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

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Lisa Brett
Councillor Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor Sharon Ball
Councillor Douglas Nicol

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 27th July, 2012

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 27th July, 2012** at **10.00 am** in the **Council Chamber - 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, 27th July, 2012

at 10.00 am in the Council Chamber - 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

   At the time of publication no notifications had been received.

7. MINUTES 18TH MAY 2012 (Pages 9 - 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 AND CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Panel will receive an update from the NHS and Clinical Commissioning Group (CCG) on current issues.

10. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES) (Pages 29 - 52)

The Panel are asked to consider an update and report on visits to Care Homes in B&NES from the BANES Local Involvement Network.

11. HEALTHWATCH POSITION UPDATE (20 MINUTES) (Pages 53 - 60)

Policy developments outlined within the Health and Social care Act currently before parliament outline a new duty on local authorities to ensure the provision of Healthwatch. Healthwatch is a development in public involvement and will be the body that replaces the existing Local Involvement Networks (LINK). In Bath and North East Somerset activity has been taking place since spring 2011 to prepare for the commissioning of Healthwatch working towards an implementation date of April 2013. The panel received a report at its meeting in July 2011 at which point the ideas for Healthwatch were being finalised. Additional position updates have been included within the LINK committee reports. A formal update is being presented to ensure the Panel has comprehensive and current information on the firm plans for Healthwatch and the development taking place towards its pending implementation.

Members are asked to consider the information presented within the report and to note the key issues described.

12. JOINT WORKING ARRANGEMENTS WITH THE NHS BEYOND APRIL 2013 (15 MINUTES) (Pages 61 - 66)

This report will provide an opportunity for the Panel to discuss the proposals for future joint working arrangements with health, as described to the Cabinet on 11 July and to receive any verbal updates as appropriate.

13. HOUSING ALLOCATIONS VERBAL UPDATE (15 MINUTES)

The Panel will receive verbal update on housing allocations.

14. CARE HOMES QUARTERLY PERFORMANCE REPORT (APRIL - JUNE 2012) (20 MINUTES) (Pages 67 - 74)

Further to the report to Panel of the 18th May 2012 which set out the Quality Assurance Framework for social care services generally, this report is the first in a

series of quarterly reports which focuses specifically on the quality of care and performance of residential and nursing homes under contract in Bath & North East Somerset.

The Wellbeing Policy Development & Scrutiny Panel is asked to note the contents of the report and contribute relevant feedback and articulate clearly the role of the panel in relation to the QAF.

LUNCH BREAK AT 12:00 (20 MINUTES)

15. HOW THE PCT MONITORS QUALITY OF NHS DENTISTRY IN B&NES (30 MINUTES) (Pages 75 - 94)

The Wellbeing PDS Panel is asked to note the PCT monitors quality of NHS Dentistry in B&NES.

16. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) (45 MINUTES) (Pages 95 - 98)

There is a new statutory requirement for the local authority to conduct research activity. This is called the Joint Strategic Needs Assessment (JSNA). The JSNA and aims to provide the big picture about current and future needs of the Bath and North East Somerset population. Our JSNA has been produced in partnership between the Public Health Team and Policy and Partnerships. This report and accompanying presentation outlines the process undertaken and highlights key findings.

The Health and Wellbeing Policy Development & Scrutiny Committee is asked to:

- Note the process and findings of the JSNA.
- Consider how the JSNA can be used as an evidence to effectively support future scrutiny activity.
- Consider who else needs to be told about the JSNA and sources of information which should be included in future updates.

17. GOVERNMENT CONSULTATION ON STANDARDISED PACKAGING OF TOBACCO (15 MINUTES) (Pages 99 - 114)

The Department of Health has launched a consultation on whether standardised (plain) packaging of cigarettes and other tobacco products should be introduced in the UK. The consultation is open until 10th August 2012.

Due to increasing restrictions on tobacco advertising in recent years, tobacco packaging has become one of the tobacco industry's leading promotional tools. Research suggests that plain packaging would increase the impact of health warnings, reduce false and misleading messages that one type of cigarette is less harmful than another, and reduce the attractiveness of products to young people.

Australia will become the first country in the world to require all tobacco products to be sold in plain packaging, from December 2012. The UK government has committed to

consulting on options to reduce the promotional impact of tobacco packaging, including plain packaging.

The Wellbeing Policy, Development and Scrutiny Panel is asked to inform the Government that it supports the introduction of standardised (plain) packaging for all tobacco products in the UK through a collective response to the consultation.

18. WORKPLAN (Pages 115 - 122)

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, 18th May, 2012

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Lisa Brett, Eleanor Jackson, Anthony Clarke, Kate Simmons, Gerry Curran (In place of Sharon Ball) and Michael Evans (in place of Bryan Organ)

1 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

3 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Bryan Organ sent his apology. Councillor Michael Evans was his substitute for the meeting.

Councillor Sharon Ball sent her apology. Councillor Gerry Curran was her substitute for the meeting.

Councillor Loraine Morgan-Brinkhurst sent her apology (no substitute present).

Councillor Simon Allen (Cabinet Member for Wellbeing) sent his apology.

Ashley Ayre (Strategic Director for People and Communities) also sent his apology.

4 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

Councillor Eleanor Jackson declared personal and non- prejudicial interest on the agenda item 'Cabinet Member update' as she is Council's representative on Sirona Care & Health Community Interest Company.

Councillor Vic Pritchard declared personal and non-prejudicial interest on the agenda item 'Cabinet Member update' as he is Council's representative on Sirona Care & Health Community Interest Company.

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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

Mr Greg Hartley-Brewer will address the Panel with his statement under item 11 on the agenda (Dental Access Update).

Mr Greg Hartley-Brewer also asked the following question to the Panel:
'Bath and North East Somerset Clinical Commissioning Group already appears to have a perception of a conflict of interest and hasn't even started its work. How are the concerns raised in the Guardian article of 27 March 2012 to be addressed?'

The Democratic Services Officer read out the answer on behalf of the Panel.
'The Panel has a specific remit which is a discharge of Health functions. Once the Clinical Commissioning Group (CCG) is formally set up and once the specific guidance on future Health Scrutiny is available, the Panel will be monitoring how the CCG operates as commissioner and provider of health care'.

7 MINUTES 16/03/12

The Panel confirmed the minutes of the previous meeting as a true record and they were duly signed by the Chairman subject to the following amendment:

- Page 9, Para 7, third sentence should read: 'The Chairman commented that this may **exacerbate** problems of homelessness…'

8 CABINET MEMBER UPDATE (15 MINUTES)

The Chairman invited Jane Shayler (Programme Director for Non-Acute Health, Social Care and Housing) to give an update in the absence of Councillor Simon Allen (Cabinet Member for Wellbeing).

Jane Shayler took the Panel through the update (attached as Appendix 1 to these minutes). In addition to the update Jane Shayler brought to the Panel some changes in governance arrangements within Avon and Wiltshire Partnership Mental Health Trust (AWP) which were covered in local news. The Chair of the AWP stepped down and was replaced with the deputy Chair whilst the Chief Executive is on a period of leave and has been replaced on interim basis by the Deputy Chief Executive. The Council will be watching the developments in the governance of the AWP.

