pre-meeting with the Chairs of the individual HOSC's or their nominee

In terms of the joint committee's conclusions and recommendations the Guidance says that one report has to be produced on behalf of the joint committee. The final report shall reflect the views of all local authority

committees involved in the joint committee. it will aim to be a consensual report. In the event there is a failure to agree a consensual report the report will record any minority report recommendations. At least 7 members of the joint committee must support the inclusion of any separate minority report in the committee's final report. Any report produced by the committee will be submitted to the local authority's council meetings for information.

The NHS body or bodies receiving the report must respond in writing to any requests for responses to the report or recommendations, within 28 days of receipt of the request.

In the event that any Council exercises its right to refer a substantial variation to the Secretary of State, it shall notify the other Councils of the action it has taken.

Financial and Administrative Support

Meetings will usually be led by each authority alternately. The Chair of the lead authority will Chair the meeting.

- The lead authority will be responsible for the servicing of the committee. Suitable officer resources (Legal, Democratic) will be provided to meet the requirements of the committee. This includes (but is not restricted to):
 - providing legal advice
 - liaising with health colleagues ahead of the meeting
 - updating action sheets from previous meetings
 - producing agenda papers and co-ordinating public forum
 - creating formal minutes and actions sheets
- If there is a specific reason, for example, if the issue to be discussed relates to a proposal specific to the locality of one Local Authority area the meeting venue can change to a more appropriate venue. The lead Local Authority would remain the same, even if the venue changes.
- Any changes to the host authority must be agreed by the committee

Petitions Statements and questions

- Members of the public and members of council, provided they give notice in writing or by electronic mail to the proper officer of the host authority (and include their name and address and details of the wording of the petition, and in the case of a statement or question a copy of the submission), by no later than 12 noon of the working day

before the meeting, may present a petition, submit a statement or ask a question at meetings of the committee. The petition, statement or question must relate to the terms of reference and role and responsibility of the committee.

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- **Response to Questions**

Questions will be directed to the appropriate Director or organisation to provide a written response directly to the questioner. Appropriately redacted copies of responses will be published on the host authority’s website within 28 days.
- Details of the questions and answers will be included on the following agenda.

Bristol, North Somerset & South Gloucestershire Local Authorities Joint Health Overview Scrutiny Committee

Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Partnership (STP)	
STP representatives attending	<ul style="list-style-type: none"> • Julia Ross, Chief Executive, BNSSG CCG • Andrea Young, Chief Executive, North Bristol Trust • Laura Nicholas, BNSSG STP Programme Director • John Readman, Strategic Director, People, Bristol City Council • Julia Clarke, Chief Executive, Bristol Community Health • 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 • Janet Rowse, Chief Executive, Sirona Care & Health • Dr Peter Collins, Medical Director, Weston Area Health NHS Trust • Colin Bradbury, Area Director North Somerset, BNSSG CCGs
Date of meeting	23 October 2017
Report for information and discussion	

1. Purpose of this Paper

The purpose of this paper is to update the Joint Health Overview & Scrutiny Committee on progress with the BNSSG STP plans.

It covers:

- Recap of the BNSSG STP
- Case for change and strategic framework development
- Developing a single commissioning voice
- STP latest work programme, including progress on re-design of clinical care pathways
- STP communications and engagement approach
- Next steps/ timescales.

2. Executive Summary

Since the joint committee received its last report in November 2016:

- The BNSSG STP has now implemented a governance infrastructure to oversee its planning processes, has some new leaders in place and made progress on a number of care pathway redesign programmes.
- The BNSSG STP was assessed as “in need of most improvement” in national rankings published on 21 July, but now has the right infrastructure in place to accelerate its rate of progress.
- Is undertaking a refresh of the STP work programme which is nearly complete and will refocus current plans on areas of greatest opportunity and impact, supported by a compelling case for change.
- Developed an ambitious programme of in-year delivery plans which are now in implementation.
- Continued to work on redesigning key patient pathways that will deliver improvements for service users as well as improving service efficiencies and care outcomes.
- Made significant progress on forming plans to address service sustainability for Weston (now known as the Healthy Weston Programme).
- Further progressed the work undertaken in the STP submission published last October to develop a more detailed understanding of the challenges and opportunities highlighted in the NHS 5 year Forward View around care and quality, population health outcomes and finance and efficiency.

3. Context

44 STPs have been created across England to help respond to NHS England’s Five Year Forward View (5YFV). The BNSSG submission, published last October sets out a vision for how health and care services need to change by 2020/21, to address the significant challenge of meeting the needs of a population that is both ageing and living with more complex long term conditions (LTCs) to a high standard and within the financial resources available.

The BNSSG STP is a 15 member partnership, including all of the key health and local authority organisations, leading area-wide health and care transformation. The Partnership is focused on how the public and local organisations best work together to meet the challenge of three key aims; improved health and wellbeing for everyone, better quality of care, and sustainable finances.

While all areas across England may be facing similar challenges, the task at hand for BNSSG should not be underestimated. We (residents, NHS, councils, volunteers) will all need to rise to the challenge to help realise our areas health and care ambitions.

4. Recap on the BNSSG STP

(Presented by Laura Nicholas, BNSSG STP Programme Director)

4.1 Introduction

The BNSSG STP plan has been in development since March 2016. A plan submission was made to NHS England in October 2016 in response to national guidance. Further work on developing the plan continued but was overtaken in November 2016, whilst the more immediate priority of developing financial turnaround plans for 2017/18 within the CCGs was completed. These plans are now largely in implementation and work on longer term transformational plans gained momentum again from early May 2017.

4.2 Governance

Since we last presented at this meeting good progress has been made, with the STP governance arrangements now in place to support our collaborative working and oversight of planning. Our sponsoring board has been established, comprising the Chief Executives of our 15 partner organisations (or their senior representatives).

