Bath & North East Somerset Council

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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Loraine Morgan-Brinkhurst MBE
Councillor Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor June Player
Councillor Sharon Ball
Councillor Sarah Bevan

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 7th October, 2011

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 7th October, 2011** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

If you need to access this agenda or any of the supporting reports in an alternative accessible format please contact Democratic Services or the relevant report author whose details are listed at the end of each report.

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

1. **Inspection of Papers:** Any person wishing to inspect minutes, reports, or a list of the background papers relating to any item on this Agenda should contact Jack Latkovic who is available by telephoning Bath 01225 394452 or by calling at the Riverside Offices Keynsham (during normal office hours).

2. **Public Speaking at Meetings:** The Council has a scheme to encourage the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. They may also present a petition or a deputation on behalf of a group. Advance notice is required not less than two full working days before the meeting (this means that for meetings held on Wednesdays notice must be received in Democratic Services by 4.30pm the previous Friday)

   The public may also ask a question to which a written answer will be given. Questions must be submitted in writing to Democratic Services at least two full working days in advance of the meeting (this means that for meetings held on Wednesdays, notice must be received in Democratic Services by 4.30pm the previous Friday). If an answer cannot be prepared in time for the meeting it will be sent out within five days afterwards. Further details of the scheme can be obtained by contacting Jack Latkovic as above.

3. **Details of Decisions taken at this meeting** can be found in the minutes which will be published as soon as possible after the meeting, and also circulated with the agenda for the next meeting. In the meantime details can be obtained by contacting Jack Latkovic as above.

   Appendices to reports are available for inspection as follows:-

   Public Access points - Riverside - Keynsham, Guildhall - Bath, Hollies - Midsomer Norton, and Bath Central, Keynsham and Midsomer Norton public libraries.

   For Councillors and Officers papers may be inspected via Political Group Research Assistants and Group Rooms/Members' Rooms.

4. **Attendance Register:** Members should sign the Register which will be circulated at the meeting.

5. THE APPENDED SUPPORTING DOCUMENTS ARE IDENTIFIED BY AGENDA ITEM NUMBER.

6. **Emergency Evacuation Procedure**

   When the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are sign-posted.

   Arrangements are in place for the safe evacuation of disabled people.

Wellbeing Policy Development and Scrutiny Panel - Friday, 7th October, 2011

at 10.00 am in the Brunswick Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

   The Chair will draw attention to the emergency evacuation procedure as set out under Note 6.

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

   Members who have an interest to declare are asked to:

   a) State the Item Number in which they have the interest
   b) The nature of the interest
   c) Whether the interest is personal, or personal and prejudicial

   Any Member who is unsure about the above should seek advice from the Monitoring Officer prior to the meeting in order to expedite matters at the meeting itself.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

6. ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

   Mr Philip Gait asked the following question:

   'I understand that this Council are considering a proposal to tender to create one large sub-regional Home Improvement Agency to cover the West of England consisting of B&NES, Bristol, South Gloucester and North Somerset.

   I further understand that this has been delegated to officers to negotiate.

   I believe that B&NES taking part in this proposal would not be in the interests of their Council Tax payers, nor more importantly, in the interests of their vulnerable residents.

Will this Scrutiny Panel set up a review of this proposal to “help the Cabinet improve the way services are delivered in Bath and North East Somerset”?

7. MINUTES 29/07/2011 (Pages 7 - 28)

To confirm the minutes of the above meeting as a correct record.

8. CABINET MEMBER UPDATE (15 MINUTES)

The Panel will have an opportunity to ask questions to the Cabinet Member and to receive an update on any current issues.

9. NHS UPDATE (15 MINUTES)

The Panel will receive an update from the NHS on current issues.

10. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES) (Pages 29 - 30)

The Panel are asked to consider an update from the BANES Local Involvement Network.

11. GREAT WESTERN AMBULANCE SERVICE (GWAS) UPDATE (15 MINUTES) (Pages 31 - 40)

Members are invited to note the contents of this report, while representatives from Great Western Ambulance Service will be present at the scrutiny panel meeting to address any issues they wish to raise.

12. SPECIALIST MENTAL HEALTH SERVICE RE-DESIGN (15 MINUTES) (Pages 41 - 68)

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

- Implementation of a Care Home and Community Hospital Liaison service can progress, reinvesting resource currently attached to Ward 4, St Martin’s Hospital.

- Plans for the implementation of the Adult of Working Age services redesign are in line with local and national strategic intentions.
- Agree the provision of mental health acute assessment and treatment services takes place in acute in-patient wards and Psychiatric Intensive Care Units rather than High Dependency Units.

13. DOMICILIARY CARE STRATEGIC PARTNERSHIP UPDATE (15 MINUTES) (Pages 69 - 74)

The Panel is recommended to:

- Note the performance of each of the Domiciliary Care Strategic Partners;
- Note the likelihood that, by mutual agreement, the Council's current contract with Agincare will not continue beyond the initial 5-year term and the options for the future provision of services currently provided by Agincare.

14. RE-ABLEMENT & 30 DAY POST DISCHARGE SUPPORT SERVICES (15 MINUTES) (Pages 75 - 80)

The report is prepared:

- To inform the Panel about the national re-ablement and thirty day post discharge support policy and the potential implications of the policy for commissioning and service delivery arrangements from 1st April 2012.
- To provide an update on the use of the re-ablement and winter pressures funding received in 2010/11 and the re-ablement funding in 2011/12 transferred to the Council under a section 256 agreement. This funding was received in order to underpin the policy reform previously mentioned.
- To outline the process that is underway to secure a number of 'Extended Research Pilots' which will provide evidence for the future use of re-ablement resources when tariff arrangements change in 2012/13.

15. ANY QUALIFIED PROVIDER COMMUNITY SERVICES (15 MINUTES) (Pages 81 - 88)

This is to brief the Wellbeing Policy Development and Scrutiny Panel on the Any Qualified Provider (AQP) Process for Community Services and the feedback received at the engagement event that took place on the 14 September 2011. The B&NES Clinical Commissioning Committee is considering the issue at its meeting on Thursday 29th September and a verbal update will be provided at the meeting on next steps.

16. UPDATE ON TRANSITION OF PUBLIC HEALTH RESPONSIBILITIES FROM NHS B&NES TO B&NES COUNCIL BY 2013 (15 MINUTES) (Pages 89 - 106)

This paper provides a briefing on the move of public health responsibilities from NHS B&NES to B&NES Council from April 2013. An accompanying report outlines the processes being undertaken to manage this transition and the key governance

arrangements.

17. HOMELESS HOSTEL UPDATE (15 MINUTES) (Pages 107 - 110)

This briefing paper aims to update the Panel on progress to provide an alternative solution to improving homeless provision in light of the decision not to proceed with the James Street West hostel provision.

18. WORKPLAN (Pages 111 - 118)

This report presents the latest workplan for the Panel.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted on 01225 394452.

BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 29th July, 2011

Present:- Councillors Vic Pritchard (Chair), Loraine Morgan-Brinkhurst MBE (Vice-Chair), Eleanor Jackson, Anthony Clarke, Bryan Organ, Kate Simmons, June Player, Sharon Ball, Sarah Bevan and Katie Hall

Also in attendance:

1 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Democratic Services Officer drew attention to the emergency evacuation procedure.

3 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Simon Allen (Cabinet Member for Wellbeing) had sent his apology to the Panel.

4 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

There were none.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

6 ITEMS FROM THE PUBLIC OR COUNCILLORS - TO RECEIVE DEPUTATIONS, STATEMENTS, PETITIONS OR QUESTIONS RELATING TO THE BUSINESS OF THIS MEETING

There were none.

7 CABINET MEMBER UPDATE (15 MINUTES)

The Chair informed the meeting that Jane Shayler (Programme Director for Non-Acute Health, Social Care and Housing) would introduce the update (attached as Appendix 1 to these minutes) in the absence of Councillor Simon Allen.

Following the update from Jane Shayler the Panel asked the following questions and made the following points:

The Panel asked what steps had been taken so Bath and North East Somerset residents are looked up properly in care centres following the investigation from BBC Panorama into abuse of vulnerable adults.

Jane Shayler informed the Panel that the Council undertakes regular contract review visits to all residential, nursing and home care providers plus some other short notice visits if particular concerns have been raised. All review visits are announced. Those inspection visits do not simply involve meeting with the registered manager and going through paper files, they also involve, walking through the facility and talking to service users, carers and staff. A simple checklist approach is not sufficient. The Council also regularly meets with the Care Quality Commission (CQC) (at least on 6 monthly basis). Also, locally we have established a Care Home Task Force comprised of GPs, consultants, nurses, social workers and other practitioners who have regular contact with residential and nursing care homes and are likely to pick up early signs of a drop in standards and/or of safety concerns. The Care Home Task Force also includes commissioning and contracting staff who gather "intelligence" about care homes coming from the Care Home Task Force and other sources liaise with CQC and ensure appropriate action is taken.

In response to a question about unannounced inspections, Jane Shayler informed the Panel that whilst commissioning and contracting staff do not make unannounced visits, they do work closely with CQC who can and do make unannounced visits to residential and nursing homes as well as other care services that are regulated by CQC..

The Panel asked whether the Care Home Task Force was not the part of their Member induction. Jane Shayler confirmed it is not although the relevant Cabinet Member was aware of its existence. The Panel asked that, in the light of the recent events in Bristol, the existence of the Care Home Task Force should be widely known. Jane Shayler confirmed that efforts would be made to raise awareness of the Care Home Task Force as well as the other ways in which anyone, including Elected Members, with any concerns about the safety and/or quality of care, could raise those concerns.

The Panel debated the Domiciliary Care Strategic Partnership issues with Jane Shayler and **RESOLVED** that a detailed report, or briefing update, on this subject should be presented to the Panel at the next meeting on the 7th October.

The Chairman thanked Jane Shayler who presented the update on behalf of the Cabinet Member.

Appendix 1

8 NHS UPDATE (15 MINUTES)

The Chairman invited Jeff James (Bath and North East Somerset and Wiltshire NHS Chief Executive) to give an update to the Panel (attached as Appendix 2 to these minutes).

The Panel asked the following questions and made the following points:

The Panel asked about the minimum waiting times for hospital admissions in Bath and North East Somerset.

Jeff James replied that the Corporation and Competition Panel are overseeing the contracts awarded to providers. The Panel published national and local report/s in terms of what the expectations from providers are nationally and locally. The PCT, as a commissioner, would always encourage competition between providers and one of the issues that would be looked at is minimum waiting time/s for hospital admissions. Jeff James also explained that the minimum waiting time should also reduce the number of people needing the service. The PCT would spend next few weeks in understanding on what the implications from the national and local reports are.

The Chairman thanked Jeff James for the update.

The Panel **RESOLVED** to have further and detailed update on minimum waiting time for hospital admissions.

Appendix 2

9 BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES)

The Chairman invited Diana Hall-Hall and Mike Vousden to take the Panel through the update.

Some Members of the Panel expressed their concern related to the Out of Hours Access to GP Services in the report and encouraged the Local Involvement Network to continue to monitor this issue.

The Chairman thanked Diana Hall-Hall and Mike Vousden for their update.

10 HEALTHWATCH STATUS REPORT (15 MINUTES)

The Chairman invited Derek Thorne (NHS BANES Assistant Director for Communications and Corporate Affairs) to introduce the report.

The Panel asked the following questions and made the following points:

The Panel expressed their concerns that the shape of the HealthWatch Board would be set up and led by the provider and not having the public involved in the organisational set up.

Derek Thorne responded that there would have to be organisational entity as such and the Council would have to procure that entity.

The Panel also expressed their concern that the Health Scrutiny role would be taken away from this Panel once the new board is in place.

Derek Thorne replied that the board would try to achieve more accessible consumer voice.

The Panel expressed their concern of having a HealthWatch board member as non-voting Wellbeing Panel Member. Members of this Panel are the elected Members who represent their communities and there might be possible conflict of interest from the HealthWatch nominee. The point was made that this issue would need further consideration before any final decision was made.

Derek Thorne said that the next step would be creation of specification for procurement process (expected for November/December 2011).

It was **RESOLVED** that the Panel noted the report and that the comments/views made by the Panel be taken on board by relevant officer/s.

11 NHS REFORM AND INTERIM COMMISSIONING ARRANGEMENTS (20 MINUTES)

The Chairman invited Jeff James to introduce the report.

The Panel asked the following questions and made the following points:

The Panel asked about the latest on the GP led commissioning.

Jeff James responded that the GP led commissioning group for Bath and North East Somerset had been launched with the established leadership of 7 GPs. The group had been working very closely with the NHS. The NHS decided that the group could start operating on their own as from October-November next year. Some of GPs had been actively involved in the Partnership Board for Health and Wellbeing work.

It was **RESOLVED** to note the report.

12 SERVICE DEVELOPMENT FOR PET/CT SERVICES FOR ADULTS (20 MINUTES)

The Chairman invited Anne Jarvis (Director South West Specialised Commissioning Group) to introduce the report.

The Panel asked the following questions and made the following points:

The Panel asked why Bristol City Council declared substantial variation on this matter.

Anne Jarvis responded that the main reason was about the travel.

Councillor Eleanor Jackson felt that the weightings outlined in the chart on paragraph 4.7 of the report (pg 36), where weighting of 60% was given to Affordability/Value for Money criteria and only 5% for Patient Engagement & Experience criteria, were not acceptable. Therefore, with the reason that this change of services had been financially driven, Councillor Jackson moved a motion to declare substantial variation. Councillor June Player seconded the motion.

Voting: 2 in favour and 8 against. Motion failed.

Councillor Bryan Organ moved a motion to support the proposal to award the two year contract to Cobalt Healthcare. Councillor Sharon Ball seconded the motion.

Voting: 8 in favour and 2 against. Motion carried.

It was **RESOLVED** to:

- Note the rigour and outcome of the PET/CT re-tendering process;
- Note the improved quality of service, patient experience and value for money the new contract will deliver;
- Note the involvement of the public, patients and carers and the support of the patient and carer who were on the assessment panel;
- Support the proposal to award the two year contract to Cobalt Healthcare.

13 GREAT WESTERN AMBULANCE SERVICE JOINT SCRUTINY COMMITTEE MEMBERSHIP AND UPDATE (10 MINUTES)

The Chairman invited Councillor Tony Clarke, who is recently appointed Chair of the Great Western Ambulance Services (GWAS) Joint Scrutiny Committee to address the Panel.

Councillor Clarke said that it is important for the Council to have 3 Members on the GWAS Joint Scrutiny Committee. The GWAS significantly improved in the last few years but the recent poor rating from the audit commission would need to be looked at. Although this is Joint Scrutiny Committee there is nothing stopping this Panel to scrutinise ambulance issues relevant to Bath and North East Somerset area.

It was **RESOLVED** to:

- Note the report; and
- Agree that Councillors A Clarke, E Jackson and S Ball be nominated to sit on the GWAS Joint Scrutiny Committee.

14 PROGRESS IN ESTABLISHING A COMMUNITY HEALTH & SOCIAL CARE SERVICES COMMUNITY INTEREST COMPANY (20 MINUTES)

The Chairman invited Jane Shayler to introduce the report. Jane Shayler informed the Panel that the 10 day period to challenge the intention to award the contract to the Bath and North East Somerset Community Health and Care Services Community Interest Company had expired without any challenge.

It was **RESOLVED** to note the update report.

15 WORKPLAN

The Panel **AGREED** the future workplan with the following additions:

- Domiciliary Care Strategic Partnership update (for October 2011)
- Minimum waiting time for hospital admissions (date to be confirmed)
- 'What is it like to be an older person in BANES – to look at the life overall rather than under the series of separate headings' (date to be confirmed)
- Dementia care in BANES (date to be confirmed)
- Psychological therapy services for adults (including the provision of counselling services in BANES) (date to be confirmed)
- Ambulance Services update (to be confirmed)

The Panel also **AGREED** to have an away day and visit the Community Health and Social services provided by the Council.

Jane Shayler said that she will be in touch with the Panel for the preferred date. The Panel agreed to have a half an hour catch-up with Samantha Jones (Corporate Policy Manager for Equalities) on Corporate Equalities issues.

The meeting ended at 1.20 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Cllr Simon Allen, Cabinet Member for WellBeing
Key Issues Briefing Note

Wellbeing Policy Development & Scrutiny Panel – July 2011

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1. PUBLIC ISSUES

Winterbourne View/Castlebeck

The Care Quality Commission (CQC) has published its report on Winterbourne View, the Castlebeck run independent hospital at the centre of a BBC Panorama investigation into abuse of vulnerable adults. The CQC inspection was undertaken in May this year. Bath & North East Somerset had no one placed at Winterbourne View during the period covered by either the Panorama investigation or CQC's inspection. The CQC report found that there were "systemic failings" in protecting vulnerable people in their [Winterbourne View's] care. In all, the CQC report published on 18th July finds that the company was failing to meet 10 of the 16 essential standards at Winterbourne View prior to its closure last month. Reports on all of Castlebeck's locations will be published later this summer while 150 services with similar characteristics to Winterbourne View are also being reviewed by CQC.

2. PERFORMANCE

Domiciliary Care Strategic Partnership

Over recent months the performance of one of the five Domiciliary Care Strategic Partners has fallen, with a number of care packages being handed back to the local authority for re-allocation to alternative providers. At the present time, per week, 121 clients receive a total of 999 visits equating to 690 care hours (ordered visits and ordered hours delivered may vary slightly). Target hours in the contract are 1870, however, this level of performance has never been achieved since the start of the contract period. For comparison, hours delivered by the other four Strategic Partners range between 670 (against target hours of 770) and 1326 (against target hours of 719). The Strategic Partner delivering significantly above target hours has achieved this by being very responsive to referrals, which are offered to all Strategic Partners on a rotational basis in line with the contractual framework.

A decision has now been reached by agreement that the contract is unlikely to extend beyond the current contractual period and will therefore terminate on 31st March 2013. The remaining hours/packages of care associated with the contract will need to be transferred to other strategic partners or re-tendered and this will need careful planning and management to ensure that it does not affect continuity and quality of care for service users and carers. Staff associated with the contract will also need to transfer to alternative employers and, considering the volume of work delivered, TUPE implications are likely to apply. Initial meetings with Trades Unions representatives have been held to discuss and agree key messages for affected members and staff. A comprehensive project plan now needs to be developed with all key stakeholders to ensure a smooth transition of service for users and staff.

Extra Care Vacancies

Extra Care housing is an independent living model of service which delivers 24 hour care and support to older and vulnerable people living in their own homes, usually within a purpose built complex. In Bath & North East Somerset there are currently five extra care schemes in operation comprising 140 individual units of accommodation with associated care services provided at all locations by Community Health & Social Care Services (CH&SC). A further 10 units of Extra Care are currently being developed within an existing sheltered housing complex.

Extra Care provides a cost effective alternative to residential care and forms a key part of the Council strategy for promoting the independence of older people and reducing overall spend on residential care. However, recent use of Extra Care has fallen, with the Midsomer Norton scheme in particular seeing occupancy levels as low as 74%.

Two potential issues appear to be affecting performance. The first is that nomination arrangements within CH&SC appear to have been less closely co-ordinated since the introduction of the new single panel arrangements (a possible unintended consequence of the new process for agreeing placements above an agreed threshold). The second relates to the perception of Extra Care amongst potential health and social care referrers with feedback suggesting that the schemes are sometimes viewed as "not supportive enough", that is, that they cannot cater for people with relatively high care and support needs, or an "unnecessary stage" in an individual's pathway from living at home and residential care.

In light of this fall in performance, nomination arrangements have been clarified and re-affirmed with all relevant parties. Also, a road show is planned to raise awareness of Extra Care and promote it as a viable alternative to residential care.

3. SERVICE DEVELOPMENT UPDATES

Loans Scheme for Homeless Households

The Non Acute Social Care Commissioning team has this month commissioned Bristol Credit Union (BCU) to carry out the loans function of the Homefinders service. Homefinders is a Council initiative that prevents homelessness by enabling people to access the private rented sector using loans for rent in advance and deposits. Roughly 60 household per year are assisted to take up new tenancies through this route. From 1 September, having identified a property that they would like to rent, individuals will now be able to arrange for advance payments to be covered by a loan from Bristol Credit Union, of which they would become a member. As part of this process, BCU will suggest the tenant sets up a Rent Direct payment. Rent Direct ensures that Local Housing Allowance payments are received into the individuals account and are directed to the landlord. This means that the individual is less likely to get into arrears and is more likely to make a success of their tenancy. Membership of BCU also opens up other financial options, such as current and savings accounts, loans for other purposes and information on benefits.

Housing Support Gateway

The 'Housing Support Gateway' was launched on June 23rd. This is an online single point of access to a large number of housing related support services, (supported housing and floating support) in B&NES. It is linked to the Homesearch Register.

Clients can apply online by themselves or with the help of other stakeholders and the system 'matches' the applicant to the services that can best meet their needs. We are hoping that the initiative will make it easier for people to apply, (they'll only have to do one form to be considered for lots of services); ensure that the people in the most need will receive the services; reduce void times, and give us as commissioners a lot of intelligence re demand and use of housing related support services.

The website address is www.housingsupportgatewaybathnes.org.uk

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NHS B&NES Key Issues Briefing Note

Overview and Scrutiny Panel – 29th July 2011

NHS Reforms
Update information on the reform programme and the PCT cluster arrangements is provided in a separate report.

Public Health
The Health and Social Care Bill will transfer public health to Local Authorities The Department of Health have recently released an update on the proposed pubic health changes in England. A specific briefing paper has been prepared and this is attached for information.

Health and Wellbeing Boards
A key aspect of the reform programme is the establishment of health and wellbeing boards. Both the partnership board and the PCT board have approved a set of principles and outline governance arrangements for the creation of a health and wellbeing board in B&NES.
We are in a strong position to build on the integration work already established over several years and plan to take an evolutionary approach whereby the existing partnership board, alters its membership to include both clinicians and HealthWatch representation, revises its terms of reference and moves into a the new role from April 2012.
The health and wellbeing board will be responsible for:

- developing a joint strategic needs assessment (JSNA)
- preparing the health and wellbeing strategy
- considering whether the commissioning arrangements for social care, public health and the NHS are in line with the health and wellbeing strategy
- considering whether the GP Consortia's commissioning plan has given due regard to the health and wellbeing strategy
- reporting formally to the NHS Commissioning Board, GP Consortium, council leadership if local commissioning plans have not had adequate regard to the health and wellbeing strategy.