The Panel made the following points:

The Chairman said that the commitment for the Carers Week is excellent and congratulated the Carers Week initiative. The Chairman also said that he was impressed with the quality account from the AWP which highlights the initiatives for carers and the Council should pick up on it.

Councillor Jackson expressed her concern that the cuts are already affecting respite care. Councillor Jackson asked if there was any information how widespread this is.

Jane Shayler said that initiatives for carers in AWP quality accounts are not just Wiltshire based but they are for BANES as well. In terms of the concerns on cuts in respite – the reverse is true. There has been further investment from some of the money transferred from the PCT to Local Authority under Section 256 Agreement. Some of that money was invested to support respite care, additional carer support and additional domiciliary care support. Jane Shayler confirmed that there were no cuts in respite care. What may be the case is that respite care was being accessed frequently by a relatively small number of people, meaning that some other people were not able to access respite at all. There has been additional investment and, also, a redistribution, which has helped to address a potential inequity. Jane Shayler accepted that for some people, this may mean they are not able to access respite quite as often as they have been used to.

Councillor Jackson said that this message is not getting out and it should be somewhere explaining this to clients. Councillor Jackson asked what can be done on passing this message to clients.

Jane Shayler said that she will raise this with the carers centre and Council/PCT joint carers lead so they can continue to work on raising the awareness.

The Chairman suggested that simple explanation to those clients who felt that they would be affected by cuts should be most appropriate way to do it.

Councillor Jackson said that 16,000 carers is the figure that we have and asked if that was under-estimate of how many carers we have, given the demography of Bath. Councillor Jackson also asked what we do about children carers supporting their parents.

Jane Shayler said that 16,000 carers may be an under-estimate as some people might not view themselves as carers. Jane Shayler also said that she would have to come back with an answer on how many children carers supporting their parents are in BANES and what we do are doing to support them as responsibility for supporting young carers sits with Children's Services and Jane does know sufficient detail of what is available to provide a full response to Councillor Jackson's enquiry.

Councillor Curran said that there are services in the Council to help and support young carers.

Councillor Jackson congratulated officers on working together with the Care Quality Commission in bringing two care homes which had had bad reports up to the appropriate standards.

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

Appendix 1

9 NHS AND CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Chairman invited Ian Orpen (Clinical Commissioning Group - CCG) to give an update.

Ian Orpen took the Panel through the update (attached as Appendix 2 to these minutes) and added that the CCG had produced a draft Standard Business Conduct Policy which will incorporate conflict of interest, hospitality gifts, etc.

The Panel made the following points:

Councillor Hall said that she was very glad that the CCG will be having Standard Business Conduct Policy and asked if the document will be public once finished.

Ian Orpen replied that the Policy will be public once it is finished. The CCG will be also looking, in near future, to have their meetings in public and have the public involved in the process.

Councillor Brett suggested that the CCG should be looking in web based forums for discussion.

Ian Orpen replied that the CCG will be looking in all sort of ways to engage public (i.e. the way Council Connect does it).

Ian Orpen added that BANES CCG met with Wiltshire CCG (which is now single CCG) and the discussion was about the work with the RUH. The RUH is also keen on having single discussion with CCG. Also, on 31st May there will be a meeting between the Council, CCG, LINk, etc to look at broadly commissioning intentions and policies for the next three years. Very much linked to the Joint Strategic Needs Assessment (JSNA).

Councillor Brett asked if the CCG board will have representatives from the RUH.

Ian Orpen replied they will not be because it would be difficult to draw the line on how widespread the board could and should be. The RUH will be the essential part of the discussion though.

Ian Orpen explained that there is a process for appointment of co-opted/lay members of the board as per national guidance.

The Chairman said that it would be inappropriate to include providers in the commissioning group.

Ian Orpen added that the CCG group sent letters to all providers explaining on what is happening so they are up to speed.

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

Appendix 2

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

The Chairman invited Diana Hall Hall and Mike Vousden to introduce the update from BANES Local Involvement Network (LINk).

Diana Hall Hall took the Panel through the update as included in the agenda and informed the Panel that is Mike Vousden's last meeting and thanked him for his work and help during the last three or so years.

The Chairman said that the Panel appreciated Mike Vousden's input and that he will be missed.

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

11 DENTAL ACCESS UPDATE (30 MINUTES)

The Chairman invited Greg Hartley-Brewer to read his statement.

Greg Hartley-Brewer read out his statement where he highlighted that he had difficulty in finding an NHS dentist when he moved to Bath. He also said that he received poor treatment on number of occasions with ADP Oldfield Park Dental Practice. When he moved to another practice (1a Queen Square) he was asked to pay £35 for hygienist service which he felt he should not pay as NHS patient. Mr Hartley-Brewer acknowledged that the Panel had a review on access to dental services which did not include quality of service from the NHS dentists and asked the Panel to take an investigation into the NHS/private relationship in Bath and North East Somerset and set up a system to monitor the type and number of treatments using the General Clinical Data Set to make sure all treatments are being provided close to national averages.

A full copy of the statement from Greg Hartley-Brewer is available on the minute book in Democratic Services.

Members of the Panel said that although they did not agree with everything that was mentioned in the statement, they felt that Mr Hartley-Brewer highlighted some really serious and important issues in relation with the quality of service provided by the NHS dentists.

The Chairman invited Julia Griffith (NHS BANES) to introduce the report.

The Panel made the following points:

The Panel asked about over-providing the service and is that the case that some areas might be saturated with service while there is a deficit in the others.

Julia Griffith responded that when the NHS dental service was commissioned, the NHS looked at the areas of deprivation, by using health needs assessment. In the main there might be some areas where there is more demand than supply but across the whole area there are practices still with capacity to take on new patients.

The Panel commented that people do stay with their dentists, even if they become private, mainly because of the comfort that they feel with their current dentists.

Some Members of the Panel said that in their Wards, such as Keynsham Wards, there is a perception that there are no NHS dentists.

Julia Griffith took that on board and said that the NHS could use particular publications, which people read, where a number for dentists could be included.

The Panel asked about the implication from Mr Hartley-Brewer that the NHS dentistry is inferior to private care.

Julia Griffith responded that the NHS does monitor commissioning of dental care and also quality of services. Organisations like Care Quality Commission (CQC) inspect both, the NHS and private. Julia Griffith said she will write a response to the issues raised in Mr Hartley-Brewer statement.

The Panel asked about the initiatives to encourage parents to take their children to dentist regularly (as a result of junk food, etc).

Julia Griffith replied that there are a number of initiatives commissioned by the NHS. Health Promotion Team goes to schools etc and raise awareness.

The Panel suggested that the NHS should use youth clubs in raising dental awareness. Julia Griffith took that on board.

Julia Griffith explained to the Panel that the NHS asks dentists if they are accepting NHS patients, and if they say yes, their contact details are available on the NHS website.

The Panel made the final comment that they are alarmed that the quality of service might not be on the level as it should be.

