Bristol City Council
Minutes of the Health Scrutiny Committee (sub-committee of the People Scrutiny Commission)

11 March 2020 at 2.00 pm

Members of the Committee Present:-
Councillors: Brenda Massey (Chair), Harriet Clough, Eleanor Combley, Gill Kirk, and Celia Phipps

Also Present:-
Councillors: Asher Craig, Deputy Mayor, Communities, Public Health, Public Transport, Libraries, Parks, Events and Equalities; Helen Holland, Cabinet Member, Adult Social Care

1. Welcome, Introductions, and Safety Information

Scrutiny Advisor welcomed all those present.

2. Elections of the Chair and Vice-Chair

Members of the Committee elected the Chair and Vice-Chair.

Councillor Brenda Massey was elected Chair; nominated by Councillor Celia Phipps, seconded by Councillor Gill Kirk.

Councillor Celia Phipps was elected Vice-Chair; nominated by Councillor Brenda Massey, seconded by Councillor Gill Kirk.

RESOLVED;

That;

- **Councillor Brenda Massey be elected as Chair**
- **Councillor Celia Phipps be elected as Vice-Chair**

3. Annual Business Report

The content of the Annual Business Report was noted.

RESOLVED;

That;

- **The Sub-Committee note and agree the Terms of Reference;**
- **The Sub-Committee note and agree the Membership;**
- **The meeting on the 11 March 2020 be the only meeting of the 2019/20 municipal year.**

4. Apologies for Absence and Substitutions

There were no apologies for absence.

5. Declarations of Interest

The following non pecuniary interests were declared;

Councillor Celia Phipps declared she was a Social Prescriber, working with Bridgeview Medical Primary care Network; employed in the Voluntary sector in partnership with Knowle West Healthy Living Centre and BS3 Community.

6. Chair's Business

The Chair explained that this was the first meeting of Health Scrutiny Sub-Committee of the People Scrutiny Commission; and this provided an opportunity to have more focus on topics for health scrutiny which was not previously able to fit on the People Scrutiny Commission work programme.

The Chair asked the Director of Public Health to provide an update on Covid-19. An update was given to the Sub-Committee.

7. Public Forum

The following public forum was received and a copy placed in the minute book;

Questions
Q1 -11: Questions from Councillor Massey.

Q12-13: Questions from Councillor Kirk.

RESOLVED;
That the Public Forum be noted.

8. Bristol mental health services update and performance report

The Director of Strategy, AWP, spoke to the report (in the published pack).
The following points were made during the ensuing discussion:

- Area placements were a significant focus; there were a number of work programmes with the aim of provision of a more sustainable service.

- Deputy Mayor (Communities, Public Health, Public Transport, Libraries, Park, Events and Equalities) raised concern about issues with communication; that people were not able to navigate the system due to lack of communication.

- The Committee was advised that the issues surrounding communication were taken on board; it was acknowledged that more needed to be done to find a way to deal with this. It was agreed that a coherent pathway that showed people what services were available, what they looked like, and what to expect, was needed.

- Whilst performance had been good there were situations where people were unable to access services due to communication problems.

- Members stated that the performance in the report did not reflect some constituents' experiences. Members were advised that whilst the Key Performance Indicators were good and showed some improvement it was acknowledged that there were experiences of waiting times which needed addressing; some could be addressed with existing resources, but this was limited.

- The Committee was advised that due to system pressures there was not the capacity to deal with those that did not engage or had disengaged – this was an indicator of pressure on the system.

- The issues were not due to workforce churn, but due to capacity - more referrals than workforce.

- There was a very low bed base compared to the rest of the UK; there was a need to improve recovery capacity. Rising caseloads had impacted the Intervention and Recovery teams. It had been identified that not all referrals had needed to be made.

- It was very important to work in partnership to utilise other sector preventative work which would free up capacity for people in need of care. Working in Multi-disciplinary teams was a positive way of providing people with more opportunities; a way of working that has not been implemented thus far.

- Delayed Transfer of Care was an issue for people with acute mental health conditions. Reasons for DToC included waiting for housing, including supported and specialist housing; key groups being stepped up into secure pathway – there was need nationally for those placements (MoJ involvement).

