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Date: 05 March 2021

Dear Sir or Madam

Joint Health Overview and Scrutiny Panel
Monday, 15 March 2021, 11.15am, Virtual Meeting

A virtual meeting of the Joint Health Overview and Scrutiny Committee will take place as indicated above.

Please note that any member of the press and public may follow the proceedings of this virtual meeting via the weblink below:-

https://youtu.be/4Se76ZK2Wdc

Yours faithfully

Head of Legal and Democratic Services

To: Members of the Joint Health Overview and Scrutiny Panel

North Somerset Councillors: Ciaran Cronnelly (JHOSC Chair for the meeting), Caroline Cherry, Ruth Jacobs, Huw James, Timothy Snaden, Roz Willis, Vacancy

Bristol City Councillors: Brenda Massey (HOSC Chair), Harriet Clough, Eleanor Combley, Paul Goggin, Gill Kirk, Celia Phipps, Chris Windows

South Gloucestershire Councillors: Sarah Pomfret (HOSC Chair), April Begley, Robert Griffin, Shirley Holloway, Trevor Jones, John O'Neill, Matthew Riddle

This document and associated papers can be made available in a different format on request.

Agenda

1 Welcome and Introductions

2 Apologies for absence and notification of substitutes

The Joint Committee to note apologies for absence and substitutions

3 Declarations of interest

To note any declarations of interest from Councillors.

4 Chair's Business

5 Minutes

25 October 2019, to approve as a correct record (attached)

6 Public Forum

To receive written submissions from any person who wishes to address the Committee. (Please see the attached Public Information Sheet). The Chairman will select the order of the matters to be received.

Please ensure that any submissions meet the required time limits and would take no longer than five minutes to read out.

Requests and full statements must be submitted in writing to the Head of Legal and Democratic Services, or to the officer mentioned at the top of this agenda letter, by noon on the day before the meeting.

7 Proposed amendment to the Joint Committee's Terms of Reference (ToR)

For review and agreement: see attached Terms of Reference.
Some minor amendments have been proposed (as highlighted in the text) to reflect developments in the health sector.

8 BNSSG Stroke Programme

9 Bristol and South Gloucestershire Community Surge Testing

10 Integrated Care System (ICS) Progress Update

Exempt items

Should the JHOSC wish to consider a matter as an Exempt Item, the following resolution should be passed -

"(1) That the press, public, and officers not required by the Members, the Chief Executive or the Director, to remain during the exempt session, be excluded from the meeting during consideration of the following item of business on the ground that its consideration will involve the disclosure of exempt information as defined in Section 100I of the Local Government Act 1972."

Also, if appropriate, the following resolution should be passed –

"(2) That members of the Council who are not members of the Health Overview and Scrutiny Panel be invited to remain."

Mobile phones and other mobile devices

All persons attending the meeting are requested to ensure that these devices are switched to silent mode. The chairman may approve an exception to this request in special circumstances.

Filming and recording of meetings

The proceedings of this meeting may be recorded for broadcasting purposes.

Anyone wishing to film part or all of the proceedings may do so unless the press and public are excluded for that part of the meeting or there is good reason not to do so, as directed by the Chairman. Any filming must be done as unobtrusively as possible from a single fixed position without the use of any additional lighting, focusing only on those actively participating in the meeting and having regard to the wishes of any members of the public present who may not wish to be filmed. As a matter of courtesy, anyone wishing to film proceedings is asked to advise the Chairman or Head of Legal and Democratic Service's representative before the start of the meeting so that all those present may be made aware that it is happening.

Members of the public may also use Facebook and Twitter or other forms of social media to report on proceedings at this meeting.

Draft Minutes

of the Meeting of the

Joint Health Overview and Scrutiny Panel
Friday, 25th October 2019

held in the City Hall, College Green, Bristol BS1 5TR.

Meeting Commenced: 13:30 Meeting Concluded: 14:25

Members Present:-

Bristol City Council
Councillors: Brenda Massey (Chair), Harriet Clough, Eleanor Combley, Gill Kirk and Celia Phipps

North Somerset Council
Councillors: Geoffrey Richardson, Timothy Snaden, Mike Solomon, and Richard Tucker

South Gloucestershire Council
Councillors: April Begley, Robert Griffin, Shirley Holloway, Trevor Jones, Sarah Pomfret, and Matthew Riddle

Officers:-
Dan Berlin (Scrutiny Advisor, Bristol City Council), Lucy Fleming (Head of Democratic Engagement, Bristol City Council), Christina Gray (Director of Public Health, Bristol City Council).

STP Representatives:-
Luke Culverwell, (NICU Lead Commissioner, NHS England), Rebecca Dunn, Programme Director, BNSSG CCG), Deborah El-Sayed, (Director of Transformation, BNSSG CCG), Dr Lou Farbus, (Head of Stakeholder Engagement, Specialised Commissioning, NHS England), Sebastian Habibi, (Programme Director Healthier Together), Martin Jones, (Medical Director), Dr Paul Mannix, (Consultant Neonatologist, North Bristol Trust), Dr Kate Rush, (Associate Medical Director, BNSSG CCG), Amanda Saunders, Neonatal Services Project Manager, NBT & UH Bristol), Julie Sharma, (Director of Business Development at Sirona Care & Health).

1 Welcome, Introductions and Safety Information

The Chair welcomed all those present.

2 Apologies for Absence

Apologies for absence were received from:
Councillors Caroline Cherry, Paul Goggin, Ruth Jacobs, John O'Neal, Roz Wills, Chris Windows.

It was also noted that Julia Ross, Chief Executive Officer for Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group was unable to attend.

3 Declarations of Interest

The following non pecuniary interests were declared;

Agenda item 10 – Councillor Harriet Clough declared as she was a current user of mental health services.

Agenda item 7 - Councillor Shirley Holloway declared she was Chair of the Legal Friends of Thornberry Hospital.

4 Chair's Business

There was no Chair's Business

5 Minutes of Previous Meeting

The minutes of the previous meeting were approved, subject to:
That paragraph 6.4, Communications and Engagement, be amended to reflect the following comments from Councillor Geoffrey Richardson;

1. He had not raised any concerns about transport.
2. In addition Councillor Richardson advised that he did not believe queries in relation to lack of transport to healthcare facilities; the CCG contacting the Local Authority Communications team; and the engagement work with Patient Participation Groups had taken place.

RESOLVED: That minutes of the meeting on 26th September 2018 be approved as a correct record, subject to the amendment detailed above.

6 Public Forum

Seven items of Public Forum Business were received and a copy placed in the minute book.

The Chair confirmed that written answers would be provided for publication on the Bristol City Council website within 28 days and circulated to Members of the Committee.

RESOLVED: That the public forum business be noted and the answers to questions circulated to the Committee when then were available.

[the written responses referred to above can be found at appendix 1 at the end of these minutes]

HEA Healthier Together 5 Year System Plan

The Programme Director of Healthier Together spoke to the report (details and accompanying slides are in the published pack).

The Committee raised concerns about mental health inequalities not being listed as one of the agreed design principles and were advised that mental and physical health and well-being were integral and this should be made more explicit.

There was a discussion about delivery of the 5 year plan, the list of priority care programmes, how success was measured and how risk was managed, and the Committee was advised that there are key deliverables and milestones which were reviewed via robust performance and risk management procedures.

The Committee noted the profile and diverse representation of people living in the Bristol, North Somerset South Gloucestershire area and were advised that more insight could be produced by engaging more with people, and enhanced linking of data between agencies, which was an area where the BHSSG was improving.

Bristol City Council Deputy Mayor, Cabinet Member for Communities stated that the 'wheel' *(shown on slide 9/36*) is not representative of Bristol's diversity and, although representative of the wider area, should not be used as an evidence base for local decisions without further drilling down of data. The Committee was advised of the need to define value, which included focusing on health outcomes that mattered to people.

The Committee asked what was being done to increase the representation of BME respondents on the Citizens Panel from the current 7% to the actual BME representation of the population across the area, which was 10%, and were advised that plans were in place to make improvements in this area. There was a discussion about population figures within the 6 localities in the BNSSG (*shown on slide 25/36*). The Committee asked for clarification of the figures and sources, and it was agreed this information would be sent to the Committee.

Delivering digitally enabled health and care, including issues with accessing services via digital technology was discussed, and the Committee was advised that digital was not a replacement to traditional ways of accessing services such as phone and face to face, and there was a need to maintain both. The Committee asked if the IT systems were being built 'in house' or whether packages were being utilised, and was advised that both were being done; for example, in outpatient care, there was a plan to procure a system. Regarding extracting insights from data, this would be done in house. Financial challenges were referred to, with the Committee being advised that growth of 3.4% in real terms was expected over the next 5 years, so it was important this was used well, including investing in primary and preventative care; together with a plan of reducing the historical deficit by £50M over the 5 years.

The Committee was advised that the draft plan would go to the Partnership Board on the 15th November for sign off, before being submitted to NHS Improvement for agreement; and then be published.

The Committee noted that transport needs should be considered in the final draft of the plan.

The Committee asked about rates of vaccinations and was advised that there would be specific commitments on screening and vaccinations agreed with Public Health England, to be reflected in the plan.

The Committee was advised that GP closures and amalgamations would be better brought to local Health Scrutiny Committees.

RESOLVED: That GP capacity and closures should be placed on the next agendas of all three Council's Health Scrutiny Committees.

RESOLVED: That each local authority would benefit from a locally focussed presentation and scrutiny of the final plan; the item should be placed on the next agendas of all three Council's Health Scrutiny Committees.

RESOLVED: That population figures within the 6 localities in the BNSSG (*shown on slide 25/36*) and the sources be clarified for the Committee.

8 Adult Community Health Services Procurement

The Associate Medical Director of Bristol North Somerset South Gloucestershire CCG and The Director of Business Development at Sirona care & health spoke to the report (details and accompanying slides are in the published pack).

The Committee was advised of the objective to achieve equity across the BNSSG by upscaling every service for parity, rather than cutting from one area to give to another. There was a discussion about the importance of being able to get people home from hospital, and that achieving a care plan could provide barriers to this. The Committee was advised that a core part of overcoming barriers was to have an integrated care plan for one person, which followed them.

The Committee noted that South Gloucestershire Council was happy Sirona got the contract; that Sirona had already provided a good service in South Gloucestershire.

There was a discussion about the need for social care and health colleagues working together, and so the Committee would have liked to hear from Council social care officers.

The Committee was advised that the procurement process had social care representation from all Local Authorities, as well as Public Health representation. The management arrangements regarding the transfer of services to Sirona was raised, and the Committee was told a Mobilisation Group for 1st April 2020 was in place; that there was also a Service Transfer Group to help manage services not in scope, which would carry on and users of those services would not notice a difference on the 1st April 2020.
It was noted that Sirona already had a contract for children's services and sub-contracted with Avon & Wiltshire Mental Health Partnership (AWP) for Child and Adolescent Mental Health Services; the arrangement with AWP should not change and Sirona would take back responsibility for children's services across South Gloucestershire and Bristol.