Membership

Membership for the health and wellbeing board in B&NES is proposed as:

For NHS B&NES	**For B&NES Council**
Chairman	Leader
Chief Executive	Chief Executive
1 Non Exec Director	1 Councillor
Chair of Clinical Commissioning Group	1 Councillor
Accountable GP	Director of Peoples Services
Additional Members	
Healthwatch x 2	Acting as consumer champion
Director of Public Health	Acting across both organisations in joint role
Finance Advisor	Nature of membership to be agreed

Cluster Management Arrangements

A single executive team of Chief Executive and five Directors is being established across the two PCts within the B&NES and Wilts cluster. Three appointments have recently been made.

Jennifer Howells is now in post as joint Director of Finance. Jenny has held the position of Joint Director of Finance across the two Trusts since March this year and her appointment through the latest process now confirms her position with us for the next two years.

Suzanne Tewkesbury has been appointed Director of Human Resources, Communications and Corporate Services to. Suzanne has held the position of Director of HR at NHS Wiltshire since 2007.

Mary Monnington has been appointed Director of Nursing. Mary has worked for South Somerset Primary Care Trust and latterly NHS Somerset as Director of Nursing since 2001.

Advertisements are now out for the roles of Interim Director of Commissioning Development and Medical Director. It is anticipated that interviews will be held for these two posts during August.

Any Qualified Provider

The Department of Health has published guidance on how the NHS will deliver greater choice. This programme of change is entitled Any Qualified Provider (AQP). Full details are available to view at
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_125442

More choice will mean that when patients are referred for selected services, usually by their GP, they should be able to choose from a range of qualified providers who meet NHS quality, prices and contracts.

To date, choice has only been available in non-urgent hospital care, but published guidance now sets out that the choice offer will be extended to community and mental health services for the first time. Following advice from patient groups, clinicians and voluntary organisations, there are eight services that have been recommended as the most suitable:

- Services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Diagnostic tests closer to home
- Wheelchair services (children)
- Podiatry (feet) services
- Leg ulcer and wound healing
- Talking Therapies (Primary Care Psychological therapies, adults)

PCT clusters, supported by Clinical Commissioning Groups may also choose other services which are higher local priorities, if there is a clear case to do so based on the views of service users and potential gains in quality and access

Every area across England will be expected to offer choice in a minimum of three services by September 2012 – Primary Care Trust clusters will engage with local patients, carers and professionals during August and September and identify their three or more community or mental health services. These decisions need to be reached by October with implementation then taking place between April and September 2012.

Healthy lives, healthy people

Update from Department of Health on key issues and proposals for the way forward.

Paul Scott, Assistant Director of Public Health, July 2011

A new public health system, with strong local and national leadership

A system focused on outcomes

The whole system will be refocused around achieving positive health outcomes for the population, rather than focused on process targets and will not be used to performance manage local areas. DH will work with stakeholders to finalise the Public Health Outcomes Framework and publish it later in the year (expected autumn 2011).

A locally-led system: local government

- Local authorities are uniquely placed to tackle the wider determinants of health (such as employment, education, environment, housing and transport), and are a natural home for a public health function focused on improving health and wellbeing across the life course.
- Local authorities will have a role across the three domains of public health (health improvement, health protection and health services quality). The Health and Social Care Bill gives unitary local authorities a new duty to take such steps as it considers appropriate for improving the health of the people in its area. DH plan to give local authorities new functions through regulations for taking steps to protect the local population's health, and for providing clinical commissioning groups with population health advice.
- Local authorities will be funded to carry out their specific new public health responsibilities through a ring-fenced grant. To maximise flexibility DH will place only a limited number of conditions on the use of the grant. The core conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the public health functions for which it has been given, and ensuring a transparent accounting process.
- Commissioning routes for programmes are set out in Appendix 2 of this summary. DH encourage local services to move forward with planning on this basis.
- In addition to local authorities role in a wider range of activities, DH will specifically prescribe that local authorities deliver the following services or steps:
    - appropriate access to sexual health services
    - steps to be taken to protect the health of the population, in particular, giving the Director of Public Health a duty to ensure there are plans in place to protect the health of the population
    - ensuring NHS commissioners receive the public health advice they need
    - the National Child Measurement Programme
    - NHS Health Check assessment
    - elements of the Healthy Child Programme.

A local community's health advisor - the Director of Public Health

- The Director of Public Health (DPH) will be:
  - the principal adviser on health to elected members and officials
  - the officer charged with delivering key new public health functions
  - a statutory member of the health and wellbeing board
  - the author of an annual report on the health of the population.
- The DPH will have responsibilities across the three domains of public health, reflecting the responsibilities of local authorities. Thus on health improvement, DH expect the DPH to lead on investment for improving and protecting the health of the population locally, and reducing health inequalities through the way the ring-fenced grant is spent (although accountability for the grant rests with the Chief Executive of the local authority).
- On health protection, DH plan to make it a requirement for the local authority to ensure that plans are in place to protect the health of the local population, under regulation making powers in the Bill. This will ensure that Directors of Public Health have a critical role, working closely with Public Health England at the local level and with the NHS, to ensure appropriate public health responses to the whole spectrum of potential problems, from local incidents and outbreaks to emergencies.
- With regard to population healthcare, Directors of Public Health and their teams will provide public health expertise, advice and analysis to clinical commissioning groups and health and wellbeing boards and (for primary care and other directly commissioned services) to the NHS Commissioning Board. This provision of public health input to NHS commissioning will become a mandated step for local authorities, using regulation-making powers in the Health and Social Care Bill. Public health specialists will also come together with other health and care experts in new clinical senates, hosted by the NHS Commissioning Board, to advise on how to make patient care fit together seamlessly.
- Directors of Public Health will be employed by local authorities, but the appointment process will be joint with Public Health England, who will be able to ensure that only appropriately qualified individuals are appointed.
- DH state that local authorities will determine the precise detail of their own corporate management arrangements. DH also state that given the importance of these new local authority public health functions, they would expect the DPH to be of Chief Officer status with direct accountability to the Chief Executive for the delivery of local authority public health functions. DH will discuss with local government and public health stakeholders how best to ensure that the Director of Public Health has an appropriate status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services.

A locally-led system: the NHS

- The NHS has four main roles in securing population health outcomes:
  - provision of accessible and high quality health care to meet the needs of the local population
  - ensuring that in delivering healthcare the opportunities to have a positive impact on public health are taken (eg. through advice, brief interventions and referral to targeted services)
  - delivery of specific population health interventions (eg. childhood immunisations and national screening programmes)
  - the NHS contribution to health protection and emergency response.

- Appendix 1 identifies a number of services that will be commissioned by the NHS Commissioning Board, funded from the public health budget.
- Local authorities, through their Directors of Public Health, will provide public health advice to clinical commissioning groups. To support the detailed implementation of this policy, DH

will engage with stakeholders on the design of the "core public health offer" from local authorities to the NHS, setting out what support local NHS bodies should expect from the local authority Director of Public Health.

A locally-led system: coordinated by the health and wellbeing board

- Health and wellbeing boards will maximise opportunities for integration between the NHS, public health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population.
- Health and wellbeing boards will provide the vehicle for local government to work in partnership with commissioning groups to develop comprehensive Joint Strategic Needs Assessments and robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of health care, social care and public health services, and taking into account wider ranging local interventions to support health and wellbeing across the life course (eg. local planning and leisure policies and working with community safety partnerships and police and crime commissioners).
- Health and wellbeing boards will have a strong role in leading on local public involvement Health and wellbeing boards, in considering their membership, will be free to invite other members to sit on the board in order to maximise the gain from health outcomes and align these with employment, welfare and reductions in offending. Each health and wellbeing board will consider its membership based on local needs and priorities.
- Health and wellbeing boards will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. In line with the Localism Bill, local authorities will have greater discretion over how to exercise their health scrutiny powers, and will be able to challenge any proposals for the substantial reconfiguration of NHS services.

A locally-led system: supported by Public Health England

- Public Health England will bring together a fragmented public health system, strengthen the national response on emergency preparedness and health protection and support public health delivery across the three domains of public health (health improvement, health protection and health service quality) through information, evidence, surveillance and professional leadership.
- Public Health England will support local action by:
    - generating information to support the development of local Joint Strategic Needs Assessments
    - building the evidence base on what works
    - communicating intelligence to local leaders about how best to tackle the public health challenges their population is facing, to support the development of joint health and wellbeing strategies
    - reporting on local government contribution in improving population health outcomes as part of the public health outcomes framework
    - advocacy to promote and encourage action right across society, including by local employers and individuals and families
    - providing robust surveillance and local response capabilities to respond to threats to public health and ensure health is protected.
- Public Health England will play a particularly key role in health protection. Appendix 3 sets out how DH are strengthening the arrangements around emergencies, highlights the clear role for Public Health England and includes the defined route for mobilising NHS and public health services to respond to emergencies.

Clear national leadership

- The Secretary of State for Health will provide national leadership, resources and the legislative infrastructure for public health.
- Public Health England will drive delivery of improved outcomes in health and well-being, and design and maintain systems to protect the population against existing and future threats to health.
- Public Health England will develop an integrated approach to information, intelligence and evidence (working alongside NICE), ensuring that local authorities, the NHS and Department of Health have the understanding, advice and tools they need to successfully drive improvements in health.
- Public Health England will be established as an integrated public health delivery body. It will bring together in one organisation the following:
  - Health Protection Agency
  - National Treatment Agency for substance misuse
  - Regional Directors of Public Health and their teams in the Department of Health and Strategic Health Authorities
  - regional and specialist Public Health Observatories
  - Cancer Registries and the National Cancer Intelligence Network
  - National Screening Committee and Cancer Screening Programmes.
- DH intends to establish Public Health England as an Executive Agency of the Department of Health. It will have a distinct identity and a Chief Executive with clear accountability for carrying out its functions. Its status will underline its responsibility for offering scientifically rigorous and impartial advice. DH will work closely with stakeholders to ensure that Public Health England is focused to offer strong support to Directors of Public Health and their partners in the local system.
- The NHS Commissioning Board will look to Public Health England to ensure appropriate population health advice is available to the NHS from the public health system.
- DH are developing further the detailed accountability relationships between the Department of Health, Public Health England and the NHS Commissioning Board in the new system.

Developing a rich and diverse workforce

- DH are working with stakeholders to develop a public health workforce strategy that will include education and training opportunities for people at different entry points, that will provide flexibility for staff to move between different employment sectors and to meet the changing public health needs of the future.
- DH are developing a high level HR “concordat” in partnership with the NHS and Local Government Employers on the effective transition of public health staff between the NHS and local authorities.
- DH are also developing a “People Transition Policy” that will set out the principles applying to the HR and employment processes supporting the transfer of staff into Public Health England.

Financing the public health system

- DH state that ‘a fundamental plank’ of their reform strategy is providing public health with dedicated resources. This will allow a strategic approach to spend on prevention, recognising that public health is a long-term investment, and that effective spend on prevention will release efficiency savings elsewhere, which can then be used elsewhere in the NHS and cross-government more widely.
- DH are continuing to engage with the NHS and local government partners to refine assessments of current baseline spending by the NHS on activity, which in future will be

funded from the public health budget. This work and decisions about the portions of the public health budget that would be distributed to local authorities, transferred to the NHS Commissioning Board to fund commissioning of specific public health programmes; or form the budget of Public Health England itself are dependent on ongoing work, including on the final agreement of commissioning responsibilities.

- DH are committed to ensuring that local authorities are adequately funded for their new responsibilities and that any additional net burdens will be funded in line with the Government's New Burdens Doctrine.
- Public health grants to upper tier and unitary local authorities will be made for the first time in 2013-14 and DH intend to provide shadow allocations for 2012-13 by the end of this year. DH intend to take forward the detailed development of the Health Premium (which will incentivise improvement against a subset of indicators from the public health outcomes framework) with a group of key partners, including local government, over the coming months.

Next steps

Completing the operational design

- DH will produce a series of Public Health Reform Updates through the autumn, including:
  - The Outcomes Framework
  - The Public Health England Operating Model
  - Public Health in local government and the DPH
  - Public Health Funding Regime
  - Workforce strategy

Managing the transition

- Subject to Parliament, upper tier and unitary local authorities will take on their new public health responsibilities in April 2013, at which point they will also take responsibility for Directors of Public Health and their functions.
- Public Health England will be created at the same time, formally taking on the functions of its predecessor bodies.
- Ahead of the formal transfer there is much that can be done to build the local relationships and develop local agreements and shadow arrangements to test elements of the new approach to public health. DH are encouraging local systems to press ahead and develop locally tailored approaches.
- Formal transition plans are to be agreed with the Regional Director of Public Health by March 2012. Ahead of this date DH strongly encourage local authorities and Primary Care Trusts to work together on developing the relationships and joint working that will facilitate a robust transition for April 2013.
- DH plan to recruit a Chief Executive for Public Health England to be in post from April 2012.
- The Regional Directors of Public Health will continue to lead the transition in their regions and DH will continue to work closely with the Faculty of Public Health, the Association of Directors of Public Health, the Public Health Taskforce, the Local Government Group and other key stakeholders in developing detailed proposals and implementing these reforms.

Appendix 1 – Headline recommendations from the Marmot Review into health inequalities *Fair Society, Healthy Lives*

- Give every child the best start in life
- Enable all children young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

NB: More detailed policy recommendations for each of these headline areas can be found at www.marmotreview.org

Appendix 2: Proposed commissioning responsibilities for public health

- Subject to further engagement, the new responsibilities of local authorities would include local activity on:
  - tobacco control
  - alcohol and drug misuse services
  - obesity and community nutrition initiatives
  - increasing levels of physical activity in the local population
  - assessment and lifestyle interventions as part of the NHS Health Check Programme
  - public mental health services
  - dental public health services
  - accidental injury prevention
  - population level interventions to reduce and prevent birth defects
  - behavioural and lifestyle campaigns to prevent cancer and long term conditions
  - local initiatives on workplace health
  - supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation programmes
  - comprehensive sexual health services
  - local initiatives to reduce excess deaths as a result of seasonal mortality
  - role in dealing with health protection incidents and emergencies as described in Appendix 3
  - promotion of community safety, violence prevention and response
  - local initiatives to tackle social exclusion.

- DH will ask the NHS Commissioning Board to commission all immunisation programmes, to ensure a single commissioner, but ensure that Directors of Public Health have a defined role in supporting reviewing and challenging delivery of services
- DH will consider what role Directors of Public Health should have with regard to national screening programmes, which will be commissioned by the NHS Commissioning Board on behalf of Public Health England.
- In addition to their new public health responsibilities, local authorities are ideally placed to maximise the opportunities to develop holistic approaches to improve health and wellbeing, such as specific services for older people and carers, local employers, local criminal justice and community safety agencies, tacking wider issues, such as air quality and noise and improving access to employment, shops and other local services through sustainable modes of transport.
- The public health budget will also fund the NHS to commission certain public health services, in light of the paragraphs above, and subject to further engagement. This includes:
  - immunisation programmes
  - contraception in the GP contract
  - screening programmes
  - public health care for those in prison or custody
  - children's public health services from pregnancy to age 5 (including health visiting).

- The NHS will also commission and deliver many more interventions that improve public health funded, from within the NHS budget over and above this. For example, providing brief interventions and referral in primary and secondary care.
- DH ask local authorities, the shadow NHS Commissioning Board (once established) and emerging clinical commissioning groups to plan on the basis of the respective responsibilities set out above.

Appendix 3: Emergency preparedness, resilience and response

- There will be clear roles and responsibilities for the Department of Health and Public Health England, Directors of Public Health and the NHS Commissioning Board with a defined route for mobilising NHS and public health services to respond to emergencies.
- The Health and Social Care Bill will update the Secretary of State for Health's powers of direction during an emergency. In addition, new arrangements provide the Secretary of State with a clear line of sight to front line responders through Public Health England and the NHS Commissioning Board.
- The Department of Health will support the Secretary of State in his responsibilities for emergency response. It will represent the health sector in the development of cross government civil resilience policy and support the UK Government's central response to major emergencies.
- Public Health England will provide public health leadership for emergency preparedness and response and will provide independent scientific and technical advice at all levels.
- Subject to regulations being made, it is intended that, within local authorities, Directors of Public Health will ensure plans are in place to protect the health of their population, working closely with Public Health England local units and NHS organisations.
- In the event of an emergency or incident, the NHS Commissioning Board, at an appropriate level, will lead the NHS response to any emergency that has the potential to impact, or impacts on the delivery of NHS services, or requires the services or assets of the NHS to be mobilised, taking scientific and technical advice from Public Health England.
- NHS-funded units will have clearer obligations to prepare for and respond to emergencies, and providers will be required to collaborate in local multi-agency emergency planning and response activity.
- Joint planning and collaborative working will lie at the heart of the health system's preparedness and response arrangements. Public Health England and the NHS Commissioning Board will work together at all levels to ensure nationally consistent health emergency preparedness and response capability. Senior leaders will be responsible for emergency preparedness and response in both the NHS Commissioning Board and Public Health England and in the Department of Health. They and their teams will work closely together, aligning with wider Government resilience hubs established by the Department for Communities and Local Government, and the existing Local Resilience Fora that provide the focus of multi-agency planning and response to emergencies. There will be a clear process to develop and test plans based on national and local risks and challenges.
- These new arrangements will be a significant improvement on the current arrangements.
- DH will manage the transition to this new approach to ensure a continuing robust and effective emergency planning system, including throughout the Olympic period.
- DH will engage with key stakeholders over the coming months to consider further the proposed model for health emergencies and incidents based on these principles.

I promised to keep you up to date with news about the recruitment to the four Director posts across the NHS BANES and NHS Wiltshire Cluster and so I'm writing now to let you know how the process is progressing.

I'm delighted to confirm that Jenny Howells has been officially appointed to the post of Director of Finance to the NHS Bath and North East Somerset and NHS Wiltshire Cluster. Those of you who know Jenny will be aware that she has held the position of Joint Director of Finance across the two Trusts since March this year, so we're particularly happy that her appointment through the latest process now confirms her official position with us for the next two years.

Unfortunately we have not been able to successfully recruit to the positions of the three remaining Director posts – Director of Commissioning, Medical Director and Director of Nursing – so the positions will be opened to expressions of interest from candidates outside of the South West region. Interviews for these posts will be held during June and I will, of course, let you know the outcome of any decisions.

Jeff James, Cluster CEO NHS B&NES and NHS Wiltshire

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Bath and North East Somerset

Local Involvement Network

Report to B&NES Wellbeing Policy Development & Scrutiny Panel, 7 October 2011

1. Hillview Lodge -AWP High Dependency Unit

Bath MIND, who are Organisational Members of the LINk, raised an issue with us relating to the operational problems, and the future of Hillview Lodge, and more particularly of The Cherries High Dependency Unit for people with mental illness. Both MIND and the LINk were concerned that The Cherries had been closed for some time, both before and after sustaining some physical damage. There was a concern that, if this closure became permanent, patients at Hillview Lodge would no longer have immediate and day-to-day access to the on-site HDU during temporary spells of high need. The only measure that could then be taken, would be to remove such patients to a Psychiatric Intensive Care Unit at some distance from their normal care-setting. This would be a procedure extremely disruptive to their continuity of care, and would almost certainly change the thresholds of transfer between care settings in view of the different logistical relationships between Hillview and remote PICU's. When patients' needs for such intensive care may only last for a matter of hours, this would be a seriously disruptive way of providing their care.

The LINk has written to the Chief Executive of AWP on this matter, and has received a reply which it will be discussing at its November meeting. We will provide the PDS Panel with a further update on this at its next meeting.

2. HealthWatch

Since our last report, the Health & Social Care Bill has passed its Committee stage, Report stage, and Third Reading in the House of Commons, and its first reading in the Lords. It will have its Second Reading in the Lords on 11 October, and will then pass into the Lords Committee stage. During the two days of the Commons Report stage, over 1,000 amendments to the overall Bill were dealt with in very hurried fashion. Of these, only about 18 related to Local HealthWatches, and none was of great significance.

The Bill is likely to come under very close scrutiny in the Lords, and the amendments that were rushed through the Commons will be subject to detailed examination in the Lords for the first time. The Government has indicated that there may be many further amendments made during the Bill's passage through the Lords.

The Party Conference season is also now underway, and there were signs that there remain many concerns about the Bill amongst the Liberal Democrats, which were held at bay during their Conference.

The latest date for formal implementation of Local HealthWatch is October 2012, and local authorities are moving towards completion of their tendering arrangements to meet this deadline.

3. Homeopathy Services Impact Assessment

Six representatives of the LINk attended the Impact Assessment meeting for future referrals for NHS-funded Homeopathic treatment. Although there was dissent amongst those attending the meeting, the LINk representatives were unanimous in supporting the PCT's proposals for the exceptional funding of Homeopathic treatment.

The LINk suggested that a recent PCT Board paper concerning this exceptional funding policy should be widely publicised.

Members also felt that, although the Impact Assessment mechanism has been much improved by its revision during the last few years, it is still a somewhat imprecise tool, and the LINk would be keen to be involved in any review of the process that is conducted in the light of experience of the revised process.

4. Out-of-Hours Access to GP Services

Following the discussion at the July meeting of the Policy Development & Scrutiny Panel, the LINk has written again to NHS B&NES, suggesting that joint discussions are held to try and find a way through the problem that some people have in accessing GP out-of-hours services, particularly when these have been moved from local surgeries to more distant central locations. They have replied that the commissioners would like to discuss this matter internally first, and that the PCT would then be happy to liaise with us on the setting up of such a meeting. At the time of writing, we are waiting to hear more on this.

5. LINk Legacy Document

The PCT and the LINk have worked together to produce a Legacy Document, which provides a record of the LINk's work over the past three years. The document, required by the Department of Health, will help considerably in the hand-over to Local HealthWatch.

6. Long-Term Conditions

The challenge for the NHS is to put in place a sustainable programme for those within this group. At present this group accounts for 70 percent of overall care and health spend, which is not sustainable. The first meeting in the South West Region was attended by teams from the whole Region, and as a result of this meeting B&NES have established an action plan, and as the voluntary sector member, Jayne Pye, a LINk Member, has taken on the task of sending out patient surveys. This is the beginning of a progressive and holistic programme attempting to meet the aspirations of patients, which are expressed thus: *"I want you to deal with the whole of me, and for you to work as one team"*

7. New B&NES Health & Wellbeing Board

Derek Thorne of the PCT and Jayne Pye of the LINk jointly gave a presentation to the Board on Local Healthwatch. The functions and intentions were outlined, and Derek asked the Board to commit to these, to offer HealthWatch commissions regarding engagement, and to agree mutual working priorities. The Board were interested and were not negative, but felt that they needed more information before any decisions were made.

