HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 6th September, 2017, 10.30 am

Councillor Vic Pritchard (Chair)	Bath & North East Somerset Council
Dr Ian Orpen	Member of the Clinical Commissioning Group
Ashley Ayre	Bath & North East Somerset Council
Mike Bowden	Bath & North East Somerset Council
Jayne Carroll	Virgin Care
Mark Coates	Knightstone Housing
Tracey Cox	Clinical Commissioning Group
Jocelyn Foster (in place of James Scott)	Royal United Hospital Bath NHS Trust
Alex Francis (in place of Diana Hall Hall)	The Care Forum – Healthwatch
Bruce Laurence	Bath & North East Somerset Council
Councillor Paul May	Bath and North East Somerset Council
Professor Bernie Morley	University of Bath
Laurel Penrose	Bath College
Hayley Richards	Avon and Wiltshire Partnership Trust
Andrew Smith	BEMS+ (Primary Care)
Jane Shayler	Bath & North East Somerset Council

Also present: Cllr Eleanor Jackson (Observer)

12 **WELCOME AND INTRODUCTIONS**

The Chair welcomed everyone to the meeting.

He explained that two information reports had been circulated to Board members, regarding the Community Pharmacy update and the Local Safeguarding Children's Board Annual Report for 2016/17. These reports were circulated for information only and would not be discussed at this meeting.

13 **EMERGENCY EVACUATION PROCEDURE**

The Chair drew attention to the evacuation procedure as listed on the call to the meeting.

14 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from:

Cllr Tim Ball – B&NES Council (Observer)
Jermaine Ravalier – Bath Spa University
James Scott – Royal United Hospital NHS Trust – Substitute Jocelyn Foster
Sarah Shatwell – VCSE Sector – Developing Health and Independence
Elaine Wainwright – Bath Spa University

15 **DECLARATIONS OF INTEREST**

Councillor Paul May declared a non-pecuniary interest as a Non-Executive Director on the Board of Sirona.

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

There was no urgent business.

17 **PUBLIC QUESTIONS/COMMENTS**

Councillor Eleanor Jackson made a statement regarding the Commissioning Process and stressed the need for full consultation with local residents regarding health projects in their areas.

Dr Ian Orpen stated that he recognised the need for full public consultation. He also highlighted the funding pressures which the NHS was currently experiencing and pointed out that time-pressures in relation to funding were a reality.

A copy of the full public statement is attached as *Appendix A* to these minutes.

18 **MINUTES OF PREVIOUS MEETING**

The minutes of the previous meeting, held on 12 July 2017, were approved as a correct record and signed by the Chair.

19 **SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) UPDATE**

Tracey Cox, Chief Officer, B&NES Clinical Commissioning Group gave a presentation which provided an update on the Sustainability and Transformation Partnership (STP).

- A Five Year Forward View Next Steps document has been published which sets out nine focus areas.
- STPs will evolve into an Accountable Care System which will work as a locally integrated health system, in which NHS organisations, often in partnership with local authorities, choose to take on responsibility.
- Only when the STP is able to demonstrate it is ready for the new system will it cease to exist.
- Collaborative working is very important across the B&NES, Swindon and Wiltshire areas.
- An update was given on each of the following areas:
    - Proactive and preventative care
    - Planned care
    - Acute collaboration
    - Digital
    - Workforce
- James Scott recently stood down as Senior Responsible Officer for the STP and a new Officer will be appointed in the near future.
- Bridget Musselwhite has been appointed as Programme Director for the STP.
- Governance arrangements have also been reviewed and a stakeholder forum has been introduced. The Forum will meet quarterly.
- STP priorities will be reviewed during September and October to ensure that the focus is on the right areas.
- A Communications Manager is now in post and a stakeholder engagement event is planned for October.

The following issues were then discussed:

- Councillor Vic Pritchard highlighted the advantages of the STP. However, he noted the absence of any reference to social care and felt that this was not receiving the profile that elected members would like. Tracey Cox stated that this was a problematic issue nationally and stressed the need for the agenda to be aligned through the development of an accountable care process.
- Alex Francis was encouraged to see that a Communications Manager was now in post. She also noted the importance of considering the different types of stakeholders and groups and the need to take into account the specific audience during the communication process.
- Dr Ian Orpen noted that the alignment of policies across B&NES, Swindon and Wiltshire should minimise any postcode lottery issues.

