HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 26th March, 2014, 10.00 am

Dr. Ian Orpen	Member of the Clinical Commissioning Group
Councillor Simon Allen	Bath & North East Somerset Council
Bruce Laurence	Bath & North East Somerset Council
Dr Simon Douglass	Member of the Clinical Commissioning Group
Councillor Dine Romero	Bath & North East Somerset Council
Pat Foster	Healthwatch representative
Diana Hall Hall	Healthwatch representative
John Holden	Clinical Commissioning Group lay member
Jane Shayler	Bath and North East Somerset Council
Douglas Blair	NHS England

43 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

44 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the evacuation procedure as listed on the call to the meeting.

45 APOLOGIES FOR ABSENCE

Councillor Katie Hall, Jo Farrar and Ashley Ayre sent their apologies for this meeting. Jane Shayler was a substitute for Jo Farrar.

46 DECLARATIONS OF INTEREST

There were none.

47 **TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR**

There was no urgent business.

48 **PUBLIC QUESTIONS/COMMENTS**

The Chair invited Karen Wilkinson (Patient Member of the RUH Bath) to address the Board.

Karen Wilkinson congratulated the Board on the Peer Challenge outcomes; in particular on the strong leadership across the Council and in the CCG and also on the clear vision and focus.

Karen Wilkinson said that the Board could consider more of the public engagement at their meetings.

The Chair replied that the public would be involved more in the meetings of the Board by watching live webcasts and also by tweeting their comments and questions during the debate. Tweets and comments would be read at the end of the meeting.

49 **MINUTES OF PREVIOUS MEETING**

The minutes of the previous meeting were approved as a correct record and signed by the Chair.

50 **10.05AM THE ROYAL UNITED HOSPITAL BATH PRESENTATION ON THE LATEST CARE QUALITY COMMISSION INSPECTION (15 MINUTES)**

The Chairman invited James Scott (Chief Executive of the RUH Bath) to give a presentation to the Panel.

James Scott highlighted the following points in the CQC presentation about the inspection of the RUH Bath (attached as appendix to these minutes):

- Our new approach
- CQC New approach: Site visits
- Key Findings by service
- Areas of Good Practice
- Areas for improvement: Should

The Board congratulated James Scott and the staff of the RUH Bath on good result and on the outcome of the CQC inspection.

The Chairman asked what would be happening from now on with the RUH considering that the CQC inspection outcomes were quite positive. The Chair asked what the CQC would be looking for in future inspections.

James Scott replied that the CQC would be keeping an eye on how the RUH would be delivering their improvement plan. James Scott also said that he would not

expect another CQC inspection for the next two years.

James Scott also said that the RUH had been placed in Band 6 Hospitals (those with the lowest risk and challenge).

Councillor Romero said that the Council held Alcohol Harm Reduction Scrutiny Inquiry Day and one of the concerns raised was on people in a need of emergency services during weekends, because of alcohol related health issues. Councillor Romero asked if the hospital had had a capacity to continue dealing with these issues effectively.

James Scott replied that gastroenterology service (specialist to look after liver disease) consultants, which were specialised in that area, had been working together with an emergency staff. The RUH had been working with the other partners to address an increase in demand of services in this area.

Bruce Laurence asked if the latest CQC inspection had been a driver for improvement.

James Scott responded that the latest CQC inspection was not a 'light touch' inspection. It was comprehensive in a way that previous inspections had not been. There was an estimate that 30 out of 35 inspectors were clinicians elsewhere in the UK, from all health backgrounds.

James Scott also said that the RUH had been incredibly active around Patient Safety Programme. The Patient Safety Programme was set in 2009 for the South West region, hosted by the RUH. The whole programme has been based on global organisation that leads patient safety across the world, called an Institute of Health Care and Improvement, based in Boston, the USA.
Diana Hall Hall thanked the RUH for inviting the Healthwatch to comment on the report. The Healthwatch also met with the CQC and welcomed their new way of working. The Healthwatch would like to work more with the RUH and be more present within the hospital.