The sponsoring board is now independently chaired by Sir Ron Kerr, who was most recently the Chief Executive of Guy's and St. Thomas's Hospitals NHS Foundation Trust in London. Sir Kerr also brings a wealth of senior experience over 30 years in both executive and non-executive roles in all parts of the NHS.

We also have an executive management group consisting of the senior responsible officers (SROs) of each of our main work streams. This group will direct and support the STP work programme. These arrangements and the arrival of new and strengthened leadership, will allow us now to accelerate the development of our STP plans.

Most partner organisations have contributed to a central fund which is paying for a small team of programme management and support which is working with partners and the Sponsoring Board to drive forward our revised and emerging work programmes.

4.3 STP refresh

Following STP organisation agreement this summer, a refresh of previously agreed STP projects and programmes is being undertaken and will be concluded in November. It was felt that this was required:

- To review, mandate and support the core programme of work that needs to be delivered during 2017/18 at the system level that will be led or facilitated by the core STP team, working with partner organisations and resourced to ensure agreed deliverables are achieved.

- To agree what further development work needs to take place to progress the scale and pace of transformational change plans for the BNSSG system.

The refresh ensures that we have a clear and prioritised work programme for the remainder of 2017/18 and into 2018/19.

4.4 STP national rankings

Members may already be aware that a national assessment of STPs was published by NHS England on 21 July. STPs were assessed on a range of performance, financial and leadership metrics and placed into one of four categories. The BNSSG STP was rated category four – in need of most improvement – along with four other STP footprints. This is disappointing, but not unexpected given the size of our challenge in light of the urgent work needed to strengthen plans for the current year

This report was an initial assessment and we feel confident that the governance arrangements now in place, the progress the CCGs are making in strengthening their leadership, additional resource in the STP core team and recent progress around the STP refresh will help us to achieve an improved position in future assessments.

5. Case for change & strategic framework development

(Presented by Gemma Morgan, Public Health Registrar, South Gloucestershire and Laura Nicholas, BNSSG STP Programme Director)

We are developing a case for change. This is an important aspect of the overall strategic framework for the STP, essentially providing the evidence we need around our BNSSG-wide population's health and care needs, quality of clinical care and health inequalities, current spend across the health and care system, and a consistent shared understanding of the key challenges we face within the STP and local authority areas. It comprises three key components:

- An assessment of the BNSSG population health needs and health inequalities.
- An assessment of the care and quality challenge.
- A revised assessment of the STP financial baseline and financial challenge.

Whilst some assessment of all three areas was made in the STP submission in October, more in-depth analysis is needed to help us to gain a more granular understanding of specific areas of challenge and potential opportunities for improvement.

Work to date has focused on the health needs analysis, but work is under way in the other two areas.

Research around the health and wellbeing gap is being led by the three Local Authority Public Health teams and draws on existing evidence including the Joint Strategic Needs Assessments (JSNAs). This is the first time that a detailed consolidated view of the health needs of the BNSSG population has been pulled together in one place. The care and quality gap is predominantly being taken from existing provider information on areas such as key performance standards, led by the CCG. The finance and efficiency research is being led by the STP Financial Lead and includes an update on the 16/17 outturn baseline and a reassessment of the potential financial gap in 2021, if nothing changes. We will be able to share this once it is signed off – expected to be end of November.

Members are asked to note the following section of the Population Health Assessment report, which provides a high-level summary of the key issues:

- Overall premature mortality rates are good compared to England, but Bristol population is amongst the worst in England for premature mortality.
- Binge drinking rate in BNSSG is greater than England.
- BNSSG smoking rates are comparable to England but smoking rate amongst Bristol males is worse than the rest of the South West and England, and the smoking rate amongst 15 year olds across all of BNSSG is worse than England.
- Emergency admissions are comparable to the England average but self-harm admissions (especially females) rate is worse than England, injury admission rate in ages 0-four and 15-24 is worse than England and alcohol-related admissions are greater than SW or England.
- Like many areas across the UK, BNSSG faces increasing pressures from a growing and ageing population.
- The NHS sector in BNSSG is currently £92.8m overspent (16/17 outturn) and current projections lead to a recurrent annual overspend of £324.8m in four years if nothing changes.

Key conditions across the BNSSG area with lower than expected outcomes compared to the national average include:

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

Common risk factors include:

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

The next steps will be to further develop the care and quality metrics drawing on sources in all our provider organisations. In phase two we will develop our whole population dataset, linking health activity records, such as primary care contacts and hospital admissions to demographic factors to identify the way resources are allocated at present, forecast trends in demand and use risk stratification techniques to target investment to best meet the needs of our population.

We will also start work now on more detailed financial planning for 2018/19 and beyond, and a prevention plan for BNSSG.

Strategic Framework Development

A summary of the case for change will form part of a public facing strategic framework and narrative that we can use to share with and engage local people in the STP.

We have used the design principles and models from a number of our key work programmes to help us to design a simple new model of care (see Appendix 1) – that will help us (along with other materials) to explain to a broad audience our ambitions for transforming care for the BNSSG population. The work to date will be refined further, in discussion with a number of stakeholders to make sure it is usable and understandable for a range of audiences. A draft for wider engagement will be ready by the end of November.

6. Developing a single commissioning voice

(Presented by Julia Ross, Chief Executive, BNSSG CCG)

Please see separate presentation pack which will be presented during the meeting.

7. STP Work programme – Examples of progress

(Presented by Dr Kate Rush, GP, Member of the BNSSG Clinical Cabinet)

The case for change is intended to provide a compelling evidence-based foundation against which we can identify the best opportunities for improvement and develop a prioritised work programme for the BNSSG STP area.

Our priorities include prevention and early intervention, integrated care, primary care, mental health and learning disabilities, the work around Healthy Weston, acute care collaboration and system productivity.