A copy of the presentation slides is attached as *Appendix 2* to these minutes.

RESOLVED: To note the STP update.

20 **B&NES/SWINDON/WILTSHIRE (BSW) SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) MENTAL HEALTH DELIVERY PLAN**

The Board considered a report which presented the STP Mental Health Delivery Plan. The Plan contained further information on priority actions to deliver the Five Year Forward View for Mental Health across the B&NES/Swindon/Wiltshire area and also set out actions for each constituent part of the STP. The Plan has been informed by the Joint Strategic Needs Assessment, a gap analysis against the Five Year Forward View and by previously identified local priorities, including those in local Mental Health Strategies and Plans.

Mental Health at STP level is implicit and it is important to provide a priority focus in its own right. There has been a powerful partnership approach in preparing the Plan. It was noted that mental health impacts across all service areas and can affect inequalities, life expectancy and other health related issues. Early intervention before a crisis occurs is key along with early help for children and young people.

The evidence showed that if more were invested in mental health services then large savings would be made. This would reduce hospitalisation and improve both physical and mental health. The challenge is to identify where the greatest value can be added and the Plan is intended to provide clear evidence based priorities.

A workshop was held in August which had highlighted the following priority/high impact areas:

- Urgent and emergency care
- Improving transitions
- In-patient access
- Workforce development

The following issues were then discussed:

- Councillor Paul May stressed the importance of employers taking action to improve the health of their employees. Hayley Richards explained that the STP is aware of this issue and that Forums are in place for this area of work. There are also links with the education sector.
- Bruce Laurence explained that some work is already taking place with employers around mental health issues. He noted that mental health is about the way society operates and stated that the Health and Wellbeing Board could take a wider view of this area to improve the resilience of the local population.
- Mike Bowden acknowledged the amount of work that has gone into the production of this Plan.
- Alex Francis pointed out that there is lots of energy and enthusiasm in the voluntary sector for this particular area of work.

RESOLVED: To note the priority actions set out in the Sustainability and Transformation Partnership (STP) Mental Health Delivery Plan.

21 **BETTER CARE FUND PLAN 2017-19**

The Board considered a report regarding the Better Care Fund Plan 2017/19 which set out the vision for integrated services in B&NES up to 2020 and how the Improved Better Care Fund grant monies (iBCF) will be utilised to support the Better Care Fund Plan.

Additional funding has been awarded for adult social care and certain conditions have to be met. Spending will need to demonstrate how it will improve performance against the following four national metric measures:

- Delayed transfers of care
- Non-elective admissions to hospital
- Admissions to residential and nursing homes
- The effectiveness of reablement

One of the main areas of focus is around patients leaving hospital, how well this works and ensuring that best practice is being followed.

The Better Care Fund schemes all have plans and these are aligned where relevant with CCG QIPP schemes and the Council Savings schemes.

The Plan has to be submitted by 11 September 2017 and provisional feedback from NHS England is positive with only a few minor amendments being suggested.

The following issues were then discussed:

- It was noted that the higher level of grant funding in the first year is to support the necessary transformational change.
- Tracey Cox stated that this is a very complex piece of work and is a robust plan.
- Hayley Richards pointed out that there are twice as many delayed transfers for mental health patients than for patients in acute care. She requested that consideration be given as to how this issue might be addressed. The report author agreed to consider this matter in the context of the Better Care Fund Plan.
- Bruce Laurence expressed concerns regarding future projections due to the anticipated decrease in the ratio of economically active people compared to those who are not economically active. This would need to be addressed to avoid difficulties in the future.
- Jane Shayler pointed out that there are a number of schemes that provide for adults of working age such as pre-crisis beds for mental health patients.

RESOLVED:

(1) To strengthen the wording on the Better Care Fund (BCF) Narrative Plan 2017-19 in relation to mental health.

(2) To approve the proposed utilisation of the BCF funds 2017-19 and the utilisation of iBCF grant monies.

(3) To delegate formal sign off of the final submission of the Plan on 11 September 2017 to the Co-Chairs of the Health and Wellbeing Board

22 **HEALTH OPTIMISATION**

The Board received a presentation from Dr Ruth Grabham and Jon McFarlane regarding pre-operative health optimisation.