Diana Hall Hall

Chair, B&NES Local Involvement Network

27 September 2011

Great Western Ambulance Service NHS

NHS Trust

UPDATE FOR B&NES COUNCIL WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL – 7 OCTOBER, 2011

Background

The way ambulance services are assessed has changed in recent months. Before April this year, speed of response was the only way their performance was measured.

While this ensured a significant concentration of effort and resources in reaching patients quickly after they dialled 999, it failed to take into account the increasing range of services and clinical skills ambulance staff now provide.

Therefore, since April, a range of ambulance quality indicators (AQIs) provide a fuller insight into the work of a modern ambulance service, giving a more comprehensive picture of how individual trusts are performing.

That said, speed of response is still an important factor in reaching those patients calling 999 with an immediately life-threatening incident – and time to respond to these calls therefore remains as one of the AQIs.

The AQIs are made up of two sets of data – one measuring clinical performance and outcomes for particular types of clinical emergencies, the other measuring how ambulance trusts provide the service to their patients.

The clinical outcome measures are:

- Cardiac arrest – the number of patients having a return of spontaneous circulation (ROSC) on arrival at hospital, and those who survive and are subsequently discharged from hospital;
- STEMI (ST-Elevation Myocardial Infarction – a particular type of heart attack) – the proportion of patients receiving the appropriate care ‘bundle’ by ambulance clinicians as well as those taken to the appropriate specialist centre for further treatment;
- Stroke - the proportion of patients receiving the appropriate care ‘bundle’ by ambulance clinicians as well as those taken for further treatment.

System indicators measure:

- Speed of response to Red 999 calls (previously called Category A – immediately life-threatening emergencies);
- Timeliness – how quickly 999 calls are answered and the time for patients to receive treatment;

- The number of 999 calls abandoned;
- The number of patients being treated without the need to go to a hospital A&E department (over the phone, by ambulance clinician on scene or by being taken to somewhere other than A&E);
- The number of those patients who re-contact the 999 service within 24 hours;
- The number of emergency patient journeys;
- The number of patients calling 999 for whom there is a frequent caller procedure in place.

What the new performance measures show

Great Western Ambulance Service (GWAS), along with all other ambulance services in England, is now publishing this performance data monthly on its website in the form of a clinical dashboard. Information that forms the system indicators outlined above is available from within GWAS on an ongoing basis, so can be published sooner (ie the latest July data went live towards the end of August). The information that makes up the clinical indicators takes longer to compile and collate, due in part because some of the indicators measure patient survival up to discharge from hospital, which could be several weeks/months after the ambulance service involvement. Therefore, these areas of the dashboard will always run several months behind the system indicators (ie data that went live at the end of August was for April).

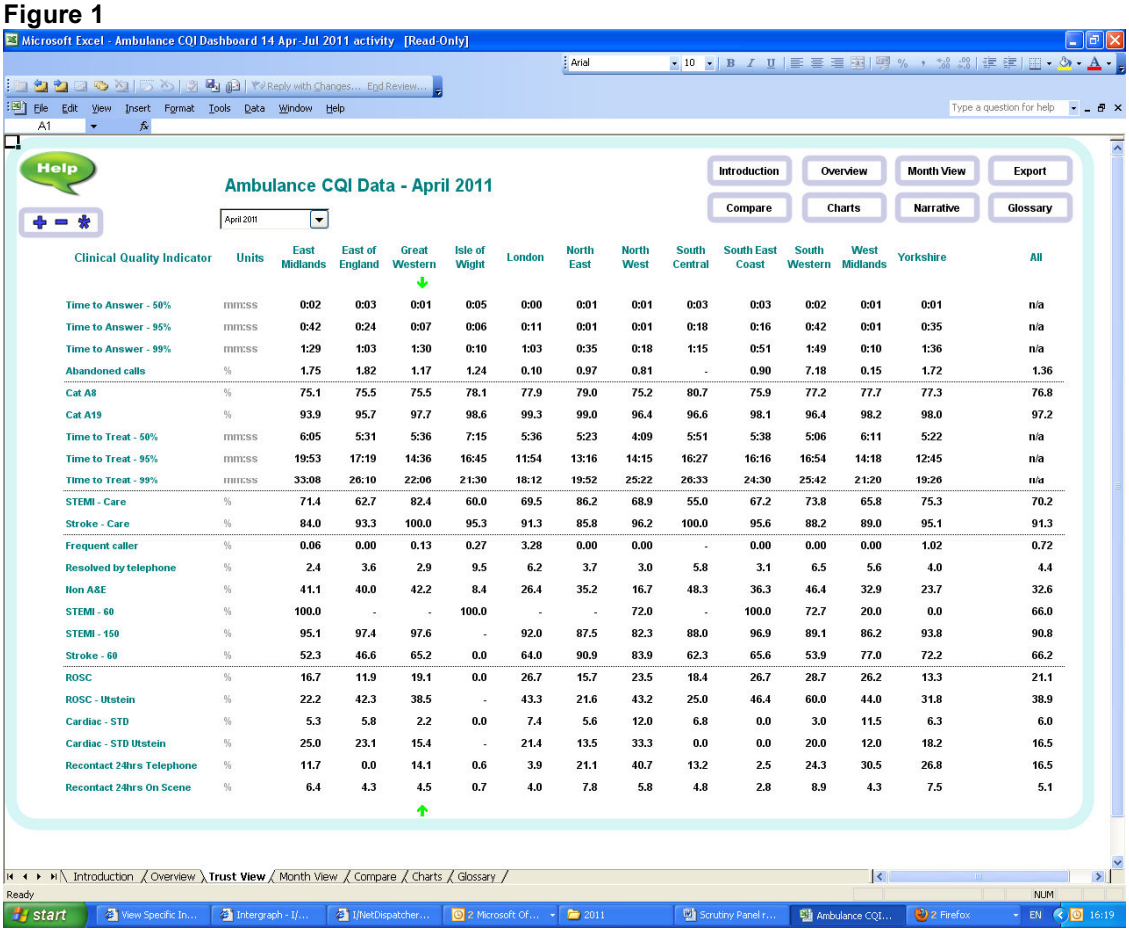
Members wishing to look at the information on an ongoing basis can go to…

http://www.gwas.nhs.uk/What%20We%20Do/How-we-are-doing.htm

…from where they will be able to access the details in a variety of ways. However, the following tables/charts from the latest available dashboard are included to provide members with an indication of how the information is presented and what it is showing.

Figure 1 (below) compares performance for all ambulance services across the whole range of indicators for the first month (April) for which they are all available.

Figure 1



Clinical Quality Indicator	Units	East Midlands	East of England	Great Western	Isle of Wight	London	North East	North West	South Central	South East Coast	South Western	West Midlands	Yorkshire	All
Time to Answer - 50%	mm:ss	0:02	0:03	0:01	0:05	0:00	0:01	0:01	0:03	0:03	0:02	0:01	0:01	n/a
Time to Answer - 95%	mm:ss	0:42	0:24	0:07	0:06	0:11	0:01	0:01	0:18	0:16	0:42	0:01	0:35	n/a
Time to Answer - 99%	mm:ss	1:29	1:03	1:30	0:10	1:03	0:35	0:18	1:15	0:51	1:49	0:10	1:36	n/a
Abandoned calls	%	1.75	1.82	1.17	1.24	0.10	0.97	0.81	-	0.90	7.18	0.15	1.72	1.36
Cat A8	%	75.1	75.5	75.5	78.1	77.9	79.0	75.2	80.7	75.9	77.2	77.7	77.3	76.8
Cat A19	%	93.9	95.7	97.7	98.6	99.3	99.0	96.4	96.6	98.1	96.4	98.2	98.0	97.2
Time to Treat - 50%	mm:ss	6:05	5:31	5:36	7:15	5:36	5:23	4:09	5:51	5:38	5:06	6:11	5:22	n/a
Time to Treat - 95%	mm:ss	19:53	17:19	14:36	16:45	11:54	13:16	14:15	16:27	16:16	16:54	14:18	12:45	n/a
Time to Treat - 99%	mm:ss	33:08	26:10	22:06	21:30	18:12	19:52	25:22	26:33	24:30	25:42	21:20	19:26	n/a
STEMI - Care	%	71.4	62.7	82.4	60.0	69.5	86.2	68.9	55.0	67.2	73.8	65.8	75.3	70.2
Stroke - Care	%	84.0	93.3	100.0	95.3	91.3	85.8	96.2	100.0	95.6	88.2	89.0	95.1	91.3
Frequent caller	%	0.06	0.00	0.13	0.27	3.28	0.00	0.00	-	0.00	0.00	0.00	1.02	0.72
Resolved by telephone	%	2.4	3.6	2.9	9.5	6.2	3.7	3.0	5.8	3.1	6.5	5.6	4.0	4.4
Non A&E	%	41.1	40.0	42.2	8.4	26.4	35.2	16.7	48.3	36.3	46.4	32.9	23.7	32.6
STEMI - 60	%	100.0	-	-	100.0	-	-	72.0	-	100.0	72.7	20.0	0.0	66.0
STEMI - 150	%	95.1	97.4	97.6	-	92.0	87.5	82.3	88.0	96.9	89.1	86.2	93.8	90.8
Stroke - 60	%	52.3	46.6	65.2	0.0	64.0	90.9	83.9	62.3	65.6	53.9	77.0	72.2	66.2
ROSC	%	16.7	11.9	19.1	0.0	26.7	15.7	23.5	18.4	26.7	28.7	26.2	13.3	21.1
ROSC - Utstein	%	22.2	42.3	38.5	-	43.3	21.6	43.2	25.0	46.4	60.0	44.0	31.8	38.9
Cardiac - STD	%	5.3	5.8	2.2	0.0	7.4	5.6	12.0	6.8	0.0	3.0	11.5	6.3	6.0
Cardiac - STD Utstein	%	25.0	23.1	15.4	-	21.4	13.5	33.3	0.0	0.0	20.0	12.0	18.2	16.5
Recontact 24hrs Telephone	%	11.7	0.0	14.1	0.6	3.9	21.1	40.7	13.2	2.5	24.3	30.5	26.8	16.5
Recontact 24hrs On Scene	%	6.4	4.3	4.5	0.7	4.0	7.8	5.8	4.8	2.8	8.9	4.3	7.5	5.1

It is encouraging to see GWAS is among the best performers (1st or 2nd) in several instances – for example in terms of the care given by our clinical crews when attending patients suffering a STEMI (82.4% - second best in the country) or a stroke (100% - joint best in the country). Also, for those patients suffering a STEMI, the 'gold standard' treatment now provided aims to ensure these patients undergo primary angioplasty at a specialist heart unit within 150 minutes of the initial 999 call – again, GWAS was the best performing ambulance service in April, achieving this for 97.6% of patients (albeit part of this measure will include a significant input from the receiving hospital).

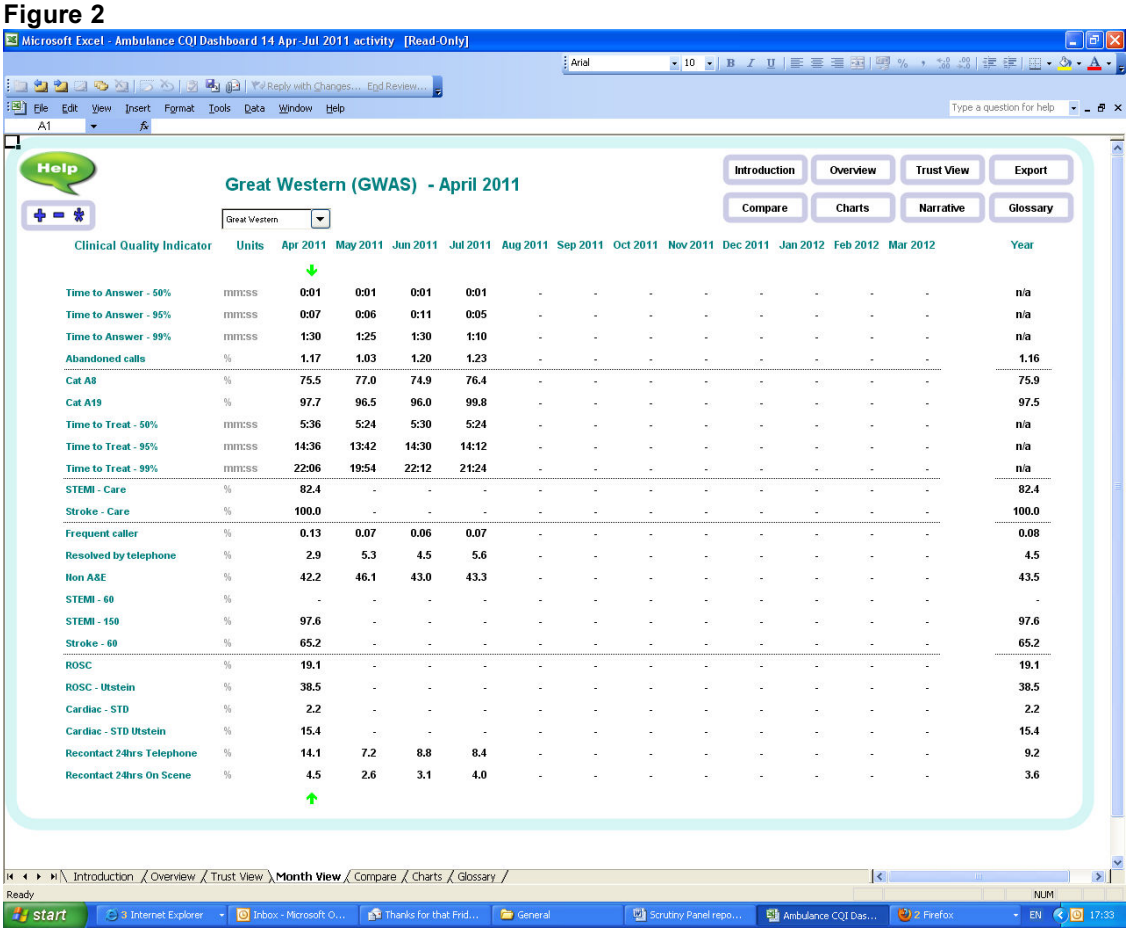
However, there are a couple of important 'health warnings' on this first set of clinical indicators:

- The ongoing value of them in terms of how ambulance services are improving the care they provide for patients will only start to emerge once there are several months' worth of data to compare;
- For some of the indicators – in particular the ROSC and cardiac arrest survival to discharge – the total number of cases is very low, so one or two cases can have a significant impact on the reported percentages.

Another important consideration to consider is that the majority of all the indicators (clinical as well as system) are not 'targets' in that there is no hit-or-miss threshold – the only exceptions being the 8-minute and 19-minute response standards to Red (Category A) 999 calls.

Figure 2 (below) provides a month-by-month indication of GWAS performance for system indicators from April-July.

Figure 2

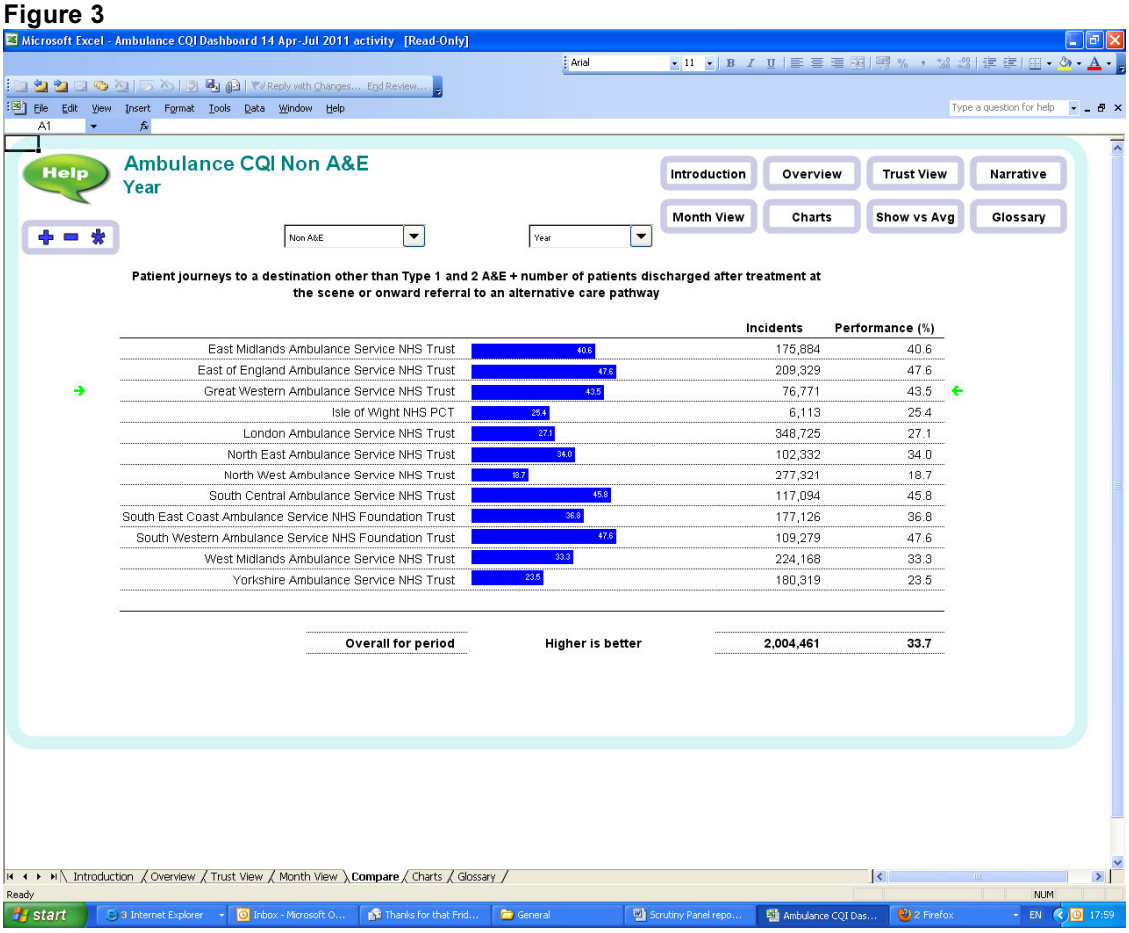


Clinical Quality Indicator	Units	Apr 2011	May 2011	Jun 2011	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Year
Time to Answer - 50%	mm:ss	0:01	0:01	0:01	0:01	-	-	-	-	-	-	-	-	n/a
Time to Answer - 95%	mm:ss	0:07	0:06	0:11	0:05	-	-	-	-	-	-	-	-	n/a
Time to Answer - 99%	mm:ss	1:30	1:25	1:30	1:10	-	-	-	-	-	-	-	-	n/a
Abandoned calls	%	1.17	1.03	1.20	1.23	-	-	-	-	-	-	-	-	1.16
Cat A8	%	75.5	77.0	74.9	76.4	-	-	-	-	-	-	-	-	75.9
Cat A19	%	97.7	96.5	96.0	99.8	-	-	-	-	-	-	-	-	97.5
Time to Treat - 50%	mm:ss	5:36	5:24	5:30	5:24	-	-	-	-	-	-	-	-	n/a
Time to Treat - 95%	mm:ss	14:36	13:42	14:30	14:12	-	-	-	-	-	-	-	-	n/a
Time to Treat - 99%	mm:ss	22:06	19:54	22:12	21:24	-	-	-	-	-	-	-	-	n/a
STEMI - Care	%	82.4	-	-	-	-	-	-	-	-	-	-	-	82.4
Stroke - Care	%	100.0	-	-	-	-	-	-	-	-	-	-	-	100.0
Frequent caller	%	0.13	0.07	0.06	0.07	-	-	-	-	-	-	-	-	0.08
Resolved by telephone	%	2.9	5.3	4.5	5.6	-	-	-	-	-	-	-	-	4.5
Non A&E	%	42.2	46.1	43.0	43.3	-	-	-	-	-	-	-	-	43.5
STEMI - 60	%	-	-	-	-	-	-	-	-	-	-	-	-	-
STEMI - 150	%	97.6	-	-	-	-	-	-	-	-	-	-	-	97.6
Stroke - 60	%	65.2	-	-	-	-	-	-	-	-	-	-	-	65.2
ROSC	%	19.1	-	-	-	-	-	-	-	-	-	-	-	19.1
ROSC - Utstein	%	38.5	-	-	-	-	-	-	-	-	-	-	-	38.5
Cardiac - STD	%	2.2	-	-	-	-	-	-	-	-	-	-	-	2.2
Cardiac - STD Utstein	%	15.4	-	-	-	-	-	-	-	-	-	-	-	15.4
Recontact 24hrs Telephone	%	14.1	7.2	8.8	8.4	-	-	-	-	-	-	-	-	9.2
Recontact 24hrs On Scene	%	4.5	2.6	3.1	4.0	-	-	-	-	-	-	-	-	3.6

The next two tables are linked in that the first (Figure 3) shows how well ambulance services are identifying those patients who can be treated without the need to be transported to an acute hospital emergency department (ED). EDs are traditionally one of the most expensive routes into the healthcare system, so identifying those patients who can be treated elsewhere – on scene by an ambulance clinician, or taken to a more appropriate location (eg a minor injuries unit or direct to a specialist hospital department) – is an important measure in ensuring ambulance services are contributing to a more cost-effective health service.