While the BNSSG STP has been going through a refresh period, the key work programmes have continued. The current clinical redesign programmes include:

- Redesign of the respiratory patient pathway
- Redesign of musculoskeletal (MSK) patient pathway
- Redesign of the diabetes patient pathway
- Redesign of the stroke pathway
- Cluster based (integrated) working.

Improving patient care has been at the heart of all of these programmes, with the STP approach ensuring a systematic BNSSG wide method has been taken in developing a shared understanding of the current situation before moving to redesign and identification of opportunities to improve services and patient experience. Together these areas represent potential improvements for a significant number of patients as well as improved health outcomes and opportunities to improve efficiency and effectiveness through more joined up care.

The redesign process has involved working with staff, the voluntary sector, patients and carers, and included:

- Researching and developing needs assessments
- Review of evidence relating to greater integration and more services provided in the community
- Documenting the current state
- Collecting user feedback via groups and questionnaires
- Collecting employee feedback
- Engaging with other key groups, for example, relevant charities
- Service walkthroughs.

Members are asked to note the progress that has been made to date on the respiratory and musculoskeletal (MSK) care pathways, as summarised under section 7.1 of this report. These are provided as examples of the work we are doing and is not an exhaustive list.

Appendices 2 and 3 provide greater detail on these individual pieces of work and will be discussed in further detail during the meeting.

7.1 Progress on re-design of care pathways

Respiratory

- The BNSSG Respiratory Programme Board agreed to prioritise Chronic Obstructive Pulmonary Disease (COPD) with four areas of work; service user and carer education and information, primary and community care and prevention, admission avoidance/ acute care/ discharge and home oxygen and end of life care.
- A series of workshops have been held with providers and other key stakeholders, including patient groups over the last seven months to help refine the way forward.
- The 'respiratory vision' is for primary, community, secondary care and the community and voluntary sector to provide an integrated respiratory service without walls across BNSSG.
- The new service model has been agreed by the BNSSG Respiratory Board on the 3 October.

- The Bristol, North Somerset and South Gloucestershire CCGs are bound by procurement law. They have agreed the most appropriate approach is not to formally tender an integrated respiratory service but to implement a non-competitive approach whereby the commissioners gain assurance from the providers that they are able to work together as a provider collaborative.
- Outcomes workshops and consultation with service users, carers and the public will form part of the next steps.
- As Members may be aware, Bristol City Council's Communications Team has led the work to campaign for clean air zones. The British Lung Foundation are campaigning for access to clean air and we would like to ask that any support Members can give to help us achieve this across the BNSSG area would be most welcome.

Musculoskeletal (MSK)

- This summer the project team undertook a desktop research exercise to understand existing patient feedback.
- To date the project team have held three workshops with a range of key stakeholders, including provider clinicians, local commissioners, health service managers, public health specialists and patients This supported mapping the current processes and further identifying any key issues that need to be resolved.
- A further workshop will be held in October to co-design the new MSK pathway with patients, providers and commissioners. Following this, a patient stakeholder session will be held to ask for further feedback and input to the first draft of the new model.
- Whilst this work is ongoing colleagues have been working on implementing a number of simple improvements that do not require re-design but will create improvements for patients, such as a shared referral form for services, aligning referral criteria and improving the triage process for clinical staff in the pain service.

8. Communications & Engagement Approach *(Presented by Julia Ross, Chief Executive, BNSSG CCG)*

8.1 General update

As part of the refresh process we are also reviewing our approach to communication and engagement.

We have an established network of experienced communications and patient & public involvement professionals across the partner organisation, which includes local authority colleagues.

We have appointed a dedicated Communications & Engagement leader to plan and coordinate this important area of work.

The aims of successful patient and public involvement are to ensure that:

- Our prioritisation and decision making reflects the needs and aspirations of local people.
- Local people are enabled and empowered to take control of their own health; and support the friends, families and communities who care for them.
- We establish effective ways of involving people who use services in designing pathways and services so that they work for them.
- Local people are kept informed and have opportunities to be involved in everything we do.

This will require development of a systematic approach based on a structured and repeatable methodology for involving service users and carers.

This is a significant opportunity to develop our approach in concert with our local authority partners, building on their knowledge and experience in engaging citizens, communities and neighbourhoods.

As well as building on the good practice that already exists locally, we are incorporating examples both from the UK and beyond, including the potential for commissioning a programme of 'deliberative research' and establishment of a citizen's panel.

A further update on progress with this will be provided to the Committee at the meeting.

8.2 Patient and public feedback report

An initial overview report has been drafted summarising desktop research already undertaken to review recent patient and public feedback gathered across the BNSSG health and care system.

This included collating feedback gathered by Healthwatch, CCGs, acute trusts, community health providers and local authorities. It covered a range of services, including; urgent care, planned care, minor injuries services, GP surgeries, community health, children and young people's health, mental health and musculoskeletal disorders.

This is an important step in clarifying 'what we know already', prior to drafting and agreeing the STP Patient and Public Involvement (PPI) strategy.

The review has also helped to start identifying groups whose voices are under-represented and this information will be fed into the PPI approach to encourage a greater diversity of voices into the conversation. Healthwatch will be closely involved in the development of the PPI strategy and further population analysis will be carried out to ensure all voices are heard.

The consistent themes that have emerged across the area from patients and public feedback include:

- Simple information is needed to enable understanding and engagement.
- Professionals and organisations should be better at sharing information, and services should be more joined up for seamless care.
- Help is needed to understand and navigate the system.
- Self-care and self-management plans should be arranged around needs of the individual, and families and carers kept informed.
- Services should be provided locally, with access to GPs and a range of other services.
- People sometimes experience long waiting times to access services.
- Transport to hospital is an issue especially for those living in rural areas.
- Access to health services can be challenging for those with disabilities.
- Discharge from hospital experience can be challenging so extra support needed.