It was **RESOLVED** to:

1. Request from Julia Griffith to draft a response to the issues raised in the statement from Greg Hartley-Brewer before the next meeting of the Panel. A copy of the response to be sent to the Panel.
2. Request from Julia Griffith, (and/or CQC), to produce a report on the Quality of NHS Dental Services. Report to be on the agenda for the next meeting of the Panel.

12 CARE SERVICES QUALITY ASSURANCE (30 MINUTES)

The Chairman invited Jane Shayler to introduce the report.

Jane Shayler suggested presenting this and the next report (The Effects of Delivering Adult Social Care Savings Targets on the Market – item 13) at the same time as there is direct link to those two reports. The Panel agreed with this suggestion.

Jane Shayler took the Panel through both reports. Jane Shayler highlighted that the findings of the Winterbourne View case will be published in August or September this year and she advised the Panel to schedule a report on that subject following the

publication of findings and as part of that that the Panel receive an advice from Jane Shayler on how the findings could be incorporated in a further development of the Quality Assurance Framework as there is a direct link to it.

The Panel made the following points:

The Panel agreed with the suggestion from Jane Shayler to have a report on findings from Winterbourne View case.

Jane Shayler said that the CQC became much more rigorous since the Winterbourne View incident and they are paying closer attention on all care homes. CQC is now releasing very strong press releases in respect on any of findings and very proactively raising any concerns on such issues. The Strategic Health Authority is also paying very close attention. Self-assessment process for learning difficulties is very detailed. It will not only put a pressure on commissioners but also on all providers, including non-specialist providers, to complete the self-assessment and show how the needs of all patients are met.

The Panel asked about budgetary considerations, in particular about saving of £1.2m on care placements.

Jane Shayler replied that she had consistently advised that the 3 year efficiency programme (i.e. reducing the costs of placements) was just that and could not be extended to a fourth year. The 3-year programme, which ends at the end of this financial year was evidence-based, including benchmarking fee-levels with other Local Authority areas and, also asking providers for detailed cost-breakdowns, showing how fees are made up, what element is profit, what element funds “hotel” – type costs and what proportion is spent directly on care provision to negotiate efficiency savings with providers, well informed evidence based programme with the fee breakdown of costs (how the costs are made up, how much profit they are taking, how much is spent on care provision, etc). It was evidence-based, including benchmarking fee-levels with other Local Authority areas and, also asking providers for detailed cost-breakdowns, showing how fees are made up, what element is profit, what element funds “hotel” – type costs and what proportion is spent directly on care provision The 3 year programme ends this financial year. It will not be going for fourth year as a fourth year of seeking efficiency savings does run a risk of seriously compromising the quality and safety of that provision. So we would need to seek savings through other means. There is a link to commissioning capacity as there is a need to keep an eye on all service providers. We are seeing individual facilities, mainly care homes, dipping in and out of an acceptable standard of care. We also need to keep up on on-going contract review. Council also agreed to fund a team for quality assurance and safeguarding team to work alongside AWP and Sirona in terms of the adult safeguarding process, including investigations, and also to have audit and quality assurance function for individual care assessments and support plans. The commissioning capacity has been increased but is not with the wealth of resources, especially given increased level of activity and referrals.

It was **RESOLVED** that the Panel noted the report and for the Panel to receive a report on findings from Winterbourne View case once it is published.

13 THE EFFECTS OF DELIVERING ADULT SOCIAL CARE SAVINGS TARGETS ON THE MARKET (20 MINUTES)

This report was covered together with the Care Services Quality Assurance report (item 12).

14 TALKING THERAPIES IN B&NES (20 MINUTES)

The Chairman invited Andrea Morland (Associate Director Mental Health and Substance Misuse Commissioning) to introduce the report.

The Panel made the following points:

The Panel expressed slight concern on finding out that provision will be moving away from GP practices and asked for assurance that variety will be kept. The panel also asked about the size of the team.

Andrea Morland said that she was also slightly concerned about that issue but it needs to be clear that in certain clinical conditions, such as anxiety, Cognitive Behavioural Therapy (CBT) is the most effective form of therapy. In depression it is a mix of counselling and CBT. Andrea Morland said that her aim in terms of talking therapies is to expand the choice with variety of appropriate services and absolutely not to remove provision at GP practices.

Andrea Morland also said that nobody really knew what the team, in its size, will look like. It was invested up to certain level with total investment of nearly £1m. There is a strong business case to continue the service.

The Panel asked how self-referral works.

Andrea Morland initially referrals were controlled through the GPs but now the service is more stable most people self-referred after getting a leaflet from their GP or from other community locations. There is a lot of different ways that people can get support and some people prefer not to go via GPs but straight to the relevant service.

The Panel asked if the safeguards are in place that patients are getting appropriate response to their mental health needs.

Andrea Morland replied that the service is working with other health professionals. The NHS has to spend money on services that meet NICE guidelines. Andrea Moreland said that there is a role to play to open access to variety of services. It is also important that we don't mistake talking therapy for specialist mental health care. Those with profound problems, in a need of specialist care, would go to the AWP.

The Panel expressed their concerns that some GPs suggest to people who have mental health problems to 'pull themselves together' etc. The Panel asked if there was any work with youth services.

Andrea Morland replied that her intention was to link with young people and she will be talking with Liz Price from Children Services and Youth Commissioning Team on the approach.

It was **RESOLVED** to note the report and to receive a further update on one of the future meetings.

15 ALCOHOL HARM REDUCTION STRATEGY BRIEFING (30 MINUTES)

The Chairman invited Cathy McMahon (Public Health Development and Commissioning Manager) to introduce the report.

The Panel made the following points:

The Chairman informed the meeting that the Panel is not in the position to note the report due to the lack of clarity on Equality Impact Assessment (EIA) for this paper. Cathy McMahon responded that the EIA had been conducted for the Strategy but not for this update.

The Panel asked whose fault is that children get alcohol at young age and how is that problem resolved.

Cathy McMahon responded that a lot of work is going on with students and young people on education in terms of alcohol and drinking, and from face to face work lots of intelligence and information is picked up.

Cathy McMahon also said that there is a big issue with young people and binge drinking. They don't drink much but they drink it quite quickly.

Some Members of the Panel highlighted the work of the Community Alcohol Partnership (CAP). Financed by supermarkets and the idea behind that partnership is to bring relevant partners (schools, Council, supermarkets, etc) to try to change drinking culture.

The Panel also expressed their concerns that people do not know how much units of alcohol is in different alcoholic drinks. The report should also say more about gender differences in consumption patterns.

Some Members of the Panel welcomed that Health Authorities will be more involved on this issue and ask for a review of licensing laws but expressed their concern that huge amount of resource will be used into work that might be duplicated with the work that police, licensing, etc. are already doing.

Cathy McMahon said that Health Authorities are very keen to engage and there would not be massive impact on resources and it wouldn't be duplication of work with police.

The Chairman summed up by saying that this is a very long term project. It would be useful to have statistics from A&E related to alcohol abuse. The big problem in Bath is 24 hour licensing laws. The enforcement opportunity had never exercised and that has to be changed. Some of the bigger off-licence chains employ youngsters who get easily intimidated by the other youngsters to supply alcohol. We will also see the impact of alcohol price increase in Scotland.