It was noted that Sirona had a close relationship with the South Gloucestershire Health Scrutiny Committee, Councillors and Officers, and had a challenging relationship which ensured accountability.

There was a discussion about working in partnership with the voluntary sector and the Committee wanted to know what Sirona intended to do with the extra money earmarked for the voluntary organisations to help build capacity. The Committee was advised that Sirona was working with organisations across the three areas; Sirona has met with 80 organisations so far, VOSCUR has been utilised; the issues in the local areas needed to be understood so the money could add value and investment decisions were to be made jointly.

The Committee asked about the proposed timescales before investment, and was advised that there was money already invested in services; there was a need to monitor the demand before investment decisions and changes were made. Sirona expected to start this process in year one, to make investments in year 3.

The Committee asked how outcomes would be measured and stated that hospital admissions should not be used as a measure; Sirona was in agreement, advising that this was reflected in the Community Outcomes Framework – what matters to people which introduced 'I' statements, eg: *what does this mean to me*?

There was a discussion about the integrated care approach, (shown on slide 7/10), and the Committee was advised that the model was meant to show that people would flow through, but not necessarily in that order, and the objective was that people should be in the left section.

The Committee asked if Sirona was confident there were enough people to carry out all the planned work, and was advised that change was required to ensure there was enough workforce to deliver services, and what was behind the model was finding ways to stem demand; from a staffing point of view the model is robust, but it was important to focus on close work with families and others.

RESOLVED: Committee Members to submit questions in writing to Council social care officers not represented at the meeting, and responses would be provided.

9 Specialised Neonatal Intensive Care

The Head of Stakeholder Engagement and Consultant Neonatologist, NHS England spoke to the report (in the published pack). Also introduced were the NICU Lead Commissioner and Neonatal Services Project Manager.

Head of Stakeholder Engagement provided a statement for clarity, that there was no planned closure for Southmead hospital or the neonatal unit at Southmead. The Committee was advised that the proposal as presented was to strengthen relationships that exist between the two neonatal units and reduce the amount of babies that needed to be transferred from Southmead to St Michaels for services not available at Southmead. The proposal would

result in all Level 3 Neonatal Intensive Care services being at St. Michael's (UHB) with a supporting Local Neonatal and Special Care unit at Southmead (NBT).

There was a discussion about plans to create 10 extra cots at St Michaels, including timescale and costs, and the Committee was advised that Southmead specialised in pre term very small babies, at risk of having complications that may need surgical expertise; so on occasions unwell babies needed to be transported to St Michaels in specialised ambulance and have surgery. It was known that 30-40% of those babies (10-14 babies per year) ended up having to be transported so there was a need to design a system where they got all things in one go.
The Committee was advised that the suggestion was to bring expertise of 2 groups of clinicians together, involving good collaboration, which enabled safer care, so more babies survived. There were proposals to transfer the 8 intensive care cots from Southmead to St Michaels, and then funding had been agreed to open an extra 2 intensive care cots also at St. Michael's. This would create 41 intensive care cots in Bristol, for babies delivered in the Bristol, North Somerset and South Gloucestershire area and wider neonatal network region.

The Committee asked how the additional 30 women giving birth at St Michaels rather than Southmead would be identified; would the need for transport to St Michaels be identified early in the pregnancy. The Committee was told that there were different choices where to give birth, but women don't have a choice about going into labour pre-term, which would remove the choice for homebirth. That group of women would still need to seek help at their local hospital, as some would go on to deliver early – although most would not. The proposal would minimise the number of babies that need to be transferred after delivery. If a woman was considered too high risk to transfer she would deliver and then move. Staff would rotate around service - this was about creating a unified tertiary care system.
The Committee was advised that there was no reduction in cot numbers; and they were expanding; this was not about cost saving, but doing what it was felt as clinically correct.

The Chair referred to difficulties in recruiting staff, and asked if there was confidence about recruitment, and the Committee was advised that there were increasing numbers of staff that wanted to come through and do neonatal work; that Southmead provides good training, but as soon as a baby developed a surgical issue or heart problem, the baby was moved to St Michaels so staff at Southmead did not all have experience of this type of care. The Committee was told that the ability to provide academic output was important. The team at Southmead have worked hard to produce published research. Amalgamating services meant the ability to do research has increased. A bigger service, bringing units together, would be positive for the city and attractive for recruitment.

The Committee asked about technological advances, and whether, with the current technology, a plateau had been reached in terms of saving very small babies, and was. advised that there were continuing debates through neonatal colleges. Technological issues included that there could be more difficulties the smaller that items were manufactured. It was explained that we used to be

pushing boundaries at 28 weeks – now those babies would be expected to be fine. There was now a focus at 24/5 weeks.

The Committee was advised that more public engagement was needed; the feedback was ongoing and interesting. The main concerns included 'where will we park', 'where will we be accommodated', 'what is the bereavement support at St Michaels?' There was a need to ensure the right bereavement support would be in place.

BCC Cabinet Member for Adult Care asked if the diversity of Bristol's communities and their different needs around birth and neonatal services had been taken into account. The Committee was advised that this had been discussed via Maternity Voices Partnership, although the majority of women who attended have had babies at term and not so many on neonatal units; there was a will to take views from as wide a group as possible. This was about a tiny proportion of women having babies - Southmead admitted 770 women in total in 2016, of which 54 delivered babies at less than 28 weeks. Head of Stakeholder Engagement stated that there would be further engagement with staff and public; there was an intention to write to the Joint Health Scrutiny Committee to invite it to monitor and scrutinise further development and engage in the process.

RESOLVED: That Committee Members could submit further questions in writing to scrutiny@bristol.gov.uk

RESOLVED: That the Joint Health Scrutiny Committee endorse the proposal to centralise level 3 NICU at St Michael's, with families still able to access level 2 neonatal services at Southmead, and the direction of travel, subject to any changes and developments be brought to the Committee for further updates and scrutiny, and is able to be fully engaged in the process.

10 Mental Health Services

The Director of Transformation and Clinical Lead for Mental Health, Bristol North Somerset South Gloucestershire CCG spoke to the report (details and accompanying slides are in the published pack).

The Committee was advised that this is not just a mental health strategy, but is a mental health and well-being strategy. It was a piece of work that had engaged nearly 2000 people. There was a need to investigate why people have experienced so many issues with mental health; mental health being part of health strategies was a really important part of societal change.

There was a discussion about public engagement, and the Committee was advised that the feedback showed early intervention and engagement may have prevented people going into crisis; the mental health and well-being strategy was person-centred; a key objective was to prevent crisis, and the data helped to understand what was needed regarding investment.

The Committee asked for reasons Vita Health won the contract and noted concerns about the choice, and was advised that there was a period of 3 months due diligence, including legal and clinical checks, to be assured about the and viability of company. References had been obtained from other areas

the company had provided mental health services. Concerns had previously been raised and details were in the public domain. Vita Health had 2 partners – Blue Bell and Windmill Hill City Farm and it was planned they would work through a hub-and-spoke model; there would be satellite clinics based in communities. They started on 1st September.

The Committee was advised that services already being delivered would continue. There were three newly commissioned services: (i) Improving access to psychological therapies; (ii) sexual violence therapies services; (iii) Crisis café in Weston.

There was a discussion about issues with provision of therapy and the Committee was advised of a gap between moderate to severe which was nationally recognised and there was work underway to address this gap, including providing different mental health services.

Recruitment was noted as a challenging issue and the Committee was advised that staffing delays would now be resolved with new recruitment. There was a 5000 person caseload inherited, and there was ongoing work to ensure the inherited waiting lists were minimised.

The Committee was advised that the Crisis Café model had been around for 7 years, but not running to the same hours. . There were also Crisis Houses, where people could stay for up to a month.

The Committee was advised that more appropriate environments than A&E or a Police station was required for people in crisis; this is what the Crisis Café provides. The Crisis café was planned to be running from May 2020, provided by Second Step. The process of developing the Crisis café was co-produced.

RESOLVED: That the Committee be provided with relevant papers related to the procurement of services.

RESOLVED: That progress and development of the mental health and well-being strategy be brought to the Joint Health Scrutiny Committee.

HEA Healthy Weston: Future at Weston Hospital

The Programme Director and Medical Director spoke to the report (details and accompanying slides are in the published pack).
The Committee was advised that there were significant staffing issues at Weston leading to issues and financial challenges.

There was a discussion about the consultation and the Committee was advised that there was a good response, which was representative of the local population; it had informed change - the final proposal changed as result of public consultation.

The Committee noted that there seemed to have been a robust and positive engagement from North Somerset scrutiny colleagues.

Recruitment and retention was discussed and the Committee asked how this was being approached with regard to planned increases in paediatric services.

The Committee was advised that there was good interest in paediatric positions at Weston Hospital, with opportunities to develop joint working with Bristol Royal Hospital for Children; there was confidence that posts would be recruited to so as to ensure cover of services.

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Chair

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APPENDIX 1

Joint Health Overview and Scrutiny Committee
Public Forum 25th October 2019

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.

Questions received (to be responded to within 28 days)

Question 1: From Imogen McCabe, Operations Manager, Southmead Project
Questions 2 – 7: From Cllr Gill Kirk, Lockleaze ward

Question1: Imogen McCabe, Southmead Project

Will Vita Minds be offering counselling to survivors of trauma, and if so what type of counselling or therapeutic support are they offering? If they are not, or if it is only CBT or

EMDR, who is going to support those that have experienced prolonged abuse resulting in trauma that may not fall under the category of PTSD?

Response from Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG):

Within our contract with Vita Minds for the provision of IAPT services we have set out a clear expectation surrounding the treatment of individuals who are experiencing common mental health problems. Provision covers depression and a range of anxiety disorders and treatment is delivered through a range of evidence-based individual and group therapies to meet the needs of the individual. For depression, treatments available include the counselling modalities of Inter-Personal Therapy and Counselling for Depression.

For those who have experienced trauma in their past, Vita Minds will offer a holistic assessment to understand how these experiences are impacting on the individual in the present. Where clinically indicated they will offer treatment, or alternatively look at whether different types of support are required to address other determinants of poor mental health (such as debt, housing, social isolation etc.). Often, experiences of trauma can manifest as PTSD and treatment for this disorder would be CBT or EMDR. The service commissioned through Vita Minds is intended to be inclusive and flexible enough to vary its interventions to meet the needs of individuals who meet their eligibility criteria. Where presentations are complex in nature due to prolonged or multiple experiences of trauma over a period of time and clinical interventions indicated fall outside of what an 'IAPT' service would provide, Vita Minds would be expected to refer to Secondary mental health services.