8.3 Staff engagement

Staff across BNSSG are a key stakeholder group, both because they are essential to the delivery of new models of care, and also because they provide an interface with patients, and can support patient engagement in the STP.

We will ensure that we involve clinicians in the development of new models of care, and will ensure that we engage with staff at all levels through timely and appropriate communication.

8.3.1 Social Partnership Forum (SPF) and staff engagement

We have established a Social Partnership Forum (SPF) which is a key part of engaging with staff through staff side and management representatives. The SPF meets bimonthly to discuss issues associated with the STP agenda. It does not seek to replace existing local organisation partnership forums.

Employers have a range of ways of communicating with staff, and will continue to use those mechanisms to engage and disseminate information about emerging models of care and service changes that may impact more locally. The STP governance structures will ensure that consistent messages about the STP more generally are agreed on a regular basis, and that these are then shared with staff through the workforce and communication leads in each organisation.

8.3.2 Clinical leadership

Across the BNSSG clinical leadership and engagement is embedded at every level:

- We have established a clinical cabinet of senior clinical leaders to help us to develop and champion our STP plans with the wider clinical staff community. This group will also help us to ensure our change plans are clinically safe, high quality and evidenced based.
- Chair of the Clinical Cabinet is a member of the STP Sponsoring Board.
- A broad range of clinical leaders from across the system are involved in reviewing and checking quality, safety, evidence and involvement in programmes and projects.
- Each programme has a clinical leader and clinical engagement is an integral part of the programme and the development of any proposed changes.

9. Next Steps/ Timescales

Our initial next steps can be broadly outlined as:

- Complete the STP refresh process, so that the existing work programme is resourced and supported to deliver as expected by end of November.
- Continue the work to develop the detailed evidence to support the STP high level strategic framework, so that we can be confident about the improvements that future big system transformation plans will deliver.
- Initial public facing narrative to be completed by the end of November.
- Progress the work to develop stronger and more inclusive communications and engagement plans so that local people feel involved in planning local service change for the future. Timescales will be agreed following a communications and engagement workshop taking place on 19 October.
- To support the vital work around 'Healthy Weston – joining up services for better care in the Weston area'. Please see separate paper for further detail.
- Outline Business Case and service specification for the respiratory pathway redesign to be completed by December 2017, ready for procurement and implementation during 2018.
- MSK detailed design and specification work to continue during 2018, to enable implementation from April 2019.

10. Risk assessment

A high level assessment of risks and mitigations is included within the STP PMO work programme. Risk identification and risk management is undertaken through the STP programme management arrangements / workstreams.

11. Public sector equalities duties

There are no specific implications for equalities arising from this report. Further consideration of any implications for equalities will be undertaken as part of specific portfolios and programmes of work arising from the further development of the STP.

12. Legal and finance implications

There are no specific legal implications arising from the recommendations in this report.

There are no additional resource implications arising from the recommendations in this report.

13. Conclusions

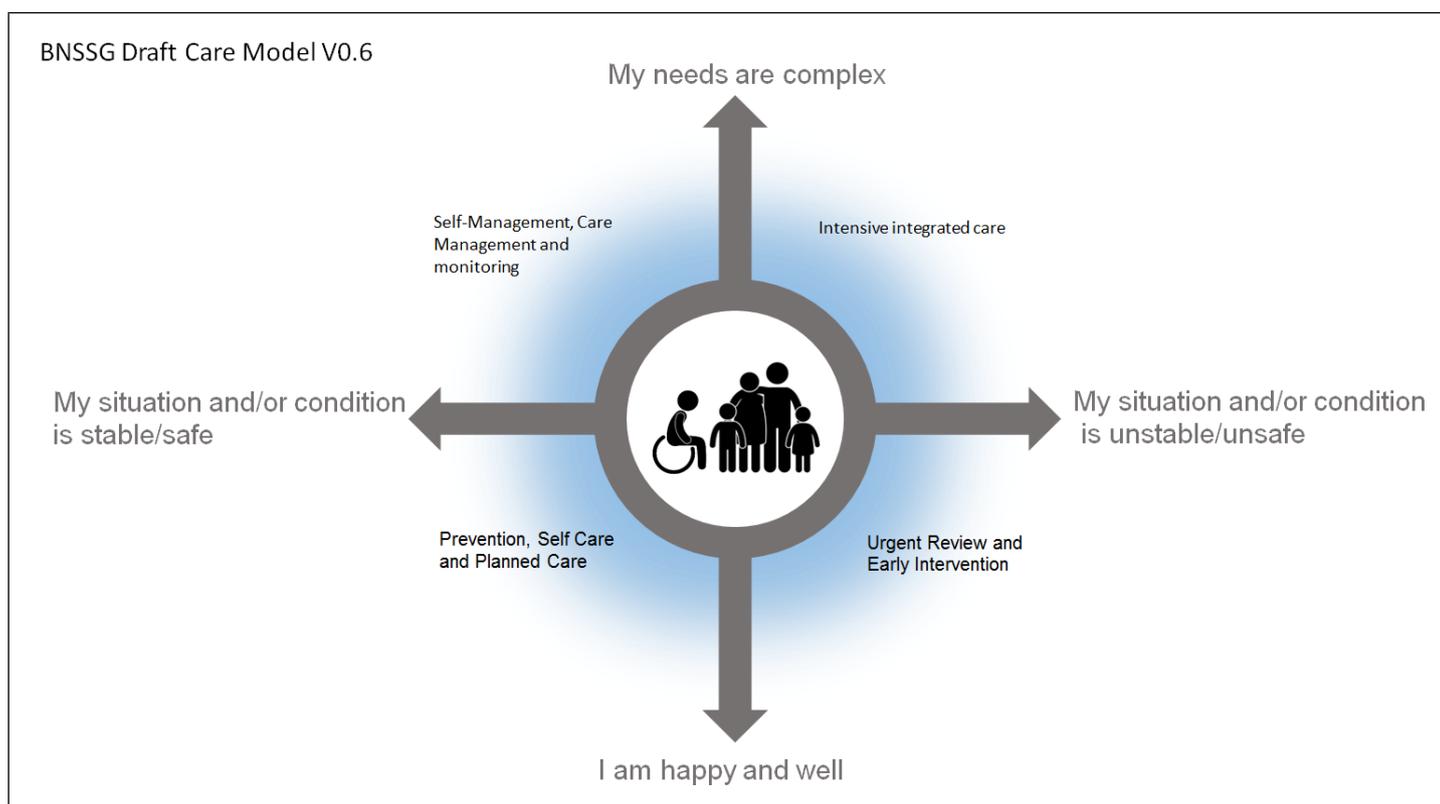
While progress on the BNSSG STP to date has been limited by shorter term priorities, the new governance and leadership arrangements we now have in place are now allowing us to significantly increase the pace of progress.