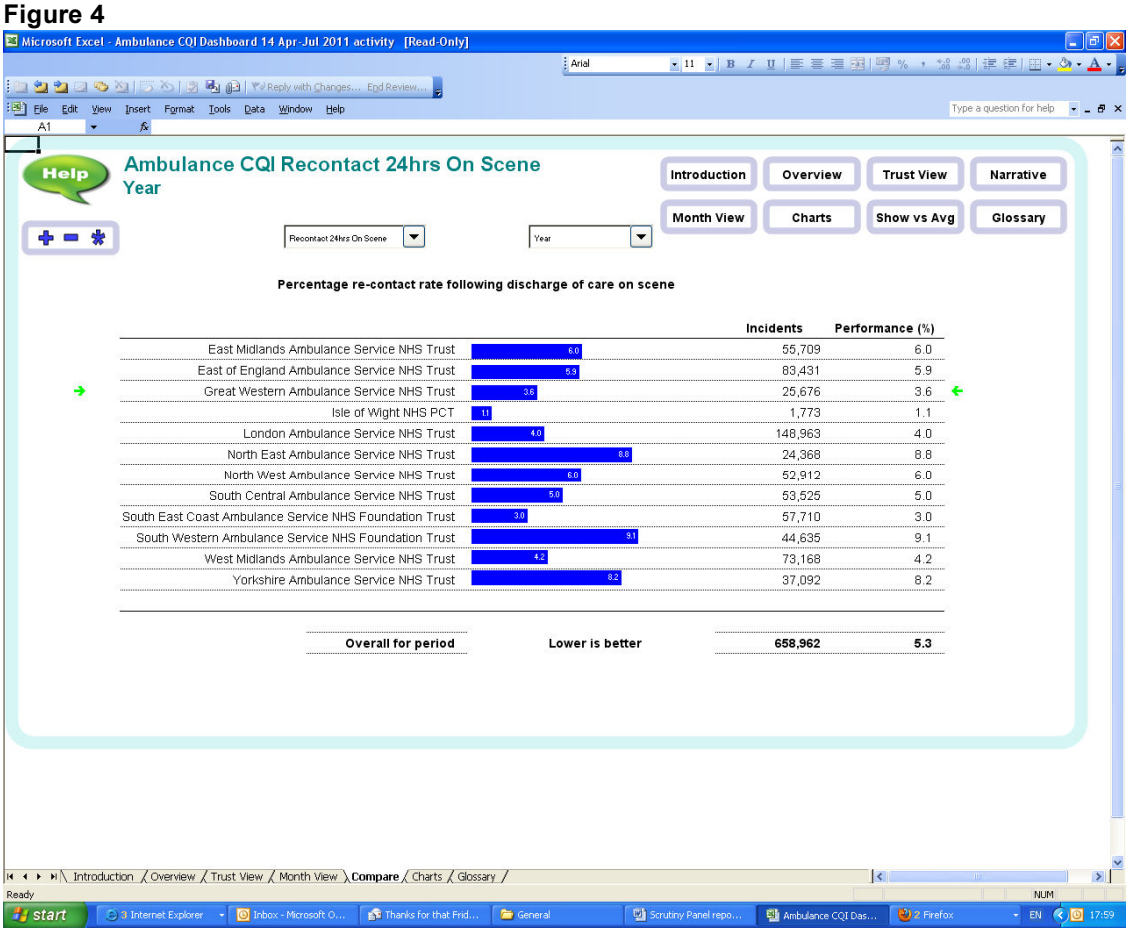
The specific data in Figure 3 shows that for the year-to-date (April-July), GWAS has been able to treat or convey 43.5% of patients without the need to take them to an ED – the third best performance.

Figure 3



Clearly the benefit – in terms of both value-for-money and patient care – of not taking those patients to an ED is undermined if they quickly come back to the healthcare system via the 999 service. Therefore Figure 4 (below) reports on the proportion of those patients who phoned 999 again within 24 hours of their first contact. Again, GWAS is among the best performers in the country with just 3.6% of those patients recontacting the 999 service. In other words, trust staff – clinicians on scene with patients and those who operate the clinical desk in our control room to provide advice on alternative destinations – are making appropriate decisions on which patients are suitable to be treated without the need to go to an ED.

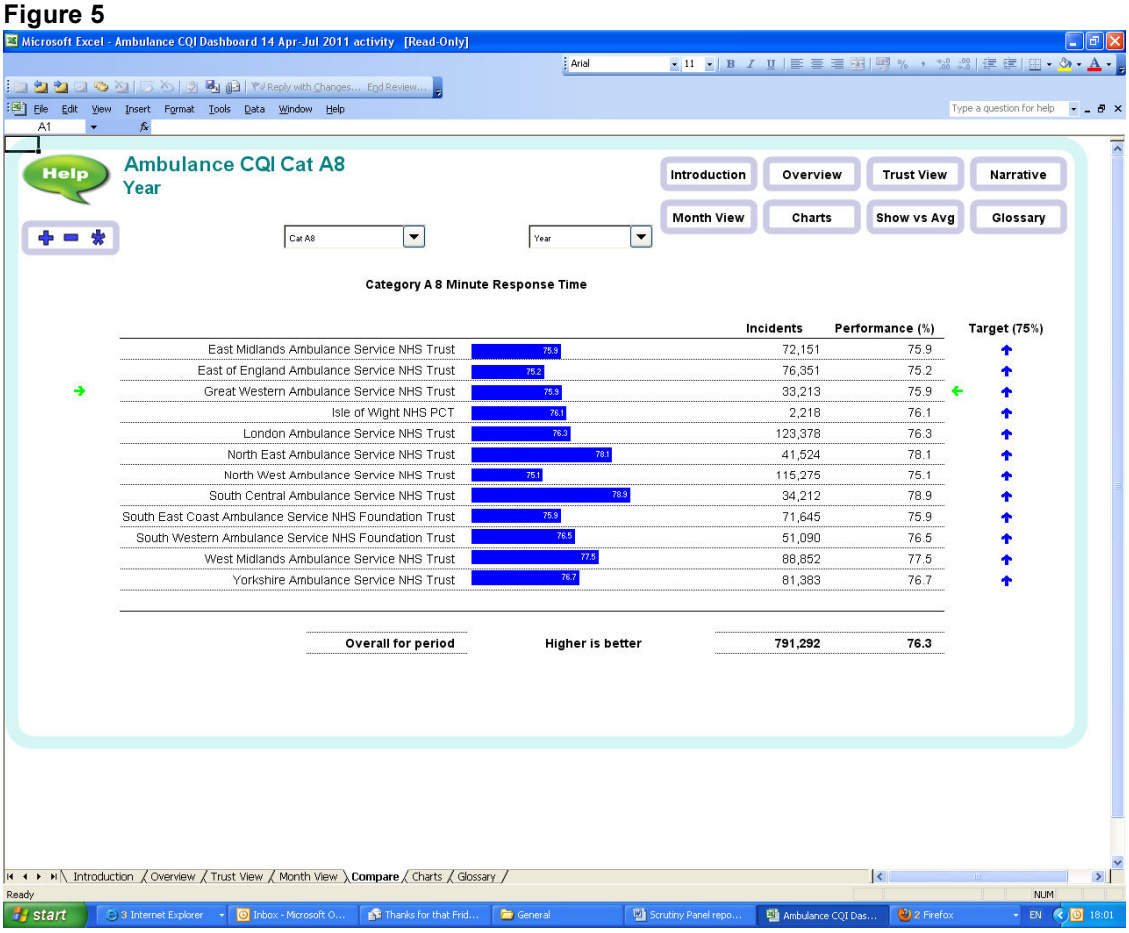
Figure 4



The final set of example tables shows the speed of response to immediately life-threatening 999 incidents. As previously mentioned, these are the only performance measures where there is a specific threshold ambulance trusts are expected to meet.

Figure 5 (below) shows ambulance service year-to-date (April-July) performance in terms of reaching patients within 8 minutes of the 999 call hitting the switchboard. The threshold of 75% is for each ambulance trust as a whole – and GWAS is currently achieving 75.9%. This initial response could be in the form of a paramedic or emergency care practitioner in a rapid-response vehicle, a double-crewed ambulance, a community first responder or fire service co-responder or a trained first-aider with a defibrillator.

Figure 5

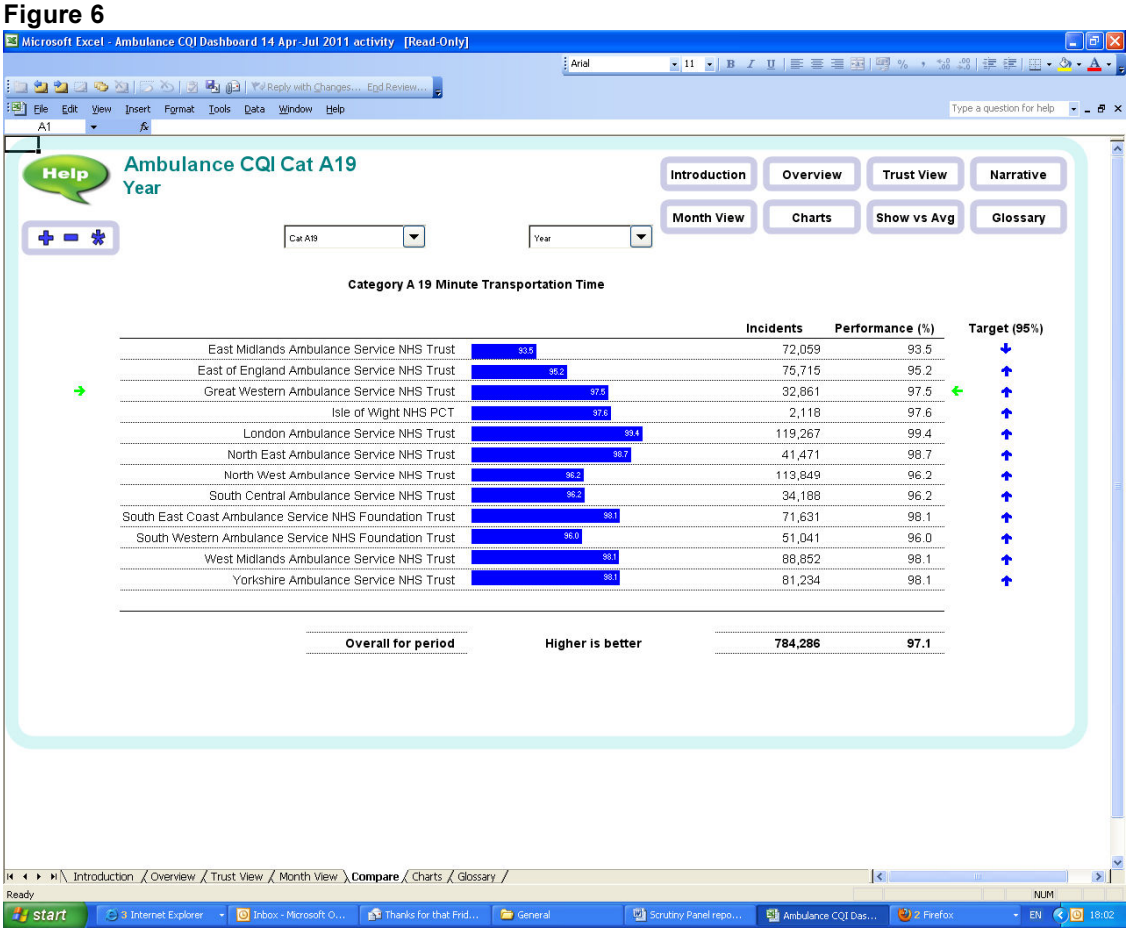


The data in Figure 6 (below) measures the secondary Red call threshold of ensuring an ambulance response capable of transporting a patient is on scene within 19 minutes of the 999 call on 95% of occasions – this will generally be a double-crewed ambulance or perhaps an air ambulance.

GWAS performance to date on this threshold is 97.5%.

While it is clearly encouraging that the trust is delivering on these specific thresholds – and as-yet unpublished data for August has further improved the year-to-date position, we are aware that it is important to ensure performance is in a strong position going into winter. The trust is again well-advanced on its preparations for severe weather – and these focus on ensuring we continue to deliver a safe and effective 999 service to all patients. That said, speed of response inevitably suffers during these periods – due to the longer call cycle of responding to and treating patients often suffering more acute conditions as a result of cold weather (typically breathing difficulties, chest pains, heart problems), while the physical act of driving a five-tonne ambulance at emergency speeds is clearly compromised by ice and snow on roads.

Figure 6



The local perspective

As mentioned previously, all the performance measures in the new clinical dashboard are applied to GWAS as a whole. Indeed, as also mentioned, several of these would not be statistically meaningful to be broken down into smaller areas due to the small numbers involved.

However, GWAS understands the desire of local communities and scrutiny panels to have an understanding of how we are delivering the emergency medical service in their areas. To that end, the following data represents a BANES-specific snapshot of some of the performance measures.

For the year-to-date, GWAS has responded to 2,767 Red (immediately life-threatening) 999 calls. Of these, there was a clinical presence on scene within 8 minutes on 76.5% of occasions, with the secondary 19-minute threshold being 95.5%.

The total number of 999 incidents GWAS has responded to within BANES so far this financial year is 7,759. Of these, 3,081 (39.7%) were treated without the need to transport patients to an ED. A further breakdown shows that 163 were assessed and treated over the phone - known as hear-and-treat – after the 999

call was transferred to either a clinician within the GWAS control room to assess or to NHS Direct. A further 2,186 patients were assessed and treated on scene by the attending GWAS clinician, with 738 other patients taken to a destination other than the ED.

The wider perspective

Panel members are no doubt aware of the GWAS announcement towards the end of August that the trust is seeking a partnership arrangement rather than looking to become a foundation trust in its own right. This was the decision of the trust Board which came to the conclusion that the size of the trust, and its previous financial and operational performance history, made it clear that attaining FT status on its own was not achievable.

Since then, South Western Ambulance Service – already a foundation trust – has publicly expressed its interest in seeking a partnership arrangement and discussions between the two trusts, along with the SHA, have continued throughout September. It is hoped we will be able to provide a verbal update at the scrutiny panel meeting.

Conclusion/recommendation

Members are invited to note the contents of this report, while representatives from GWAS will be present at the scrutiny panel meeting to address any issues they wish to raise.

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	October 7th 2011	**AGENDA ITEM NUMBER**
TITLE:	**Specialist Mental Health Service re-design**	
WARD:	ALL	
AN OPEN PUBLIC ITEM		

List of attachments to this report:

Appendix 1a – Care Home and Community Hospital Liaison plan and engagement

Appendix 1b – Impact Assessment

Appendix 2 – Primary Care Liaison

Appendix 3 - Recovery and Intensive services

Appendix 4 – Model of High Dependency In-Patient services

1 THE ISSUE

1.1 This paper sets out a single plan for modernisation of specialist mental health services in Bath and North East Somerset i.e. those provided by The Avon & Wiltshire Mental Health NHS Trust.

1.2 It covers a 3-5-year strategic approach to the transformation of services, setting out the policy and commissioning context, the vision for service development and detail of planned service changes.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

2.1 Implementation of a Care Home and Community Hospital Liaison service can progress, reinvesting resource currently attached to Ward 4, St Martin's Hospital.

2.2 Plans for the implementation of the Adult of Working Age services redesign are in line with local and national strategic intentions.

2.3 Agree the provision of mental health acute assessment and treatment services takes place in acute in-patient wards and Psychiatric Intensive Care Units rather than High Dependency Units.

3 FINANCIAL IMPLICATIONS

3.1 The redesign of specialist mental health services is taking place within the context of needing to deliver value for money NHS funded services that enable savings to be realised through improved pathways of care – The Quality, Innovation, Productivity and Prevention scheme. It is also impacted upon by the re-design of community social care services. There are, however, no direct financial implications for the council from these proposals.

3.2 It is recognised that in the current NHS financial environment service aspirations will need to be delivered with no overall increase in the recurring investment in mental health services. Service changes should be planned to maximised efficiency and improve experience, be cost neutral, or predicated on an 'invest to save' basis where time-limited funding is provided to bridge the transition to a new service model. The savings and reinvestments across the three areas are described below:

3.3 **Summary of new investments, by year**

Scheme	2011-12	2012-13	2013-14	Total Recurrent
Strengthen Intensive Delivery Services (formerly crisis teams)	40	40	0	80
Care Home and Community Hospital Liaison	42	42	0	84
Total	**82**	**82**	**0**	**164**

3.4 **Split of savings by QIPP and Reinvestments, by year (£000's).**

	2011-12	2012-13	2013-14	Total
~ QIPP	679	448	860	1987
~ reinvestment	82	82	0	164
~ risk share PICU/OOA	233	-	(233)	0
~ Savings Over/(under)	271	(63)	(291)	(83)
Total identified savings	1265	467	336	2068

4 THE REPORT

4.1 **The following commissioning principles and priorities**, as articulated in the B&NES Joint Mental Health Commissioning Strategy 2008-2012, have guided the development of local mental health services and informed the shape of the Avon and Wiltshire's Mental Health Partnership Trust's strategic plans in B&NES. They are:

- High quality, safe, effective services that work in partnership with GPs and other health and social care professionals: where the interests of B&NES residents comes first and foremost.
- Services are ageless and rapidly accessible. There is genuine health and social care join up.
- They are accessed increasingly through a single point of access that is primary care and community focussed. As such, early intervention and engagement is a routine hallmark.

- Where appropriate, treatment and brief interventions will also be provided in the community, not hospitals. This supports the existing range of home treatment, outreach and liaison services.
- Where hospital services are provided they are to operate to national best practise standards.
- Specific service aspirations envisaged by NHS B&NES are specialist services for those with ADHD, Aspergers and eating disorders (all in primary care settings) and the development of a 'Step Down' in-patient service for those currently placed out of area.

4.2 **The aims for the current service improvement plan** are that the people of B&NES will have:

- Access to specialist MH services in their local GP practices
- Rapid, highly specialist single assessments
- Treatment according to need: crisis intensive support for those in acute need; brief intervention in the community; or seamless transfer to a range of more specialist, longer term services, including in-patient where necessary.

These services will be:

- Demonstrably accessible, high quality, safe and effective.
- Recovery and re-enablement focussed
- Delivered as close to people's homes as possible
- Ageless – but appropriate to need
- Wherever possible, working with carers and the individuals who provide a wider network of support to people with mental heath difficulties.

4.3 **Summary of current provision and proposed changes**

4.3.1 The current service provision consists of:

Community Services

- 1 adult Crisis Service
- 1 adult Assertive Outreach Service
- 1 adult Early intervention service
- 2 adult CMHTs
- 1 older adult CMHT
- Acute hospital liaison at RUH
- OP liaison/in-reach to care homes and Community Hospitals

In-patient Services

- 23 acute mental health beds (Sycamore, at Hill View Lodge)
- 6 high dependency beds (Cherries, Hill View Lodge)
- 1.6 Psychiatric Intensive Care Unit beds (PICU) based in our specialist units in Bristol
- 5 Rehab beds at Whittucks Road
- 20 older adult beds for dementia at St Martin's Hospital.

4.3.2 The current provision is in place following previous modernisation programmes**.** Work to modernise and redesign the Adult Community and Inpatient services took place between 2004 and 2007 and saw the implementation of Assertive Outreach teams, Early Intervention teams and Crisis Resolution and Home Treatment teams with the with the eventual reduction in 2007 of adult inpatient beds. A significant amount of work has since been undertaken between the PCT and Trust in 2008/09 to modernise older adult services. This resulted in a strengthening of community, liaison and home treatment services for older adults and a concomitant transfer of services from in-patient settings to the community. Ward 2 was closed, reducing beds from 37 to 20.

4.3.3 **Work to further modernise adult and specialised services to create a portfolio of Services for B&NES has been under development using the guiding principles set out above.**

These service developments include:

- Comprehensive **in-reach service in care homes and community hospitals** – providing assessment and on-going treatment and care for older adults with mental health problems in residential settings (see Appendix 1a and associated Impact Assessment Appendix 1b)
- Comprehensive **primary care liaison services** – providing expert advice to GPs on management of patients; as well as specialist (and sometimes joint e.g. IAPT) assessment and allocation to either brief intervention or structured treatment services for those with secondary care and complex needs (see Appendix 2).
- Enhanced community services – **Intensive Services** for those in acute crisis and **Recovery Services** – care planning and review for those with longer term treatment needs (see Appendix 3).
- Strengthened **A&E and Ward Based Liaison in RUH** – all age assessment and referral services in A&E and treatment services for people on acute wards to manage mental health difficulties and reduce potential delayed transfers of care.
- An expanded **Early Intervention Team** – designed to engage with young adults in a range of community settings and manage emerging psychoses.

4.3.4 In the current financial climate, commissioners and AWP are fully signed up to making these changes either cost-neutrally (through redesign of services and efficiencies) or through re-patterning of services (e.g. changing the service model from one reliant solely on in-patient services to more community models). In all cases, the question of service quality (safety, effectiveness and the evidence-base) and levels of access has primacy. Therefore, it is through changes to the following services that we wish to release money for re-investment:

- **Further reduction of 8 older adult dementia beds (2012-13)**
  B&NES is not using more than 59% of its commissioned capacity on Ward 4. It is therefore more efficient to reduce the staffing and ward size down to match levels of demand observed over the past 18 months (see Appendix 1a and 1b)
- **Re-provision of the six High Dependency (HDU) beds into the acute ward (2011-12)**
  The HDU model of care has been recognised by both commissioners and the Trust as sub-optimal. There has been no national evidence-base for this model, providing as it did an intermediate step between acute and PICU that was hard to define. Commissioners have therefore been working with AWP for some time to discuss how to best provide high quality acute in-patient services according to best practice and evidence (Appendix 4).

  During this period there has been some significant structural damage to the unit leaving it unsuitable for service users and service users requiring inpatient treatment have either been cared for within an acute admission ward, Sycamore, or within a Psychiatric Intensive Care Unit (PICU) according to individual needs.

  We have noted that during this time, there has been no additional demand for external (to AWP) PICU places and bed occupancy has remained within national standard rates (for the last year in fact). With the enhanced staffing level and skills on the acute ward from the staff previously working on the HDU and more fully supported crisis services it is envisaged that all in-patient need can be managed within the existing local acute beds and 1.6 PICU beds. (This will be subject to ongoing review regarding PICU capacity.)

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 A corporate equalities impact assessment has not been completed for the whole of the programme because the service delivery is not altered, rather it is the structural arrangements for the delivery of health services that have been improved.

6.2 However, as part of the NHS engagement and impact assessment processes for re-investment of older adult in-patient beds into the community, the equalities impact was assessed by both staff and stakeholder groups. The only potential adverse impact was related to some people, who are not B&NES residents, being delayed discharges from Ward 4 beds and the effect that can have on them and the resultant local NHS treatment and Assessment bed availability for B&NES clients.

6.3 The potential adverse impact from delayed discharges is mitigated by:

- AWP developing a primary care liaison model that will be involved much earlier in the care pathway processes across all area's and avoid out of area admissions wherever possible thereby improving the patient experience.

- AWP Care Home liaison service will work with providers to increase their confidence in dealing with changes in care needs at home rather than through admission.

- If out of area admissions for assessment do occur then AWP will implement their return to area policy as soon as possible.

- The mental health commissioners liaising with other surrounding local authority commissioners to explain our community centred model and the latest developments in order for them to plan their pathways and improve, where necessary, their discharge processes.

- The NHS 6 PCT/AWP Modernisation Board will discuss all NHS service changes and QIPP initiatives, including B&NES, and monitor the implementation effects so that front line staff can manage their caseloads, care pathways and capacity differently on an informed basis. (In some cases this will mean implementing a model similar to the one that has been successful in B&NES.)