- It is important for patients to be as fit as possible prior to undergoing surgery. Evidence relating to the effects of smoking and obesity on outcomes has been considered.
- Smokers are 38% more likely to die after surgery and are at increased risk of heart and lung complications, post-surgical infections and poor wound healing. Pre-operative smoking cessation is effective.
- The statistical evidence relating to obesity is more limited. However, there is an overall increased risk of anaesthetic airway complications and surgical site infection for all surgeries.
- It was proposed that prior to surgery GPs would discuss smoking cessation and weight loss with patients as appropriate. Patients would then be offered physiotherapy and advice about weight loss and giving up smoking. Patients would then have three months in which to prepare for surgery.
- There will be a staged approach to the pathway as follows:
    - Stage 1 – Hip and knee replacement surgeries – this will aim to build on the success of the Hip and Knee Programme
    - Stage 2 – Smoking cessation across all surgeries
    - Stage 3 – Weight loss across all surgeries
- This will be introduced from 1 October 2017.
- The proposals will lead to improved patient outcomes following surgery and reduced length of stay in hospital.
- There will be a public engagement process.

The following issues were then discussed:

- Councillor Vic Pritchard noted the strong evidence relating to smoking. It was acknowledged that some patients will not wish to engage and that they cannot be compelled to take part.
- Councillor Paul May stressed the need for publicity about the proposals to raise awareness. Tracey Cox confirmed that further patient engagement is planned prior to the introduction of stages 2 and 3.
- Alex Francis stated that Healthwatch has been involved in this project. She queried the capacity for health organisations to support patients. She also noted the complexity of patients and the many different reasons for certain lifestyle choices such as smoking. It will be important to support healthcare professionals to enable them to carry out these, often difficult, conversations with patients.
- Dr Grabham stated that Virgin Care has the capacity to support patients through this process. The initial conversations with patients will be with their GP who will then make a referral. The referral support service will then provide the necessary support and advice.
- Professor Bernie Morley commented on the data provided and the need to

make this as clear as possible to understand.

- Ashley Ayre noted that people are often more willing to make lifestyle changes at a time of crisis.
- Hayley Richards endorsed the proposals and pointed out that people suffering from a mental illness are often less likely to attend for regular health checks. It will be important to evaluate the impact of intervention on different sectors of the population.
- Bruce Laurence felt that it was very important to give people support and opportunities to improve their health. He noted that this proposal appears to be the right level of "carrot and stick" as it provides an assertive approach while not being mandatory.
- Mark Coates recommended that patients should be asked why they did or did not take up the offer of advice and support.

A copy of the presentation slides are attached as *Appendix 3* to these minutes.

RESOLVED: To fully endorse the pre-operative health optimisation proposals.

23 DATE OF NEXT MEETING

It was noted that the next meeting would take place on Wednesday 25 October 2017.

The meeting ended at 12.35 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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First :thank you. Would like to make it clear that I am speaking as an ordinary Radstock resident, but with a good feeling for public opinion because of my weekly surgeries in Radstock/Westfield. Nothing I am going to say impinges on the current planning application for the new Waterloo Road doctors' surgeries, because I am going to talk solely about the commissioning process.

I have had a lot of time to meditate on the NHS from a hospital bed in recent months, and it seems to me that nothing has changed since the Salmon Report in 1970. We have world class medical staff and dreadful IT systems and administration. We also have a problem with aged unsuitable buildings. Radstock Pharmacy!!!

The problem is that decisions are taken from lofty heights without proper **local consultation** unlike, for example**,** MOD/Foxhills. Local people should be involved in NHS major projects. Any business carefully tests out its customer base: HHS have not.

I have studied the committee papers for today with great interest, especially those relating to mental health, and welcome much that I have read, especially the principle of patient involvement/choice. I particularly like the mental health charter, if it is implemented .