Dr Simon Douglass and Dr Ian Orpen commented that quality summit, organised by the RUH, had been quite successful because it highlighted staff's passion and dedication and also highlighted hospital's focus on patient safety.

It was **RESOLVED** to note the presentation and to congratulate the RUH Bath on the outcome of the Care Quality Commission inspection.

RUH Presentation

51 **10.20AM FEEDBACK FROM THE LOCAL GOVERNMENT ASSOCIATION HEALTH AND WELLBEING PEER CHALLENGE (20 MINUTES)**

The Chairman invited Helen Edelstyn (Strategy and Plan Manager) to give a presentation to the Board (attached as appendix to these minutes)..

The Board highlighted the following points:

The Chair said that Dr Orpen and he were invited to speak at the Local Government Association event looking at the Health and Wellbeing Boards – One Year On. Progress of the Health and Wellbeing Boards across the country has been different, but some of the work carried out by this Board has been recognised as a good practice.

Councillor Romero commented that the value of the Director of Public Health awards should be acknowledged and highlighted. Councillor Romero felt that volunteer element had not been sufficiently structured and perhaps it could be picked up within Connecting Communities work

Diana Hall Hall drew the Board's attention on the part that the Healthwatch has in the whole process.

John Holden highlighted that there was quite a lot of partnership work and the Board should not lose the sight on the accountability because of it.

The Chair agreed with a comment from John Holden.

Councillor Vic Pritchard (Chairman of the Wellbeing Policy Development and Scrutiny Panel) congratulated the Board on the outcome of the Peer Challenge though he didn't agree with the comment on the lack of joint work between the Board and Wellbeing PDS Panel. Councillor Pritchard said that he has been meeting on regular basis with Councillor Allen (quarterly meetings) to discuss future workplans.

Bruce Laurence highlighted the focus on inequalities and also on provider side.

Dr Simon Douglass commented that the Board should commit to reduce inequalities.

The rest of the Board welcomed the feedback from the Per Challenge.

It was **RESOLVED** to:

1. Thank stakeholders from across the health and wellbeing sector for the participation in and contribution to the peer challenge;
2. Note the key feedback from the Health and Wellbeing Peer Challenge; and
3. Agree that the next step, in response to the feedback, would be a development session in April 2014.

Peer Challenge

52 **10.40AM 'WHAT WORKS' MENTAL HEALTH CONFERENCE (20 MINUTES)**

The Chairman invited Ronnie Wright to introduce the video showing ‘What Works’ Mental Health Conference.

The Health and Wellbeing Board welcomed the video.

53 **11.00AM NHS B&NES CLINICAL COMMISSIONING GROUP 5 YEAR PLAN AND**

BETTER CARE FUND (50 MINUTES)

The Chair invited Dr Ian Orpen, Dr Simon Douglass and Jane Shayler to give a presentation and introduce the report.

Dr Orpen and Dr Douglass gave a presentation (attached to these minutes) where they highlighted the following points:

- Patient - a real case study : Bath & North East Somerset CCG
- History: context of CCG
- Symptoms: challenges facing CCG
- The uncomfortable truth: financial challenge going
- Diagnosis, treatment plan and Prescription: how the CCG plans to tackle the issues facing it focussing on the 6 priority areas
- Prognosis: the object of developing a sustainable health and social care service
- Transformational Leadership Board – that will be responsible for delivery of the plans
- Operation Plan for 2014-16 with special focus on
    1. Urgent Care
    2. Primary Care
    3. Long Term Conditions and Frail Older People
    4. Planned care
- Quality Objectives that support the plans
- Enablers that will help deliver the plan

The Chair thanked officers and providers who worked on the 5 Year Clinical Commissioning Group Plan.

Councillor Romero welcomed the Plan though she expressed her concern that, although 30% of the population were 'under 25', there was hardly any mention of the young people in the Plan. Councillor Romero hoped that the Better Care Fund would have more focus on the young people. Councillor Romero welcomed that databases and IT had been joined up between organisations.

Dr Orpen responded that children services were an important part of the Plan. The CCG had to concentrate on key areas, on priorities, which didn't mean that the other areas were forgotten.