14. Recommendations

- Members are asked to note the report.
- Members are invited to comment on how we can best engage with them and their communities as our plans develop over time.
- We would like to suggest that we provide a further update to this Committee in early 2018.

15. Appendices

Appendix 1 – New Model of Care



Appendix 2 – Respiratory Care Pathway work

We know that there are opportunities in relation to respiratory to work collaboratively with all stakeholders to:

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

As such, respiratory was identified by the BNSSG STP in late 2016 as a priority work programme.

Public Health led the work to produce a BNSSG respiratory chapter for the Joint Strategic Needs Assessment. This has informed all of the design work.

We know that smoking is the most important risk factor for Chronic Obstructive Pulmonary Disease (COPD) and that average smoking rates in the general population are 13.8% in South Gloucestershire, 18.1% in Bristol, 16.3% in North Somerset as compared with an average of 16.9% for England as a whole.

Within these averages, there is a huge variation in smoking rates between deprived and affluent areas, for example, 7% of households in Westbury on Trym contain a smoker as compared with 34% in Hartcliffe and Withywood and in North Somerset, smoking prevalence ranges from 10% in Clevedon to 40% in Weston Super Mare.

We also know, for example, that of the 7,000 people diagnosed with COPD in Bristol, approximately 2,240 (32%) of them continue to smoke (*BLF, Commissioning Excellence in COPD, 2010*).

The BNSSG Respiratory Programme Board agreed to prioritise COPD in the first instance and identified the following four areas of work:

- Service user and carer education and information
- Primary and community care and prevention
- Admission avoidance, acute care and discharge
- Home oxygen and end of life care.

The process to implement these priorities began in February 2017, with providers working together to develop a new integrated model of care. A series of workshops were held with providers and other key stakeholders, including patient groups over the last seven months to help refine the way forward.

The British Lung Foundation has fed back on their involvement to date, stating: “The British Lung Foundation are pleased to be a part of the Respiratory Programme, making sure that the patient perspective has been well-represented at all stages of the service design process”.

The ‘respiratory vision’ is for primary, community, secondary care and the community and voluntary sector to provide an integrated respiratory service without walls across BNSSG.

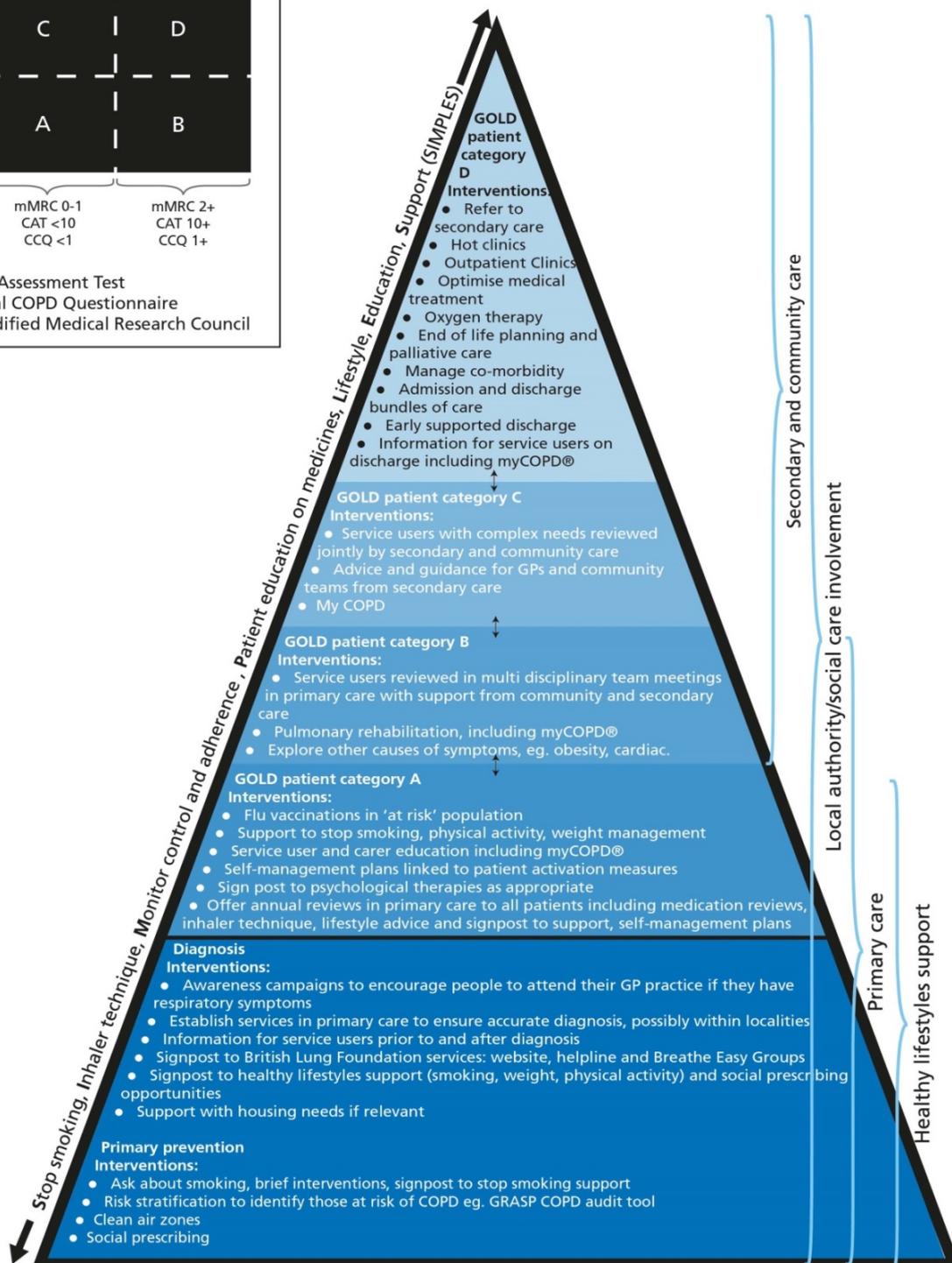
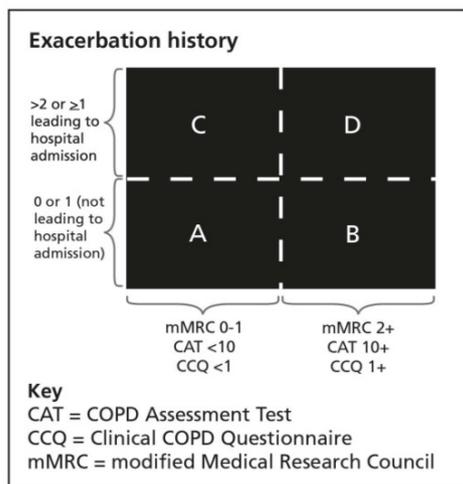
The key principles behind this service design are:

- People are provided with education and support to help them manage their health and wellbeing, including via technology
- Prevention is prioritised and everyone is encouraged to live healthier lives
- People receive an accurate and timely diagnosis
- People can access the same level of service across BNSSG
- Services are provided in an integrated way by teams without walls, maximising the skills of the multi-disciplinary team members including the community and voluntary sector
- We address inequalities in health by providing services in a way which achieve a fairer distribution of health
- The service user experience is paramount
- Services are provided in an efficient way to achieve the best value for money
- Where possible, services are provided close to where people live, using localities and clusters of practices

- People plan for the end of their life so they are helped to achieve the type of death they want
- Both people's mental health and physical health are considered and treated
- Services recognise the impact of the wider determinants of health, such as polluted air, social isolation and housing and try to address them.

The new service model, which was been agreed by the BNSSG Respiratory Board on the 3 October, is set out below:

Respiratory High Level Service Design



The Bristol, North Somerset and South Gloucestershire CCGs are bound by procurement law. They have agreed the most appropriate approach is not to

formally procure an integrated respiratory service but to implement a non-competitive approach whereby the commissioners gain assurance from the providers that they are able to work together as a provider collaborative. This is a two stage process.

Stage 1: Identifying the Provider Collaborative

The CCGs have identified the providers in the provider pool, they are:-

- Community service providers - Sirona, Bristol Community Health and North Somerset Community Partnership
- Acute trust providers - North Bristol Trust, UH Bristol and Weston Area Health Trust
- Primary Care

Stage 2: Capability Assessment

- A single written response is required from the Provider Collaborative, in the form of a **memorandum of understanding** (MoU), which describes the proposed governance model and how it will work from a strategic, commercial, legal and operational perspective. The MoU should be signed by all the providers in the Provider Collaborative.
- A second assessment focuses on how the provider will achieve the required outcomes, it covers vision, capability, quality. IT, workforce, finance, information governance and mobilization.

In summary:

- The key driving force for the prioritisation of this transformation programme is to achieve improved services for people with respiratory conditions. Currently services are fragmented and provision is subject to wide variation across BNSSG.
- This transformation programme is also supported by several national drivers which includes the STP itself, increase in the role of community & voluntary sector, the personalisation agenda, 5 Year Forward View, increased demand for services (access to 7 day services), increased focus on prevention, self-care and supporting people to recover quickly and manage their conditions.
- Local drivers for respiratory conditions include the limited admission avoidance and early supported discharge services in North Somerset, the number of non-elective admissions for pneumonia in North Somerset as compared with their peer group, the high number of short stay admissions at Weston for pneumonia, which is an ambulatory care sensitive condition so should be treatable outside of secondary care
- The establishment of an outcome based integrated respiratory service could lead to a range of benefits, including better quality outcomes for patients, better use of the existing workforce, less duplication and better value for money.

Finally, Members are asked to note the table below which outlines key past and future milestones in relation to respiratory transformation.