It was **RESOLVED** to:

1. Nominate Councillor Kate Simmons as Panel's representative to sit on the Alcohol Harm Reduction Steering Group; and
2. Hold an enquiry day with relevant experts and stakeholders to formulate policy on approaches to key issues such as Early Morning Restriction Orders, late night levies and health bodies' involvement in licensing decisions.

16 PUBLIC HEALTH TRANSITION ASSURANCE PLAN UPDATE (30 MINUTES)

The Chairman invited Paul Scott (Assistant Director of Public Health) to introduce the report.

The Panel made the following points:

The Chairman asked about the level of finances for this matter.

Paul Scott said that the Local Authorities budgets for Public Health will be announced next year. The expectations are that budgets should be the same for each authority. The report is more flagging the potential risk.

The Panel asked about the governance structure.

Paul Scott replied that under current proposal the Director of Public Health will be one of Divisional Directors within People Directorate. The Department of Health is suggesting that the Director of Public Health should be one of the Chief Officers.

The Panel asked about the intention to work with West of England and what influence the Government would have.

Paul Scott said that collaboration with the authorities within West of England region will continue. The Government is setting the targets and it is up to Local Authority to set prioritisation on areas where they want to improve services.

The Chairman summed up by saying that on page 116 of the report (under 9.21) there was omission of homelessness. The Panel agreed with this remark.

It was **RESOLVED** to note the report and include homelessness into 9.21 (Tackling Social Exclusion) of the Assurance Plan.

17 HOME HEALTH AND SAFETY POLICY 2012 (20 MINUTES)

The Chairman invited Chris Mordaunt (Housing Services manager) to introduce the report.

The Panel made the following points:

The Panel asked where the money comes from for the changes to the current policy.

Chris Mordaunt replied that money for:

- disabled facilities grant – approximately 50% from Government and other 50% from Council's revenue budget
- home improvement loans – mixture of Housing Services revenue and Health and Social Services budget
- empty properties – envisaged funding to come from two year pot money that was agreed by the current administration.

The Panel welcomed the paper and asked if the paper had been submitted to the Cabinet.

Chris Mordaunt replied that last year the revised policy had been submitted to the Cabinet who asked for the policy to be back in year time. We plan to bring the policy back to the Cabinet this summer.

Jane Shayler said that Panel is asked to comment on proposed amendments. All those comments will be submitted to the Cabinet Member who will consider those before the final report goes to the Cabinet.

The Chairman pointed to the page 191 of the report under bullet point 6 (Exceptional Cases) it should be Cabinet Member who should make a decision on exceptional cases and not Housing Service Manager. That would help the administration to be more transparent.

The Panel heard from the officers that these exceptional cases happen 2-3 times per year.

The Panel agreed with the Chairman's suggestion.

The Panel said that the Equality Impact Assessment (EIA) was very good but it underestimated the needs of those with severe mental health illness.

Chris Mordaunt replied said that in practice there is reasonable allowance for these groups. The Council also commission services from Care and Repair whose key role is to work with vulnerable people. There are some procedures to deal with those issues but there is a scope to in the EIA.

Member of the Panel asked about ethnic minorities and how they are kept informed about services.

Chris Mordaunt replied that the service had been in contact with some communities recently and there is on-going work in that area.

It was **RESOLVED** to note the report and for the officers to take on board comments made by the Panel.

18 WORKPLAN

It was **RESOLVED** to note the workplan with the following additions:

- Half Day open session on Joint Strategic Needs Assessment before autumn this year.
- Report on the Quality of Dental Service with NHS registered dentists (for July meeting)
- Winterbourne View findings – September 2012 (to be confirmed)
- Talking Therapies update – date to be confirmed
- Scrutiny Inquiry Day with relevant experts and stakeholders to formulate policy on approaches to key issues such as Early Morning Restriction Orders, late night levies and health bodies' involvement in licensing decisions (subject to the agreement from policy Development and Scrutiny Chairs and Vice Chairs).

The meeting ended at 2.50 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 – May 2012

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1. PUBLIC ISSUES

Carers Week 18th – 24th June

To mark Carers Week, raise awareness of the challenges facing the estimated 16,000 carers in Bath and North East Somerset and to promote some of the support and services available to carers, the Carers Centre, which is jointly funded by the Council and Primary Care Trust, has organised a week of events. The full programme can be accessed on the Carers Centre website at www.banescarerscentre.org.uk but the following gives a flavour of what is planned:

Monday 18th - Bath Peer Support Group
A peer support group for carers to help each other
10.45am to 12.15pm
Somer Community Room, Kingsmead Court, Kingsmead North, Bath BA1 1XB

Tuesday 19th - Two's Company
12.30pm to 3.00pm
Come along together for a scrumptious cream tea.
Saltford Hall, Wedmore Road, Saltford, BS31 3BY

Wednesday 20th - Carers' Forum
Have your voice heard on Sirona Care and Health's Services, developing carers' services for 18-30's and working carers and setting up a social enterprise for Give Us a Break.
Workshops 10-12.30pm or 6-8.30pm
Food 12.30pm to 2pm or 5-6pm
Health checks and fitness session 2-5pm
St Luke's Centre, Wellsway, Bath BA2 4SJ

Thursday 21st - Golden Oldies
With all the classic songs from the 50s, 60s and 70s, enjoy an unmissable hour of fun-filled singing, dancing and socialising for Goldies everywhere.
Somer Community Centre, Twerton , Bath BA1 2DJ
2.30pm to 3.30pm

Friday 22nd - Carers for Each Other
Trip to Weston Super Mare for carers with learning disabilities
10.00am-3.00pm
Saturday 23rd - Carers' Week Family Day

Come on your own or bring your whole family to enjoy a variety of activities including computer tuition, cookery workshops, fitness sessions, health checks, therapies and more for ages 1 to 101.

2.00pm-6.00pm
Keynsham Baptist Church , High Street Keynsham BS31 1DS

Sunday 24th - Pub Quiz
7.30pm – 10.00pm
Come and test your general knowledge and gain peer support at the same time. Prizes to be won.
Salamander 3 John Street, Bath BA1 2JL

2. PERFORMANCE

There are no key performance issues to highlight.

3. SERVICE DEVELOPMENT UPDATES

Autism Service

Funding has been identified for two social work posts to fulfil community care responsibilities for adults with a diagnosis of Autism Spectrum Condition (ASC). This service enhancement has been commissioned from Sirona Care & Health and will be managed within the Sirona Complex Health Needs team. The post holders will care-manage all adults with ASC across the spectrum. This key development recognises the need to ensure that the assessment and care management of adults with ASC is undertaken by staff who have a good understanding and awareness of the needs of people with ASC, and an ability to commission quality services from skilled providers to meet the individual's needs. It is intended that the service will have a particular focus on supporting people to live independently in their own homes and on supporting people into employment.