Question 2: Cllr Gill Kirk, Lockleaze ward

The evolution of the BNSSG STP in its journey towards becoming Integrated Care Systems has caused some confusion, partly due to the various acronyms in use at various times, to cover Sustainable Transformation Plans and Partnerships, (STP) Accountable Care Organisations (ACO), Integrated Care Organisations (ICO) and Integrated Care Systems (ICS) and Integrated Care Providers (ICP). To make things simpler and more intelligible for the residents councillors represent, could we ask for the following clarification:

a. Could we have a summary of the journey of BNSSG from the initial setting up of the STP in 2014, with a projected timeline towards its aspiration to becoming an Integrated Care System (ICS)?

Response from Healthier Together Director:

Sustainability and Transformation Partnerships were established in 2016 with the purpose of bringing together organisations delivering health and care services within a geography, in our case Bristol, North Somerset and South Gloucestershire. Over the course of 2017 and 2018 the concept of STPs evolved to take responsibility for the health and wellbeing of the population living in the area as well as the delivery of health and care services. Improving population health is a core component of an Integrated Care System, requiring a system of organisations to work more closely together with a focus on the health and wellbeing of their population and a shift in resources to preventing deterioration in health. ICSs also take more delegated authority for health and care from regional and national NHS England/Improvement, enabling them to manage performance and delivery locally.

Question 3: Cllr Gill Kirk, Lockleaze ward

It is our understanding that NHS England expects all STP areas to become ICS's by April 2021.

a. Can you confirm when BNSSG expects to apply to be an ICS?

b. Is there an expectation by NHS England for all areas to go on to become Independent Care Providers, and if so, by what date?

Response from Healthier Together Director:

As set out within the national NHS Long Term Plan, all systems are expected to be maturing as ICS's by April 2021. NHSE/I has published a maturity framework to validate what this means.
There isn't an expectation around Integrated Care Providers – however we are currently working with our six integrated community localities to develop integrated care partnerships.
[Healthier Together Partners: UH Bristol & Weston Area Health Trust, North Bristol Trust, BNSSG CCG, Sirona care and health, Bristol City Council, North Somerset Council, South Gloucestershire Council, Avon and Wiltshire Partnership Trust, South West Ambulance Trust, One Care]

Question 4: Cllr Gill Kirk, Lockleaze ward
We understand ICS to be an informal alliance of organisations in a partnership, (not requiring substantial contractual or structural change) working together to set strategy, finance, workforce planning and general integration. It overlays but does not replace regular commissioning processes and contracts; Integrated Care Provider system involves merging multiple services into a single long term contract held by a single provider, which can be an NHS or a Private provider.
a. What will be the necessary steps for BNSSG to take in order to become an ICS or an ICP?
b. Will BNSSG ICS aim to be run by a Lead provider? Can you guarantee that any lead provider would be an NHS body?
c. Does an ICP system carry more likelihood of services being run by private providers than an ICS system?
Response from Healthier Together Director:
a. We will set out some of the next steps to mature as an ICS in our 5 year system plan.
b. BNSSG is developing a partnership model as we mature to an ICS.
c. We have no plans to establish Integrated Care Providers run by private providers.

Question 5: Cllr Gill Kirk, Lockleaze ward
Could you update us on the response to the Integrated Care Provider consultation run by NHS England in 2017?
Response from Healthier Together Director:
The response to the consultation can be found here:
https://www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/

Question 6: Cllr Gill Kirk, Lockleaze ward
Have there been requests for further legislation, regulation and public consultation as a result of MP's concerns and judicial review, and will BNSSG need to wait on the outcomes of these challenges before proceeding towards an ICS/ lead provider system?
Response from Healthier Together Director:
We aren't aware of these requests locally. Multiple individuals from each local authority and Health and Wellbeing Boards are involved in the development as we set out what an ICS means for our system. Fundamentally, we know that working as a partnership across health and care is a critical step in delivering improved services.

Question 7: Cllr Gill Kirk, Lockleaze ward
What systems of democratic accountability and consultation will be put in place as organisations join into an ICS and especially if services are merged to become an ICP?
Response from Healthier Together Director:
This hasn't yet been defined and the Local Authority officers are involved in the development and design.

Joint Health Overview and Scrutiny Committee Public Information Sheet

Petitions, Statements and Questions

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(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

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

Joint Health Overview and Scrutiny Committee
15 March 2021

~~Sustainability and Transformation Plan~~ Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) Joint Health Scrutiny Committee: Terms of Reference

1) Bristol City Council, North Somerset Council and South Gloucestershire Council to collectively review and scrutinise the work of the Bristol, North Somerset and South Gloucestershire (BNSSG) ~~Sustainability and Transformation Plan (STP)~~ Integrated Care System (ICS), also known as 'Healthier Together' 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~~ ICS 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~~ ICS is only relevant for one authority and therefore should be referred to that authority's Health Scrutiny Committee for scrutiny. 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.

4) 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.

5) Make reports or recommendations to the relevant health bodies as appropriate and/or the constituent authorities' respective Overview and Scrutiny committees or equivalent.

6) 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~~ Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) 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
- 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 s 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.

Joint Health Overview and Scrutiny Committee

15 March 2021

Report of: BNSSG Stroke Programme

Title: BNSSG Stroke Programme

Ward: BNSSG

Officer Presenting Report: Chris Burton (Stroke Programme Senior Responsible Officer and Medical Director, North Bristol NHS Trust) & Rebecca Dunn (Stroke Programme Director, BNSSG CCG)

Contact Email Address: Jeremy.westwood@nhs.net / Rebecca.dunn8@nhs.net

Recommendation
The committee is asked to:

1. Note this update report and the progress made by the BNSSG stroke programme in planning for consultation
2. Share comments and feedback on the plan for public consultation, considering whether the committee supports it as a plan for a full and meaningful consultation, particularly considering flexibilities that may be required in delivering the consultation in the context of the pandemic and any government restrictions at that time
3. Support the draft evaluation criteria that have been developed as appropriate for the decision-making process that will confirm the final option for implementation in the period following consultation
4. Note that once a decision to consult has been made by the BNSSG governing body we will discuss with JHOSC the proposed date by which we would require JHOSC to provide any comments on our proposals. In addition, to confirm how JHOSC would like to be consulted with on our proposals once the decision to consult has been made,

Summary

Recommendation 1.

The BNSSG Stroke Programme has galvanised stakeholders from all backgrounds and professions around a shared vision for stroke care for the future; a vision for everyone in BNSSG to have the best opportunity to survive and thrive after stroke.

There are compelling reasons to change the provision of stroke care in BNSSG:

- Demand for stroke care is increasing by 3-5% every year and the specialist stroke workforce available to provide care is limited.
- The provision of stroke services varies depending on where people live in BNSSG.
- Outcomes for people that have a stroke in BNSSG vary depending on where they receive treatment and our current service provision does not consistently meet national standards.
- NHS commissioners have a responsibility to ensure that every pound spent on behalf of tax payers offers as much health benefit to the population as possible and the way stroke services are currently organised and configured does not consistently deliver that.

To address the case for change, clinicians of all professions, people with lived-experience of stroke, voluntary sector workers, social care staff, and service managers have been working together to redesign the stroke service provided to people in BNSSG. They are working to produce evidence based proposals directly in line with the draft National Stroke Service Specification with the aim of ensuring that everyone in BNSSG will benefit from life-changing treatment in a specialised hyper-acute stroke unit, usually in the first 72 hours following a stroke.

Clinicians, patients, and health and care leaders are also looking at how best to improve community-based stroke support across BNSSG. Our ambition is for a new integrated community stroke service that will support the delivery of the proposals for hospital care and, most importantly, ensure that everyone in the BNSSG area has improved, and equal, access to rehabilitation care at home and in the community.

Since we last met with the JHOSC we have been continuing to make good progress on designing and refining a proposed new model of stroke care, developing proposed options for how that care could be delivered in BNSSG in the future, working with our regulators and the South West Clinical Senate in terms of assurance on the development of our pre-consultation business case and the progress of our work, and in planning and preparing for public consultation. We believe we are on track to hold our public consultation in the summer of this year.

<u>Recommendation 2.</u>

We have drafted a plan for public consultation that outlines the principles driving our approach and the core activity we will deliver to encourage responses to our twelve-week consultation. Our plan describes in detail how we will make sure we get as broad and as diverse a range of views and opinions as possible, including those from the nine protected characteristic groups under the equalities legislation and those from seldom heard and marginalised groups. It describes how we will use different research methodologies to engage a representative sample of the BNSSG catchment population. We will also focus on making sure we reach out to those who are most likely to be impacted by stroke and therefore most likely be impacted by our proposed changes to the way stroke services are delivered.

Importantly, our consultation plan takes account of the pandemic environment we are currently in and has described how we will engage and consult in a covid-safe way and in line with government regulations at that time, being flexible in our planning as needed. We have purposefully sought to exploit digital means of engagement – for example, through online listening events – but also to recognise the digitally excluded and those who can't or don't want to use digital means to engage, through the provision of printed materials, a telephone enquiry line and telephone surveys.

Responses to our consultation will be analysed by an independent agency, as per best practice. Their report will be considered in full by BNSSG governing body members in the decision-making phase of our programme. The report will form an important part of our decision-making business case. We are planning that responses to the consultation will be considered by the governing body later this year alongside a range of other data and evidence (clinical, financial, workforce, estates etc) we have collated over the course of our review.

Recommendation 3.

As previously discussed with JHOSC members, we have used a clinically led evaluation process to help assess and evaluate our potential options to deliver our proposed new model of care for stroke services. Option development is a careful process over a period of time, assessing, evaluating and funnelling potential options from a long list to a medium list and eventually leading to a shortlist of potential options for consultation. Whilst we have not yet launched our consultation (which is planned to take place in the summer this year), nor yet confirmed through our public governing body meeting the options on which we will consult, we are already starting to map out the work we will need to progress once consultation has been completed. As we approach the pre-election period before local elections, we are aware that JHOSC may not meet again until mid to late summer. For that reason, we want to share with members now the refined evaluation criteria that we propose to use in our decision-making process later this year. Our original evaluation criteria were developed in conjunction with local people and clinicians as part of the BNSSG Healthy Weston Programme. This was agreed by the Joint Health Overview and Scrutiny Committee (JHOSC) on 26 September 2018. The suite of evaluation criteria was tailored to the BNSSG Stroke Programme with the support of specialist stroke clinicians in order to ensure that it was appropriate for application to the stroke service.

Following consultation with the public on the options for service change, further decision making will be required as part of the BNSSG Stroke Programme. The JHOSC are asked to confirm that the proposed evaluation criteria are appropriate for final decision making, noting that these have been reviewed and updated by the BNSSG Stroke Programme Team.

Recommendation 4.

Whilst we are not planning to launch our consultation on stroke services until the summer of this year, we are aware that JHOSC may not meet again for several months due to the pause over the pre- and post-election period. We want to confirm that once the BNSSG CCG governing body has taken the decision to consult we will liaise with JHOSC to agree a date by which we would require JHOSC to provide any comments on our proposals. In turn we will also provide JHOSC with the proposed date by which the CCG intends to

make a decision as to whether it will proceed with the proposal(s). This is in accordance with our duties set out in regulation 23 of the Health Scrutiny Regulations.