John Holden highlighted three points of the Plan:

a) Provision of health services in the community with reference to provision of services in a cluster population of 30-50,000. John Holden commented that, for him, it looked like GPs would operate on cluster level, rather than on individual level.
b) Organisational chart – John Holden expressed his concern on the accountability in the system. There should be much tighter, smaller

membership, practice.

c) The whole ethos was about getting money out of the acute centre into the community arena. John Holden expressed his concern that it was hard to see a mechanism for making that happen, as there was nothing to force the pace of that transition.

The Chair commented that the involvement of Primary Care in terms of our strategies was vital.

Dr Douglass commented that the Plan was still in draft. In terms of getting money out of the acute centre into the community arena – these were still untested waters. There has been an opportunity to make this happen because of the investment into great working relationships. Dr Douglass also said that he noticed change in the way providers work, for the better.

Diana Hall Hall commented that the patient was, and should be, in the centre of thinking. Diana Hall Hall said she was interested in the public engagement at the primary care. Diana Hall Hall said it would be helpful to know what the local GPs think about this.

The Board agreed with the comments from John Holden, Dr Douglass and Diana Hall Hall.

Douglas Blair commented that the NHS England was responsible for the primary care commissioning. The NHS England would need to be clear what would be locally expected from the primary care.

Pat Foster commented that the Healthwatch welcomed the Plan and also the Better Care Fund.

It was **RESOLVED** to approve recommendations as listed in the report.

CCG 5 Year Plan

54 **11.50AM TWITTER QUESTIONS (10 MINUTES)**

The Chair welcomed twitter questions and comments from the public.

Jeremy Bond welcomed the opportunity to watch live webcast of the meeting and to be able to submit his comment via Council's website.

The Chair also welcomed some other comments from Twitter and replied that questions/comments would be forwarded to the Wellbeing Policy Development and Scrutiny Chairman as it did fall within the Health Scrutiny remit.

The meeting ended at 12.15 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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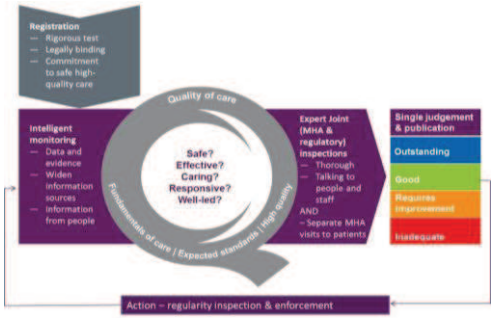
Royal United Hospital Bath NHS

RUH Health & Wellbeing Board – 26th March 2014

Healthcare you can Trust

Our new approach



2

CQC New approach: Site visits

- **Eight Core service areas** : A&E, Medicine, Surgery, Critical Care, *(Maternity & Family Planning),* Children's Care, End of Life Care, Outpatients.
- Announced and unannounced
- Large teams – chair, team leader(s), doctors, nurses, AHPs, managers, experts by experience, CQC inspectors, analysts, planners
- Presentation by CEO
- Visits to clinical areas
- Staff focus groups (junior/senior doctors and nurses etc.)
- Patient and public listening event(s)
- Interviews with senior managers

3

Key Findings by service

Accident & Emergency

- Safe and effective. Good clinical outcomes – and improving. Patients with mental health needs could be waiting a long time for assessment but efforts were being made to improve this. Staff caring and A&E was well led by a strong and cohesive team. Service changes had improved response to demand for services. Staff felt better able to cope with pressures.

Medical Care (including older people's care)

- Safe and effective. Good clinical outcomes. Better record keeping and **warning notice lifted**. Staff were caring but staffing levels had an impact on patient care particularly at busy times and on busy wards (eg MAU). Good dementia care on wards – and developing. Patient discharge was well supported but some delays to the discharge of patients with complex needs. – and improving.