Intensive Community Detoxification

The first three clients have successfully completed an Intensive Community Detoxification programme at a specialist supported living scheme run by DHI in Bath. The service, commissioned by Supporting People and Communities is delivered in partnership with DHI and the Specialist Drug and Alcohol Service, (SDAS) and was set up 6 months ago when the old Stall Street Dry House project closed. As well as the detox unit, the supported living scheme provides a further 10 'Dry house Units' (3 more than Stall Street), and another 6 continue to be delivered in an established supported living scheme also run by DHI. By remodelling and integrating the supported houses fully into treatment provision, we aim to offer a sufficiently robust structured package of support to those wishing to become drug and alcohol free. More people will be given an opportunity to detoxify and experience rehabilitation and we expect this to be of particular value to offenders returning to the community homeless, and other homeless people who wish to become abstinent. A full review of the service will be carried out this Autumn when it will have been up and running for 12 months.

Housing Renewal Policy (Home Health and Safety Policy)

This revised policy sets out the criteria for accessing a number of schemes which promote independent living for vulnerable households in B&NES in the community by

providing advice and assistance, including financial assistance, for adaptations, repairs and improvements. The policy also covers a scheme to encourage the owners of empty properties to bring those properties back into use. The policy has been reviewed a year after approval by Cabinet and revisions include the expansion of eligibility criteria for home improvement loans to include low income families with dependent children under 16 years of age.

The policy has 5 areas main areas:

- **Adaptations for disabled people –** to improve the housing conditions of eligible disabled people by providing Disabled Facilities Grants (DFG) to purchase adaptations that assist independent living.
- **Home safety repairs and improvements -** advice and financial support for vulnerable households in the form of loans or grants to remedy and alleviate serious health and safety hazards in their homes. It operates alongside the Housing Services Enforcement policy on the improvement of rented homes which fall below acceptable health and safety standards.
- **Home energy efficiency improvements -** advice and financial support to help vulnerable and low income households insulate their homes or make them more energy efficient. These improvements will make it more affordable for vulnerable people to stay warm.
- **Community alarm grants -** grants for community alarms that makes them safer in their homes.
- **Empty Home assistance –** to improve the availability of housing in the area by assisting owners of empty homes to bring their properties back into use by giving advice and financial assistance in the form of loans or grants.

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Wellbeing Policy Development and Scrutiny Panel
May 18th 2012
Key Issues CCG/PCT Briefing Note

1. Conflict of interests

Some recent local and national media interest has focused on the role GPs will be playing in the future decision making of the NHS and a perceived problem regarding any conflict of interests. It is not unusual for GPs to have interests within health care provider organisations and a question has been raised as to how such GPs can manage the assessment and awarding of contracts where a tender may be received from a company in which the GP is involved.

B&NES CCG is confident that this issue is being properly addressed. Currently, In line with NHS governance standards all GPs within the Clinical Commissiong Group have declared their interests and these are held within a register. GPs who are part of decision making committees are asked to declare their interests at the start of the meeting and these are recorded. Should there be a material conflict of interest the individual concerned would not participate in any decision.

Some comment has been raised regarding local health care company Assura Minerva who run Bath NHS Healthcare Centre and other clinical services. All declarations of interest in Assura are registered where applicable. To demonstrate transparency and open governance, on being elected to the Interim B&NES GP Consortium Board, Dr Ian Orpen, Chair of the CCG resigned as a member of Assura Minervas Clinical Management Board. In addition all GP partner members of the consortium board have agreed to forgo any profit their practices might receive as a result of being members of partners in Assura.

Managing good governance is an essential part of the new commissioning structures. As final authorisation gets underway and the regulatory framework is fully put in place it is anticipated that national guidance will be applied that specifically address how decisions can be taken if a situation arose where a majority of local GPs are conflicted.

2. Summary care record

The programme to establish a summary care record was reported to the panel at its last meeting. The summary care record is establishing a national shared record service so that clinicians can see critical information on patient's medication, allergy records and medical reactions to enable safer and more efficient emergency care treatment at any clinical location that a patient may be brought to.

Letters have now been distributed to all adults in B&NES. An information helpline is in operation and local enquiries are being dealt with through the PALs service. People have a 12 week period to respond to the offer to opt out of the system. For those who do not opt out, records will be automatically established and the system put in place over the next 10 months.

3. Our healthy conversation event

On 18th April the latest 'Our Healthy Conversation' was held at the Fry club in Keynsham. The event focused on the subjects of clinical commissioning, Joint Strategic Needs Assessment and urgent care. Panel members will be aware that these events are held regularly by the PCT to provide opportunity for partners, stakeholders and members of

the public to be informed on current developments and engage with managers to influence health and social care. 60 people attended the event which was lively and well received. Feedback is currently being compiled and will be circulated to all health and wellbeing network contacts. Panel members are always invited to attend these events. The next one will take place in September.

4. NHS Commissioning infrastructure Developments

National and Regional

National announcements have been made regarding appointments to the NHS Commissioning support team and the development of the local structures of the NHS Commissioning Board. The Commissioning Support Team reports to National Director of Commissioning Development Dame Barbara Hakin. Four sectors have been agreed across England within the Operations Directorate being:

Richard Barker-Regional Director, North of England currently Chief Operating Officer, NHS North of England
Dr Paul Watson-Regional Director, Midlands and the East currently Chief Executive, NHS Suffolk
Dr Anne Rainsberry-Regional Director, London currently Chief Executive, NHS North West London and Deputy Chief Executive, NHS London
Andrea Young-Regional Director, South of England
currently Chief Operating Officer / Deputy Chief Executive, NHS South of England

The Regional Directors' first key task is to work with Primary Care Trusts, Strategic Health Authorities and other stakeholders to co-design a proposal for the final model of the Commissioning Board's network of Local Area Teams. There will be up to 30 Local Area Teams set up from care trust clusters replicating the current PCTs. There is no single, ideal model or geographical footprint for Local Area Teams as the design must take account of local geographies, service patterns and relationships to develop a resilient and realistic solution that will establish the definitive local presence of the NHS Commissioning Board.

5 Clinical Commissioning Group Update

Appointments

The B&NES Clinical Commissioning Group continues to develop its senior team and has made some senior appointments:

- Tracey Cox has been appointed as Interim Chief Operating Officer
- Sarah James has been appointed as Interim Chief Finance Officer
- Dr Simon Douglass is acting as CCG Accountable Officer Designate and is currently going through the formal national assessment process for appointment which will be confirmed by the Appointments Commission in due course.

These appointments strengthen the capacity of the CCG which is working towards taking up its full statutory responsibilities in April 2013 at the conclusion of the PCTs.

Other senior commissioners have been assigned to the CCG for the transition period as the CCG looks to retain as much senior commissioning capacity as possible.

Authorisation

There are 4 waves for submission to Authorisation from July to November and B&NES CCG have settled on Wave 3 (1st October). There is a massive task to prepare to meet all 119 criteria across 6 domains. It is the intention of the CCG to be fully authorised without conditions which would be the risk of going earlier, inadequately prepared. The name of the CCG has been confirmed in line with DH guidance as:

NHS Bath & North East Somerset CCG

A key part of the authorisation process is the CCG constitution and we are currently working this up basing it on guidance from the DH and BMA as well as linking with the Avon Local Medical Committee and others. CCGs are a membership body and practices are the members and to this end we have a small working party of GPs and practice managers looking at the constitution as it is developed.