7 CONSULTATION

7.1 Trades Unions; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners; Section 151 Finance Officer; Chief Executive; Monitoring Officer

7.2 There has been engagement with AWP staff over the last 6 months through newsletters and meetings this includes engagement with the integrated team. Redesign proposals for adult community services is commissioner led and representation from service users via an AWP wide Modernisation Board is provided via B&NES joint funded Service User Reference Group. Development plans have been presented to the Professional Executive Committee of the PCT and the Mental Health Modernisation Project Board and associated pathway group. The Mental Health Provider Forum and Voluntary Sector Network are also aware of the proposals.

7.3 An engagement event took place regarding the reduction in older adult beds and the shift of resource into new community services with both staff and stakeholders. The feedback from these events was very positive.

7.4 Further meetings are planned with the GP Forum Plus (October 19th 2011), Voluntary Sector Mental Health Network (November 3rd) in addition to the ongoing meetings and engagement above. In addition there will be a 3-month formal staff consultation for the service redesign, delivered by AWP.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Human Resources; Health & Safety; Impact on Staff

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Council Solicitor), Head of Paid Service, Strategic Director and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Andrea Morland, Associate Director Mental Health and Substance Misuse Commissioning 01225 831513
Background papers	*Equity & Excellence: Liberating the NHS (DH 2010)*, sets out ambitions to make primary care the nexus of health care planning, commissioning and delivery, with acute/secondary care services restricted for those with the most severe conditions. Care close to home is emphasised, as is a focus on clinical outcomes and the patient experience. *The Transforming Community Services (DH 2010)* program states that Community services are changing to provide better health outcomes for patients, families and communities and to become more efficient; by providing modern, personalised, and responsive care of a consistently high quality that is accessible to all. *No Health without Mental Health (Royal College of Psychiatrists & Academy of Medical Royal Colleges 2009)* The report recommends that Primary Care Practitioners become more skilled in the identification of symptoms, especially depression, anxiety and cognitive impairment in people with chronic physical illnesses; adding that Primary Care Developments need to include the timely availability of specialist mental health advice & support. *Age Consultation 2011 (Equality Act 2010:* Ending age discrimination in services, public functions and associations).This means that any age-based practices by the NHS and social care would need to be objectively justified, if challenged. *Bath and North East Somerset Joint Mental Health Commissioning Strategy 2008-2012*
Please contact the report author if you need to access this report in an	

alternative format

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Appendix 1a

In-reach service in care homes and community hospitals plan
(This is supported by an initial detailed proposal presented to B&NES/AWP Project Board in June 2011)

1. Background

In 2008 a significant amount of work was undertaken between the PCT and the Trust to modernise older adult services. Ward 2 at St Martins Hospital was closed, reducing beds from 37 to 20. This enabled a strengthening of community, liaison and home treatment services for older adults and a concomitant transfer of services from in-patient settings to the community. It has also had a marked effect on ward based activity as described below.

1.1 Ward Activity levels

Following the strengthening of older adults' community services, Ward 4 at St Martins Hospital has been running at, on average, 75% (15 of 20 beds) occupancy during 2010/11. NHS B&NES use 59% (12 of the 20 beds) and the balance is used by other PCTs (3 of the 20 beds). (See table) This represents over capacity in the system.

A Summary of In-patient Activity - NHS B&NES

APPENDIX 1 - OPERATIONAL PERFORMANCE DATA

B&NES - INPATIENT USAGE DURING 10/11					OBDs	
BATH AND NORTH EAST SOMERSET PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	3630	59%
BATH AND NORTH EAST SOMERSET PCT	OP NSom IP Cove	Older Adult	OBD	Inpatient	73	
BATH AND NORTH EAST SOMERSET PCT	OP Bristol IP Laurel	Older Adult	OBD	Inpatient	11	
BATH AND NORTH EAST SOMERSET PCT	OP Wilts IP Charter House	Older Adult	OBD	Inpatient	150	
BATH AND NORTH EAST SOMERSET PCT	OP Wilts IP Amblescroft North	Older Adult	OBD	Inpatient	81	
BATH AND NORTH EAST SOMERSET PCT	OP Bristol IP Aspen	Older Adult	OBD	Inpatient	299	
BATH AND NORTH EAST SOMERSET PCT	OP Swindon IP Hodson	Older Adult	OBD	Inpatient	15	
					4259	
The 1011 users of St Martins						
BATH AND NORTH EAST SOMERSET PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	3630	
BRISTOL PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	194	
NORTH SOMERSET PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	27	
SOUTH GLOUCESTERSHIRE PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	469	
SWINDON PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	27	
WILTSHIRE PCT	OP BANES IP Ward 4	Older Adult	OBD	Inpatient	389	
					4736	76%
NB						
1. An Operational bed days relates to 85% of 365 days per annum =					310.25	
2. St Martins has 20 operational Organic beds, total capacity			20	310.25	6205	100%

1.2 Length of stay

For the 67 admissions prior to end of May 2011 the average length of stay was 8.67 weeks. This includes 3 Delayed Transfers Of Care of 26, 29 and 39 weeks. If these 3 admissions are excluded the average length of stay reduces to 7.6 weeks. The aspiration of the Older Person's services is to reduce this to 6 weeks. This will be achieved through improved coordination with community teams, more proactive and timely inpatient assessments and treatment and better discharge planning.
As AWP move from a commissioning environment with an emphasis on bed numbers to one based on defined episodes of care this will further focus attention on the inpatient pathway leading to additional inroads into length of stay.

It is to be remembered that the AWP inpatient model will view the total bed resource within older people's services as a resource pool to be used flexibly in the event of unexpected peaks and troughs.

1.3 B&NES use of out-of-area beds.

Analysis of activity shows that there were only fifteen admissions of B&NES patients to beds in other parts of AWP during 2010/11.

Eleven of these admissions were in respect of older people with functional mental health problems who would not have been admitted to Ward 4. Currently there are only three beds available at Hillview Lodge for older people with mental health problems and inevitably there will be occasions when there will be capacity issues. The transition towards age-less services in AWP should offer the opportunity more equitable access to beds at HVL in the future.

In 2010/11 four B&NES dementia patients were admitted to other dementia units in AWP. Three of these patents were admitted elsewhere because Ward 4 was closed to admissions due to D & V. All these patients were transferred to Ward 4 when it reopened. One patient was admitted to a Bristol bed at Callington Road because there was no female bed available on ward 4. This patient was discharged after a few days before transfer to Ward 4 could be arranged.

2. Financial effect of releasing current un-used beds capacity into re-investment

It is estimated by reducing the capacity of the ward from 20 to 12 beds the running costs could be reduced by £184k. In order to support this reduction in beds the Trust is proposing the development of a Care Home Liaison Service (CHLS).

3. Service developments

3.1 What the Care Home Liaison Service will offer:

'A "Dementia Quality Mark" for care homes is being developed and piloted in the South West and B&NES is doing well in engaging local care homes in the initiative. This CHLS model would go some considerable way in further supporting this move. The developments within the B&NES Community and the move towards sheltered housing and supporting people in their own homes to maintain independence meant that staff in care homes are working with clients with increasingly complex mental health needs.

A Care Home Liaison service would support and educate staff to meet the challenges resulting from these changes and demands. The team would serve to carry out prioritised assessment, deliver consultation and advice, facilitate case discussions, disseminate information at carer/relative groups and deliver educational programmes that support staff to meet the mental health needs of the residents in

their care. This would enable care homes to feel more confident at managing complex service users with support, and would therefore prevent placement breakdown and re-admission back to hospital, or on to a different placement – often at much higher cost to the individual or the Council (£750 – £900pw).

The key priorities in mainstream services are to change attitudes and improve skills in detection and assessment of mental illness, and equip staff with guidance on initial management and referral pathways to appropriate other services. By educating and empowering staff, the Care Home Liaison Service has a significant role in addressing these points, and makes an important contribution to the provision of quality care for older people with mental health needs.

In B&NES we have seen the benefits from the establishment of the Intensive Support team in 2009 brought about as a result of the reinvestment of resources released from the closure of Ward 2. The IST has helped to prevent some unnecessary admissions to Ward 4 and has helped to facilitate more timely discharges in some circumstances. Any subsequent development of a care home liaison service in B&NES would work closely with the IST to potentially make further improvements to these processes.

3.2 Community Hospital Liaison

NHS B&NES would also like to increase the community hospital liaison capacity working alongside the Acute Hospital Liaison Nurse at the RUH. This is vital to enable people to return home or to ongoing support accommodation.

Next steps

Share the proposal to reinvest money released from bed reduction into Community Hospital and Care Home Liaison services via completion of an impact assessment and engagement process with local staff and stakeholders.

Present resultant papers to the Wellbeing Policy Development and Scrutiny Panel.

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Appendix 1b

REPORT TO THE WELLBEING POLICY DEVELOPMENT AND SCRUTINY COMMITTEE AT BATH AND NORTH EAST SOMERSET COUNCIL

PROPOSED CHANGES TO: Ward 4 bed base, St Martin's Hospital

Prepared by:

- Andrea Morland, Associate Director Mental Health and Substance Misuse, B&NES Joint Commissioning Team
- Julie Warner, Operational Services Manager, Liaison & Later Life SBU, Avon and Wiltshire Mental Health Partnership Trust.
- Alison Griffin, Head of Engagement and Responsiveness, Avon and Wiltshire Mental Health Partnership Trust

Date: October 7th 2011

DECISIONS REQUESTED

The PDS is requested to determine whether the proposed service change outlined in this paper constitutes a substantial variation or development*. (N.B. a substantial variation is a proposed major change in healthcare provision.)*

PART ONE – Description of proposed service changes

1. The current service

Currently in B&NES we have 20 beds provided on Ward 4 at St Martin's Hospital for people with dementia.

We have community mental health teams, an intensive support service and a therapies team. These teams were developed and strengthened using investment from closing what were then underutilised beds in 2008 – the bed base reduced at this point from 40 to 20 beds which reflected actual use.

During the following 2 years we have seen bed usage for B&NES clients at St Martin's fall even further as the teams have become embedded and admissions have been avoided.

1a. Admission rates on Ward 4 2010/11

During 2010/11 B&NES patients accounted for 3630 of the 6205 available bed days on Ward 4. This is 59%. This equates to 12 beds.

To date during 2011/12 the **total** admission rate on Ward was 76%. This includes 17% of patients from *outside* B&NES. Therefore B&NES admission rate is at 59%.

B&NES use of out-of-area beds.
Analysis of activity shows that there were only fifteen admissions of B&NES patients to beds in other parts of AWP during 2010/11.

Eleven of these admissions were in respect of older people with functional mental health problems who would not have been admitted to Ward 4.

In 2010/11 four B&NES dementia patients were admitted to other dementia units in AWP. Three of these patents were admitted elsewhere because Ward 4 was closed to admissions due to D & V. All these patients were transferred to Ward 4 when it reopened. One patient was admitted to a Bristol bed at Callington Road because there was no female bed available on ward 4. This patient was discharged after a few days before transfer to Ward 4 could be arranged.

2. What are the proposed service changes

We would like to repeat the process we carried out in 2009 and develop new community services with the money released from the under-utilised beds. We can use the money released from the beds to develop a care home and community hospital liaison service in the community to support and train staff in those facilities to provide the best care.

We would also like to improve the ward environment on ward 4 – which releasing space taken up by the beds would help us achieve.

There would be no change in location of services or the way in which the services are accessed.

2a. Care Home Liaison

The developments within the B&NES Community and the move towards sheltered housing and supporting people in their own homes to maintain independence means that staff in care homes are working with clients with increasingly complex mental health needs.

The team would serve to carry out prioritised assessment, deliver consultation and advice, facilitate case discussions, disseminate information at carer/relative groups and deliver educational programmes that support staff to meet the mental health needs of the residents in their care. This would enable care homes to feel more confident at managing complex service users with support, and would therefore prevent placement breakdown and re-admission back to hospital, or on to a different placement – often at much higher cost

‘A “Dementia Quality Mark” for care homes is being developed and piloted in the South West and B&NES is doing well in engaging local care homes in the initiative. This CHLS model would go some considerable way in further supporting this move.

The key priorities in mainstream services are to change attitudes and improve skills in detection and assessment of mental illness, and equip staff with guidance on initial management and referral pathways to appropriate other services. By educating and empowering staff, the Care Home Liaison Service has a significant role in addressing these points, and makes an important contribution to the provision of quality care for older people with mental health needs.

2b. Community Hospital Liaison

NHS B&NES would also like to increase the community hospital liaison capacity working alongside the Acute Hospital Liaison Nurse at the RUH. This is vital to enable people to return home or to ongoing support accommodation

3. Why are these changes being proposed?

- In order to improve the experience of people with dementia living in residential homes and thereby improve the outcomes for people living in care homes.
- To improve the skills and confidence of staff working in care homes.
- To reduce admission to hospital or moves to nursing home provision from residential.
- To fulfil the aims of the B&NES Commissioning strategies to enable B&NES older citizens to stay in their homes and receive local services.
- To address any inequity that exists for older people with dementia by training staff to identify and treat dementia without it meaning a move of residence.
- To make best use of the financial and staff resources by releasing some of the money for re-investment into effective service development and provision. 50% of the savings approximately will go into the main NHS savings schemes in order to meet these national savings targets and to be available for investment in other aspects mental healthcare.
- A risk is that with an unexpected peak in demand the bed base would not be big enough and we would have to use out of area assessment and treatment facilities

4. Rationale - There are other options that could be explored in relation to the over capacity in the bed base

- **Keep the bed base at 20 beds**

This would keep finances tied up in a bed base which is currently not being used by the population of B&NES, and which data shows is consistently under used and therefore does not present a good value for money option. This option would facilitate other out of area clients access to beds

- **Take all the savings into the PCT central NHS savings schemes**

This would not meet the quality, improvement and productivity requirements in B&NES to support the care home sector and meet our strategic aims outlined above for older adults with mental health problems. Without supporting care homes, there is a risk that there would be a further reliance on in-patient services which would not be in the best interest of the service users.

Invest the money in the liaison service in the RUH

NHS B&NES have already invested significantly in liaison services in the RUH and investment is being sought from other service areas to enhance the current resource.

We therefore believe this would not be the most appropriate area for investing these resources.

5. Summary of involvement outcomes

As confirmed in Part 2 and 3, the outcomes of involvement is that the proposal to repeat our successful approach from 2009 and reinvest money released from under-utilised bed base in community services is welcomed

6. Timescales

Once agreement has been reached regarding the reduction of beds on Ward 4 from 20 to 12, the team will plan the reduction with careful consideration to all the service users to ensure that all service users are able to complete their in-patient assessment in a full, consistent and appropriate way, with beds being reduced one by one as they become vacant. This will be planned between the in-patient and community team to ensure that nobody is displaced through this process. We would also need to take into consideration the group of people currently occupying the beds who are non B&NES people. Again we would need to ensure that whilst we did not displace these people & create a problem with their assessment process, we would also need to ensure engagement with their 'home' team to enable return as soon as possible (this may mean transfer to another in-patient unit or return to the community setting)
We would expect to be able to complete this process within 8 weeks.

7. Additional information

Commissioners are currently working on specifications for a primary care liaison services for all adults with mental health problems in B&NES and a strengthened all age crisis response service which will provide additional support in the community for adults of all ages.

In addition the commissioner for long term conditions is working with colleagues to further development the liaison service that works into the RUH – which has been very successful in B&NES but would benefit from increased capacity if possible.

We are also in discussions around the possibility of formalising the arrangements for GP support into care homes in the area which would further support the liaison model and provide holistic joined up services.

8. Does the NHS consider this proposal to be a substantial variation or development?

No – there is no reduction in service in relation to the bed base but a releasing of monies for reinvestment into service development that meets both strategic, patient and operational aspirations.

PART TWO – Patients, carers and public representative views – summary of the potential impact of proposed service changes

Patients, carers and public representatives are asked to comment on the following areas, in relation to the proposed service changes detailed in Section 2:

Benefits of the proposed service changes	**Ward 4** More therapeutic space, opportunity to change environment if less beds on ward. Only B&NES population using the beds. Change of practice would reduce number of admissions and allows more care in the community. **Care home liaison** Reduced numbers of service users coming back to hospital from care homes if more support is in the care home. More stability for the service user. More cost effective. Help care homes know criteria for admission – less service users coming back to St Martins. More person centred. Improve quality of care. **Community Hospital Liaison** Physical and mental health catered for – whole person approach. Opportunity to talk to a person not an automated call. More time to get to know patients and their families.
Any disbenefits, including how you think these could be managed	Length of stay - for care homes needs to be agreed. Reduction of resources on ward will need to be managed. Supervision – small team.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	No changes to location. Should make access to a hospital bed when needed much easier.
How do you think the proposed changes will affect the quality of the service	Shouldn't change the quality of the service. More therapeutic space. More resources to tap into care home liaison. AWP staff available to train staff in care homes. Speedier referral and assessment.
Impact of the proposed changes	Need to protect the remaining beds

on health inequalities	for B&NES residents. If all patients are B&NES patients this will provide a more accurate reflection of care provided and improve communication.
Any other comments	Care liaison – could carers self refer?
If you are a representative of an organisation, such as LINKs, please indicate how you have drawn on the views of others from your group	Meetings and discussions. Sharing information.

PART THREE – Impacts at a glance

Impacts	***NHS View***	***Patient/carer/public representatives' view***
Impact on patients	● = positive impact	● = positive impact
Impact on carers	● = positive impact	● = positive impact
Impact on health inequalities	● = negative impact for some	● = negative impact for some
Impact on local health community	● = positive impact	● = positive impact

● = significant negative impact
● = negative impact for some
● = positive impact

GLOSSARY

- list definitions of any technical terms, acronyms etc

Appendix 2

Primary Care Liaison Service (PCLS)
Commissioners are developing a specification for all PCTs across AWP with local variation possible.

1. Background

As part of plans for redesign and modernisation of community services, the Trust has consulted widely with GPs, service users, carers and commissioners about the best ways to ensure seamless access for assessment and, where indicated, brief treatment. This has been combined with feedback from patient surveys, praise and complaints which coalesces around a need for the Trust to have much greater visibility in primary and community settings, offering expert advice (pre-referral) and assessment, with rapid access to treatment according to need. This proposal builds on pilot work conducted in 2010/11 by the older adult SBU in South Gloucestershire and Swindon and the Primary Care Eating Disorder Service in Bristol (see appendix 3).

2. What the Primary Liaison Service will offer:

- **Advice and support** for primary care staff to manage patients' mental health needs and determine whether a formal assessment is necessary
- **Triage and full assessment** for all those referred by GPs
- **Treatment** according to need:
  - **Signposting, advice and onward referral** (straight to the secondary care service where this is clinically indicated)
  - **Brief intervention:** up to six sessions with a qualified MH practitioner
  - **Allocation to structured/on-going treatment** – into one of the secondary care treatment clusters with associated evidence-based care packages.
- **Management of discharge and step-down** planning back to full primary care/GP management of service users.

Services will be provided in the community in GP practices and other settings, by negotiation, and by fully qualified mental health practitioners.

The key issues for B&NES are:

- Continuing to improve access and communication – initial ideas revolve around how the PCLS can relate to the GP Clustering arrangements in B&NES and this will be discussed in development.
- The relationship with IAPT services and the need to ensure a smooth and realistic pathway for service users.
- The relationships between the PCLS and community services – both mental health and mainstream heath ad social care services provided by the new Community Interest Company form October 2011.

For B&NES, the following volumes of existing primary care referrals for assessment and brief intervention are anticipated to transfer to this new 'front end' service:

Adults of a Working Age

Outcome of referral (excludes referrals that are open, but have not yet been seen) - external only

Referrals and outcome (% and number in brackets)	Q4 9/10	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11
% Screened and discharged	40% (89)	41% (88)	37% (87)	41% (89)	36% (89)
% Assessed (face to face) and discharged	18% (39)	23% (49)	19% (45)	18% (40)	20% (49)
% Requiring brief intervention (six face to face contacts or less)	27% (60)	25% (54)	32% (74)	31% (68)	38% (93)
% Requiring substantial intervention (more than six face to face contacts)	15% (32)	12% (25)	12% (27)	10% (22)	6% (16)
% Open and awaiting assessment	0% (0)	0% (0)	0% (0)	0% (0)	0% (1)

Older Adults

Outcome of referral (excludes referrals that are open, but have not yet been seen) - external only

Referrals and outcome (% and number in brackets)	Q4 9/10	Q1 10/11	Q2 10/11	Q3 10/11	Q4 10/11
% Screened and discharged	21% (19)	28% (37)	16% (25)	25% (41)	18% (32)
% Assessed (face to face) and discharged	18% (17)	17% (23)	21% (32)	18% (30)	18% (32)
% Requiring brief intervention (six face to face contacts or less)	23% (21)	27% (36)	26% (40)	31% (51)	47% (82)
% Requiring substantial intervention (more than six face to face contacts)	38% (35)	27% (36)	35% (54)	25% (41)	16% (29)
% Open and awaiting assessment	0% (0)	0% (0)	1% (2)	0% (0)	1% (1)

3. Development: next steps

Proposals are being developed by Commissioner and GP colleagues during August/September 2011 for discussion with AWP. Subject to approval and amendment as a result, it is envisaged that this service would be ready to implemented during quarter four of 2011-12, dependent on local discussions to tailor the model to existing local access points and primary care services. It represents a transfer of existing resource from CMHT-type services (assessment and brief intervention functions) and as such is expected to be cost-neutral. Any efficiencies generated will be discussed with Commissioners and GPs with a view to them being used to support other service developments in 2012-13 and beyond.