- If someone had a specific need the supported housing staff may require specialist training and so this would take more time. There was little provision outside acute mental health.

- The Committee was advised that there were good close relationships and links to social care; housing was coming on board with a better relationship with AWP now.

- It was very positive that the staff retention rate had improved.

- There had been workshops with GPs to instil confidence regarding prescribing; GPs were under pressure and so there was a need to ensure they were aware that specialist support was available if needed and that it was accessible. Relationships with GPs had improved. There had been plans for future programmes for newly qualified GPs to acquire mental health specialisms.

- Shared care protocol had been important to enable people to live independently in their communities.

- Out of area placements was a national issue. There had been a struggle to get beds in the country.

- People have needed to be placed a distance away from their homes which was not good for their treatment pathways, and so the strategy had been to get them back as soon as possible. This was not just about beds, but the whole system, including what happened in the lead up to needing a bed in the first place.

- Beds were not the whole story – early interventions and care could prevent a need for beds. There was a need for community solutions so as to lower the need for hospital stays. Resource pressures meant there was a need to come up with creative and flexible solutions.

- There was evidence to show that when a Trust concentrated on community mental health, need for bed numbers went down.

- The Committee was advised that a completed single mental health strategy was due in June 2020. There was a need to ensure it represented views of communities and other stakeholders. There was a need for a joint vision – THRIVE was part of that.

- The production of the strategy required a robust evidence based to inform it, which included an understanding of need in different parts of the city. There would be a focus on well-being to crisis.

- The Director of Public Health told the Committee that the Council was part of an editorial team commenting on the strategy; and that it had been to the Health & Wellbeing Board for comment. The next version would go to the Health & Wellbeing Board again before Cabinet and partner organisations decision making bodies.

- There was a lot of ownership of the strategy; with all partners invested in it.

- The Cabinet Member for Adult Social Care raised an issue of how jobs could be more joined up – voluntary community work and formal mental health employment; which would increase pathways into mental health work more generally.

- The Committee was advised that despite increase in retention there was still an issue of workforce shortages including psychiatrists. There were plans to increase pathways to enter mental health work, which included apprenticeships.

- Director of Public Health stated that this issue links with BAME mental health groups; there was a need to reach communities which would help to build workforce. There were good links which could be built on.

- AWP have had 2 people on the Stepping Up programme.

- There was a discussion about the gap between primary and secondary care. The Committee was advised that there was a group in the middle where there was a gap of service provision. AWP was commissioned to provide high need service provision; there was work starting to bridge the gap.

- There was ongoing work with partners to implement a system that worked with Sirona as they embedded community models – which was a system response.

9. Hospital pressures

Head of Service Hospitals and Front Door spoke to the report (in the published pack).
During the ensuing discussion the following points were made:

- Community services were being developed; an in-house trading company was being investigated for homecare provision. There was a review on current in-house services – how they were used and how they could be improved.

- The Committee was advised that in-house homecare company could provide greater value for money and this in principle was a sustainable proposition.

- It was damaging to older people's health to remain in hospital longer than required; there was concern about step down not being back to home. The Committee was advised that a mixed model approach was important, that the aspiration was to have as many people at home as soon as possible, but appropriate pathways were required for those who presented with complex needs.

- There was value in keeping people well at home; there was a need to utilise the voluntary and charity sector to improve the offer and achieve this; the way the voluntary sector was enabling services now was not sustainable.

- 3% of annual income related to the Community Care contract must be spent on the voluntary sector. £3M /year would now go into the voluntary sector. There was ongoing work to ensure value would be added within the sector, which included how and where money should be spent; there had been innovative projects come forward. The voluntary sector would now help to design the system.

- The challenges have included the move to what the goals were for individuals rather than what prescribed goals should be; which referred to the Wigan model, which would achieve buy-in via co-production of services.

- The Cabinet Member for Adult Social Care said there had been workshops with national and local providers which highlighted that organisations were more engaged with this approach than originally thought, which was positive. This provided a positive opportunity to use direct payments in a way that people would like, which took note of their own goals, what the individual would like.