Compiled by Derek Thorne NHS B&NES Assistant Director Communications & Corporate Affairs 01225 831861

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Bath and North East Somerset

Local Involvement Network

Report to B&NES Wellbeing Policy Development & Scrutiny Panel, 27 July 2012

1. The LINk's Host Organisation

Following the Council's decision to re-commence its tendering process for a Local Healthwatch organisation, Scout Enterprises, the LINk's Host organisation for the past four years, has been asked to extend its contract until 31 October 2012 to allow time for a fresh tendering process to be run.

2 B&NES Cancer Services User Group for RUH

Members of the LINk are keen to see the setting-up of a Cancer Services User Group for RUH patients, and have been exploring this possibility for several months. On approaching the RUH, they received the response that the Trust did not see any need for such a group, since there are already other groups in existence that provide feedback on cancer services users' experience and needs. The LINk feels that the Trust is confusing the purpose of these existing groups with the purpose of a Cancer Services User Group, which is to provide mutual support for patients undergoing treatment. We are currently pursuing this issue for RUH patients through other channels.

3. Transition from Children's to Adults' Care in B&NES

The LINk has received concerns from a severely disabled service-user's family about the serious problems they have experienced in the transition for that service-user from services provided to children to those provided to adults. They are anxious that their experience, and that of their many friends in similar situations, should be used to improve this very important transition process, which can be the cause of many serious problems.

The LINk has agreed to undertake a project to look at this area, and is going to meet with the family in the near future to discuss their experiences and the best way to take this work forward to include the experiences of as many similarly placed service-users as possible.

4. LINk's Visits to Care Homes in B&NES

The LINk has conducted a short series of visits to care homes in B&NES, and has now finalised its report on this. The Report is attached as an Annex to this paper for the Panel's information, and the LINk's Deputy Chair, Jill Tompkins will present this to the Panel.

Diana Hall Hall
Chair, B&NES Local Involvement Network
17 July 2012

Annex 1

Bath and North East Somerset Local Involvement Network

Visits to Residential Homes in BANES- February to June 2012

It was decided in response to conversations with our members, the public, and other interested parties that quite often difficulty was experienced when the need arose to find a suitable residential place for an elderly person.

As some of the members of BANES LINk have been trained in the “enter and view” procedure we set up a group to plan a series of visits to homes in the BANES area. The programme was based on being able to familiarise ourselves with what was being offered to prospective residents and their families.

We chose homes of similar size that were on different locations that would give choices to meet the varying needs of the elderly clients. Every establishment made us welcome. The families and friends of residents came to talk to us. We had a great rapport with everyone.

The facilities clearly varied. All of them were clean and well kept. The residents, whenever possible, were included in any replanning, choice of decorations and the homes made it as homely as was practicable.

We would like to thank all the staff for making us welcome, and we never felt that we were on their way.

It is hoped that in the not too distant future we will be able to visit other providers to add to our portfolio, and trust that this is seen as a positive piece of work by the Council.

Jill Tompkins
Vice Chair, B&NES Local Involvement Network
July 2012

Report

on

Bath & North East Somerset LINk's Visit to Cleeve Court Care Home, Twerton, Bath

24 February 2012

Cleeve Court Care Home Visit Report

24 February 2012 at 10.30 am

Address of Care Home:

Bath Community Resource Centre
Cleeve Green'
Twerton,
Bath BA2 1RS

1. Background to Visit

1.1 The Bath & North Somerset Local Involvement Network ("LINk") decided to conduct a series of visits to care homes in Bath & North East Somerset. Although the LINk has formal, statutory powers (given under Part 14 of the Local Government and Public Involvement in Health Act 2007) to "enter and view" any premises in which health or social care is provided, it decided to conduct these visits on an informal basis, rather than invoke these powers.

1.2 The purpose of the visit was to acquire an overview of the services that are provided by talking to the residents, their carers and the home's staff. The areas of care that we decided to focus on were:

- Independence, choice and flexibility for residents;
- Facilities and activities available;
- Dignity, respect and privacy of residents;
- Management, staffing, medicines, GP care, etc;
- Communication
- Involvement of Carers;
- Engagement with the local community.

1.3 The LINk's Host (its support organisation) contacted the manager of the home prior to the visit, to inform him of the LINk's wish to informally visit the home, to explain the purposes of the visit, and to advise him of the number and identity of visitors. We asked him to send us some information on the home in advance of the visit, and he sent us the *Sirona* prospectus provided to prospective residents and their families.

1.4 The LINk visitors were the B&NES LINk Deputy-Chair Jill Tompkins, LINk Committee Member Pat Jones, and Host Manager Mike Vousden. They carried out their announced and informal visit to Cleeve Court on Friday 24 February at 10.30am.

1.5 We met with Shaun Lock the home manager, and Yvonne Case the incoming home manager, who would be taking over management from 25 February. On arrival, we were welcomed and asked to sign in.

2. Overview of Cleeve Court Care Home: information we were given

2.1 Cleeve Court is a care home situated within the Bath Community Resource Centre in Twerton, which opened in 2007. It is spread over two floors - the first and the second floors of a building which has a Day Centre on the ground floor.

2.2 Cleeve Court, like the overall Resource Centre, is provided and run by *Sirona*, a new Community Interest Company, under contract to Bath & North East Somerset Council. The company was formed in October 2011 as an independent non-profit distributing organisation providing publicly-funded health and social care services. Sirona is responsible for the delivery of the community healthcare and adult social care services previously provided by Bath & North East Somerset PCT and Council respectively.

2.3 The home is registered for 45 residents over 50 years of age. The second floor provides 20 places are for people who are frail, and the second floor has 25 places for people diagnosed with dementia. There are also two places for the provision of residential respite care for people living in the community. All rooms have *en suite* toilet and washing facilities, and resident-couples can be

accommodated in adjacent, connected rooms which they can use as a separate living room and bedroom. The youngest resident at present is 45 years, and the home always has a waiting-list of would-be residents. There is no upper age-limit for residents, provided that their needs can be met at the home.

2.4 We asked about the independence and self-determination of residents, and we were told that they are free to bring their own furniture and belongings to furnish their rooms, and to spend as much time in their rooms as they wish. Meals are taken to residents' rooms if they wish to have them there. Residents who are safe to do so, may come and go from the home as they please. Residents are not allowed to smoke in their rooms, or anywhere else inside the home. There is a small open-air smoking area directly accessible from inside the home.

2.5 Hairdressing is provided at the home in a dedicated salon: this service is chargeable to residents. Chiropody is available on the same basis.

2.6 Residents are encouraged to pursue activities that interest them, and there is an Activities Room on the ground floor of th building. There is an Activities Coordinator who works for three hours daily on weekdays. Some activities, such as quizzes, bingo and reminiscence groups are held in the lounge and Activity Room.

3.0 Staffing of Cleeve Court

3.1 Overall staffing consists of:

Manager
8 Senior Support Workers
60 Support Workers
12 Night Support Workers
9 Housekeeping Assistants
4 Catering Assistants
3 Cooks

The level of staffing is assessed on a monthly basis. We were told that staff-retention is very good, and that all speak good English, with all but one being a native English speaker.