Approval		Progress
Authority to proceed	May 17	Done
Design		
Programme structure and milestones agreed	April 17	Done
Roles and responsibilities agreed	April 17	Done
Change programme		
Service development workshop 1	4 May 17	Done
Service development workshop 2	16 May 17	Done
Recommendations from workshops 1 & 2 agreed by the Programme Board	23 May 17	Done
Service development workshop 3	6 June 17	Done
Service development workshop 4	20 June 17	Done
Recommendations from workshops 3 & 4 agreed by the Programme Board	4 July 17	Done
High level design phase		
High level model of care designed	July 17	Done
Consultation on the high level service design	July to October 17	Done
Outcomes workshops and consultation with service users, carers and the public	Sept/Nov 17	1 st workshop held on 26/9/17, 2 nd workshop planned for 2/11/17
Approval for the commissioning approach	Nov 17	
Outline Business Case and service specification approval	Dec 17	
Contracting		
New contracts (variations) drafted	Dec-17	
New contracts (variations) agreed	Feb-18	
Service transformation		
Service transformation begins	Apr-18	
Checkpoint - Transformation on track?	Jul-18	
Checkpoint - Transformation on track?	Oct-18	
Service transformation complete	Apr-19	

Appendix 3 - Musculoskeletal (MSK) Care Pathway work

There are over 200 musculoskeletal (MSK) conditions affecting millions of people, including all forms of arthritis, back pain and osteoporosis. Some, including those resulting from injuries, can result in long-term disability. It is estimated that up to 30% of all GP consultations are about musculoskeletal complaints. The ageing population will further increase the demand for treatment of age-related disorders such as osteoarthritis and osteoporosis. People with musculoskeletal conditions

need a wide range of high-quality support and treatment from simple advice to highly technical, specialised medical and surgical treatments.

The MSK programme was identified as a priority within BNSSG in 2016. It was highlighted again as a BNSSG STP 2016/2017 'spotlight' priority.

It is locally recognised that there are significant opportunities for improvements in both quality of service and efficiency. This is supported with national benchmarking data and information held locally. Some of the rationale can be summarised as:

- The South West region has the highest number of MSK related 'years lived with disability' in England including conditions such as low back pain, neck pain, osteoarthritis and rheumatoid arthritis.
- It is estimated that approximately 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.
- There appears to be a reducing number of patients who feel supported in managing their long term condition.
- Fragmented elective pathways for patients with attendances at multiple providers.
- Average costs for knee replacement surgery are significantly higher than the England average.

The aim of the MSK project is to improve the pathway for patients accessing care for MSK conditions, encouraging a more integrated approach to deliver reduced wait times, improved outcomes and experience within a sustainable budget.

The main areas identified include:

- Outpatient Musculoskeletal Physiotherapy
- Musculoskeletal Podiatry
- Musculoskeletal interface services (Locally known as MATS, CATS and MSK)
- Specialist Pain services
- Rheumatology services
- Elective orthopaedics
- Referral management services.

The scope of the programme does not include children, trauma orthopaedics and patients outside BNSSG.

This summer the project team undertook a desktop research exercise to understand existing patient feedback. This drew on evidence from a range of sources, including PALS reports, complaints, Friends & Family data, Healthwatch

reports, Joint Strategic Needs Assessments, Mental Health Needs Assessment, and other relevant local or national reporting.

The findings can be summarised as follows:

Generally patients are happy with the service from clinical teams. Complaints are rarely about quality of clinical service delivery. However the following comments are made around the process:

- There were many reports of lack of clarity in communication regarding appointments, services being referred to, wait times and results.
- Long wait times and lack of clarity on next steps.
- Cancellation of appointments and intervention, sometimes due to not being given the right information before the appointment or the consultant not having the right information to hand.
- Lack of understanding of impact of condition- feeling of not being taken seriously
- Patients booked in to the wrong clinics.
- Patients having difficulty booking appointments or getting through to the team to discuss.
- Limited choice in where patients can have physiotherapy and no option for self-referral.
- Patients being “bounced around” specialities and hospitals.
- Patients being referred back to GP from AQP if cancel due to “breaching 18 weeks”.

To date the project team have held three workshops with a range of key stakeholders, including provider clinicians, local commissioners, health service managers, public health specialists and patients This supported mapping the current processes and further identifying any key issues that need to be resolved. Feedback on these events from attendees has been positive, including, “Good cross section of all those involved in various stages of the patient pathway” and “Lots of great ideas- I hope you can make these happen!”

A further workshop will be held in October to co-design the new MSK pathway with patients, providers and commissioners. Following this, a patient stakeholder session will be held to ask for further feedback and input to the first draft of the new model. We have worked with existing patients to develop an online questionnaire for service users, and this invites respondents to get further involved by attending a workshop.

The Patient and public and involvement and equalities team have been working to ensure that events are widely attended from across BNSSG and that we are reaching groups who share a protected characteristic. The event has been advertised by Healthwatch and at various other events. The team have also attended patient representative groups in order to seek feedback, and encourage people to attend the engagement events. We would like to feedback to Members following these events, most likely in December/ January, and would welcome your feedback in the meantime, or at that stage both on the process and of course potentially as users of the services.

If there is a significant change to the way in which MSK services are to be delivered, we will ensure that we undertake suitable further public engagement on the model and how the service is intended to be commissioned and delivered.

We have also identified a patient representative who will be working with us on the Programme Board.

Whilst this work is ongoing colleagues have been working on implementing a number of simple improvements that do not require re-design but will create improvements for patients. This includes:

- Having a shared referral form for the three physio/ interface services in the community which will also be used for the three physio services in the acute trusts for outpatients. This will be available to GPs across BNSSG to refer to on EMIS via managed referrals and other methods such as paper or ICE.
- Aligning referral criteria which alongside the access policy will create a consistent approach across the area and reduce the number of unnecessary referrals to orthopaedics in secondary care.
- Connecting care will be completing some work with providers and GPs to test ways of allowing improved access to shared records to reduce duplication in notes.
- Improving the triage process for clinical staff in the pain service.
- The six physiotherapy services will soon meet to discuss how waiting times can be reduced across the area.