Surgery

- Safe and effective . Good safety checks and cleanliness and infection control . Some areas could have been better maintained (eg PACU). Equipment was usually available when needed, although some checks were not done as required. Staff were caring and services were responding to patient needs. Staffing levels sometimes delayed patient surgery and delayed patient transfers between theatre, recovery and ward areas. Some concerns, at busy times and in busy areas (eg SSSU). Care was improving care for people with dementia and learning disabilities . Most teams worked well together

4

Key Findings by service

Intensive / Critical Care

- Safe and effective. Staffing levels in the critical care unit needed to improve to reduce the pressures on staff. Clinical outcomes good - improving. Staff showed outstanding consideration and compassion. Staff morale was improving and there was effective team working, although training and professional development needed to improve. There was an unacceptably high level of delayed discharges because of capacity problems elsewhere in the hospital, and this added to the pressures on the unit. The trust was taking action to managed risks but national delays to recruiting staff had not been effectively communicated . Staff told us risks were now being managed effectively

Children's Care

- Children received safe and effective care. Staffing met needs of children in centre. Staffing in the neonatal unit needed to improve to meet intensive care standards, and the supervision of children in A&E needed to improve. Service was caring and responsive eg parents praised the neonatal unit and commented on how it created a feeling of calm and wellbeing. Staff engaged well with the children and treated them with dignity and respect. Staff told us they felt supported and took pride in their work, although in some areas they needed further specialist training. Risks needed to be better monitored to demonstrate that these were being managed effectively.

5

Key Findings by service

End of Life Care

- Safe and effective. Service was integrated with GPs and community services, which supported effective discharge arrangements and care at home. Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect from reception staff through to consultants. Staff had appropriate training and supported patients to be fully involved in their care and decision making. The service was well-led and staff were dedicated to improving standards of end of life care across the hospital.

Outpatients

- Safe and effective. Staff needed to improve understanding of MCA (2005). Patients waiting times were within national targets. Some patients waited longer for appointments at the pain management clinic, and some patients waited a long time for consultations when clinics were busy. Patients told us the breast care clinic was outstanding. The outpatient clinics were managed differently by departments and information on quality and safety was just beginning to be shared. The trust had commissioned work to review and further improve outpatient services.

6

Areas of Good Practice

- Good progress towards **seven-day working**, for example, in the A&E department, for patients receiving emergency medical and surgical care.
- Patient **in-hospital mortality rates** were lower than expected and there was no difference between weekday and weekend mortality.
- The trust had developed a number of **innovative services** to cope with winter pressures and a high demand for services.
- The A&E department had a rapid assessment team known as 'senior with a team' (**SWAT**). This team had improved the speed at which patients who arrived by ambulance were assessed, investigated and treated.
- Regional and national recognition for developing **Dementia Charter Marks** (with the Alzheimer's Society) for its model of dementia care at ward level.
- **Coombe Ward** had been redesigned and refurbished as a dementia-friendly ward.

7

Areas of Good Practice

- WHO surgical checklist was well embedded. Staff understood its value and importance - no **never events** in surgical theatres for 18 months.
- The emergency surgical ambulatory clinic was s designed to see patients with urgent general surgical problems - helped to avoid hospital admissions and had reduced the time inpatients waited for emergency surgery.
- Staff in the **critical care** unit showed dedication to the service and provided outstanding compassionate care.
- The **neonatal unit** created a calm environment and was designed to enhance people's feeling of wellbeing.
- End of life care was an **integrated pathway of care** with GP and community services and provided a 24-hour service based on good out-of-hours arrangements with a local hospice.
- Patients overwhelmingly told us that the **breast care clinic** provided an excellent service.
- '**See it my way**' events were held for staff - these events had patients telling stories of their experiences of care

8

Areas for improvement: Should

- The trust needs to ensure that there are effective operations systems to regularly assess and monitor quality of the services provided; to identify, assess and manage risks and to make changes in treatment and care following the analysis of incidents that resulted in, or had the potential to result in harm.