So, as a result of the diabolical experience Radstock residents have had I would propose the following charter for you:

- From the outset, all facts must be carefully verified.
- Those affected by the decision MUST be fully consulted, as well as all neighbouring businesses.
- Costs must be appropriate and proportionate to the benefits
- There must be accountability and transparency to the democratically elected representatives of the people.
- No section of the public should be disadvantaged, and proper risk assessments must be made.
- Local people must taken seriously. For example, if the location is wrong or dangerous.
- No blackmail or bogus facts. The public expect the highest ethical standards from all professionals

NHHS fails on all counts, as did the East of Bath Park and Ride, St Nicholas CE School, etc. Please change this patriarchal culture

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BANES, Swindon and Wiltshire STP update

- The current context
- Progress update
- Where we are now?
- What the future might look like
- How we are engaging?

The current context

Last presentation December 2016, since then:

- Sustainability and Transformation Plan became Sustainability and Transformation **Partnership**
- Five Year Forward View Next Steps document published – nine areas

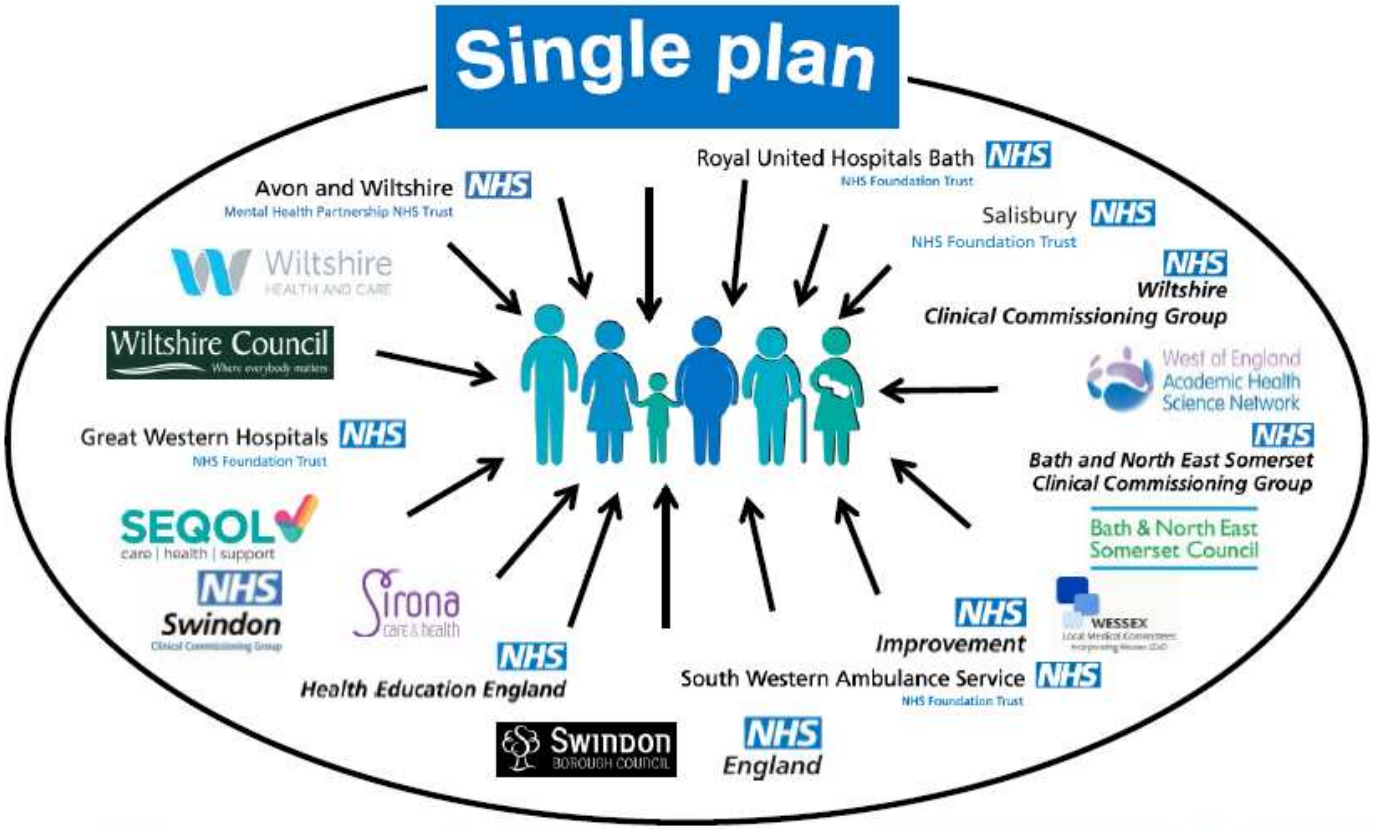
Urgent and emergency care	Primary care	Cancer
Mental health	Integrated care locally (STPs)	Funding and efficiency
Workforce	Patient safety	Harnessing technology and innovation

- STPs given oversight remit for priority programmes (yellow)

- Accountable Care System defined as an "**evolved** version of an STP that is working as a locally integrated health system… in which NHS organisations, often in partnership with local authorities, choose to take on responsibility."