3.2 We were told that training is given to staff to a high standard, through a mandatory general training package, together with some more specific training (eg, for dementia care). Some of the staff are trained in medicine administration.

4. Visitors and Relatives

4.1 Visiting is allowed at any time acceptable to residents. Visitors are welcome to eat with their relatives if they are there during mealtimes (a small charge is made for this).

5. Observations of the LINk Visitors during Visit

5.1 We met a number of staff during our visit, and were able to note their professionalism.

Report

on

Bath & North East Somerset LINk's Visit to the Heather House Care Home, Batheaston, Bath

1 February 2012

Heather House Care Home Visit Report

1 February 2012 at 10.30 am

Address of Care Home:

Heather House Nursing Home
Bannerdown Road
Batheaston
Bath BA1 7PL

1. Background to Visit

1.1 The Bath & North Somerset Local Involvement Network ("LINk") decided to conduct a series of visits to care homes in Bath & North East Somerset. Although the LINk has formal, statutory powers (given under Part 14 of the Local Government and Public Involvement in Health Act 2007) to "enter and view" any premises in which health or social care is provided, it decided to conduct these visits on an informal basis, rather than invoke these powers.

1.2 The purpose of the visit was to acquire an overview of the services that are provided by talking to the residents, their carers and the home's staff. The areas of care that we decided to focus on were:

- Independence, choice and flexibility for residents;
- Facilities and activities available;
- Dignity, respect and privacy of residents;
- Management, staffing, medicines, GP care, etc;
- Communication
- Involvement of Carers;
- Engagement with the local community.

1.3 The LINk's Host (its support organisation) contacted the manager of the home prior to the visit, to inform him of the LINk's wish to informally visit the home, to explain the purposes of the visit, and to advise him of the number and identity of visitors. We asked him to send us some information on the home in advance of the visit, and he sent us the brochure provided to prospective residents and their families, and also the *Statement of Purpose* of its proprietorial company (Blanchworth Care Group).

1.4 The LINk visitors were the B&NES LINk Deputy-Chair Jill Tompkins, LINk Committee Member Pat Jones, and Host Development Worker Carole Pullen. They carried out their announced and informal visit to Heather House on Wednesday 1st February at 10.30am.

1.5 We met with Sally Bushell Operations Manager for Blanchworth Homes, and were introduced to Lorna Flick, Manager Heather House and Jason, Clinical Manager Heather House. They were expecting us, and made us feel very welcome. We were asked to observe the routine of signing-in.

1.6 In the introductory discussion, the Home's managers emphasised that Heather House is the residents' home, and that the focus of care is on facilitating the residents to make their own choices, on fostering the residents' life skills and preferred life-styles, and on encouraging them and helping them to act in their own best interest. Choice was always mediated by risk assessment by staff.

1.7 Sally explained that the Blanchworth Care Group have homes in many areas, and cater for various types of resident-funding. Heather House has both self-funded and local authority funded residents. Some residents could be eligible for NHS Continuing Healthcare funding of all their nursing and residential needs.

1.8 Sally confirmed that all Care quality Commission visits to the home had been unannounced visits. Inspections by the Local Authority are normally pre-announced, and are usually carried out by social workers coming in to carry out annual reviews on care plans etc; however to Sally's knowledge there had not been any Local Authority visits.

1.9 The LINk visitors requested a copy of the pro-forma Care Plan document, and were provided with a copy to take away with them.

2. Overview of Heather House Care Home: information we were given

2.1 Heather House has dual registration with the Care Quality Commission for provision of both Personal ("Residential") and Nursing care.

2.2 Heather House is registered for a maximum of *36* residents, with *28* single rooms and *4* double rooms. When we visited there were 21 residents.

2.3 This is a *General Care home*, not able to take dementia residents, although have residents with "confusion"

2.4 Have to meet the residents' needs: all residents have ongoing assessments for care and mental health.

2.5 Not registered for dementia.

2.6 All residents come to the home initially on a 4 week trial basis, and are assessed individually to ensure their needs are being met.

2.7 Residents have access to a local advocacy service.

2.8 *All residents are required to register with a GP. The home has a contract with a local GP*.

2.9 There is a number-coded door entry system

3.0 Staffing of Heather House

3.1 The Home Manager, Lorna Flick, is a dignity champion, and is fully qualified.

3.2 Clinical Manager, Jason, has been at Heather House for 8 months, is fully qualified and has specialist mental health training.

3.3 The staff are from multi cultural backgrounds.

3.4 At interview, applicants must be able to read and speak English

3.5 There are two day-time shifts for morning and afternoon, with five members of staff on each. For the night-shift, one nurse plus one other carer are on duty.

3.6 There is a recently-appointed activity co-ordinator, who is also a senior care assistant at the home. The activity co-ordinator will liaise with the residents on how they would like things run.

3.7 To cope with fluctuations in resident numbers, agency staff or staff from other homes within the Company can be brought in. The balance of staff and resident numbers is monitored by the Manager.

3.8 There are regular communication/staff meetings.

3.9 There is an external training co-ordinator for all staff.

3.10 All staff have to attend an induction programme, usually at St Martins Hospital training centre.

3.11 In-house training for "end-of-life" is provided by Dorothy House, and all staff are required to have this training

3.12 There is an ongoing training programme for all staff.

3.13 Each member of staff has a yearly Appraisal and approximately twelve Supervision sessions (CQC require 6 supervisions per year)

4. Visitors and Relatives

4.1 Visitors are offered refreshments during their visit and can stay for a meal although this is chargeable.

4.2 If visitors have travelled a distance then if a room is available they are able to stay overnight at no extra cost.

4.3 A relatives meeting is held every 3 months.

4.4. Relatives are actively involved in the care planning process which starts at the initial assessment. A care plan is subsequently drawn up and agreed by the relatives and the residents.

5. Observations of the LINk Visitors during visit

5.1 The rooms viewed were very nice light rooms, there was a separate dining room, a communal lounge and a “quiet” room.

5.2 There was a choice of menu and residents can have their meals in their own rooms if they so wished. Lunch is usually served from 12pm.

5.3 There were quite a lot of steps, however alternative routes were available.

5.4 The staff were friendly and approachable.

5.5 An activities board is displayed in the foyer.

5.6 A refreshment trolley is regularly brought round.

5.7 Visitors are welcomed.

5.8 Pets are allowed to visit.

5.9 There is a chiropodist and hairdresser who regularly visit.

6. Reflections of the LINk Visitors after the Visit

6.1 LINk visitors were made to feel very welcome and the staff spent time answering our questions.

6.2 We were able to wander freely, talk to the residents and have access to the kitchen area.

6.3 From the rooms viewed there didn’t appear to be shower facilities (this was subsequently clarified by telephone that there are showers available).

6.4 The overall feeling was that the residents were safe and cared for and there was adequate staffing and they came across as passionate and caring.

6.5 It was felt that the garden needed a little attention.

6.6 Some of the internal steps were quite steep and could cause a problem for those less able.

6.7 It was a very positive informal visit.

Report

on

Bath & North East Somerset LINk's
Visit to the Smallcombe House Care Home,
Bathwick Hill, Bath.

