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	• 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 Directory, 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

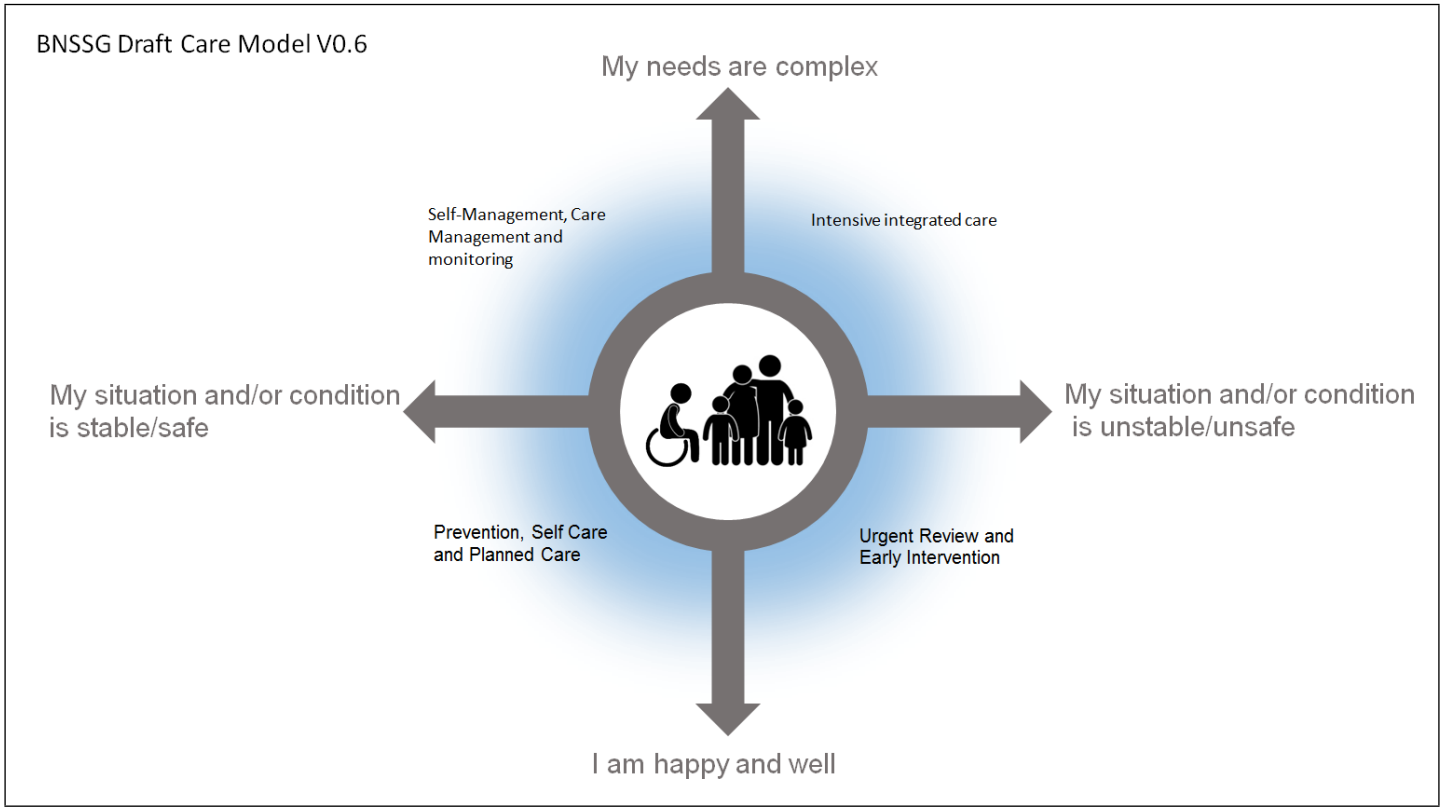
While progress on the BNSSG STP to date has been limited by shorter term priorities, the new governance and leadership arrangements we now have in place are now allowing us to significantly increase the pace of progress.

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:

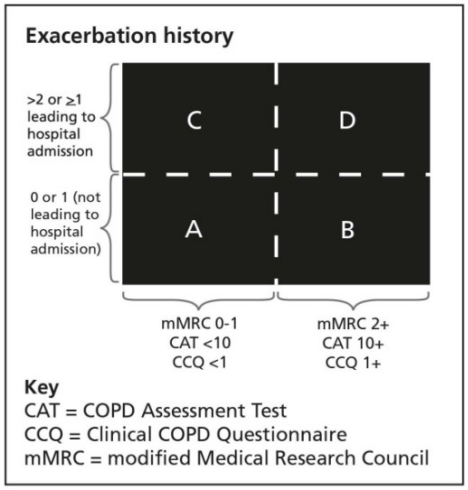
- People are provided with education and support to help them manage their health and wellbeing, including via technology
- Prevention is prioritised and everyone is encouraged to live healthier lives
- People receive an accurate and timely diagnosis
- People can access the same level of service across 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:

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

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	1st workshop held on 26/9/17, 2nd 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