What does it mean for the BSW STP?

Putting the person at the centre of our planning



What does it mean for the BSW STP?

- STP has an increasing assurance responsibility
- It is a means to an end not the end itself
- Future state is likely to recognise value of both local systems and larger (BSW) area – it won't be an either/or equation
- STP will need to plan for its own demise and grow new arrangements
- Only when the STP is able to demonstrate it is ready for the new system (ACS or equivalent) will STP cease

Progress update – What we said we'd do

Focus on collaboration and reducing variation

- **Proactive and preventative care**
  Diabetes – enrolment to national diabetes prevention programme
  Re-procurement of 111 service

- **Planned care**
  Alignment of clinical policies to reduce 'postcode lottery' between CCGs (consistent access to care)

- **Acute collaboration**
  Align back office and clinical support functions such as Occupational Health, payroll management and pathology services

- **Digital**
  Develop a digital strategy for the STP

- **Workforce**
  A combined approach to staff health and wellbeing

Where are we now?

Changes to STP Leadership

- Senior Responsible Officer (SRO)
- Programme Director

Governance refresh

- Maintains commitment to working across health and local authorities to lever improvement
- Increases non-executive input and ownership at board level
- Gives executive board explicit responsibility to deliver programme of change
- Introduces a stakeholder forum to increase the voice of the patient/carer/service user

STP priorities refresh (September and October)

- Our shared view of the future state
- Are we doing the right things?
- What are our real transformational challenges and are we up for tackling them?

Where are we going?

- Working in systems / partnerships / alliances will be the norm
- Local authorities are in the driving seat for wellbeing – levering improvements through full portfolio of activities (transport, education, planning, leisure, economic development etc)
- Wellbeing defined as both physical and mental wellbeing
- Health services support health and wellbeing through continued shift in emphasis

hospital care **community care** **primary care** **self care**

- Pattern of provision of care and commissioning of care may change
- Providers taking 'lead provider' responsibilities and undertaking tactical commissioning
- Commissioners working differently – health and social care integration
- Alignment of NHS commissioners to give stronger strategic commissioning voice

The STP is dead, long live ……????

Communications and engagement

- Communications Manager appointed and post
- Newsletter (**ST**op **P**ress) launched in August 2017
- Stakeholder forum being set up to meet three times a year
- Stakeholder engagement event planned for October
- BSW STP website updated
- Social media presence – BSW STP is now on Twitter **@bsw_stp**
- New email address for feedback and engagement – **bswstp.communication@nhs.net**

BSW STP

Any questions?