- *Staffing levels, training, impact of service changes*
- *Monitoring – trust, divisional and service levels; risk registers to demonstrate risks are being managed / mitigated; checks eg on equipment monitored.*
- *Monitoring and learning from incidents and complaints*
- *Patient needs met but monitoring and response in busy areas, staff working under pressure (eg surgical lists, critical care, neonatal unit) supervision of children in A&E*
- *Patient flow – patients on the appropriate wards - or monitoring where patients are on outlying wards (eg critical care in PACU)*

9

BATH AND NORTH EAST SOMERSET

HEALTH AND WELLBEING BOARD PEER CHALLENGE

NHS Bath and North East Somerset Clinical Commissioning Group

Bath & North East Somerset Council

healthwatch Bath and North East Somerset

LGA HEALTH AND WELLBEING PEER CHALLENGE

- Took place in January 2014
- Scope of the peer challenge:
  - Effective vision
  - Leadership
  - Relationships
  - JHWS delivery
- First peer challenge to include a focus on a JHWS priority area 'helping children to be a healthy weight'

FINDINGS FROM THE PEER CHALLENGE

- Relationships that form part of the health, care and wellbeing system are very strong
- B&NES HWB is setting the stage to provide effective system leadership in the future
- Joint commissioning is part of the DNA of the health, care and wellbeing system
- Ambitious in seeking to address the wider determinants of health
- B&NES has a comprehensive and convincing analysis of the health and wellbeing of the population with the JSNA at the heart of this

THE CHALLENGE

- Build the capacity of Healthwatch
- Make the most of communications to promote the HWB vision and ambitions
- Ensure effective delivery and monitoring of the JHWS
- Go further with our relationship with providers to co-design solutions
- Articulate what we want our health and wellbeing system to look like in 5 years time
- Go further in reducing the health inequality gap

NEXT STEPS

The peer team feedback will be fed into future action planning:

- A closed HWB development session in April to explore the LGA peer challenge feedback areas
- We are confident that we can drive forward our potential and deliver on the challenge areas

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Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

Seizing Opportunities -

NHS Bath and North East Somerset CCG
5 year Strategic plan 2014-19
2 year Operational plan 2014-16

March 26th 2014

Healthier, Stronger, Together

Patient
Bath and North East Somerset CCG

A real life case study

- History and Symptoms
- Diagnosis
- Treatment plan
- Prescrition
- Prognosis

NHS Bath and North East Somerset Clinical Commissioning Group

History

What we already know about this patient

- One of 211 clinical commissioning groups
- 27 GP practices form BaNES CCG
- BaNES CCG is in the top 25% of CCGs
- Stable financial history– 2014/15 relatively secure, but challenges coming 2015/16
- Healthy, wealthy, happy people

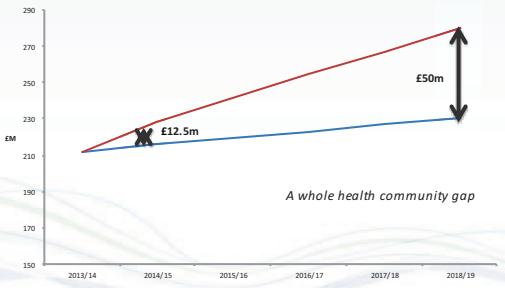
NHS Bath and North East Somerset Clinical Commissioning Group

Symptoms

If our population was 20 people

NHS Bath and North East Somerset Clinical Commissioning Group

The uncomfortable truth



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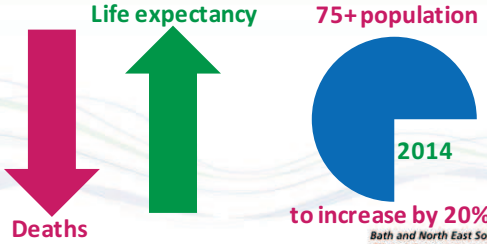
Diagnosis

Demographic changes



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Diagnosis

The number 20 bus route

75.5 → 77.9 → 80.3 → 81.7 → 83

Pockets of significant deprivation and a widening picture of health inequalities

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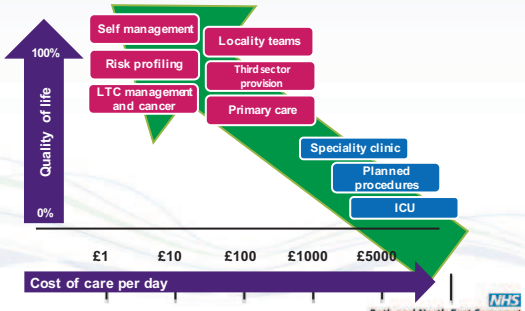
Treatment plan