Key Contact: Denise Claydon, Avon and Wiltshire Mental Health Partnership Trust

Appendix 3

Enhanced community services: Intensive Service and Recovery Service

Intensive Service

- All of the CRH teams, including the B&NES team, have for many years not been able to balance the need to offer urgent and emergency assessments, with the requirement to offer home based interventions as an alternative to admission. Many service users assessed by the CRHTs are not taken on to the caseload following assessment.
- Resolving that situation requires a system wide approach, meaning that in the future urgent assessments will be undertaken by Primary Care Liaison (PCL) services, with emergency assessments being undertaken by Intensive teams.
- This should mean that a higher proportion of the service users being referred to the team are then taken on to require Intensive interventions, meaning that more service uses will be offered alternative acute intervention than a hospital admission.
- To ensure that service users are not disrupted in their experience of care the Intensive service will 'wrap-around' the Recovery service i.e. work in partnership in cases requiring Intensive intervention
- The vision for the service is that it will intervene proactively with service users who are experiencing an acute episode of mental ill health and where possible offer an alternative to admission, or enable service users to leave hospital earlier then would be possible without their intensive intervention.
- Within B&NES it is planned to improve the night service from on-call to a 'waking' service. In B&NES this expansion will require additional investment of £80k. This extension will enable the team to deliver all aspects of its acute service throughout a 24 hour period.
- The Intensive team will be the service that assess when risks can no longer be managed in the home environment and admission to hospital is required. The Intensive team are therefore also required to assess when those risks have been mitigated and intensive home intervention can re-commence.
- It is likely that this kind if intervention will be required for people in care clusters 4, 5, 8, 14, 15 and 17 (likely volumes in each to be confirmed).
- Within B&NES the Intensive service will work closely with PCL to improve the out of hours services currently provided at the Emergency Department of the RUH

Recovery Service

- Within B&NES this service will provide ongoing assessment and, a comprehensive, multidisciplinary, interventions-focused service to individuals who are assessed as needing the ongoing involvement of a specialist mental health service.
- The service will use a shared caseload approach and retains the capacity, within one team, to step up or down the level of service provision according to the presenting need, up to and including the Assertive Outreach function.
- The vision for the service is that service users will have improved outcomes in their mental health, and social functioning through experiencing therapeutic interventions in this service. This will be achieved by adopting a recovery and outcome focussed philosophy

- The service has been planned to deliver episodes of interventions to service users, and therefore will move away from the historical model of some service users have lengthy, even lifetime contact with specialist mental health services.
- The skill mix of the recovery service has been planned to allow a higher proportion of service time to be available to deliver therapeutic interventions in line with NICE guidance.
- The recovery services will be available Monday- Friday 8am-8pm, to support the inclusion of service users in employment and training, as well as to offer wider choice to service users about accessing mental health services.
- By moving away from lengthy contact for service users with services, the aspiration of the service is to deliver interventions to more people requiring support with their mental health.

Development: next steps

- Quarter 2 2011 - Finalisation of service model and re-investment with commissioners
- Quarter 3 2011- Workforce process commenced to facilitate new model
- Quarter 3 2011- Business Continuity Plan developed and enacted to maintain service quality and safety through change process
- Quarter 4 2012 - Service Go-Live

Key Contact: Fiona Davies, Service Director and Justine Faulkner, Clinical Director

Appendix 4

Proposal to develop the model of delivery for High Dependency In-Patient services

1. Purpose of the Report

To describe the potential model of service provision that could be developed by replacing the existing High Dependency Units (HDU) with the appropriate use of Psychiatric Intensive Care Unit (PICU) beds and improved in-patient care management which will provide care to service users within a nationally determined governance framework. This change to practice would bring AWP service into line with nationally determined best practice, and ensures that service users will be treated either on acute wards or on PICU wards according to their clinical need.

2. Background

2.1 Ten years ago the first ever NHS National Service Framework for mental health was published, setting standards for the way people with mental illnesses should be diagnosed and treated. It led to significant investment in mental health services and a set of nationally prescribed models of care to ensure the best outcomes for people.

Today, expectations are more ambitious and go beyond simply treating mental ill-health. Commissioners and providers of services aim to deliver mental health services which offer real choice to the people who use them, support them in their recovery and enable them to maintain mental well being. Services outside hospital are continuing to develop so that they offer consistent and high quality support close to people's homes, including help to stay at work and to participate fully in their local communities

The B&NES Commissioning Strategy for Mental Health, in line with modern mental health care practice, is based on the premise that care for serious mental illness is best delivered to people in their own homes, with medical and other care staff

working in multidisciplinary teams in community settings. Admission to hospital is a part of the system of care, rather than its core.

2.2 Within the old Avon area of AWP there has been a development over the last decade of using High Dependency Units, usually attached to adult acute wards. There were 30 such beds across 4 of AWP sites in 2010/11 as shown in the table:-

PCT Area	**HDU**	**No of Beds**
B&NES	The Cherries, Hillview Lodge	6
Bristol	Lime, Callington Road	4
	Mason, Southmead	8
North Somerset	Juniper, Long Fox Unit	6
South Gloucestershire	Oakwood, Southmead	6
Total		30

These were set up as small units with a high staffing level aimed at *rapid* turnover of patients too unwell to be easily managed on an open acute ward but not fully meeting the criteria for a psychiatric intensive care unit (PICU).

However, in practice, most of the HDUs have been used as PICUs, *providing care in a locked facility for extensive periods of time*. The therapeutic environment is often poor due to the limited size of the units (this has been the case at Hillview Lodge) and individual therapy input is also compromised due to the needs of the general ward as a priority.

2.3 It is clear that the HDU provision within AWP, not just in B&NES, is a localised model of care with no reference to any nationally set guidance or criteria. Commissioners wish AWP to adhere to nationally agreed models of service delivery as this allows the Trust, commissioners, service users and the regulators to measure their performance against set standards and expected outcomes.

To this effect and as part of the redesign of the acute care pathway, all elements of inpatient services have been scrutinised. In this context it has become clear that AWP need to take advantage of improved bed management opportunities and enable care to be delivered in more appropriate locations (home, acute in-patient unit, PICU).

It is worth noting that the HDU model exists only in the former Avon area. Services in Swindon and Wiltshire have provided well for their service users without HDU provision, in line with the national model.

3. What services will be provided?

Services to people who may previously have received a service in an HDU will be provided either on an acute ward or a PICU ward according to clinical need. The following will be considered and/or implemented:

a) potential increased provision of recognised and approved PICU beds to maintain access to PICU care across services and minimise the risks of out-of area PICU placements. B&NES have used no out of area PICU beds in 2010-111 or to date 2011-12

b) enhanced acute care provision in existing units. This includes a programme of development already underway to enhance the staff skill-set to manage risk and high expressed emotion in a proactive manner on acute wards using highly developed engagement skills. Due to critical damage being caused to B&NES HDU (The Cherries) this is already in place on the acute in-patient unit.

c) provision of an upgraded inpatient unit model to include more integration with other aspects of the service and with enhanced therapeutic delivery as part of the service redesign. This will improve the quality of the in-patient episode.

In 2010/11 North Somerset and South Gloucestershire approved this service development. In 2011/12 Bristol are supportive of this change and was an element of their paper to the HOSC in July 2011.

4. Expected Benefits

There are a number of service quality benefits from this proposal.

Service users requiring complex and intensive support will have access to environments specifically designed for their needs with appropriately trained staff and access to equitable services.

- All inpatient services provided will meet national criteria and standards and be externally accredited through a process led by the Royal College of Psychiatrists.
- It will allow for investment in a co-ordinated way into PICU services and other services where required such as Crisis Resolution and Intensive Home Treatment teams
- Replacement of the HDUs would improve the financial viability of inpatient units and bring the unit costs in line with national reference costs

5. B&NES development plans – activity to support practice

Start of Period : 01-Sep-2009 **End of Period :** 31-Aug-2010

Ward	Type	Occupied Bed Days	Leave days	OBD + Leave	% leave	No. of beds	Days in Period	Potential Bed Days	% occupancy excluding leave	% occupancy including leave
AOWA Cherries HDU	Adult HDU	2,339	108	2,447	4.4%	6	365	2,190	106.8%	111.7%
AOWA Sycamore	Adult Acute	6,529	1,493	8,022	18.6%	23	365	8,395	77.8%	95.6%

Start of Period : 01-Sep-2010 **End of Period :** 31-Aug-2011

Ward	Type	Occupied Bed Days	Leave days	OBd + Leave	% leave	No. of beds	Days in period	Potential Bed Days	% occupancy excluding leave	% occupancy including leave
AOWA Cherries HDU	Adult HDU	401	21	422	5.0%	6	365	2,190	18.3%	19.3%
AOWA Sycamore	Adult Acute	7,140	947	8,087	11.7%	23	365	8,395	85.1%	96.3%

It can be seen that during the last calendar year September 2010 – August 2011 that despite the High Dependency beds not, in the main, being used (very badly damaged for a long period of this review), the occupancy rates on the ward have

not increased above national benchmark for the acute ward (excluding leave). This in part has been due to much better practice on the use of section 17 leave.

5. Engagement Process

Staff, service users and carers across all the HDUs have already been engaged in a process of discussion about these beds for the past year.

Meetings will continue to be held to enable staff and stakeholders to understand more about the proposal.

AWP understand that this proposal is acceptable to both service users and staff. Service Users from the former Avon area are aware that this model of service does not exist in other parts of the trust or elsewhere in the country and are supportive of this change to practice. However, this has been clarified through a formal process in each area.

Feedback in B&NES is that we need to attend to the need for an extra care area for short periods of time and that the lack of availability of the HDU beds as a facility has not had a detrimental impact on practice.

6. Summary

This change in practice represents an advance in the way the Trust supports one of its most vulnerable cohort of inpatients. It is important that the models of care provided are delivered in line with best practice, and in a way that can be accredited and benchmarked nationally.
The Trust is proposing this service change because it delivers many benefits for users and carers. It:

- would enable the delivery of safer, more effective, quality care
- will improve the care pathway for service users
- is more economically viable for inpatient services, protecting longer term viability and accessibility

On the basis of the experience in B&NES the proposed local developments do not appear to represent a significant change in service (and have not been deemed to be so in any other area within the former Avon area). The Trust continues to provide high quality inpatient services for this very vulnerable client group. Access has not changed but services have been delivered in a more appropriate way.

Next Steps

As:

- the B&NES HDU beds are already out of use
- the cost of repairing the Cherries back to it's HDU shape is potentially quite high and
- there is the potential to reinvest the money into services as part of redesign

we need to discuss options with the Wellbeing Policy Development and Scrutiny Panel as part of Specialist Mental Health Service re-design programme.

Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	7th October 2011	**AGENDA ITEM NUMBER**
TITLE:	Domiciliary Care Strategic Partnership	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: None		

1 THE ISSUE

1.1 This report presents an update on the Domiciliary Care Strategic Partnership Contract, which is in place with the following five providers:

- Carewatch
- Agincare
- Somerset Care
- Care South
- Way Ahead

2 RECOMMENDATION

The Panel is recommended to:

2.1 Note the performance of each of the Domiciliary Care Strategic Partners;

2.2 Note the likelihood that, by mutual agreement, the Council's current contract with Agincare will not continue beyond the initial 5-year term and the options for the future provision of services currently provided by Agincare.

3 FINANCIAL IMPLICATIONS

3.1 Any transfer of services from Agincare could result in a transfer of Agincare staff providing these services in accordance with Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). Agincare's employees are on Local Authority terms and conditions, which are generally more favourable than those of independent sector employees of home care providers. As with the current contract future contractual arrangements are likely to reflect the additional cost of transferring staff's terms and conditions.

3.2 Agincare B&NES is no-longer recruiting new employees and it is therefore possible that the staff team employed by Agincare could decrease over the remaining life of the current contract. This will potentially result in a further decrease in the hours of service delivery from Agincare, which, in turn would result in an increase in the cost per hour of care delivered under the current contract.

4 THE REPORT

4.1 The Local Authority has a rolling five year contract in place with each of the five domiciliary care providers set out in paragraph 1.1. The first five year break clause in the contract occurs at the end of March 2013.

4.2 During the last financial year the Authority spent £4.525 million on services commissioned through this domiciliary care partnership arrangement.

4.3 The Local Authority's in-house home care service staff team transferred under TUPE regulations to Agincare B&NES, one of the five strategic partners. At the time of transfer the service amounted to 1200 care hours per week. Agincare, following lengthy discussions, has stated that they cannot agree to carry on into the next five year period under the current contract arrangements. Careful consideration was given to proposals to vary the contractual arrangement made by Agincare. However, Commissioners believe that transfer of the remaining hours of home care to an alternative provide will secure improvements in both value for money and quality of care.

4.4 None of the other four providers (Carewatch, Care South, Way Ahead or Somerset Care) have to date expressed a wish not to continue under their current contract arrangements and there are currently no concerns about the performance of any of these other four providers.

4.5 Carewatch, Care South, Way Ahead and Somerset Care have been extremely supportive to the Council and responsive with regards to taking over care packages from other providers who have given notice. Ensuring that vulnerable people continue to receive a service they need to remain living in their own home.

4.6 All of the strategic domiciliary care providers successfully provided a service to people during the snow last winter.

4.7 Carewatch, Care South, Way Ahead and Somerset Care have demonstrated a willingness to support the Council in making financial savings and have accepted inflationary uplifts lower than those suggested in the contract.

4.8 The following tables shows each of the Domiciliary Care Strategic Partner's 'target hours' agreed at the start of the contract; hours of service commissioned; and number of service users as at the 6th September 2011.

AREA	PROVIDER	TARGET HOURS	HOURS ACCEPTED	NUMBER OF SERVICE USERS	NUMBER OF VISITS
Bath North	Agincare	391	68	16	104
Bath North	Carewatch	719	553	80	774
Bath North	Way Ahead	519	396	63	607
Bath South	Agincare	576	172	33	254
Bath South	Care South	470	241	40	416
Bath South	Somerset Care	670	740	91	909
Keynsham	Agincare	310	173	30	245
Keynsham	Way Ahead	602	611	65	874
North East Somerset	Agincare	593	257	41	396
North East Somerset	Care South	739	626	73	839

Provider	Target Hours	Total Hours Accepted	Total Number of Service Users Supported
Agincare	1870	**670**	121
Care South	1209	867 + 39 = **906**	113 + 1 = 114
Way Ahead	1121	1007 + 42 = **1049**	128 + 5 = 133
Carewatch	719	553 + 688 = **1241**	80 + 80 = 160
Somerset Care	670	740 + 25 = **765**	91 + 6 = 97

4.9 The total commissioned hours across the whole Strategic Partnership is 4631 out of a total commissioned hours of 5112 as at the 6th September 2011.

4.10 When the in-house Home Care Service was transferred to Agincare in September 2009 the service was delivering 1200 hours per week. Agincare are now only consistently delivering 600 -700 care hours a week. Over the term of the contract Agincare recruited only a small number of new staff (approximately 12) on a casual basis. In spring this year, Agincare sought additional funding from the Council to continue to employ these casual staff. The Council was not in a position to provide the requested additional funding and, as a consequence, Agincare decided not to continue to employ these casual staff. Agincare B&NES are no longer taking on new staff either on a casual or permanent basis.

4.11 Since July 2011 there has been a slight increase in the number of care hours being commissioned outside of the domiciliary care strategic partnership. Whilst to some extent, this reflects individuals exercising their right to choose the provider of their home care services. However, the Commissioner will need to monitor this trend closely and will continue to seek to ensure best value from its contracts with Strategic Partners.

4.12 Commissioners are planning on the basis that the Council's contract with Agincare will cease on 31st March 2013. It is essential that continuity of service is secured and that the Council achieves both good quality care and value for money from the future provider of this service. In light of legal advice, two options have so far been considered. These are i) to prepare for, and go through an open tendering process for any hours delivered by Agincare; and ii) to re-distribute the hours to the remaining Strategic Partners.

4.13 The option of re-tendering is unlikely to be attractive to providers because of the low volume of care hours likely to transfer following re-tendering and the financial implications associated with any potential TUPE transfer of the current Agincare staff on current terms and conditions.

4.14 There is also insufficient evidence to suggest that there is a need to introduce another provider as the volume of work currently being commissioned from the strategic partnership has remained fairly static since the commencement of the contract and the other four strategic partners have demonstrated that they have the capacity and flexibility to pick up work across the whole of Bath & North East Somerset.

4.15 The redistribution of the hours delivered by Agincare amongst the other four strategic partners is likely to be achievable and could be progressed within the existing contractual arrangement. Analysis of any potential TUPE implications will need to be undertaken in sufficient time to enable a smooth transfer of both the service and associated staff to take place.

5. RISK MANAGEMENT

5.1 Planning for the transfer of the service will be subject to a full risk-assessment in accordance with the Council's policy and this risk-assessment will be reviewed on a regular basis over the next 18-months.

6 EQUALITIES

Once drawn up, plans for managing the transfer of service will be subject to a proportionate Equalities Impact Assessment in accordance with Corporate guidelines

7 CONSULTATION

7.1 Select from: *Ward Councillor; Cabinet Member; Trades Unions; Overview & Scrutiny Panel; Staff; Service Users; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer*

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Customer Focus; Human Resources; Other Legal Considerations

9. ADVICE SOUGHT

The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	*Angela Smith 01225 396229*
Background papers	*None*
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	7th October 2011	**AGENDA ITEM NUMBER**
TITLE:	Re-ablement & 30 Day Post Discharge Support Services	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix I – Outline Service Specifications		

1 THE ISSUE

1.1 To inform the Panel about the national re-ablement and thirty day post discharge support policy and the potential implications of the policy for commissioning and service delivery arrangements from 1st April 2012.

1.2 To provide an update on the use of the re-ablement and winter pressures funding received in 2010/11 and the re-ablement funding in 2011/12 transferred to the Council under a section 256 agreement. This funding was received in order to underpin the policy reform previously mentioned.

1.3 To outline the process that is underway to secure a number of 'Extended Research Pilots' which will provide evidence for the future use of re-ablement resources when tariff arrangements change in 2012/13.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to:

2.1 Note the report and signal ongoing support for the work in progress.

3 FINANCIAL IMPLICATIONS

3.1 Potential financial implications, including the impact of the changes on funding arrangements for the new Social Enterprise, are covered in the body of the report.

3.2 The final tariff arrangements, due to be implemented in acute hospitals to support the new policy framework, have yet to be announced. However it has recently become clear that the focus of the new arrangements has been narrowed to include only those patients discharged from hospital with the following conditions:

- Stroke rehabilitation
- Cardiac rehabilitation
- Fragility hip fractures

4 THE REPORT

Background

4.1 The revised NHS Operating Framework for 2010/11 detailed *"changes to the tariff to cover re-ablement and post-discharge support"* as well as an intention to ensure that acute hospitals retain responsibility for patients for up to thirty days after discharge. Readmissions during this thirty day period will no longer attract an additional tariff as they previously did, with the aim of ensuring that appropriate care and support services are in place, first time, to facilitate timely and successful discharges, effectively reducing and preventing emergency readmissions.

4.2 Therefore, from 1st April 2011 the requirement on commissioners to pay for emergency readmissions (within thirty days) was removed, with some defined exceptions, although readmissions following outpatient procedures or A&E attendances are excluded from this rule.

4.3 For emergency readmissions within thirty days of discharge following a non-elective admission, commissioners and providers are required to agree a local threshold rate based on the last complete twelve months data, above which there will be no payment. This threshold must be set to deliver at least a 25% reduction in the readmission rate of the previous year.

Policy Context

4.4 In 2010/11, Primary Care Trusts received £70 million additional funding for re-ablement and post discharge support linked with a requirement to develop local plans to inform future commissioning activity. Further allocations were made in 2011/12 and these are set to peak in 2012/13 when it is anticipated that a well evidenced and appropriate range of services will be in place to enable commissioning responsibility to transfer from PCTs/Local Authorities to acute hospitals.

4.5 The types of post-discharge support that might be included in hospitals' thirty day responsibility include homecare re-ablement, intermediate care services, rehabilitation, community health services and follow-up outpatient attendances.

4.6 A number of services will be excluded including pre-existing long-term residential and home care services provided by local authorities and care services provided under a GP contract.

Policy Implications

4.7 High level analysis of the activity of the new Social Enterprise indicates that a significant percentage of business is generated by discharges from the RUH, for example admissions to, and treatment in community hospitals. Other services delivered by community health & social care staff fall within the spectrum of 'post discharge support' including the community stroke service, COPD service, intermediate care and district nursing. The funding implications of the new policy framework for the new Social Enterprise will need to be clearly analysed once the final arrangements are announced.

4.8 Under the current post discharge commissioning arrangements, GPs take a lead role in influencing the services that are put in place to support re-ablement. The new policy framework could potentially take away from GPs the responsibility for the key period post discharge, which tends to be the determinant of whether someone heads to independence or to long term institutional care. Similarly Local Authority commissioners are also likely to be impacted by the change in policy, for example increase/decrease in demand for LA funded/contracted services such as domiciliary care, however it remains unclear at the present time what the full extent of any impact might be

4.9 The long term sustainability of services and the balance of health & social care re-ablement provision within the local market will need to be closely monitored as the new policy framework emerges. Whilst it is unlikely that any acute trust would deliberately de-stabilise its local system of provision, any un-intended consequences of change may be detrimental to the long term sustainability of local services. In particular, a number of services are commissioned from the voluntary sector, tied into three year contracts and the implications of this policy on personal budgets and the likely roll out of personal health budgets also need to be understood more fully.

Early Implementer Sites

4.10 Earlier in 2011 commissioners took part in a series of three Early Implementer Project workshops with the DH policy team where it was acknowledged that post discharge support was not only about preventing readmissions to hospital, but also to residential care, and that a focus on the provision of early re-ablement support could help prevent escalations in both health and social care needs and promote independent living.

4.11 On this basis a scoping exercise was completed with a number of local provider organisations to identify potential areas for further market testing of re-ablement services. This was further refined, between January and March 2011, by the work of an experienced OT who worked alongside the RUH's Discharge & Therapeutic Evaluation Team to identify current gaps in health and social care provision. Eight key areas were identified as follows:

- Mental health liaison support across secondary, community and primary care
- The integrated re-ablement & ICT teams
- Home from Hospital scheme
- Handyperson services
- Community transport
- Medicines management support

- Assistive technology, in particular telehealth
- Alcohol liaison services in secondary care

Extended Research Pilots

4.12 Five of these areas were felt to be suitable for attracting expressions of interest from qualified local providers to deliver the 'Extended Research Pilots' previously mentioned. The aim of the pilots will be to establish a firmer evidence base for a range of health and social care interventions and enhance understanding of the likely future demand for re-ablement and post discharge support services.

4.13 Outline service specifications (attached as Appendix 1) were drawn up and circulated to local providers at the beginning of August 2011 with a closing date for expressions of interest of 2nd September 2011. The service specifications were designed to encourage partnership arrangements and innovative proposals by keeping them 'open to interpretation' with the provision of detailed information being kept to a minimum. The intention was to encourage providers to signal, through their submissions, the types of interventions they believed worked well in practice and to provide evidence for this.

4.14 Fourteen expressions of interest were received across all five categories; several of these offer creative and flexible solutions and provide good evidence of outcomes for service users. Submissions are currently being evaluated by health and social care commissioners with input from the GP Accountable Officer of the CCG and a service user representative.