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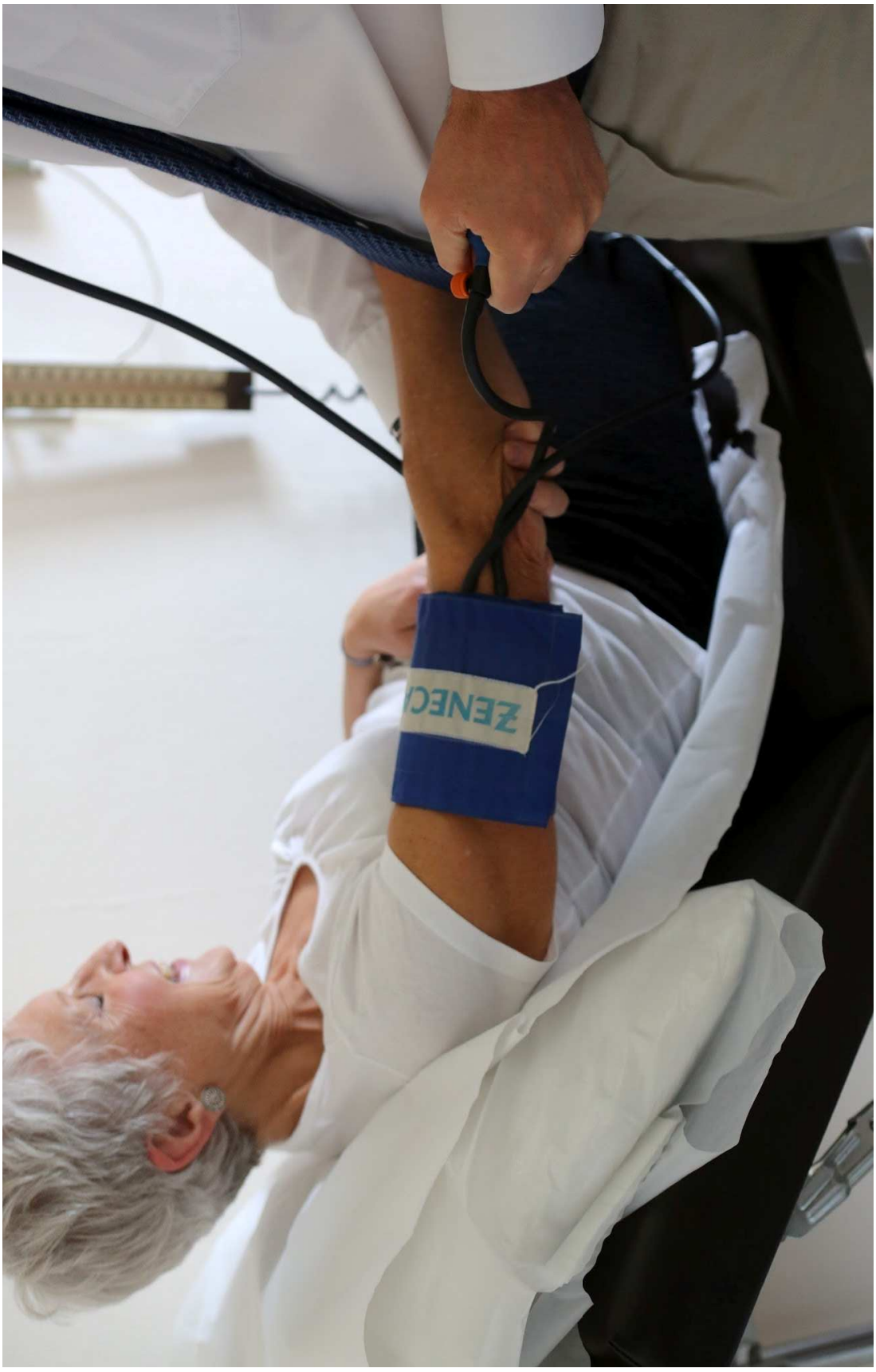
Bath and
North East Somerset
Clinical Commissioning Group

Preoperative Health Optimisation

Health & Wellbeing Board 6th September 2017

Healthier. Stronger. Together



Background of B&NES Work

- Learning from other CCG's
- Focus on improvements in surgical outcomes.
- Long term health improvements if sustained.
- Surgery is an opportune moment to engage.
- Patients take responsibility for their outcomes.

Smoking and Surgery – The Risks.