Finally, Members are asked to note the table below which provides a summary of our key past and future milestones:

Phase 1: Start Up	
Project Initiation Document signed off	31/5/2017
Project Plan complete	31/5/2017
Phase 2: Assessment	
“As is” workshops completed	20/7/2017
Quick Wins Table produced for project group	26/9/2017
Clinical Feedback Survey Report Completed	6/10/2017
Recommendation reports signed off and agreed	10/10/2017
Clinical Evidence Reports	10/10/2017
Lessons Learnt Report	10/10/2017
Patient Feedback Report Completed.	17/11/2017
Finance and Activity Baseline agreed	01/12/2017
Phase 3: High Level Design	
High Level Design Workshop Completed	17/10/2017
First Draft for Model produced	17/11/2017
Patient and Public Model feedback workshop completed	23/11/2017
Presentation to the clinical forums of proposed model	23/11/2017
Wider stakeholder meeting for feedback on proposed model	7/12/2017
Service Specifications Drafted	27/2/2018
Phase 4: Commissioning	
Commissioning Strategy Paper to executive team and joint commissioning executive	31/1/2018

Notice to current providers on intention to commission new model and how.	31/3/2018
Phase 4: Design for Delivery	
Procurement or non-procurement plan for delivery of model.	31/3/2019
Phase 5: Delivery	
Implementation of new model with provider(s)- service starts	1/4/2019
Phase 6: Project Close	
Handover and project closure Report	1/10/2019
Lessons Learnt	1/10/2019
Phase 7: Benefits and Realisation	31/3/2020

Joint Health Overview Scrutiny Committee

Healthy Weston Programme Update	
Presented by, including organisation	<ul style="list-style-type: none"> Julia Ross, Chief Executive, BNSSG CCG
Date of meeting	23 October 2017
Report for information	

1. Purpose of this Paper

To brief Joint HOSC on the programme known as “Healthy Weston - joining up services for better care in the Weston area”.

2. Executive Summary

The Healthy Weston Programme is North Somerset CCG’s new vision to improve health and care services in Weston-super-Mare, Worle, Winscombe and the surrounding villages of the south rurals.

Our vision places greater emphasis on organising and delivering services that help to keep people healthy and out of hospital, and when they do need care, providing a more seamless experience across the range of health and care services with a focus on being treated in the community and closer to home.

It sets out a proposed way forward for organising and delivering health and care services across the local health and care system in a way that better meets the needs of local people, and ensures services meet national quality standards and are affordable within available funding for the long-term.

This is in response to the increasing demand and changing needs that come with an ageing and growing population, as well as the need to address challenges in attracting, recruiting and retaining specialist staff to run services, alongside significant financial pressures.

3. Healthy Weston

3.1 Introduction

A Commissioning Context document (final draft available at https://www.northsomersetccg.nhs.uk/media/medialibrary/2017/09/draft_healthy_weston_context.pdf) has been developed in North Somerset that sets out a clear vision and direction of travel for local services. This work is

focused on the population living in and around Weston-super-Mare. In the Weston locality there are a number of recognised clinical and financial sustainability issues at the acute provider, and amongst some local primary care services.

As part of transforming services, the CCG want Weston General Hospital to play a vital role in organising and delivering services differently by putting it at the heart of a more integrated and proactive local health care system that will better meet the specific needs of local people. This means treating more people in the community and helping them to stay in their own homes for as long as possible before needing hospital treatment, and where hospital treatment is required, helping them to return home as soon as possible.

This is not about starting again, or duplicating work that is already underway, but rather about translating design into delivery. This is to enable a step change in the way we organise and provide local services. The context document has been developed through an intense period of stakeholder engagement and involvement over the past three months. The work has identified three overarching priorities of enabling primary care to deliver at scale and provide system leadership, integrated community services and a resolution to the challenges in acute provision.

3.2 Temporary overnight closure of Weston A&E

The long-term future of urgent and emergency care services at Weston is a crucial strand of the work. The CCG will continue to gather views from health and care partners, staff, stakeholders and the public on how sustainable services could be delivered. The CCG and WHAT's (the organisation that runs Weston General Hospital) shared goal is to make sure local people can access safe, high quality, sustainable urgent and emergency care services from wherever they live in North Somerset, as close to home as possible.

In the meantime, the temporary closure of overnight A&E services remains in place until safe and sustainable staffing levels can be achieved throughout the night. Whilst WAHT are making progress with recruiting permanent medical staff, and continue to do all they can to recruit the numbers needed, we acknowledge that it will continue to be difficult and the A&E department will not reopen overnight in the short-term. During the temporary overnight closure, patients continue to receive safe care at an alternative hospital and the NHS continues to cope well.

3.3 Healthy Weston Next steps

The BNSSG Governing Body approved the new vision 'Healthy Weston: joining up services for better care in the Weston area' at the BNSSG Governing Body (in common) meeting on 3 October 2017.

A final version was published on the CCG website on 11 October 2017 and will be accompanied by a public facing summary of the document.

At the time of writing this report, it is planned that the next phase of talking and listening to views of staff, stakeholders, patients and the public will commence on 18 October 2017.

4. Risk assessment

A full programme of work to develop the vision of the Commissioning Context which will include a risk register for each workstream.

5. Public sector equalities duties

An Equality Impact Assessment will be a key part of the next phase of work to develop detailed proposals for service reform and implementation of a new, integrated care system. The local population of the Weston area has areas of high deprivation. The CCG know from previous engagement work that additional travel for patients and visitors resulting from any rationalisation of services will be a concern. This will have to be a balanced against the clinical and financial viability of services. Also, by bringing routine and preventive care closer to home, there is the opportunity to better serve the local population's overall needs.

6. Legal and finance implications

The CCG has a statutory duty to involve patients, carers and the public in the development of commissioning plans to change and develop local health services. This is detailed in Section 14z2 of the health and Social Care Act 2012. The right of patients to be involved in the planning and development of health services is further set out in the NHS constitution.

The commissioning context document asserts that whatever is done, will happen within a clearly defined financial envelope so it is affordable and sustainable. The financial section indicates the level of affordable service expenditure for North Somerset which is compatible with longer term financial resilience, moving the CCG from an underlying deficit to a 1% surplus. The document then goes on to explore the idea of a provider alliance with a capitated budget model.

8. Recommendations

That Joint HOSC notes the contents of this paper.