We also wish to discuss how JHOSC would like to be consulted with directly about our proposals. For example, what information you would like to consider – either shared in advance or as part of our next and future meetings, and how often you would like to meet during our consultation period.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

DRAFT Proposed Public Consultation Plan

February 2021

1.1. Consultation process

Legal requirements

As an NHS commissioner we are required to show how the proposals we are putting forward meet the four tests for service change laid down by the Secretary of State for Health and the fifth test set by NHSE. These are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear clinical evidence base to support the proposals
- Support for the proposals from clinical commissioners
- Assurance that any significant hospital bed closures can meet one of three conditions:
    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

There is also a legal duty on NHS organisations to involve patients and the public in the planning of service provision, the development of proposals for change and decisions about how services operate:

- **Section 242, of the NHS Act 2006**, places a duty on the NHS to make arrangements to involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.

- **Section 244** requires NHS bodies to consult relevant local authority Overview and Scrutiny Committees on any proposals for substantial variations or substantial developments of health services. This duty is additional to the duty of involvement under section 242 (which applies to patients and the public rather than to Overview and Scrutiny Committees)

- **The NHS Act 2012, Section 14Z2** updated for Clinical Commissioning Groups places a duty on CCGs to make arrangements to ensure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

    - in the planning of the commissioning arrangements by the group

- in the development and consideration or proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them
- in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

We need to make sure that our consultation activities meet the requirements of The **Equality Act 2010**, which requires us to demonstrate how we are meeting our Public Sector Equality Duty and how we take account of the nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Impact Assessment *(in development)* will assess the impact across these 9 protected characteristics, and list the associated mitigations. It will also recognise the considerations regarding the prevalence and impact of strokes, and also how the COVID-19 may affect these groups.

1.2. Consultation principles and priorities

The BNSSG Stroke Programme recommends launching a public consultation about potential options for stroke treatment and care.

Our consultation plan will be underpinned by some fundamental principles and priorities. As well as shaping the content and activity of our consultation, these principles and priorities will form the basis of our evaluation of the plan.

Our legal duties:

- **Consultation proposals must still be at a formative stage:** Public bodies need to have an open mind during a consultation and decisions cannot already be made. People need to be clear on what can and cannot be influenced by public input and opinion.

- **There must be sufficient information around proposals to permit informed consideration:** People involved in the consultation need to have enough information to provide an informed input into the process. This might include an impact assessment of the costs and benefits of the options being considered.

- **Consultations should last for a proportionate amount of time:** Sufficient time should be given to enable people to make an informed response and there must be enough time to analyse the feedback. The proposed consultation period is 12 weeks.

- **Consultation feedback must be conscientiously taken into account:** Decision-makers should be able to evidence how they have taken consultation responses into account. At least one month has been allocated for compiling consultation feedback after the end of the consultation period. The feedback will be taken into account when creating a Decision Making Business Case and considered in detail by the BNSSG CCG Governing Body before they make a final decision on which solution to implement to meet the challenges set out in our case for change.

Consultation principles:

Consulting with people who may be impacted by our proposals

- We will reach out to people where they are, in their local neighbourhoods and in local networks.
- We will make sure that there are 'no surprises' for staff whose jobs may be affected by the review and that they will hear from us first about the proposals and have an opportunity to respond. We will ensure that they are aware of the process, understand how their roles may be impacted and will ensure they understand how they can give their views on the consultation.
- We will cover the geography, demography and diversity of Bristol, North Somerset and South Gloucestershire.
- We will identify groups more affected by stroke and in particular, what it is about these groups that may make it more likely that they will have a stroke. Particular reference will be given to protected characteristics and consideration of health inequalities across BNSSG, also in line with the Public Sector Equality Duty (PSED).

Consulting in an accessible way

- We will provide detailed information on websites to ensure transparency. We will also produce targeted public-facing documents (some printed as we know not everybody wants to access information digitally), summaries, case studies and social media content.
- We will make sure our public information is consistent and clear; written and spoken in 'plain English' avoiding jargon and technical information; accessible to everyone and available on request in a range of languages and formats.
- We will make clinical information and agreements available to the public.
- We will provide a range of opportunities for involvement and engagement with our consultation; reaching out to people where they are, in their local neighbourhoods and in local networks, physically and digitally.

Consulting through a robust process

- We will make sure that local people and the staff working in organisations affected by the proposals across Bristol, North Somerset and South Gloucestershire have confidence in our consultation process, ensuring it is open, transparent and accessible.
- We will be clear and up front about how all views can influence decision-making, explaining it will not be possible to do everything everyone wants and why difficult decisions have to be made.
- We will widely advertise and do our best to make sure people are aware of our consultation even if they choose not to participate.
- The consultation will run for twelve weeks to allow people to give their views and we will provide regular reminders about progress and the closing date.
- We will strive to ensure we are acknowledged locally and nationally to have undertaken a meaningful and effective consultation process and will seek support for our consultation plan and process from the Health Overview and Scrutiny Panel in our ongoing engagement with them.

Consulting collaboratively

- We will work collaboratively with individuals, stakeholders and partner organisations to deliver to our legal duty and to maintain our agreed consultation principles. We will also make the most of the opportunities of partnership working to reach out to as many people as we can in a meaningful way across Bristol, North Somerset and South Gloucestershire.
- Our information will be relevant to local groups, being clear about what the proposals mean for each geographical area and for each group of people taking account of their interests, diverse needs and preferences.

Consulting cost-effectively

- We will strive to ensure our consultation budget is spent wisely and used effectively in terms of reach and response, delivering good value for money.

Consulting for feedback

- We will monitor and evaluate our consultation process consistently and in a systematic way, including capturing feedback and comments from events, meetings, surveys, discussions and individual responses
- We will commission several interim reports in terms of consultation response analysis, to assess progress on where, how and from whom we are receiving feedback and responses, so we can target our activity to address gaps in feedback geographically or demographically
- The analysis of feedback will be done independently, and the independent report shared publicly
- The results of our consultation and the feedback received will be thoroughly and conscientiously considered and used to inform decision-making.

1.3. Planned consultation approach and methods

Our current approach will include a variety of consultation methods to reach a wide range of people, in particular higher risk and harder to access groups and those communities who may be disproportionately impacted by the proposed changes.

Table 1 outlines the planned consultation methods.

Our consultation plan and consultation document will:

- Offer the same level of information to people attending events and/or who ask to be given updates
- Be clear how proposals have been developed including why some have been discounted and others preferred
- Put as much information as possible in the public domain including showing the clinical, operational and population health evidence behind the need for change and for our proposals
- Provide regular updates to everyone in the local health and care system about progress and next steps in the programme and enable clinicians and other key programme decision-makers to have wide-ranging discussions which enable challenge and debate.

The consultation plan and the consultation document will be reviewed with our Patient and Public Involvement Forum, Stroke HIT Service User Group and the programme's Communications and Engagement Group to take on board any additional comment or ideas and to ensure that they are clear and well-understood.

In addition, we will seek advice from an independent research and evaluation organisation to help us design non-leading questions that meet the highest standards of research design for this sort of exercise and undertake cognitive testing on the consultation questionnaire to ensure that our target audiences find it easy to understand and respond to.

We will also present interim results half way through the consultation which will be shared with BNSSG CCG Patient and Public Involvement Forum (PPIF) for reflections on initial findings. This will allow the opportunity for discussion and analysis on themes to date, as well as helping to identify any groups or areas which may need further engagement.

It is also recognised that the COVID-19 outbreak has affected, and continues to affect, people and their communities differently. It is important that the planned consultation methods and approaches consider how specific groups may be disproportionately affected by COVID-19, and the impact this may have on their ability to engage effectively.

Table 1 – Overview of planned consultation methods

Consultation method	Approach overview / description	Target responses/reach
General publicity & information sharing	Public information promoted via a diverse mix of physical and digital channels (with use of physical channels adapted to reflect changes in response to Covid-19) e.g. advertising in local media, posters and postcards, support on social media, as well as via NHS organisations and established stakeholder channels. This will include proactive and tailored information to be communicated or shared with specific communities or groups	n/a
Website / online media	Designated webpage with comprehensive guide to consultation, events and activities, regularly updated Including information to help the public to understand the impact of the proposed changes on them individually	n/a
Telephone and freepost	To support open and accessible communications between the programme and interested parties, the consultation team will be directly accessible via telephone and post mechanisms in addition to online contact information. This will ensure the opportunity to give feedback is available to those who may be digitally excluded or less digitally experienced. There is a need to offer a range of methods of engagement to ensure certain groups are not excluded.	n/a
Representative survey	Random sampling led by an independent provider to gain the views of a representative sample that is reflective of the geography and demography of the region. Within this approach we have the ability to boost specific sub-groups e.g. specific geographical areas or demographic groups who are disproportionately impacted by proposals.	**N=1000**

	Although the gold-standard method for this approach is face-to-face, we currently recommend using a computer assisted telephone or CATI approach instead to reduce the risk and safety concerns about face to face interviewing due to Covid-19. This may be reviewed in the future should the current situation change.	
Online quantitative survey	This work would supplement the representative sample outlined above and would be comprised of a self-selecting sample, who respond to the survey in response to general publicity or specific outreach. We would be able to compare the two samples and identify any key differences or similarities between them, both in terms of response and demographic monitoring. Independent free text coding of survey responses would also be conducted to develop a deeper understanding of any insights gathered, including areas of concern and potential mitigations.	**N=1000**
Listening events & community workshops	These will be public meetings and drop-in sessions to provide an opportunity for detailed conversations with the public, local commissioners and providers. The exact details of these events are still to be finalised, however we would be likely to arrange multiple events which would give us sufficient coverage in terms of geography. Whether these events are remote or in-person is entirely dependent on our ability to hold face-to-face meetings in the summer of 2021 because of the covid-19 pandemic; which we will assess nearer the time. As it stands, it is expected that any large scale events would be held remotely using video conferencing with the option	**N=100**

	of 'dialling in' to the meeting. Smaller meetings with specific groups or communities may take place in person if it is safe and appropriate to do so. These sessions would take a lead from voluntary sector organisations already very active in the community (Bristol After Stroke and the Stroke Association) with supported face-to-face and virtual groups already occurring. Each meeting or event, where possible, will have a feedback loop built in to inform those involved of how comments have or will be used in the development of the proposals.	
Qualitative focus groups and interviews	Particular groups or individuals are likely to be disproportionately impacted by our proposals and we will need to make extra effort in order to ensure the views of these groups are captured effectively. We are likely, therefore, to hold a number of targeted focus groups and interviews in order to develop insights which may be specific to these groups. These additional engagement activities are likely to be distributed appropriately on a geographical basis as well, to ensure that our feedback reflects the population as much as possible. Whether these focus groups and interviews are remote or in-person is entirely dependent on our ability to hold face-to-face meetings in the summer of 2021 because of the covid-19 pandemic; which we will assess nearer the time	**N=15 - 30**
Staff engagement	There is already representation of each clinical area and staff group on the clinical design group for the proposed reconfiguration. Through cascade via clinical leads in each provider and clinical area, MDT colleagues have been involved in co-design of the proposals and comments have been shared, collated and used to guide and refine the development of the pre-	**Representation from each discipline, where possible, and each clinical team across each of the 3 providers and community service**

	consultation business case. Before and during the public consultation there will be deliberate, focused staff engagement events organised in each of the different clinical areas in the current stroke pathway to allow staff to provide formal feedback or comments on the proposals. This will include all members of the multi-disciplinary team, in both acute and community settings and also carers and other community staff employed by local authorities. The format will likely be a blend of in-person (where Covid-19 restrictions permit), telephone and digital engagement methods. Each meeting or event will have a feedback loop built in to inform those involved of how comments have or will be used in the development of the proposals. It is expected that further staff engagement will take place up to and once the Decision Making Business Case is approved. Any employer-led formal consultation with employees, on potential changes to individual job roles to support the implementation of proposed changes, would happen at this stage. As the staffing models are developing it is becoming clear that there are sufficient roles in the proposed reconfigured services for all staff currently employed in stroke care services across BNSSG.	**providers impacted by these proposals**