4.15 At the time of writing, it is anticipated that final decision will be made during the week commencing 26th September 2011 and that ERPs will be awarded on the following basis:

Integrated health & social care re-ablement	Two providers	Total funding £208k
Intensive home from hospital support	Two providers	Total funding £50k
Handyperson & Minor Adaptations	One provider	Total funding £50k
Step down accommodation & support	One provider	Total funding £100k
Telehealth (to support congestive heart failure)	One provider	Total funding £75k

5 RISK MANAGEMENT

5.1 Although this work is supported by the RUH who have been fully involved and consulted throughout the process, with future tariff and commissioning arrangements still unclear there are a number of risks associated with initiating ERPs at this stage:

- Lack of clarity in relation to future funding leading to market instability
- Lack of stability for staff recruited to facilitate/deliver ERPs

- Potential disruption for service users when ERPs end

5.2 In order to minimise and mitigate risks it will be important, as soon as tariff and policy arrangements are clarified, to communicate this to successful providers and emphasise the requirement to ensure that robust evaluation data is collected throughout the lifespan of each ERP.

5.3 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 Until the new policy framework has been clarified by the DH it will be difficult to complete a full equalities impact assessment.

7 CONSULTATION

7.1 Consultation with a range of stakeholders was carried out earlier in the year at the Health & Wellbeing Partnership Network Event.

7.2 *Ward Councillor; Cabinet Member; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners;*

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Customer Focus; Sustainability; Impact on Staff

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Sarah Shatwell, Associate Director Non-Acute & Social Care 01225 477162 Sarah_Shatwell@bathnes.gov.uk
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	7th October 2011	**AGENDA ITEM NUMBER**
TITLE:	Any Qualified Provider Community Services	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Please list the appendices here, clearly indicating any which are exempt and the reasons for exemption Appendix 1 : Any Qualified Provider Stakeholder Engagement Report		

1 THE ISSUE

1.1 To brief the Wellbeing Policy Development and Scrutiny Panel on the Any Qualified Provider (AQP) Process for Community Services and the feedback received at the engagement event that took place on the 14 September 2011. The B&NES Clinical Commissioning Committee is considering the issue at its meeting on Thursday 29th September and a verbal update will be provided at the meeting on next steps.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel are asked to note:-

2.1 The DH Policy requirements for the implementation of Any Qualified Provider for community services.

2.2 The feedback received from local stakeholders as part of the engagement event that took place on the 14th September on potential priority service areas and the criteria that should be used to select the 3 service areas.

3 FINANCIAL IMPLICATIONS

3.1 The financial implications of implementing AQP are currently unknown and will need to be worked through as part of the implementation process. However, as some of the current services identified nationally for potential consideration as part of an AQP approach are managed as part of a block contract process, there is the potential risk of increased costs of service provision.

4 THE REPORT

4.1 On 19 July 2011 the Department of Health (DofH) published operational guidance to the NHS setting out plans to deliver the Government's commitment to extending patient choice of provider. The guidance is available via: **http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128455**

The guidance confirms the principles that govern an AQP approach to contracting for services:

- Providers qualify and register to provide services via an assurance process that tests providers' fitness to offer NHS-funded services.
- Commissioners set local pathways and referral protocols which providers must accept
- Referring clinicians offer patients a choice of qualified providers for the service being referred to
- Competition is based on quality, not price. Providers are paid a fixed price determined by a national or local tariff.

4.2 The AQP process is not a procurement process to secure one preferred provider for a particular service through a competitive tender process. Instead, all providers that pass through a qualifying process become eligible to offer the specified service. This approach is similar to that adopted for the Any Willing Provider process, implemented in the autumn of 2010 for elective care services.

4.3 It is anticipated that the DofH will establish a national qualification process and that details of how potential providers will be qualified will be published in the autumn. The guidance describes how the DofH qualification process will ensure that all providers offer safe, good quality care, taking account of the relevant professional standards in clinical services areas. Providers should be qualified if they:

- are registered with CQC and licensed by Monitor (from 2013) where required, or meet equivalent assurance requirements3
- will meet the Terms and Conditions of the NHS Standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law
- accept NHS prices
- can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and
- reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols

4.4 The roll out will start with selected community and mental health services from April 2012. The guidance proposes 8 potential services areas for the application of AQP or other identified local priority services areas. PCT clusters, supported by Clinical Commissioning Groups (CCGs), should select three or more services for implementation in 2012/13. The nationally identified list of potential service areas based on engagement at national level with patients is:-

4.5

- Services for back and neck pain
- Adult hearing services in the community
- Continence services (adults and children)
- Direct Access Diagnostic tests
- Wheelchair services (children)
- Leg ulcer and wound healing
- Primary Care Psychological Therapies (adults) ('talking therapies')
- Podiatry services

4.6 The guidance sets out key actions for implementation:

- **by 30 September 2011**, all PCT clusters, supported by CCGs, should have engaged patients, patient representatives, Health and Wellbeing Boards, healthcare professionals and providers on local priorities for extending choice of provider.
- **by 31 October 2011**, clusters and CCGs should have used the feedback from this engagement to identify three or more community or mental health services for implementation, drawing from the national list or local priorities.
- SHAs should be notified of cluster/CCG priorities for 2012/13. This information will be shared with the Department to inform the next phase of the national choice offer.
- **By September 2012,** clusters should have implemented patient choice of Any Qualified Provider for the selected services, taking account of the NHS Operating Framework and standard contract. The DofH expects some AQP services to be available before this date

4.7 In addition to this, the DofH will work with volunteer PCT Clusters to produce 'Implementation Packs' for the priority services. Each region is, currently, confirming volunteer AQP commissioners (PCT clusters working with emerging CCGs) to co-produce packs with the Department. These` implementation packs are to be available for the NHS to use from November 2011. Our Cluster has been confirmed as the lead for the implementation pack for wheelchair services.

5 Any Qualified Provider Stakeholder Engagement

5.1 The PCT with the support of the CCG held a stakeholder engagement event on the 14th September 2011. Forty nine people attended the meeting and heard a presentation on the local context and background. There was opportunity for questions and discussion. Two forty five minute facilitated workshops were held in small groups giving opportunity for the expression of all views. The workshops considered 2 questions:

- What local services might we want to prioritise?

- What criteria should be set in finalising the choices?

5.2 The summary feedback is attached at Appendix 1. Feedback from this engagement is to be used to inform the selection of 3 or more community or mental health services for the implementation of AQP.

5.3 The B&NES Clinical Commissioning Committee will be reviewing this feedback at its meeting on the 28th September 2011 to confirm the areas to be selected. A verbal update will be provided at the meeting on next steps following this meeting.

6 RISK MANAGEMENT

6.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6.2 As stated above in paragraph 3.1 there is the potential risk for additional costs pressures in the system as many community services are currently commissioned on a block contract basis. These risks would need to be mitigated through the setting of appropriate referral and treatment thresholds.

6.3 There are also additional risks associated with a lack of available management capacity to procure new service arrangements.

7 EQUALITIES

7.1 An equalities impact assessment has not yet been carried out as it is not yet been confirmed what the 3 short listed services areas for the implementation of the AQP policy will be.

7.2 All potential providers for community services will be required to demonstrate adherence to Equality legislation and good practice as part of the AQP accreditation process.

8 CONSULTATION

8.1 Information was taken to the B&NES LiNK at its public meeting on August 2nd 2011 and subsequently distributed to the LiNK network.

8.2 A 3 hour workshop with public stakeholders was held on September 14th offering people the opportunity to hear information, discuss and debate and feed in views and perspective on local AQP choices. Invitations to attend the meeting were distributed across local providers and B&NES health and wellbeing network. The network is a virtual grouping of 120 contacts covering patients, service users, carers, voluntary sector agencies, primary care, parish councils, partners and providers. The outcome of the meeting is attached at Appendix 1.

8.3 Information has also been published on the PCT's website.

9 ISSUES TO CONSIDER IN REACHING THE DECISION

9.1 The implementation on Any Qualified Provider for Community Services will potentially have an impact on the following areas: - *Social Inclusion and Customer Focus.*

10 ADVICE SOUGHT

10.1 As this is a briefing update on a Department of Health policy initiative no advice has been sought at this stage.

Contact person	*Tracey Cox, Programme Director, Commissioning, NHS B&NES* *Telephone 01225 831736* *Email : tracey.cox@banes-pct.nhs.uk*
Background papers	*Further information on this policy initiative can be found at :-* **http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128455**
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Any Qualified Provider
Stakeholder Engagement Report

Background

Guidance on Any Qualified Provider specified that commissioners should engage with the public and local stakeholders during September on local priorities. Feedback from this engagement is to be used to identify 3 or more community or mental health services by October 31st.

Engagement Approach

To respond to the engagement exercise NHS B&NES took the following approach:

Initial Public Briefing

Information was taken to B&NES Link at its public meeting held on August 2nd presented and subsequently distributed to the Link network.

Website

Information published to public website with opportunity to express views

Stakeholder consultation

A 3 hour workshop with public stakeholders was held on September 14th offering people the opportunity to hear information, discuss and debate and feed in views and perspective on local AQP choices. Invitations to attend the meeting were distributed across local providers and B&NES health and wellbeing network. The network is a virtual grouping of 120 contacts covering patients, service users, carers, voluntary sector agencies, primary care, parish councils, partners and providers.

Clinical Commissioning Committee

A presentation was made to the clinical commissioning committee seeking views and clinical input into the decision making

Wellbeing Policy Development and Scrutiny Panel

A public paper was taken to the scrutiny panel presenting the local position and inviting comment

Stakeholder Meeting Wednesday 14th September 2011

Forty nine people attended the meeting and heard presentation on the local context and background. There was opportunity for questions and discussion. Two forty five minute facilitated workshops were held in small groups giving opportunity for the expression of all views. The workshops considered 2 questions.

- What local services might we want to prioritise?

- What criteria should be set in finalising the choices?

What local services might we want to prioritise

Category	Number of identified selections	Other categories
Wheelchair services for children	5	
Psychological therapies	4	
Musculo skeletal services for back and neck	3	
Continence services	2	
Diagnostic tests closer to home	2	
Podiatry services	2	
Venous leg ulcers	1	
Adult hearing services	0	
Other	1	Public health and LTC

Reasons given in support of choices
Need to choose something practical.
Preferable to choose something that will work and can be tested.
Best to select a simple service that will give a good chance of success in the choice programme.
Identify services that are responding to urgent needs.
Don't choose something that is working well already.
Useful to also include a more complex patient pathway to test out the potential of the model.
Consider practicality of market entry.
Innovation and prevention.
Multidisciplinary component.
Good to test more complex services.

Additional comments raised in discussion
Information needed for people to make choice is a crucial infrastructure priority to be addressed.
How can we manage demands that are met by a service but not required? Fixed tariff should cover this.
How will we engage difficult to reach groups?
Concern about extra bureaucracy.
It will need generations to get public into mindset of choice.
People will need to get used to operating in a choice model.
Brokering of the information to support choice is underdeveloped.
People want expert advocacy rather than being overwhelmed by choice.
How can we ensure focus on quality with proliferation of providers?
Need to have the right people in place to facilitate choice.
Clarity about need and choice required at referral.
What will be involved in the choice needs specifying?
What if people want to choose something else?

What criteria should be set in finalising the choices?

Participants were broadly content with the criteria presented by the commissioner. These were:

- Access to Services
- Quality and responsiveness
- Financial
- Innovation & new models of provision
- Patient pathways are easily defined
- Provider availability
- Workforce

Participants were invited to propose other criteria. No distinction was made between criteria for choosing the service itself or criteria for selecting qualifying providers. Conversations tended to focus on criteria for the provider. From the discussions the following position was declared.

Top criteria in hierarchical order where more than 1 group raised the point.

Category	Number of identified selections	Notes
Quality assurance inc clinical quality	8	Covers all aspects of quality
Customer care and clear information for users	6	Covers approach to customers, advice to customers, ease and clarity of information
Financial viability and value for money	5	
Clear Outcome measures	4	
Access to services- inc transport, flexibility, location opening times	4	
Workforce skills and capacity	3	Covers workforce ability and sustainability

Additional criteria proposed by single groups

Safety
Safeguarding
Sustainability
Communications with other professional groups
Ability to integrate with other services
Interface with electronic systems
Market already developed
Ability to scale up
Mapped to JSNA priorities
Good market intelligence
Impact on provider landscape
Ability to maintain choice
Services where there is a problem
Good customer care
Innovation

Bath & North East Somerset Council		
MEETING:	Wellbeing Policy, Development and Scrutiny Panel	
MEETING DATE:	7 October 2011	**AGENDA ITEM NUMBER**
TITLE:	Update on transition of public health responsibilities from NHS B&NES to B&NES Council by 2013	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Public Health Transition Governance Plan		

1 THE ISSUE

1.1 This paper provides a briefing on the move of public health responsibilities from NHS B&NES to B&NES Council from April 2013. An accompanying report outlines the processes being undertaken to manage this transition and the key governance arrangements.

2 RECOMMENDATION

The Wellbeing Policy, Development and Scrutiny Panel is asked to:

2.1 Note the information contained in the briefing and accompanying report.

2.2 Comment on any areas of concern or potential opportunity.

3 FINANCIAL IMPLICATIONS

3.1 Work has been carried out to identify the complete range of public health spend in every Primary Care Trust (PCT) in England. This has been in line with Department of Health guidance and templates. A detailed submission was sent to the South West Strategic Health Authority on 15 September. This was signed off by Chief Executives of both B&NES Council and PCT.

3.2 The Department of Health is collating this information to inform a national exercise that will decide 'shadow' budgets for the public health operations/functions of the successor bodies to NHS B&NES (i.e. The Local Authority, Public Health England and NHS commissioning bodies). These shadow budgets will be in place for April 2012 and it is anticipated that there will then be a further period of analysis prior to final sign-off between NHS B&NES and successor bodies in line with Department of Health requirements. Final responsibility of the council for public health duties will start in April 2013.

4 THE REPORT

4.1 In 2010, the Department of Health set out changes to the public health system as part of the NHS White Paper. These included the creation of a national public health service, called Public Health England, and the transfer of local public health responsibilities from PCTs to local authorities.

4.2 Local authorities will take on their new public health responsibilities in April 2013, at which point they will also take responsibility for Directors of Public Health and their functions.

4.3 A Public Health Transition Group has been established which is chaired by the Strategic Director for People and Communities. The membership and Terms of Reference of this group are shown in Appendix 2 of the accompanying report.

4.4 This group is managing key processes during the transition including accountability, finance, staff, risks and performance.

4.5 The group reports on progress to the monthly Change Programme Board of the Council. An initial briefing report was provided for the Wellbeing Policy, Development and Scrutiny Panel in March of this year.

4.6 It is proposed that 'Section 113' (Local Government Act, 1972) provisions will be used for the Director of Public Health, Assistant Director of Public Health and Assistant Director of Health Improvement to act as joint officers of the council and the Primary Care Trust from October 2011. This will enable them to contribute to the development of the new People and Communities Directorate. These arrangements underpin the partnership arrangements that currently exist between the PCT and the Council.

4.7 An NHS human resources framework is expected in Autumn of 2011 which will outline the process for staff transfers to local authorities. More specific details of the public health responsibilities within local authorities is also expected in Autumn 2011. For this reason, arrangements for secondment of the wider public health team will be considered from January 2012.

4.8 A future role of the local authority will be to provide public health advice to the Clinical Commissioning Group. The local public health team and Clinical Commissioning Group are working closely together to develop these roles and responsibilities for the future, alongside the still emerging national policy detail.

5 RISK MANAGEMENT

5.1 A risk register of issues associated with the transition of public health responsibilities has been produced and is being managed by the Public Health Transition Group, with monthly reporting to the Change Programme Board.

6 EQUALITIES

6.1 Public health is an important advocate of equality issues in identifying needs of vulnerable and high risk groups and assessing current service provision and outcomes to measure progress between different groups, according to their needs. Ensuring a robust public health function is therefore an important requirement in promoting health equality at population level. The changes described in this paper are about a shift of strategic public health to the council from the NHS, rather than provision of a service, so there is no reason why there should be an impact on equalities issues.

7 CONSULTATION

7.1 Public engagement to discuss public health changes has happened through a Healthy Conversation event in February 2011 and a Local Involvement Network (LINk) meeting in April 2011.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 There is no specific decision being sought at this point in time.

9 ADVICE SOUGHT

9.1 The Strategic Director for People and Communities has reviewed this report. The Monitoring Officer and Section 151 Officer have been copied into the report and will be asked to make formal comments as further detailed work is undertaken prior to any formal transfer of function."

Contact person	Paul Scott, Assistant Director of Public Health
Background papers	*List here any background papers not included with this report because they are already in the public domain*
Please contact the report author if you need to access this report in an alternative format	

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Public Health Transition 2011-2013

Governance Plan

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1. Purpose

1.1. To set out a joint governance plan for public health responsibilities of the B&NES/Wiltshire Primary Care Trust (PCT) Cluster and B&NES Council following the move to Cluster PCT arrangements in June 2011.

1.2. To outline timetables for key actions locally and nationally.

2. Context

2.1. In 2010, the Department of Health set out changes to the public health system as part of the NHS White Paper[1]. These included the creation of a national public health service and the transfer of health improvement responsibilities from PCTs to local authorities. These changes were set out in more detail by a series of public health consultation papers[2]

2.2. In March 2011, the Transition Managing Director for Public Health England wrote to PCT and council Chief Executives outlining transition arrangements for the development of Public Health England[3]. Part of this emphasised that existing PCT boards remain statutorily responsible for Public Health until April 2013 but that cluster PCT Chief Executives together with Local Authority CEOs should develop a joint governance plan for Public Health, to be in place by June 2011. The letter set out a timetable for national actions and these are highlighted in Appendix 1.

2.3. In July 2011, the Department of Health published its response to the consultation process and an update on changes to the public health system[4].

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[1] DH (2010) *Equity and excellence: Liberating the NHS* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[2] DH (2010) Healthy *lives, healthy people: our strategy for public health in England* *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941*

[3] Marsland (2011) *Public Health England* http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_125240

[4] DH (2011) *Healthy lives, healthy people: Update and way forward.* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129334.pdf

The update largely reiterated the consultation proposals but also gave more clarity that local authorities will have new functions through regulations for taking steps to improve and protect the local population's health, and for providing clinical commissioning groups with population health advice. The paper also gave some more information on updated timelines for transition, including:

- Local authorities will take on their new public health responsibilities in April 2013, at which point they will also take responsibility for Directors of Public Health and their functions.
- Public Health England will be created at the same time, formally taking on the functions of its predecessor bodies.
- Formal transition plans are to be agreed with the Regional Director of Public Health by March 2012. Ahead of this date DH strongly encourage local authorities and Primary Care Trusts to work together on developing the relationships and joint working that will facilitate a robust transition for April 2013.
- DH plan to recruit a Chief Executive for Public Health England to be in post from April 2012.

2.4. This document sets out the key systems for accountability, the issues and timetables and puts them within a framework of governance during the transition period.

2.5. A Public Health Transition Group has been established which is chaired by the Strategic Director for People and Communities, the membership and Terms of Reference of this group are shown in Appendix 2.

3. Governance Framework

3.1. Accountability

3.1.1. The existing Board of each Primary Care Trust will retain the statutory responsibility for public health functions and outcomes until April 2013.

3.1.2. Many of the decisions about public health issues are also influenced or taken at the B&NES Health and Wellbeing Partnership Board and the Professional Executive Committee of the PCT. From May, these are changing to the Health and Wellbeing Partnership Board and the Clinical Commissioning Board.

3.1.3. The Health and Wellbeing Partnership Board will become the central point that brings together planning and accountability for delivery of NHS, social care and public health services. However, accountability for critical operational and financial decision making in relation to public health will remain with the Board of NHS B&NES during the transition period.

3.1.4. In addition, public health plans which have a direct relation to NHS commissioned work and are of significant scale will need engagement with the Clinical Commissioning Group. This might be through the CC Executive Board, the CCG or through CCG representatives at the Health and Wellbeing

Partnership Board or the Public Health Transition Group as relevant to the issue.

3.1.5. The Department of Health guidance on the development of Public Health England mentioned in 2.2 above states that robust systems must be put in place to ensure that PCT cluster Chief Executives and their executive teams are fully cognisant of the public health responsibilities they retain and act accordingly.

3.1.6. This includes the requirement to have governance systems and management functions that enable each PCT DPH to fulfil their Executive Director function and Public Health advisory role for the relevant PCT until such time formal transfers of responsibilities take place. Processes for enabling this in B&NES will include:

- The DPH will continue to fulfil their role as an executive director on the Board of NHS B&NES during the transition period.

- The DPH should ensure that public health advice is available for the PCT Cluster executive team. This advice may be sought from the B&NES or Wiltshire DPH, or both, as relevant to the issues under discussion.

- The DPH will be a core member of the Health and Wellbeing Partnership Board

- It is not currently clear what role the DPH will play in relation to the Clinical Commissioning Group or the Clinical Commissioning Committee and this is currently being discussed by the relevant partners. It is envisaged that the DPH should be a member of the Clinical Commissioning Committee until at least April 2013 when they formally transfer to the local authority.

3.1.7. In terms of management arrangements, it is proposed that the DPH, the Assistant Director of Public Health and the Assistant Director for Health Improvement have authority under Section 113 of the Local Government Act 1972. This will allow the post holders to discharge duties on behalf of B&NES Council and to act as senior officers of the new People and Communities Department. Similarly, the Strategic Director for People and Communities, who is already accountable to the PCT CEO, operating under section 113 to manage children's and community health commissioning on behalf of the PCT, would have this arrangement extended to include managing Public Health responsibilities on behalf of the PCT.

3.1.8. The Public Health Team would remain fully part of NHS B&NES and plans will be developed between September and December 2011 to transfer relevant operations, staff and resources to B&NES Council during 2012/13. Given the envisaged diminution of PCT capacity as we move towards April 2013 it may be appropriate to transfer functions from April 2012 utilising Section 75 of the National Health Service Act 2006 prior to formal transfer in April 2013.

3.1.9. The DPH would have line management responsibility to the Strategic Director for People and Communities with professional accountability jointly to the Chief Executive of B&NES Council and the PCT Cluster (via a bi-monthly joint meeting).

3.2 Performance and risk

3.2.1 Performance and risk reporting will become integrated in to the Council's systems. Regular reports will be provided to the PCT Board and the Health and Wellbeing Partnership Board to provide assurance and accountability.