NHS Bath and North East Somerset Clinical Commissioning Group

Treatment plan

Our vision

To **lead** our health and care system **collaboratively** through the **commissioning** of **high quality**, **affordable**, **person centred care** which harnesses the **strength of clinician led commissioning** and **empowers** and **encourages individuals** to **improve** their **health** and **well being** status.

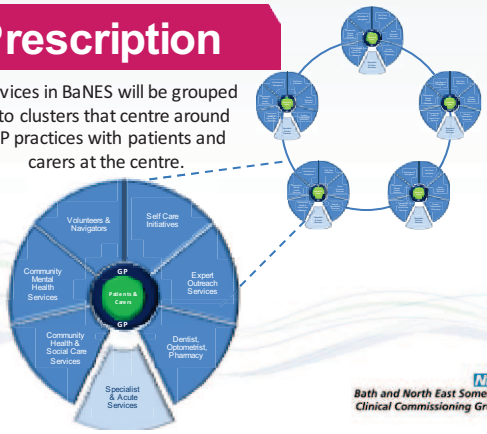
Healthier

Stronger

Together

Prescription

Services in BaNES will be grouped into clusters that centre around GP practices with patients and carers at the centre.



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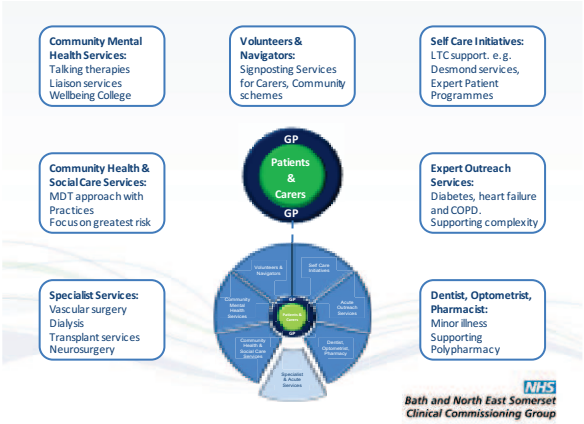

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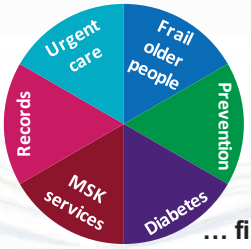
Prescription

Six priorities, daily, for five years…



MSK = Musculoskeletal

… finish course.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

Care for frail older people

WHAT Safe and compassionate care from every service - through a new community cluster team.

WHY Care centred around each individual in our increasing longer-living population.

SO? By working together health and social care teams spend more time with patients than currently.

1 RESULT Reduced unnecessary hospital admissions, loneliness and isolation. Increased wellbeing and positive mental health.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

Prevention and self care

WHAT Commissioning services to prevent illness, rather than focusing on treating illness.

WHY Evidence shows prevention programmes can reduce avoidable health problems.

SO? So this makes for healthier people and allows the health system to focus on those people whose health problems are unavoidable.

1 RESULT Earlier diagnosis and treatment, and delay progression of disease.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

Diabetes care

WHAT Redesigning the diabetes care pathway.

WHY We want patients to get the right level of care in the most appropriate place.

SO? So that we're able to support the growing number of people living with diabetes, which is increasing by 5% every year.

1 RESULT A better experience for patients from high quality timely care close to home.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

Musculoskeletal services

WHAT Head to toe review and redesign of the service – with your experiences at its heart.

WHY It makes the biggest impact on improving the quality of the service while reducing spend.

SO? So if we ignore this we won't be able to care for the growing needs of our ageing population.

1 RESULT A better experience for patients: high quality timely care close to home.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

Patient record systems

WHAT Health professionals seeing info when they need it.

WHY For patients: less repetition, less frustration, more confidence in your consultation and treatments. For your health professionals: more efficient, more effective and safer decision.