Ensuring Engagement Methods are Accessible

The Equality Impact Assessment (EIA) *(in development)* will give consideration to the delivery of specific activities within the consultation need to be made to ensure the opportunity to be involved is fully accessible and meets the diverse needs of the population. It is also important that those who are the most affected by stroke have equitable access to any engagement activities that are planned.

A range of both physical and digital channels will be used when sharing and promoting information about the consultation and the associated activities. This will ensure that those who are digitally excluded or less digitally experienced, for example those who are older or from areas of higher deprivation, still have the opportunity to be engaged and feedback. The EIA will describe how in general, people from more deprived areas have an increased risk of stroke. We also know that those from deprived areas are more likely to be disproportionally affected by COVID-19. By offering a range of channels and methods for engagement it means that these individuals will still have the opportunity to be involved in the consultation process.

Considerations around the format of any engagement activities and their promotion will also be taken. For example, there may be a need for disabled people to have information in a specific format, for example braille, larger font or audible. There are also considerations around ethnicity and language. Across BNSSG 10% are from black or minority ethnic (BME) backgrounds, and how individuals from BME backgrounds are almost twice as likely to have a stroke as white people. Within our consultation principles we have emphasized the importance of consulting with those who may be impacted by the changes, and making sure we consult in a way that is accessible. To address this we will offer and deliver translations and interpreter services for any engagement activity and materials.

Another factor which will be addressed is making sure that there are a range of dates and times for any activities. This will avoid exclusion of groups, for example those who may be of a younger working age, or individuals who are parents or carers with commitments during certain times or days.

Currently it is still unclear whether face to face events and meetings will be allowed to take place due to COVID-19 restrictions. As it stands, it is expected that any large scale events would be held remotely using video conferencing with the option of ‘dialling in’ to the meeting. Smaller meetings with specific groups or communities may take place in person if it is safe and appropriate to do so. This approach will continue to be reviewed as clarity becomes available on the restrictions in place. Again, the benefits of being able to offer both online and face to face activities means that there are a wider range of options for people to engage from different groups. Any accessibility requirements for both options will be considered, for example if organising a physical meeting making sure that the location is accessible and has the correct facilities for specific needs of a group or individual, or making sure that online meetings consider that some participants may be using screen readers and the delivery of the session needs to be suitable.

As we move closer to the consultation we will continue to define and develop the details of the engagement activities. We will continue to refer to the EIA (*in development*) for reference to ensure that the engagement activities delivered meets the broad range of requirements of the population of BNSSG.

1.4. Consultation materials

At the core of our consultation will be a consultation document and summary which clearly lay out the basis on which we are consulting, the background to the consultation, a summary of the data upon which options have been developed and what the proposals/options are, and signposting for more detailed technical information if needed. This document will be presented in language which easy to understand by the public, will also seek feedback and will also promote the various other methods by which people can engage in the consultation.

The consultation document and associated materials will be published on a dedicated section of the *Healthier Together* website under the *BNSSG Stroke Programme* section. This will be clearly signposted from the CCG website and system partner websites. It will host general information about the programme and consultation, including the case for change, structure charts and maps; meeting papers and other key decision documents; clinical evidence and data used to inform the design of proposals and decisions; documents and data relating to the *BNSSG Stroke Programme;* and the consultation questionnaire.

It is essential to ensure that we target, and cater for, groups and individuals with additional requirements, those responding on behalf of another individual and those who are less familiar with the subject matter. To best meet the needs of people with additional requirements we will:

- Produce documents in plain English
- Produce our summary consultation document and response form in an aphasia friendly version
- Produce our summary consultation document and response form in accessible formats, such as ‘Easy Read’ and audio formats
- Produce materials in different print formats on request e.g. Large Print, Translation Service, Braille

Throughout the consultation period we will receive regular response monitoring reports from the independent consultation analysis agency (who we will use to analyse the responses). We will monitor this information closely to identify any demographic trends which may indicate a need to adapt our approach regarding consultation activity. An example would be under representation from a particular demographic group or geographic area, particularly where there is a demonstrable disproportionate impact upon individuals within that group.

1.5. Public relations, stakeholder management, news and media

We will work with the media on a proactive and reactive basis – updating them proactively with key updates and milestones and responding quickly to any of their enquiries as they arise. To support us to do this we will create a rolling set of questions and answers and briefing documents on key elements of the programme. These will be updated regularly as the consultation progresses.

We will actively promote consultation events and opportunities through the local news media and social media, and will also consider, where required, advertising in local press and on social media to further amplify the messages and encourage involvement.

Specific media handling plans will be created for significant milestones throughout the consultation, including in each case, key messages, detailed questions and answers, targeted media, arrangements to offer broadcast interviews and photograph/filming opportunities, a record of who has been approached and briefings offered.

Detailed communications and consultation plans will be put in place to cover the launch, proactive public relations activity with all our stakeholders and reactive communications. A bank of stories and case studies that illustrate the case for change and the expected benefits of the proposals will be developed. An efficient and effective approvals process will also be important in terms of reacting quickly to negative or inaccurate articles and signing of the development of any new materials to respond to issues and themes as they come through the consultation.

Contact us:

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www.bnssghealthiertogether.org.uk

DRAFT Evaluation Criteria (Version 5) Amended to Include Stakeholder Feedback from NBT, UHBW, and Patient Representatives at 3rd March 2021

Evaluation criteria	Defined as
 **1 Quality of Care**	1.1 Clinical effectiveness 1.2 Patient and carer experience 1.3 Safety (e.g. workforce rotas)
 **2 Access to care**	2.1 Impact on patient choice 2.2 Distance, cost and time to access services 2.3 Service operating hours
 **3 Workforce**	3.1 Scale of impact 3.2 Impact on recruitment, retention, skills
 **4 Value for money**	4.1 Operating Costs to the system (Workforce costs and other direct costs) 4.2 Capital cost to the system 4.3 Transition costs required 4.4 Net present value (10, 20 and 60 year)
 **5 Deliverability**	5.1 Expected time to deliver 5.2 Co-dependencies with other strategies/strategic fit

1

Sub-criteria: Quality of Care

Evaluation criteria	Questions to test
▪ Clinical effectiveness	▪ Will this option lead to people receiving equal or better quality care in line with national guidance standards or best practice? ▪ Will this option improve outcomes of care, including mortality, independence and quality of life? ▪ Will this option result in more effective prevention? ▪ What impact will this option have on health inequalities in relation to health outcomes? ▪ Will this option lead to more people being treated by teams with the right skills and experience? ▪ Will this option sustain or even improve the current quality of care received by non-stroke patients?
▪ Patient and carer experience	▪ Will this option improve continuity of care for patients? (e.g., reduce number of hand offs across teams / organisations, increase frequency of single clinician / team being responsibility for a patient)? ▪ Will this option enable greater opportunity to link with voluntary / community sector health and wellbeing services? ▪ Will this option improve quality of environment in which care is provided? ▪ Does this option strengthen the *(opportunities for*) communication with patients and their carers about their individual condition in particular, about a planned discharge?
▪ Patient safety	▪ Will this option allow for patient transfers/emergency intervention within a clinically safe time-frame? Will travel time impact on patient outcome? ▪ Will this option offer reduced levels of risk (e.g., staffed 24/7 rotas, provide networked care, implement standardization)?

2

Sub-criteria: Access to Care

Evaluation criteria	Questions to test
▪ Impact on patient choice	▪ Does this option increase or decrease choice for patients? ▪ Does this option improve equitable access to services? ▪ Will this option make it easier for people to understand which services they can access when and where? ▪ Will this option account for future changes in the population size and demographics? ▪ Will this option provide sufficient capacity within the services to meet demand?
▪ Distance, cost and time to access services	▪ Will this option increase/reduce travel time and/or cost for patients to access specific services? ▪ Will this option involve patients travelling more/less frequently, change the number of journeys to access urgent medical intervention? ▪ Will this option reduce/increase patients' waiting time to access services? ▪ Will this option increase/reduce travel time and/or cost for carers and family? ▪ Will this option support the use of new technology to improve access?
▪ Service operating hours	▪ Will this option improve operating hours for the service? ▪ Does the option reduce the risk of unplanned changes and improve service resilience? ▪ Does the option maintain or enhance the ability of the service to adapt to planned or envisaged future changes?

3

Sub-criteria: Workforce

Evaluation criteria	Questions to test
Scale of impact: existing staff: • The HASU and ASU • The sub-acute workforce • The non-stroke workforce • All staff groups	▪ Will this option improve the resilience of current staff (e.g. recruitment, retention) ▪ Will it support the talent management of existing staff e.g. enable maintenance and /or enhancement of skills, competencies, career pathways, enable them to work at the maximum capability of their role ▪ Is the staff travel, relocation or retraining required in line with organisational change principles? ▪ Will this option have a disproportionate impact on staff with protected characteristics
Scale of impact: future workforce	▪ Is it possible to develop the workforce model required to deliver the option e.g. skills base, new competencies, new roles etc against the anticipated timeline for implementation? ▪ Will it support the financial sustainability of the workforce e.g. reduction in agency spend ▪ Will this option enable accountability and governance structures to support staff? ▪ Will this option increase multi-disciplinary/cross-organisational & system working/greater diversity & inclusion?