3.2.2 NHS B&NES will receive assurance for their public health responsibilities in relation to performance and risk through the joint meetings of Cluster and Council Chief Executives with the DPH and also through the Health and Wellbeing Partnership Board.

3.2.3 A separate risk register dealing specifically with the transition process has been produced. This will be reviewed by the Public Health Transition Group and key risks will be reported to the Change Programme Board each month. The register will continue to be updated as Public Health England and associated national guidance develop further and as the transition progresses.

3.3 Finance

3.3.1 The DPH, or their representative, will work closely with the lead finance officers of the PCT cluster and B&NES Council. They will:

- Identify and quantify the key programmes of public health spend during and after the transition period.
- Agree the use of allocated budgets in 2011/12 and prepare for the first indicative local authority public health budget being published in April 2012.
- Agree and undertake a process for identifying budgets, expenditure and accountabilities to be allocated to public health during and after transition.
- Agree a process for executive sign-off and mechanisms for resolving disagreement.

3.4 A significant part of this work was carried out during August and September 2011. A detailed submission quantifying current spend on public health by the entire PCT (not just public health department) was sent to the South West Strategic Health Authority on 15 September. This was signed off by Chief Executives of both B&NES Council and PCT. This will inform the shadow local authority public health budget, published in December 2011 and the final allocation in April 2013..

3.5 Staff

3.5.1 The Department of Health is developing an overarching human resources framework that will cover all staff in the NHS affected by the changes set out in Equity and Excellence: Liberating the NHS. This will include all public health staff currently working in the NHS and includes those who will move to local authorities. A separate public health professional workforce strategy will be produced by autumn 2011. This will cover those who will form part of Public Health England and those with whom it will have close associations and the wider professional networks. The South West regional public health transition groups for programmes and workforce development will be important partners to work with during the transition period.

3.5.2 During 2011/12 and 2012/13 the public health staff currently employed by NHS B&NES will remain employed by the PCT on their current terms and conditions. The proposals outlined at 3.1.7 to 3.1.9 above will also enable public health staff to participate in the development of the new council and departmental functions and structures.

3.5.3 Staff currently playing a role in areas that may form part of future public health responsibilities but who are not in the public health team will be kept informed of change as part of the overall system changes within the PCT and the council. Examples of these can be found in the far reaching Public Health Outcomes Framework published by the Department of Health in 2010.

3.5.4 It is currently anticipated that staff employed by NHS B&NES who are fulfilling public health provider functions will transfer fully to the social enterprise in October 2011. Future governance of these staff will be provided by the social enterprise and assurance will be via contractual performance and quality meetings.

3.5.5 Staff currently employed by B&NES Council who are fulfilling public health provider functions will be kept informed of change as part of the overall system changes within the PCT and the council. It has not yet been determined where the most appropriate location will be for these staff who work as part of council services, which is why they are not currently planned to join the community health and social care services in October 2011.

3.5.6 A map of staff who are in the public health team or playing a public health role has been drawn up for the Public Health Transition Group.

3.5.7 A review of proposals will take place when relevant guidance from the DH is received and no later than December 2011. This will inform a further paper to the Board early in 2012.

3.6 Programmes and relationships

3.6.1 The Department of Health has set out a number of key programme areas to help local areas identify a standard set of public health activities during transition. These include:

- Health protection
- Emergency planning

- Information and intelligence
- Health improvement
- Support to NHS Commissioning Board, including QIPP, screening and quality assurance
- Professional leadership

3.6.2 Work is developing in B&NES to map out existing work in each of these areas and to identify the aspects of these that are carried out in local, West of England and regional forms and how these might most effectively be delivered in the new arrangements. Critical issues have also been identified for inclusion in the Risk Register identified above to ensure that all critical work and risk is kept in sight and key deliverables are achieved.

3.6.3 A brief project plan is now under development and will form the basis upon which future reporting on the transition will take place to the PCT Board and the Health and Wellbeing Partnership Board. This plan, along with the Governance Plan will also be regularly reviewed by the Public Health Transition Group.

Appendix 1

Timeline for the development of Public Health England.

April 2011

- Develop a draft accountability framework to define formally the relationship between the Department of Health and Public Health England
- Develop a draft operating model for PHE

Between April- October 2011

- Establish the structure for taking forward the financial, commissioning and relationship flows between PHE and the rest of the Health and Care system including working relationships with Local Authorities
- Appoint a Chief Operating Officer and designate new senior leadership team for PHE

By Aug 2011

- Complete structure definition to enable staff mapping

Between summer 2011 – April 2012

- Formal consultation with Trades Unions, staff and then plan and map staff into new structure, including all parts of PHE – HPA; NTA; Public Health Observatories; Cancer Registries; Regional Public Health Groups; Department of Health policy staff; National Screening Committee, taking account of indicative budgets for 2012/13

April 2012

- Staff migrate into the new structure
- Shadow Local Authority budgets

July 2012

- PHE will take on full responsibilities, budgets and powers

April 2013

- Public Health budgets allocated directly to Local Authorities

Appendix 2

Public Health Transition Group

Terms of Reference

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1. Purpose

The purpose of this group is to oversee the transition of public health responsibilities from B&NES Primary Care Trust in its current form to B&NES Council and, where appropriate, to the GP Commissioning Consortium and the PCT Cluster. The group will also identify and manage risks or barriers that could negatively affect the transition. This work will include the following:

Coordination of the transition of public health responsibilities

- Propose timescales for different aspects of the transition (eg. Functions, governance, transfer of staff, budgets, etc) and seek agreement though the appropriate PCT and Council decision making processes.
- Develop a business continuity plan to ensure stability for the existing public health programmes during the period of transition.

Capacity, capability and design of future public health programmes

- Support the recruitment of a new Director of Public Health.
- Identify future public health responsibilities of existing and new organisations.
- Design a model for future public health arrangements in B&NES, showing how public health could work in the new organisational forms.
- Identify existing resources that will transfer or contribute to these arrangements.
- Identify potential gaps in resources or guidance.

Finance and resources

- Identify historic NHS B&NES and council spend on public health work streams and advise both organisations on recommended spend in the future, in line with guidance as this emerges and taking in to account local financial position.
- Agree a process for identification and final sign off of budgets, spend and financial accountabilities of key partners in relation to public health programmes.
- Scope the implications for finance, HR, management, IT support and advise on the necessary capability and capacity.

Communications and marketing

- Coordinate reports to the executive teams of the Council, the PCT and the GP Consortium.
- Oversee the coordination of a consultation response to the Department of Health for the Public Health White Paper and associated documents
- Scope the implications for communications support and advise on the necessary capability and capacity.

Information and intelligence

- Scope implications for intelligence support and advise on the necessary capability and capacity.

Workforce

- Identify staff that will be involved in the public health transition process.
- Identify workforce development needs within and outside of public health to enable an optimal transition of roles.
- Develop a HR framework for secondment and transition of staff.
- To oversee the HR framework and to ensure appropriate consultation with appropriate employee/union representatives.

2. Membership

Name	Role or representation
Ashley Ayre (Chair)	Acting Strategic Director, People and Communities
Jeff James	PCT Cluster CEO
Dr Pamela Akerman	Acting Joint Director of Public Health
Cllr Simon Allen	Cabinet Member for Wellbeing
Ros Brooke	Non-executive Director, Trust Board, NHS B&NES
David Trethewey	Divisional Director, Policy and Partnerships
William Harding	Head of Human Resources
Amanda Phillips	Director of Personnel and Organisational Development
Rachael Eade	GP Commissioning Consortium Member
Paul Scott	Assistant Director of Public Health (Project Lead)
Denice Burton	Assistant Director – Health Improvement
Sarah James	Deputy Director of Finance
Tim Richens	Divisional Director, Finance
Dr Mark Evans	Health Protection Agency

It is proposed that the group would seek representation and advice as required from HR, finance, IT, communications, Council Legal Services and other key colleagues.

3. Meeting frequency

Meetings will be held every 6-8 weeks during 2011, with regular attendance from core members and attendance as required from non-core members according to the agenda.

4. Constitution, reporting arrangements and links

The group has no executive powers but will report monthly to the Change Programme Board of B&NES Council.

5. Interfaces

The group needs to relate to the GP Clinical Commissioning Group, the PCT Cluster, the Commissioning Support Unit scoping project and the People and Communities Leadership Team.

6. Administration

Agenda and papers to be sent out one week before the meeting. Minutes of the meeting to be sent within one week of the meeting.

7. Review

The terms of reference will be reviewed in December 2011.

Appendix 3

Public Health Transition Group

Options Paper for the Timescale for Transition

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1. Purpose

To set out options for the transition of key public health responsibilities and resources from NHS B&NES to B&NES Council. To identify potential benefits and risks associated with different options. To make recommendations on a preferred option.

2. Background

Recent consultation papers[5] from the Department of Health (DH) outlined changes in the public health system. This involved the creation of a new national service 'Public Health England' operating within the Department of Health. It also proposed moving responsibility for public health to councils. The timetable for these local changes are shown below:

Start to set up working arrangements with local authorities, including matching of Primary Care Trust (PCT) Directors of Public Health to local authority areas	During 2011
Develop the public health professional workforce strategy	Autumn 2011
Publish shadow public health ring-fenced allocations to local authorities	April 2012
Grant ring-fenced allocations to local authorities	April 2013

The Department of Health also recently published guidance[6] on the future of PCTs in the near future, in the form of PCT Clusters and also the governance of public health during the transition period[7]. The guidance clarifies that the existing Board of each PCT will retain the statutory responsibility for public health functions and outcomes until April 2013. The Director of Public Health will continue to fulfil their role within the PCT Board. Directors of Public Health will not be consolidated at cluster level, in order to support the transfer of this function to local authorities. However, robust systems must be put in place to ensure that PCT cluster Chief Executives and their executive teams are fully cognisant of the public health responsibilities they retain and act accordingly.

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[5] Healthy lives, healthy people: our strategy for public health in England
http://www.dh.gov.uk/en/Publichealth/Healthylivieshealthypeople/index.htm

[6] PCT Cluster Implementation Guidance
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123996.pdf

[7] Marsland (2011) *Public Health England*
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_125240

3. Options for transfer of governance, staff and financial responsibilities

	Statutory accountability until April 2013	**Governance of performance and risk**	**Staff** (Note – this refers to public health commissioning staff. Public health provider staff will be part of the social enterprise).	**Budget and responsibility for expenditure**	**Benefits and risks**
Option 1	NHS B&NES Board	Council takes on from **October 2011**	Staff would work from current location but be line managed as part of the People and Communities Department structure from **October 2011**, as part of the emerging people's directorate. They would be managed by the Director of Public Health, under the Strategic Director of the People's and Communities Department, using section 113 arrangements. Decisions about staff contractual transfer waits until 2012 when HR guidance from DH published.	No transfer until further changes are signed off by NHS B&NES Board for 2012/13.	This option allows for accountability to stay with the PCT Board, but for the public health commissioning team to have consistent line management arrangements during the transition period and to enable them to contribute to shaping the emerging people's directorate from the earliest stages. There would be very little visible change for the team in 2011/12 which provides stability. The council is still creating its new structures and 2011 could be too early for a move of public health responsibilities. The PCT is still working hard on identifying expenditure across wider public health programmes and further national guidance is expected before the end of 2011.
Option 2	NHS B&NES Board	Council takes on from **April 2012**	No change of line management arrangements or secondment until April 2012. Decisions about staff contractual transfer waits until **2012** when HR guidance from DH has been published.	No transfer until further changes are signed off by NHS B&NES Board for 2012/13.	Allows more time for council to have developed new structures. Budget and expenditure may be clearer from April 2012 as shadow budget published nationally by DH. More clarity may be available from Public Health England about which programmes should be considered as public health expenditure and how commissioning should account for these responsibilities amongst organisations. Makes it harder for public health to be a co-partner from the start in the creation of the people's directorate and may miss opportunities for integrating public health functions with other emerging functions of the council during 2011/12.

Option 3	NHS B&NES Board	Council takes on from **April 2013**	No secondment at present time. Decisions about staff contractual transfer waits until **2012** when HR guidance from DH has been published.	Council has new budget allocated from Public Health England from **April 2013**.	Allows a lot of time for council to have developed new structures. Shadow budget will be clear from April 2012 as indicative budget published nationally by DH. Makes it harder for public health to be a co-partner from the start in the creation of the people's directorate and may miss opportunities for integrating public health functions with other emerging functions of the council during 2011/12. Council may start to feel pressure on areas covered by the national public health outcomes framework published from April 2012, but council won't yet have responsibility until April 2013.

4. Recommendations

The above table highlights that each option is associated with different benefits and risks. The Public Health Transition Group have reviewed these issues and have recommended that Option 1 provides the best opportunity, with the caveat that this should only happen with specific criteria in place. These are to be set out by the Public Health Transition Group but are likely to include a minimum of:

- A joint governance plan having been signed off for public health responsibilities of the B&NES/Wiltshire Primary Care Trust (PCT) Cluster and B&NES Council following the move to Cluster PCT arrangements in June 2011.
- The Director of Public Health continuing to fulfil their role as an Executive Director of NHS B&NES during the transition period of 2011-2013.
- The new Health and Wellbeing Partnership Board having been established and the Director of Public Health being a member of this board.
- The initial outline of the People's Directorate Structure having being established and agreed with the role of the Director of Public Health clearly indicated.

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	7th October 2011
TITLE:	Homeless Hostel Update
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 This briefing paper aims to update the Panel on progress to provide an alternative solution to improving homeless provision in light of the decision not to proceed with the James Street West hostel provision.

2 RECOMMENDATION

The Wellbeing Policy Panel is asked to:

2.1 Note and comment on the issues raised in this report

3 FINANCIAL IMPLICATIONS

3.1 The future development of the direct homeless hostel could have financial implications for the Council and in particularly the Supporting People and Communities revenue support budget. There will also be the opportunity to utilise some of the under spend of the Government Homelessness Grant to facilitate progress of the proposed option.

3.2 At this stage this briefing report has no identified financial implications as proposals are at an exploratory stage but the evaluation and consideration of final proposals will include full financial implications. Any revenue implications will need to be agreed with the Supporting People and Communities Commissioning body.

4 THE REPORT

4.1 The Council, through Supporting People & Communities funding, commission Julian House to provide a direct access homeless hostel. The service is provided from a basement in Manvers Street Baptist Church which is leased to Julian House from the Church. It provides 18 beds for men plus 3 for women. It is open every evening from 8pm until 8.30am providing shelter, food and support.

4.2 However, the facilities and accommodation are poor and do not meet modern hostel standards. There are a number of specific issues which include: limited capacity; dormitory style accommodation; inadequate provision for women – simply a small room where beds are laid out as required; lack of meeting rooms (including private rooms) to engage with clients and encourage them to work with support services; inability to host additional services and some doubts over the long term security of tenure.

4.3 In light of the decision not to proceed with the James Street West homeless hostel scheme officers were asked to investigate alternative solutions. The following provides an outline of what is likely to prove the best, and at present only proposed solution in the circumstances.

4.4 Julian House are planning to undertake some refurbishment in the near future, which will include improved ventilation and other superficial changes. However, more significantly they are in negotiation with their landlords to discuss a potential extension to their hostel lease which is due to come to end in 7 years. Julian House are also considering leasing another 2 properties in Bath. This could present an opportunity to remodel provision by designating Manvers Street as male only accommodation; reducing units of accommodation and redesigning interior; utilising the new buildings as move-on for more settled service users & provision of a new service for female rough sleepers.

4.5 We have had positive preliminary discussions with Julian House around this proposal. However, it is important to note that the proposal outlined above has been developed at short notice and needs further in-depth work in order to test out viability and strategic fit. In particular this proposal raises the following issues around risk, including:

(1) Where will the capital funding to remodel the existing hostel come from? Julian House have advised that they may be in a position to fully fund these works. However, it is important to note that the design work has not been commissioned.

(2) The remodelling would only be financially viable if the landlords agreed an extension to the Julian House lease.

(3) Would a female only provision be viable? If finances for this service have to be taken from the current contract, how does this affect the viability of the existing Julian House service?

(4) The Government is currently consulting on changes to how Housing Benefit is calculated for residents in supported housing schemes. This could potentially affect the viability of the model, particularly the move-on element.

(5) The proposed model relies on the availability of two properties in central Bath. Should these not be secured, the model cannot work.

(6) This model has not been formally put before the Supporting People & Community Commissioning Body and so the financial resources have not been identified to procure a new service for female rough sleepers.

4.6 Officers are now working with Julian House to offer our assistance in moving this proposal forward. However, until the landlords of Julian House make their intentions clear there is relatively little progress that can be made.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has not yet been undertaken.

6 EQUALITIES

6.1 No equalities impact assessment has yet been completed on the proposed solution. However it is well documented that rough sleepers frequently have health/disability issues and it is known that the provision, particularly for women, in Bath is inadequate. The core of this proposal would address the current adverse impact on both groups.

7 CONSULTATION

7.1 To date consultation on this model of provision has been restricted to the Cabinet Member for Housing & Major Projects and the Homelessness Partnership. The Homelessness Partnership comprises a range of organisation involved in homelessness, including Julian House, DHI, Shape Housing Association, Somer Community Housing Trust, Bath Abbey Homelessness Initiative and others.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Human Rights

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Graham Sabourn, Associate Director (Housing Services) Ann Robins, Supporting People Manager/Planning & Partnership Manager
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **7th October 2011**
TITLE: **WORKPLAN FOR 2011/12**
WARD: All
AN OPEN PUBLIC ITEM
List of attachments to this report: Appendix 1 – Panel Workplan

1 THE ISSUE

1.1 This report presents the latest workplan for the Panel (Appendix 1).

1.2 The Panel is required to set out its thoughts/plans for their future workload, in order to feed into cross-Panel discussions between Chairs and Vice-chairs - to ensure there is no duplication, and to share resources appropriately where required.

2 RECOMMENDATION

2.1 The Panel is recommended to

(a) consider the range of items that could be part of their Workplan for 2011/12 and into 2012/13

3 FINANCIAL IMPLICATIONS

3.1 All workplan items, including issues identified for in-depth reviews and investigations, will be managed within the budget and resources available to the Panel (including the designated Policy Development and Scrutiny Team and Panel budgets, as well as resources provided by Cabinet Members/Directorates).

4 THE REPORT

4.1 The purpose of the workplan is to ensure that the Panel's work is properly focused on its agreed key areas, within the Panel's remit. It enables planning over the short-to-medium term (ie: 12 – 24 months) so there is appropriate and timely involvement of the Panel in:

a) Holding the executive (Cabinet) to account

b) Policy review

c) Policy development

d) External scrutiny.

4.2 The workplan helps the Panel

a) prioritise the wide range of possible work activities they could engage in

b) retain flexibility to respond to changing circumstances, and issues arising,

c) ensure that Councillors and officers can plan for and access appropriate resources needed to carry out the work

d) engage the public and interested organisations, helping them to find out about the Panel's activities, and encouraging their suggestions and involvement.

4.3 The Panel should take into account all suggestions for work plan items in its discussions, and assess these for inclusion into the workplan. Councillors may find it helpful to consider the following criteria to identify items for inclusion in the workplan, or for ruling out items, during their deliberations:-

(1) public interest/involvement

(2) time (deadlines and available Panel meeting time)

(3) resources (Councillor, officer and financial)

(4) regular items/"must do" requirements (eg: statutory, budget scrutiny, etc)?

(5) connection to corporate priorities, or vision or values

(6) has the work already been done/is underway elsewhere?

(7) does it need to be considered at a formal Panel meeting, or by a different approach?

The key question for the Panel to ask itself is - can we "add value", or make a difference through our involvement?

4.4 There are a wide range of people and sources of potential work plan items that Panel members can use. The Panel can also use several different ways of working to deal with the items on the workplan. Some issues may be sufficiently substantial to require a more in-depth form of investigation.

4.5 Suggestions for more in-depth types of investigations, such as a project/review or a scrutiny inquiry day, may benefit from being presented to the Panel in more detail.

4.6 When considering the workplan on a meeting-by-meeting level, Councillors should also bear in mind the management of the meetings - the issues to be addressed will partially determine the timetabling and format of the meetings, and whether, for example, any contributors or additional information is required.

5 RISK MANAGEMENT

5.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

6.1 Equalities will be considered during the selection of items for the workplan, and in particular, when discussing individual agenda items at future meetings.

7 CONSULTATION

7.1 The Workplan is reviewed and updated regularly in public at each Panel meeting. Any Councillor, or other local organisation or resident, can suggest items for the Panel to consider via the Chair (both during Panel meeting debates, or outside of Panel meetings).

8 ADVICE SOUGHT

8.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

Contact person	Jack Latkovic, Senior Democratic Services Officer. Tel 01225 394452
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Last updated 28.09.11.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
7th October 11						
	Cabinet Member update		Cllr Simon Allen			
	NHS update		Jeff James/Derek Thorne			
	LINk update		Diana Hall Hall			
	Mental Health Service re-design		Andrea Morland			
	Domiciliary Care Strategic Partnership update		Sarah Shatwell			
	Public Health - transfer to Local Authority		Pamela Akerman			
	Ambulance Services update		John Oliver (GWAS)			
	Update on homelessness situation		Graham Sabourn			
	Any Qualified Provider		Tracy Cox			
	Re-ablement/30 days post discharge support		Sarah Shatwell			
18th November 11						

Last updated 28.09.11.

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
	Cabinet Member update		Cllr Simon Allen			
	NHS update		Jeff James/Derek Thorne			
	LINk update		Diana Hall Hall			
	Medium Term Resource and Financial Plans	AA	JS			
	Minimum waiting time for hospital admissions - 18 week referral to treatment target		Tracey Cox			
	Dementia care in BANES		Andrea Morland and Corinne Edwards			
	Minimum waiting time for hospital admissions – 18 week referral to treatment target (tbc)		Tracey Cox			
	Sirona Care and Health update		Jane Shayler			
27th January 12						
	Service Action Plans	AA	tbc			
	Strategic Transitions	AA	tbc			

Last updated 28.09.11.

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
16th March 12						
	RNHRD Update (tbc)		RNHRD rep			As a result of the meeting between the Chair and Vice Chair and CX from RNHRD in Sep 2011
	Personal Budgets policy framework	AA	JS			
18th May 12						
Future items						
	HealthWatch update		Derek Thorne			
	'What is it like to be an older person in BANES – to look at the life overall rather than under the series of separate headings'			Possible review - tbc		
	Psychological therapy services for adults (including the provision of counselling services in BANES)		Andrea Morland			

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