Smoking and Surgery – The Risks

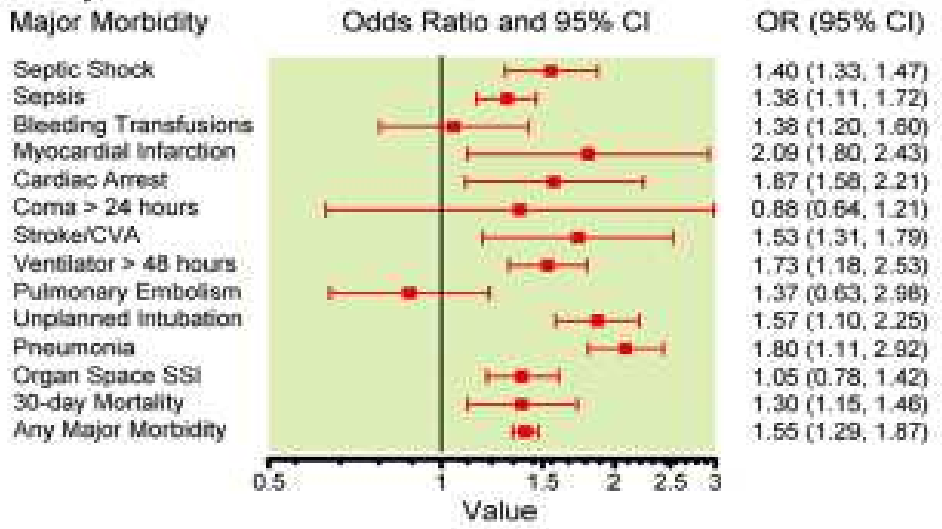
- Evidence is clear and robust
- Smokers 38% more likely to die after surgery.
- Increased risk of:-
- Heart & lung complications.
- Post surgical infection & poor wound healing.
- Pre-operative smoking cessation is effective.

Smoking and Surgery – The Risks

Smokers are 38% more likely to die within 30 days of surgery than non-smokers (Turan 2011).

ANESTHESIOLOGY
The Journal of the American Society of Anesthesiologists, Inc.

635,265 surgical (non-cardiac cases)
109% increase LRTI
57% increase cardiac arrest
80% increase chance of MI
73% increase stroke
42% increase in SSI



From: Smoking and Perioperative Outcomes
Anesthes. 2011;114(4):837-846. doi:10.1097/ALN.0b013e318210f560

Smoking and Surgery – The Risks

Does Smoking Cessation Reduce Risks?

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

Smoking Cessation Reduces Postoperative Complications: A Systematic Review and Meta-analysis

Edward Mills, PhD, MSc,[a,b] Oghenowede Eyawo, MPH,[b] Ian Lockhart, DLitt et Phil,[c] Steven Kelly, MSc,[c] Ping Wu, MBBS, MSc,[a] Jon O. Ebbert, MD, MSc[d]

[a]Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, Ontario, Canada; [b]Faculty of Health Sciences, University of Ottawa, Ottawa, Canada; [c]Outcomes Research and Evidence-Based Medicine, Pfizer Ltd, Walton on the Hill, United Kingdom; [d]Mayo School of Medicine, Mayo Clinic, Rochester, Minn.

- Relative risk reduction of 41% for prevention of post-op complications
- Each week of cessation increases magnitude of effect by 19%
- Reduced total complications, wound healing complications and pulmonary complications seen

Obesity and Surgery – The Risks

Obesity and Surgery – The Risks

- Evidence is more limited.
- Obesity is a risk factor, specific to surgeries.
- Overall increased risk:-
- Anaesthetic airway complications
- Surgical site infection for all surgeries
- Evidence for Hip and Knee Surgeries

Obesity and Hip & Knee Replacement Surgery – The Risks

Kununtsor et al. Patient-related risk factors for periprosthetic joint infection after total joint arthroplasty: a systematic review and meta-analysis. *PLOS one*, 2016.