5

Sub-criteria: Deliverability

Evaluation criteria	Questions to test
▪ Expected time to deliver	▪ Is this option deliverable within 3 years? ▪ How quickly could this option deliver benefits?
▪ Co-dependencies	▪ Is this option compatible with the Healthier Together STP vision? ▪ Does this option enable the system to maximise the role of and adapt to new technologies? ▪ Will this option be co-dependent on other models of care / provision being put in place and if so, are these deliverable within the necessary timeframe? ▪ Will the wider system be able to deliver on this change including the community and voluntary sector? Can the additional capacity requirements be delivered? Will it destabilize any other providers in a way that can not be managed? ▪ Does the system have access to the infrastructure, capacity and capabilities to successfully implement this option in particular, a reduced length of acute stay with sufficient capacity outside of the acute trusts to support it ? ▪ Are there identified negative impacts for non-stroke patients that cannot be mitigated?

4 Sub-criteria: Finance/Value for Money

Questions to test

- The Stroke Strategic Business Case is based on two hypotheses:
  - Ensuring quickest access to specialist clinicians & interventions (potentially longer travel times offset by 24hour availability of specialist care) improves patient outcomes and reduces long term costs of healthcare
  - Rehabilitation out of bedded-hospital care improves patient outcomes and reduces long term costs of healthcare
- Long list options all involve the transfer of activity between acute providers and/or the transfer of activity from acute sector to community sector
- Due to imminent changes to the basis for calculating provider income for health services (incl. stroke pathway activity) all analysis is based on the cost to each provider of delivering the services, how this is contracted will depend on the NHS finance and contracting regime at the point of implementation.
- Demographics mean that demand for stroke services are growing, and change will take a number of years to transition therefore costs should be modelled over a 5 year time horizon; including modelling a 5 year do nothing scenario including national efficiency assumptions
- Acute Hospital beds remains the most scarce resource in the BNSSG health economy, therefore options that reduce demand for beds have a particular premium associated with their opportunity costs
- The largest economic benefits are expected to be reduced costs of social care and continuing healthcare from improved acute care; and the likelihood of returning to work following stroke. These benefits will be referred to in the narrative of the business case; however these benefits are assumed to be outside the scope of finance and value for money tests due to complexity regarding the Health vs. Social Care funding routes.

4

Sub-criteria: Finance/Value for Money

Evaluation criteria	Questions to test
▪ Operating costs	▪ What would be the workforce costs to the system of each option? ▪ What would be the total direct costs (Workforce, Diagnostics, Therapies, Clinical Administration, Drugs, Clinical Supplies, Ambulance and Patient Transport)? ▪ What is the full system cost as a result of the proposed changes?
▪ Capital cost to the system	▪ What would the capital costs be to the system of each option, including refurbishing or rebuilding capacity in other locations? ▪ Can the required capital be accessed and will the system be able to afford the necessary financing costs?
▪ Transition costs	▪ What are the transition costs (e.g., relocating staff, training and education costs)?
▪ Net present value	▪ What is the 10, 20 and 60 year NPV (net present value) of each option, taking into account capital costs, transition costs and operating costs?

Joint Health Overview and Scrutiny Committee

15TH March 2021

Report of: The Directors of Public Health

Title: Bristol and South Gloucestershire Community Surge Testing

Ward: All

Officers Presenting Report:
Christina Gray DPH Bristol & Sara Blackmore DPH South Gloucestershire

Contact Telephone Number:
Christina Gray 07827 955809

Recommendation
It is recommended that the Joint Health Overview & Scrutiny Committee note this report

Summary

It is in the nature of viruses to adapt and change. Many changes are of no consequence, however some changes may result in greater harm or challenge. For this reason, Public Health England undertakes regular additional analysis on samples of all positive cases. Around 20% of all positive tests are routinely sampled.

As a result of routine sampling 11 cases of interest were identified in Bristol and South Gloucestershire between the middle of December to the middle of January. These cases were a combination of a known variant of concern 202012/01 (commonly known as the 'Kent' or 'UK' variant) with an additional change on the spike protein called E484K.

All of these cases were historic, in the sense that they were already in the Test and Trace system. Additional public health investigation was instigated utilising enhanced contact tracing methodologies; epidemiological mapping techniques; additional testing and further genomic sequencing.

On 5th February 2021 the local authorities of Bristol and South Gloucestershire were advised by Public Health England that wider population testing should be undertaken. The local incident management group undertaking the local investigation also identified that additional analysis should be undertaken on all positive results at this time.

This work was undertaken as part of a national programme called Operation Eagle which is focused on the identification and control of new variants of concern.

Context

Between 7th February and 15th February over 40,000 asymptomatic tests were undertaken and all positive results from all sources were sent for additional analysis.

Testing was progressed in three phases:

- 6 Mobile Testing Units
- 13 Collect and Drop sites at libraries and community centres
- A variety of outreach efforts including community conversations and engagement; letters to all clients of social care;

Less than 1% of 42,000 the asymptomatic surge tests completed have come back with a positive result for COVID-19. This compares to a positivity rate of 3% from symptomatic test sites. This is reassuring to note.

All positive cases have been sent off for additional analysis called genome sequencing. We are still awaiting the genome sequencing to be completed on these positives, to confirm whether or not there is any further detection of this new variant.

Proposal

To note this report, acknowledge the extraordinary efforts of local communities, local authorities and partners; and consider the recommendations of the Directors of Public Health as set out below.

We should expect, and prepare for, the emergence of changes in the virus.

Case identification and isolation of case and contacts remains the most important action in containing the virus.

Local authorities will need to maintain capacity and capability to support outbreak management and to support individuals to isolate.

In addition, it will continue to be important to support national and global efforts to understand and enable science to 'stay ahead' of the virus. This may well require the collection of additional case samples to support this effort

Joint Health Overview and Scrutiny Committee

15 March 2021

Report of: Healthier Together, Integrated Care System (ICS) for Bristol, North Somerset and South Gloucestershire

Title: Integrated Care System (ICS) progress update

Ward: Bristol, North Somerset and South Gloucestershire (BNSSG)

Officer Presenting Report:
Sebastian Habibi, Healthier Together Programme Director
David Moss, Integrated Care Partnership (ICP) Discovery Programme Director

Contact Telephone Number: 0117 900 2583

Recommendation

To receive an update from Healthier Together on the progress to date and our next steps as an Integrated Care System.

Summary

The report covers:

1. Integrated Care System (ICS) designation
2. Publication of the Government white paper: 'Integration and Innovation: working together to improve health and social care for all'
3. Progress on formalising how we will work together through the development of a Memorandum of Understanding
4. ICS work at 'place' level – the Integrated Care Partnership Discovery Programme.

Context

We established Healthier Together as a Partnership in 2016 to work together across the NHS, local government and social care to improve health and wellbeing for the people of Bristol, North Somerset and South Gloucestershire (BNSSG).

Membership comprises of:

- Bristol, North Somerset and South Gloucestershire CCG (CCG)
- Bristol City Council (BCC)
- North Somerset Council (NSC)
- South Gloucestershire Council (SGC)
- Avon & Wiltshire Mental Health Partnership NHS Trust (AWP)
- North Bristol NHS Trust (NBT)
- One Care (BNSSG) Ltd (One Care), on behalf of the BNSSG GP Collaborative Board
- Sirona Care and Health (Sirona)
- South Western Ambulance Service NHS Foundation Trust (SWASFT)
- University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)

Our shared ambition is to:

"…build an integrated health and care system where the community becomes the default setting of care, 24/7, where high quality hospital services are used only when needed, and where people can maximise their health, independence and be active in their own wellbeing. We want to increase the number of years people in BNSSG live in good health; reduce inequality in health outcomes between social groups; and help to create communities that are healthy, safe and positive places to live. In redesigning our system, we also want to make it easier for staff to work productively together and develop a healthy and fulfilled workforce."

Proposal

Members are asked to note the information presented within this report. Discussion on the plans and next steps is welcome so we can take account of questions and feedback as our work develops.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together Integrated Care System (ICS) update to the Joint Health Overview and Scrutiny Committee (JHOSC)

15 March 2021

1. Integrated Care System (ICS) designation

1.2 Background to ICSs

In an integrated care system, NHS organisations work in partnership with local councils and others to take collective responsibility for:

- Improving the health and wellbeing of the populations they serve;
- Delivering integrated services; and,
- Managing resources.

Integrated care systems have allowed organisations to work together and coordinate services more closely, to make real, practical improvements to people's lives. For staff, improved collaboration can help to make it easier to work with colleagues from other organisations. As integrated care systems mature they will better understand data about local people's health, allowing them to provide care that is tailored to individual needs.

The Local Government Association has highlighted six principles for achieving integrated care, based on engagement with councils throughout England:

- Collaborative leadership
- Subsidiarity - decision-making as close to communities as possible
- Building on existing, successful local arrangements
- A person-centred and co-productive approach
- A preventative, assets-based and population-health management approach
- Achieving best value.

NHS England has highlighted four development themes for the next phase of development for integrated care systems, drawing learning from experience nationally and internationally:

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes;
- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

For a number of years the Partnership has been working towards becoming an integrated care system. This moves us on from a 'sustainability and transformation partnership' (STP), essentially recognising the progress we have made in closer collaborative ways of working.

1.2 Designation as a maturing ICS in BNSSG

In December 2020, our Partnership was recognised as a 'maturing' integrated care system (ICS) by NHS England and Improvement. The designation was supported by the Partnership Chief Executives from across Bristol, North Somerset and South Gloucestershire. A copy of the signed letter of support from our Chief Executives for our designation as a 'maturing' ICS is set out at Appendix 1. This is welcome recognition of the progress we have made in deepening our relationships across the Partnership and of the work already underway to join up services to deliver better outcomes for the people of BNSSG.

The NHS Long Term Plan, published in 2019, confirmed the intention for every part of England to be served by an integrated care system from April 2021. With each part of the country now ready to function as an ICS, progress is underway to establish ICSs in law. Further information outlining these changes and what this means is outlined in section two of this report.

2. Publication of the Government white paper: 'Integration and Innovation: working together to improve health and social care for all'

2.1 Overview of Government white paper

On Thursday 11 February, the Department of Health and Social Care published a white paper detailing the legislative recommendations for Integrated Care Systems (ICSs). The paper, *'Integration and Innovation: working together to improve health and social care for all'*, sets out proposals for legislating for ICS. It reinforces the goal of joined up care for everyone and sets some key measures, including:

- Establishing a statutory basis for Integrated Care Systems in England.
- Removing the existing regulations that require competitive procurements for NHS services.
- Putting the Healthcare Safety Investigations Branch permanently into law as a Statutory Body so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong, so that mistakes can be learned from, and this strengthens its legal footing.
- Merging three of the national regulatory bodies to fold Monitor and the Trust Development Authority (i.e. NHS Improvement) into NHS England.
- A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and improve powers for the Secretary of State to directly make payments to adult social care providers where required.

- Legislation to help support the introduction of new requirements about calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

The White Paper builds on engagement that was undertaken by NHS England and Improvement and a discussion paper published in late 2020. Our Partners jointly responded to the discussion paper in a letter that confirmed support for the principle of establishing ICSs on a statutory footing. Our response also emphasised the importance of a permissive approach to legislation that would enable local systems to build on existing arrangements and reflect differences in geographical footprints and populations. Our system response to this consultation is set out at Appendix 2.