SO? So it's a better experience for everyone.

1 RESULT Joined up working between health and social care services.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

Urgent care

WHAT A streamlined urgent care system.

WHY To make sure patients are assessed and treated by the right clinician first time. And to help them choose the right service when they need it.

SO? So that our local health system can manage increasing demands.

1 RESULT Reduced the number of times a patient is passed from clinician-to-clinician which in reduces clinical risk.

NHS Bath and North East Somerset Clinical Commissioning Group

Prescription

- Plan delivers all nationally mandated items including surplus, contingency, non-recurrent investment (headroom) and contribution to Better Care Fund
- Resource releasing (QIPP) target between 1.4-1.8% of income pa
- Recurrent investment created at 1% of income pa
- Running costs reduction target of 10% in 15/16

NHS Bath and North East Somerset Clinical Commissioning Group

Prognosis

- A sustainable health economy where resources are used to deliver the safest & most effective care at best value
- Realistic, balanced plans which support delivery of our priorities and our statutory obligations
- Clever use of funding to drive beneficial and innovative change through collaborative approaches
- Effective use of Better Care Fund

NHS Bath and North East Somerset Clinical Commissioning Group

Prognosis

In five years time…

Empowered people

Looking after the vulnerable

Integrated care

NHS Bath and North East Somerset Clinical Commissioning Group

Prognosis

In five years time…

Knowledge & voice

Enhanced integrated 24/7 teams

Connected data

Success based on experience

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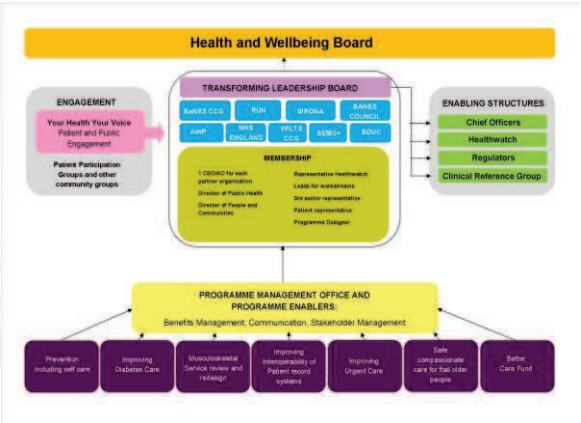

Operational Plan for 2014-16

NHS Bath and North East Somerset Clinical Commissioning Group

Urgent Care

- New integrated Urgent Care and Out of Hours services model
- Ambulatory care pathways that work across primary and secondary care
- Review impact of the 2013-14 winter pressures initiatives
  - with a view to commissioning on a substantive basis to create additional capacity in the system

NHS Bath and North East Somerset Clinical Commissioning Group

Primary Care

- Review of local enhanced services to ensure they are 'fit for purpose'
- Develop a local Primary Care Strategy
- Bed in new relationships with LMC and provider organisations

NHS Bath and North East Somerset Clinical Commissioning Group

Long Term Conditions and Frail Older People

- Cluster Model, active ageing service and redesigned adult social care pathway
- Review Dementia challenge fund initiatives – view to commission long term
- Establish diabetes working group & design new pathways

NHS Bath and North East Somerset Clinical Commissioning Group

Planned Care

- Develop proposals for an integrated Musculoskeletal (MSK) Service
- Review Ophthalmology services with the RUH
- Review the provision of physiotherapy services

NHS Bath and North East Somerset Clinical Commissioning Group

Quality Objectives

- Culture of continuous improvement and innovation
- Work collaboratively with our local providers to ensure staff are delivering high quality
- Ensure consistent access to effective treatments

NHS Bath and North East Somerset Clinical Commissioning Group

Enablers

- Citizen participation
- Interoperability
- Integrated Care
- Personal Health Budgets
- Primary Care Development

NHS Bath and North East Somerset Clinical Commissioning Group


Bath & North East Somerset Council
NHS
Bath and North East Somerset Clinical Commissioning Group
Thank you!
Any questions?
Healthier, Stronger, Together