- The Chair stated that it was important to ensure the home was ready for people to return to, which included appropriate adaptations. Some of that meant working with housing providers as well. All services need to work together. This needed to be considered if home care was to be taken in-house.

RESOLVED;

That the viability of using an in-house trading company for homecare provision should continue to be investigated and findings reported to the Committee.

There was a 10 minute break at 3:20.

10 Bristol GP closures and new arrangements

The Director of Commissioning, BNSSG CCG, spoke to the report (in the published pack). The Area Director (Bristol) and the Director of Business Development, Sirona, was also present.

During the subsequent discussion the following points were made;

- The Committee noted that GPs were independent but integral to NHS.

- There was a resilience dashboard to understand what were the key indicators to show any issues with practices.

- There had been a Primary Care strategy developed. It was agreed that this should be brought to the Committee at a later date.

- Members raised residents' concern that the temporary arrangements including portacabins would last more than 1 year.

- The Committee noted that due to a low amount of residents that had asked for information and/or support with moving practices as part of the dispersals it suggested a well-managed process.

- The Committee was advised that, regarding Bishopston, planning permission process had taken longer than envisaged, and so would be longer than 10 months; it was the intention to maintain Bishopston.

- Increased lists as a result of housing delivery activity were discussed, and Members were advised that there were assessments for the capacity of each practice and how this related to how they operate and utilise space. For example, Horfield was identified as needing more space to meet need, although after further analysis better use of space was identified as a solution.

- There were ongoing meetings and partnership working with Council planning, public health and housing teams to work in an integrated way. There was a need to gain a better understanding of how planning for new housing related to and impacted upon need and capacity.

- Members were advised that some practices worked with a reduced number of Partners as opposed to GPs; that some new GPs did not necessarily want to be Partners; and that different practices worked on differing ratios of GPs/Partners.

- To ensure appropriate capacity there was a need for practices to work together.

- There was a challenge around appropriate bus routes between practices. The Committee was advised that transport was an important consideration when assessing dispersal arrangements and decisions.

- Part of the new community health contract involved ensuring community services could work more closely with GP practices; workforces were already working closer together. The Committee was advised that the aim was to take as much pressure/load as possible from GP practices, and there was a strong willingness for improved partnership working.

- Members were advised that the participation patient groups (PPG) would exist within surgeries; it was also important for full consultation and so feedback from many patients as possible was key. There was work to improve PPG engagement; this had not happened in some parts of Bristol.

- The Chair stated that there was a strong group at Greenway Community Practice.

- The Chair raised concern that some patients had issues seeing the same GP on occasions.

- There was a discussion about 'did not attend' rates and the related costs to practices.

- The Committee was advised that there was not local routine monitoring of missed appointment rates. This was monitored nationally; not for smaller localities.

- There had been communication about costs to pratices due to missed appointments. Previous publication of these figures did not work.

ACTION:
The Sub-Committee to receive clarification as to whether personal list systems were in operation in GP practices.

RESOLVED;
That the Primary Care strategy be on the Health Scrutiny Sub-Committee work programme 2020-21.

11 Service transfer of the Adult Community Contract

The Director of Commissioning, BNSSG CCG, spoke to the report updating the Sub-Committee on the mobilisation and service transfer of the adult community contract. The Director of Business Development, Sirona, was also present.

During the ensuing discussion the following points were made;

- The Committee was advised that, from 1 April 2020, there would be a single adult community services provider and single children's service provider over the Bristol, North Somerset, and South Gloucestershire area.

- Appropriate TUPE arrangements for all staff (3000 approx.) would be in place by the 1 April 2020.

- Part of the contract specification was a requirement to level up services, which would result in a consistent offer based on need.

- The integrated care approach had a focus on prevention and early intervention.

- Members of the Committee agreed that there should be a focus on consistency of approach across the area, and it was positive that Continuing Healthcare (CHC) teams were brought in-house, which could provide more consistency and higher standards.

12 Work programme

The work programme was noted.

RESOLVED;

That the mental health strategy would be brought to the Health Scrutiny Sub-Committee on the 2020-21 work programme.

Meeting ended at 4.45 pm

CHAIR _____