2.2 The ICS elements of the Government white paper in more detail

As outlined above, it is intended that legislation will be brought forward to ensure every part of England is covered by an ICS. ICSs will be established in the form of an NHS ICS statutory body and an ICS health and care partnership.

The ICS NHS body will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions. The ICS partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector to address the health, social care and public health needs of an area.

It is intended that health and wellbeing boards (HWBs) would remain in place and continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to regard.

2.3 Next steps

We have been informed that the Bill is set to be brought forward in the next, rather than current, parliamentary session and is expected to become law from April 2022.

The White Paper proposes a permissive approach whereby the legislative framework will prescribe minimum requirements for consistent operating arrangements and give local systems flexibility in developing decision-making structures and processes, at both ICS and place levels. We expect this framework to give us considerable flexibility in key areas, including:

- The development of an outcomes framework for measuring progress against our shared aims for improving health and wellbeing and reducing inequalities.
- The membership and governance of our statutory ICS Partnership, so that we can build on our existing arrangements within Healthier Together.
- The definition(s) of Place within BNSSG, so that we can build on the six integrated care localities that we have developed across BNSSG.
- The strategic relationship of our ICS to local Health and Wellbeing Boards.

- The approach to continued development of joint commissioning between the NHS and local government within BNSSG.
- Agreements on data sharing and interoperability of digital infrastructure within BNSSG.
- Collaboration in organisation development, workforce planning, recruitment and retention, learning and development and in facilitating movement of staff across BNSSG.
- Sharing of estate and other resources.
- Joint approaches to performance and quality improvement.
- Approaches to joint ownership and management of risk.
- Schemes of delegation.
- Collaboration in communications and public engagement.

We had already commenced a process within BNSSG to develop our ways of working as a newly designated ICS and we will now use that process to facilitate engagement in preparing to implement the new legislation. This process is outlined in section three of the report below.

3. Formalising how we will work together

Our designation as a maturing ICS is welcome recognition for the progress we have made as a Partnership from 2016 to 2020 and in responding to the Covid-19 pandemic. We now turn our attention to how we will work together in the next phase of our journey and in preparing to implement the new ICS legislative framework from April 2022.

As a Partnership we have agreed to formalise how we will work together in our next phase of development as an ICS through a Memorandum of Understanding (MoU) and supporting frameworks. This will be a suite of documents that we will develop together so that we can build shared ownership and commitment to collaborative ways of working. The Memorandum covers a range of topics, they are:

- Memorandum of Understanding and supporting documents, including
    - Organisational development plan
    - Financial framework
    - Performance management and improvement framework
    - Quality improvement and oversight framework
    - Communications and engagement framework
    - Outcomes framework

The purpose of developing these agreements is to better enable us to deliver on our shared ambition as a Partnership, helping us to take practical steps to realising our plans to:

- Improve and coordinate health and care at place and neighbourhood level
- Measure and monitor population outcomes, ensure high quality and optimise performance

- Make sure our services fit with people's lives by continuously engaging and communicating with the people we serve
- Make it easy for people working in health and care to work with each other
- Make sure our workforce is health and fulfilled, we must support our people and develop skills and capabilities across the system
- To keep improving the health and care services we provide we need to be more productive as a system and save money to reinvest in our capabilities.

Our Chief Executives started this work in January 2021. The next step that we are currently working through is engaging with the leadership of each of our constituent organisations.

A timeline of next steps is broadly as follows:

Date	Activity
February – March	Workshops to engage the leadership of each partner organisation to explore roles in the partnership and collect feedback
March – May	Functional experts develop and review key areas of agreement
July	Draft documents reviewed by the Partnership Board
September	MoU endorsed by the partners and signed off by the Partnership Board
Monthly	Regular touchpoints with BNSSG Executive Group and Partnership Board

4. The Integrated Care Partnership Discovery Programme

4.1 Background

A key feature of ICSs is 'systems within systems'. This means that within a partnership that makes up an ICS there are also smaller partnerships centred around more local areas and populations. It's essentially a three-tiered model as follows:

1. **System:** ICS level – setting and leading overall strategy, working at large scale.

2. **Place:** Integrated Care Partnership (ICP) level – where the majority of changes to clinical services will be designed and delivered, providers working together to join up services or form alliances .

3. **Neighbourhood:** Primary Care Networks (PCN) level – where GPs and community-based services work together to deliver coordinated, proactive care and support.[1]

Within BNSSG we have a shared ambition to create thriving and dynamic integrated partnerships at place level. We want to establish ICPs that will:

[1] Reference The Kings Fund: Integrated care systems explained | The King's Fund

- Focus on population health and wellbeing
- Work with communities and the voluntary sector to build on the asset base of individuals and communities
- Join up care in the community, delivering a preventive, proactive model of care
- Make the community the default setting of care, meeting the majority of people's needs close to where they live
- Engage with communities in co-design
- Optimise our resources to deliver efficient and effective services.

This work builds on the progress made over the last three years in developing integrated care in six BNSSG localities, as illustrated below.

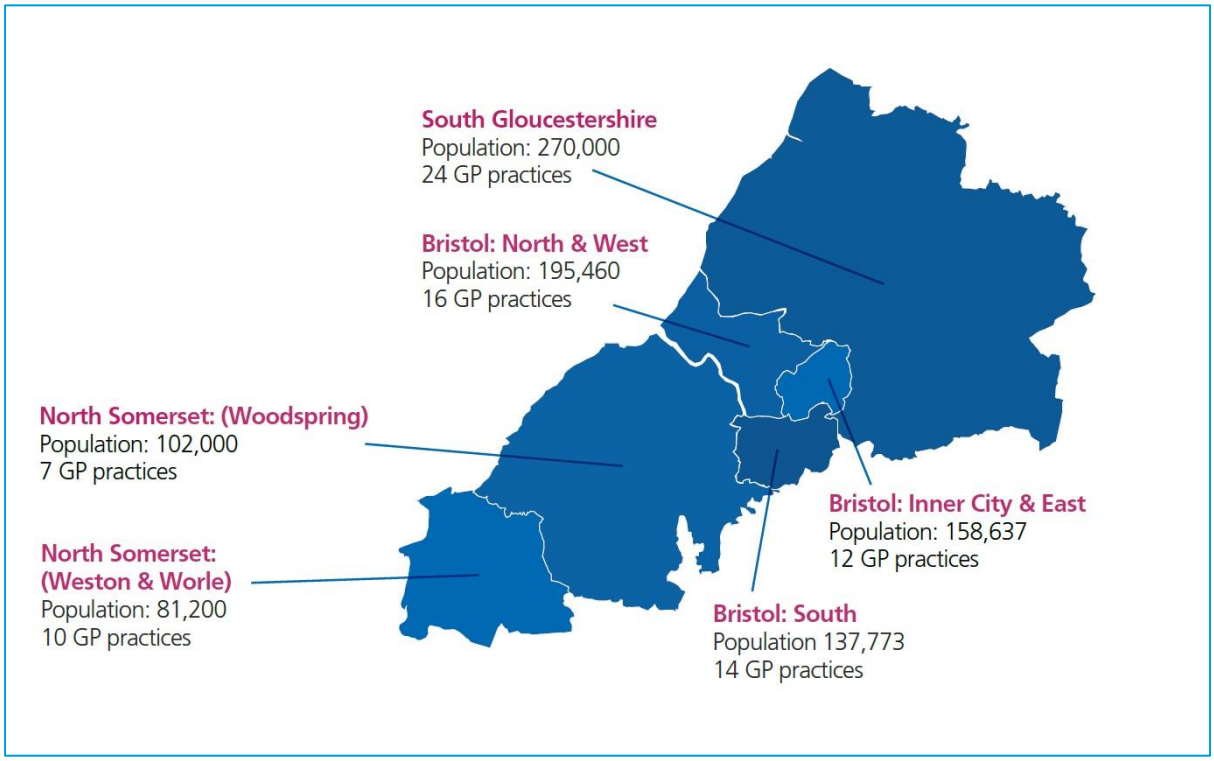

Figure 1: Six localities within BNSSG.

Primary care has been preparing over the last three years to take its place at the heart of ICPs, with GPs taking a leading role. Partnership Forums have also been convened at locality level, and we now have a single provider of community services as a cornerstone for service delivery, enabling localised care within an overall BNSSG-wide framework. The Building Healthier Communities Together Programme is working to establish locality Voluntary, Community & Social Enterprise (VCSE) partners to ensure the third sector is embedded fully within localities and can ultimately be members of the ICP partnerships.

Over time, our collective ambition is to radically reduce health inequalities and improve outcomes for local populations. To enable this, each ICP will be wholly responsible for the delivery of integrated out of hospital care for its whole population, with delegated resources and local commissioning arrangements in place, where appropriate.

In the short term, there is an opportunity for us as a system to develop formally constituted ICPs, which are able to deliver a population health model to deliver community mental health services by April 2022.

4.2 Scope of the Discovery Programme and governance

In July the BNSSG Partnership Board agreed to establish an Oversight Group to deliver the ICP discovery programme, and work on this began in October 2020.

Sourcing and collating national and international examples, the purpose of the programme is to bring together all partners and enable informed dialogue for shared decision making about: the potential scale and scope of ICPs; what model(s) might be most suited to our context; and what is required to make them successful.

The ICP Discovery Oversight Group is chaired by Mike Jackson, Chief Executive of Bristol City Council, and has representatives from all the Healthier Together partners and the voluntary sector.

There is no fixed view on the most appropriate model for ICPs in BNSSG – that is something that we will work out together as a system through the process of discovery and dialogue.

4.3 Current focus of work

Establishing formalised ICPs will enable the integration of services to deliver a full population health model of care, wrapped around people and communities. To support this, colleagues from across the BNSSG areas are working together to help:

- Develop options around the scope and scale of ICPs.
- Provide examples of how ICPs could work practically, including in the model of care and partnership agreement.
- Develop options for the enabling factors that will be required to make ICPs work – for example data (including needs assessments, equity audits and citizen insights), digital infrastructure, governance and decision-making, and contractual and financial frameworks.
- Enable ICPs to extend the range and depth of services provided to frail and older people and in same day urgent care, and respond to commissioner requirements for a population health model to deliver community mental health services as the next stage in the journey.
- Establish a stakeholder engagement and communication programme to ensure we inform and involve key audiences every step of the way.

4.4 Next steps and timescales

Our immediate ambition is to have in place shadow ICPs from April 2021, with formally constituted ICPs in each locality ready to respond to requirements for a

population health model to deliver community mental health services from April 2022.

We would welcome ongoing discussions with members as this work evolves to seek views and input to all elements of the programme.

Appendix 1 – letter of support for designation of BNSSG as a 'maturing' ICS

(see attached)

Appendix 2 – BNSSG outline response to NHSEI consultation on ICS next steps

(see attached)

If you have further questions that have not been addressed during the meeting please contact The Healthier Together Office, bnssg.healthier.together@nhs.net and we will be happy to help.