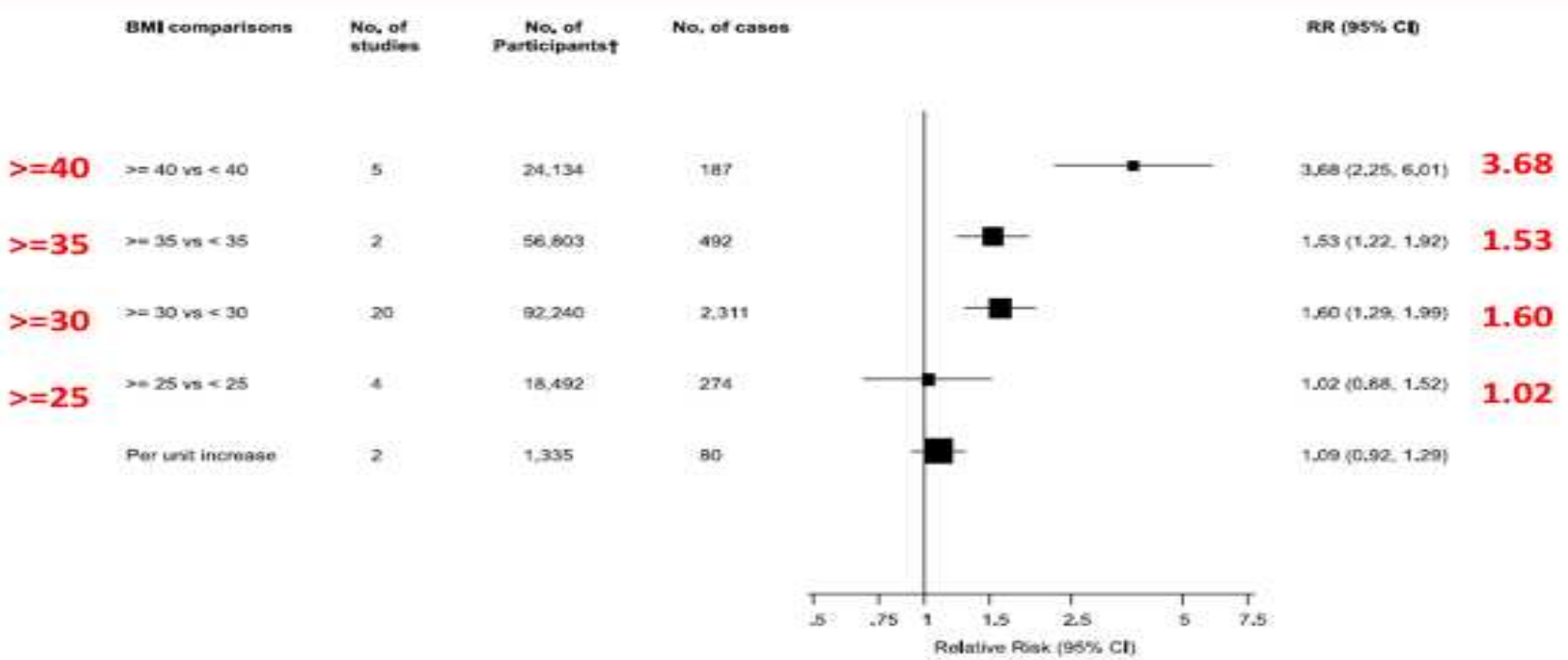


Fig 4. Body mass index comparisons and risk of periprosthetic joint infection. CI, confidence interval (bars); RR, relative risk; †, are number of participants or arthroplasties.

Obesity and Hip & Knee Replacement Surgery – The Risks

Liu et al. The influence of obesity on primary total hip arthroplasty outcomes: a meta-analysis of prospective cohort studies. *Ortho & Trauma: Surgery & Research*, 2015, 101(13)

- **Synthesis of 15 studies. n=11,271**

Risks for obese versus non-obese patients	Risk Ratio (95% C.I.)
Higher complication rate	1.68 (1.23, 2.30; p=0.0004)
Risk of dislocation	2.08 (1.54, 2.81; p< 0.0001)
Deep infection	2.92 (0.74, 11.49; p=0.13)

- Additionally, found lower Harris Hip Score and increased operating time.
- Conclusion: **Obesity negatively influences the overall complication rate, dislocation rate, functional outcome and operative time.**

Obesity and Hip & Knee Replacement Surgery – The Risks

Busato et al. Influence of high BMI on functional outcome after total hip arthroplasty, *Obesity Surgery*, 2008, 18(5).

- **Multicentre study. n=20,553**

- Analysis categories of:
  - Normal weight (<25kg/m^2)
  - Overweight (25kg/m^2 to 30kg/m^2)
  - Obese (>30kg/m^2)

- **"High pre-operative BMI has almost a perfect dose-effect relationship with decreased ambulation during a follow-up period of 15 years, but pain relief is equally effective for all BMI groups."**

- **"Overweight and obesity are modifiable risk factors that may warrant physicians giving recommendations to patients before or after THA to improve post-operative functional outcome quality."**

So where is B&NES Going?

- Review evidence to frame thinking.
- Will take a staged approach to pathway.
- Stage 1-Hip and Knee replacement surgeries.
- Aims to build on the success of the Hip & Knee Programme.
- Stage 2 -Smoking cessation across surgeries.
- Stage 3 -Weight loss across surgeries.
- Beginning Stage 1st Oct 2017.

Any Questions?