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

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Tel: 0117 900 2583

19th October 2020

Elizabeth Mahoney
South West Regional Director
NHSEI

Dear Elizabeth

Integrated Care System Designation

I am writing to confirm our collective support for Bristol North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Partnership (STP) to come together as an Integrated Care System (ICS), working as partners to improve the health and wellbeing of our population.

We see the coming together of our ICS as part of an ongoing development journey for our partnership. A key priority for the next phase of our development journey is to develop a Memorandum of Understanding (MoU) between us as health and partners about how we will move forward as an ICS.

We will develop the MoU through a process of facilitated engagement with our system leaders and the leadership of our sovereign organisations, including engagement with our Boards, Governing Bodies and Elected Members. We have no presumptions at this point about the future form that our ICS will take, especially the role of the Local Authorities in the ICS, as this will be a key focus of our engagement in developing the MoU.

We are proud of the progress we have made through collaboration in service of the people of BNSSG since our partnership was established in 2016. We have submitted information separately, using the template provided by your team, to demonstrate that BNSSG meets NHSEI minimum operating requirements of an ICS. This submission also includes examples of the progress we have made to date and an outline of our ICS development plans going forwards.

We are due to meet with you on 21 October to discuss next steps. Please don't hesitate to contact us should you require any further information in the meantime.

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

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Yours sincerely,

Julia Ross
Joint STP Lead Executive and Chief Executive of Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Robert Woolley
Joint STP Lead Executive and Chief Executive of University Hospitals Bristol and Weston NHS Foundation Trust

Andrea Young
Chief Executive of North Bristol NHS Trust

Dave Perry
Chief Executive of South Gloucestershire Council

Dominic Hardisty
Chief Executive of Avon and Wiltshire Mental Health Partnership NHS Trust

Janet Rowse
Chief Executive of Sirona Health & Care

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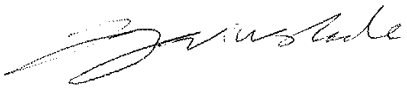
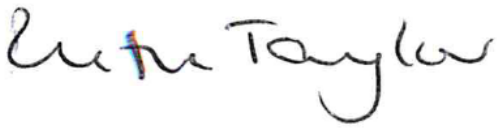


Jennifer Winslade
Executive Director of Quality and Clinical Care, South Western Ambulance Service NHS Foundation Trust

Jo Walker
Chief Executive of North Somerset Council

Mike Jackson
Executive Director of People, Bristol City Council



Ruth Taylor
Chief Executive of One Care

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

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8 January 2021

Simon Stevens
Chief Executive
NHSEI

Dear Simon

BNSSG Outline Draft Response to NHSEI consultation on ICS Next Steps – December 2020

Thank you for the opportunity to respond to this discussion document.

We have reviewed the document at a meeting of our ICS Executive Group in December and sought feedback from CEOs on behalf of our ICS partners. We have summarised this feedback in responding to the four questions that you have invited us to address, as set out below.

We support the four overarching aims set out in the document and the stated intention that the further development of Integrated Care Systems (ICS) will be designed to enable these aims. We particularly welcome the focus of these aims on tackling wider determinants of health, reducing inequalities and in promoting social and economic development, as statements of common purpose between the NHS and Local Authorities We also support the permissive approach that is proposed and the emphasis on primacy of 'Place' and the principle of subsidiarity. To this end we welcome the opportunity to influence the policy development process and look forward to further opportunities to engage on many important details that are yet to be determined.

One particular issue that we would like to see addressed going forwards is to recognise the broad range of partners that need to be able to participate fully in ICSs in order to achieve the stated aims. A clear example of this is in community services where in our ICS the lead provider is Sirona Care and Health: a social enterprise organisation that was established as a Community Interest Company (CIC) under the Government's *Transforming Community Services* programme. We also expect that the proposed legislation and guidance would recognise that the development of ICS should enable full participation by General Practitioners as independent contractors and should build on the development of Primary Care Networks.

We are conscious of the limited time that our partners have had to consider responses to the discussion document and would very much welcome opportunities for further and broader engagement to secure the level of buy-in that will be necessary for ICSs to succeed. This will be important in engaging staff and minimising risk of disruption and loss of talent during the process of change. This engagement must involve all ICS partners, including Local Authorities, General Practice, Social Enterprises and other key providers.

Q1. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

We support the principle of establishing ICSs on a statutory footing and other legislative changes to enable ICSs to be successful. Establishing ICSs on a statutory footing has the potential to strengthen accountability for improving health and wellbeing outcomes, reducing inequalities and in the efficient allocation of resources to these ends.

How the ICS statutory duties are defined will be a critical design question. We expect new legislation and guidance to strengthen alignment between the statutory duties of ICSs, Local Authorities, NHSE/I and other statutory bodies, and to address risks of potential conflicts of interest. One example is in the interaction of system and organisational accountabilities, including with regard to accountability for service delivery and outcomes. Another example is in the interaction between the ICS and the statutory regulators with regard to oversight and intervention functions.

There is support within our ICS for legislative change to regulations on procurement and competition to better enable collaboration in service design and delivery.

In addition we expect to see further action from Government to establish a sustainable funding position for social care to enable ICSs to achieve the stated aims. This is a longstanding issue, which was the subject of a Royal Commission in 1999 and, more recently, the independent commission established by the coalition Government in 2010. The importance of this issue has been highlighted further during the pandemic, by the critical role that additional investment in social care has played in reducing risk of acute hospitals becoming overwhelmed.

We would welcome the opportunity to engage in developing further policy details before legislative proposals are put before Parliament.

Q2. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

The feedback from our ICS partners is generally supportive of Option 2. There is a view that this would be welcome as a means of more clearly defining system leadership accountability for the ICS, in the form of an ICS Board and in the role of a full time Accountable Officer. There is also support for embedding CCG functions within the ICS as an enabler of strategic commissioning and, where appropriate, as a basis for delegating commissioning functions to placed-based partnerships and other provider collaboratives.

Establishing ICSs as corporate statutory bodies with appropriate duties and powers will not, of itself, be sufficient to provide greater incentives for collaboration than is the case within the current statutory framework. This is because greater incentives for collaboration will necessarily depend upon strengthening and deepening the commitments of our organisations and our system leaders to partnership working. We have recognised this as an overarching principle in our approach to ICS development locally. We therefore welcome strongly the permissive approach to ICS development that is advocated in the discussion document. One example of where a permissive approach will be vital is with regard to determining the appropriate geographical footprints necessary to enable meaningful collaboration with Local Authorities within ICSs.

Engagement within our ICS has also highlighted questions that will need to be addressed as further detailed policy is developed with regard to the democratic accountability of ICSs under Option 2. This in turn raises questions about how the role of the ICS Board will relate to the roles of Elected Councillors and to the roles of Non-Executive members of provider Boards; and on the role of the Placed Based Leader and the strategic relationship to Health and Wellbeing Boards. We would like to see further details on these issues as part of the narrative on how ICSs will strengthen public accountability.

Q3. **Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?**

We support a permissive approach to defining ICS membership and governance. There is also strong support within our ICS for the stated intention that Local Authorities will be equal partners in ICSs. In a system such as ours this means that all three Local Authorities within our ICS should be represented as equal partners.

We think that the proposals should be strengthened to achieve the policy ambitions on inclusive membership. In particular, we expect that further proposals will give greater emphasis to the important roles of other partners within an ICS. For example, Sirona Care and Health is a social enterprise organisation and the lead provider of community services within our ICS. We are aware of similar arrangements within other ICSs and we think that such a significant feature of community services provision in England should be acknowledged and addressed specifically. Given the critical importance of community services within our system it is vital that Sirona is enabled to participate fully in our ICS, and in our place based partnerships. This will depend on access to equivalent resources and other support from NHSE/I as is provided to NHS Trusts/Foundation Trusts performing equivalent roles in other ICSs. We expect this to be addressed as the policy and legislative proposals are developed further.

We would like to see further details on proposals for how General Practice as independent contractors, Primary Care Networks and other providers will be enabled to participate in ICSs and placed based partnerships.

We therefore expect that new legislation and guidance will address the challenges of partnership governance between organisations that have different legal forms, organisational governance and accountabilities.

We note the emphasis in the discussion document on the role of place based partnerships and other provider collaboratives, which in practice may carry out important functions of ICSs in line with the principle of subsidiarity. These different strands of policy need to be fully aligned so as to avoid creating new and unintended barriers to integration. We expect that new legislation and guidance will provide a coherent framework within which all these structures are enabled to work effectively together within an ICS. This is important for enabling service integration across traditional sectoral boundaries and also to avoid creating excessive burdens for organisations that need to participate in multiple levels of governance.

We recognise that some of these issues are not straightforward and need to be balanced within an overall permissive approach and with appropriate safeguards/oversight. We would therefore welcome opportunities to engage in further detailed policy design prior to proposals being introduced into Parliament.

Q4. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

There is support within our ICS for transferring or delegating commissioning functions from NHSEI to ICS bodies to help ensure that these services are aligned to the needs of our local populations and to enable integration.

There is also recognition that the opportunities and risks will vary for different services. We would welcome opportunities for further engagement as the detail of these proposals are developed so that we may better understand the opportunities and risks in relation to different services.

The principle of integrated commissioning is broadly welcomed and will need to take account of Local Authority footprints diversity of need. For example our ICS footprint covers the cities of Bristol and Weston Super Mare, as well as large swathes of rural areas.

With regard to primary care commissioning, our discussions have acknowledged the challenges of incorporating within a local ICS structure those services currently commissioned nationally from General Practice and other primary care providers. These challenges are deeply political as much as they are practical and commercial. We request that policy intentions on this issue be clarified at the earliest opportunity to help secure buy-in from primary care colleagues and to avoid uncertainty becoming a barrier to partnership working within ICSs.

For specialised services there is support for commissioning functions to be transferred or delegated from NHSE/I to ICSs where this is appropriate to the level of population that is being served and it increases opportunities for integration. This is important for maximising quality of care and economies of scale, as well for maintaining an appropriate level of coherence in specialised services pathways between ICSs and Places, and for avoiding unwarranted variation.

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Where services need to be planned and managed at pan ICS population levels then the commissioning structures will need to reflect this. This is the case for some of the specialised services provided by our two Acute Trusts, our Mental Health Trust and for the services provided by our Ambulance Trust.

Lead commissioning arrangements may be appropriate in some cases where one ICS commissions services on behalf of others, or where commissioning responsibilities may be delegated to a provider collaborative. Where commissioning responsibilities have already been devolved to provider collaboratives spanning multiple ICSs then these should be allowed to continue (e.g. as is the case now for some specialist mental health services).

We would welcome the opportunity for further engagement in the development of proposals for how various commissioned elements could work across different levels and on the design of appropriate safeguards relating to financial and other risks.

Yours sincerely,

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