20th March 2012

Smallcombe House Care Home Visit Report

20th March 2012 at 10.30 am

Address of Care Home:

Smallcombe House
Oakwood Gardens
Bathwick Hill
Bath BA2 6EJ

1. Background to Visit

1.1 The Bath & North Somerset Local Involvement Network ("LINk") decided to conduct a series of visits to care homes in Bath & North East Somerset. Although the LINk has formal, statutory powers (given under Part 14 of the Local Government and Public Involvement in Health Act 2007) to "enter and view" any premises in which health or social care is provided, it decided to conduct these visits on an informal basis, rather than invoke these powers.

1.2 The purpose of the visit was to acquire an overview of the services that are provided by talking to the residents, their carers and the home's staff. The areas of care that we decided to focus on were:

- Independence, choice and flexibility for residents;
- Facilities and activities available;
- Dignity, respect and privacy of residents;
- Management, staffing, medicines, GP care, etc;
- Communication
- Involvement of Carers;
- Engagement with the local community.

1.3 The LINk's Host (its support organisation) contacted the manager of the home prior to the visit, to inform her of the LINk's wish to informally visit the home, to explain the purposes of the visit, and to advise her of the number and identity of visitors. We asked her to send us some information on the home in advance of the visit, and she sent us the brochure provided to prospective residents and their families, and also the *Statement of Purpose* for the Service Provider (The Salvation Army).

1.4 The LINk visitors were the B&NES LINk Deputy-Chair Jill Tompkins, LINk Committee Member Ann Harding, and Host Development Worker Carole Pullen. They carried out their announced and informal visit to Smallcombe House on Tuesday 20th March at 10.30am.

1.5 We met with Mrs Ena Caddy, Care Home Manager, Smallcombe House who was expecting us, and made us feel very welcome.

1.6 In the introductory discussion, the Home manager emphasised that Smallcombe House is the residents' home, and that the focus of care is on facilitating the residents to make their own choices, on fostering the residents' life skills and preferred life-styles, and on encouraging them and helping them to act in their own best interest. Choice was always mediated by risk assessment by staff. Smallcombe House aim to provide residential care for older people within a Christian environment. The home is a non profit organisation.

1.7 Ena explained that the Salvation Army have 17 care homes across England, Scotland and Northern Ireland and cater for various types of resident-funding. Smallcombe House has both self-funded and local authority funded residents.

1.8 Ena confirmed that all Care Quality Commission visits to the home had been unannounced visits. The Salvation Army also conduct their own yearly inspection, a copy of the most recent inspection report and inspection toolkit was given to the LINk visitors. The Salvation Army also carry out monthly monitoring visits, a copy of the latest report (14/3/2012) was given to the LINK visitors.

1.9 The LINk visitors requested a copy of the Care Plan Diary and were provided with a copy to take away. (Ena informed us that these are going to be computerised shortly).

2. Overview of Smallcombe House Care Home: information we were given

2.1 Smallcombe House is registered with the Care Quality Commission for provision of Residential care without nursing.

2.2 Smallcombe House is registered for a maximum of 32 residents. There are 32 single rooms; some have interconnecting doors which would be suitable for couples. When we visited there were 26 residents, of those, currently 17 are private and 9 local authority. Fees received from the LA are less than private, the Salvation Army subsidise the difference. If there are empty rooms, Smallcombe House will offer respite care as long as residents meet the criteria.

2.3 This is a General Care home for older people aged 65 and over, a service is provided for people with short term memory loss, and early stages of dementia.

2.4 All residents come to the home initially on a 4 week trial basis, and are assessed individually to ensure their needs are being met. This period can be extended if needed.

2.5 All residents are required to register with a GP. The home has good support from their House GP who holds a monthly surgery at the home if required.

2.6 Residents are not allowed to drink as the home is not covered on insurance for alcohol consumption. Residents can only smoke in the patio area outside.

3.0 Staffing of Smallcombe House

3.1 The Home Manager has worked at Smallcombe House since 1999 and lives on site.

3.2 The home is currently undergoing a staff restructure; LINk visitors were given an updated Statement of Purpose (dated 19/3/2012) which details the new streamlined structure to be implemented with effect from 1/4/2012.

Ena advised there are currently staff vacancies; this is partly due to a change in the shift work patterns.

3.3 There is a part time (Monday-Friday) activity co-ordinator, at the home. The activity co-ordinator will liaise with the residents on how they would like things run.

3.4 To cope with fluctuations in resident numbers, agency staff can be brought in. The balance of staff and resident numbers is monitored by the Manager.

3.5 There are regular communication/staff meetings and a staff room is available.

3.6 All staff have to attend an induction programme; a copy of the Staff Induction Programme was given to the LINK visitors.

3.7 Ongoing staff training is done through the Age Care Chanel/ (part of Age UK) via DVD;s and workbooks.

3.8 Each member of staff has a yearly Appraisal, and Supervision sessions every 6-8 weeks (CQC require 6 supervisions per year). The Care Home manager has monthly supervision.

4. Visitors and Relatives

4.1 Visitors are offered refreshments during their visit and can stay for a meal although this is chargeable.

4.2 If visitors have travelled a distance then if a room/flat is available they are able to stay overnight at a small fee. If the resident is in an “end of life” position, then families are not charged.

4.3 Relatives are invited to the quarterly house meetings.

4.4. If a resident does not wish to see a visitor then the visitor is told the time is not convenient.

5. Observations of the LINk Visitors during visit

5.1 The residents en suite rooms viewed were basic furnished rooms (residents can bring their own furniture if they want to as long as it is fire compliant, they are also encouraged to decorate their room to their individual taste).

There is a separate kitchen on each floor which families are able to use and two bathrooms on each floor with hoist facilities (this may change to “wet rooms” in the future). Baths can be taken every day but staff assistance would be needed.

The home has a separate dining room, a communal lounge and a “quiet” room, a medical room, and a room which is used by the Hairdresser who visits once a week.

There is a laundry room (all personal laundry, towels, etc is done on the premises as long as the item is named).

There is a small outside patio area.

Residents can have a telephone point in their room at their expense and will have to

cover any installation charges. Mobile phones are permitted.

5.2 Ena advised after consultation with the residents their families, staff and other Salvation Army care homes that the homes now use external contract caterers “Apetito” who provide frozen food for care homes. LINk visitors were given an “Apetito” brochure and a copy of the menu choices chart for the next two weeks.

Meals can be taken in the residents own room if they so wish.

5.3 An activities board and newsboard is displayed in the foyer. There is also a kitchen club where residents can cook.

5.4 A refreshment trolley is regularly brought round.

5.5 Visitors are welcomed although preferably not around lunchtime.

5.6 LINk visitors were advised that staff sometimes bring their dogs in but it is not encouraged for residents to bring in their own cat or dog as it may cause a risk to other residents.

5.7 The dining room is painted a bright yellow which we were informed is in line with dementia guidelines and encourages stimulation.

5.8 There is a shop trolley with a plan to turn an unused space into a proper shop.

5.9 Ena advised that the home pride themselves in “end-of-life” care and dignity in care. They work closely with the GP’s and have an end-of-life pathway policy.

6. Reflections of the LINk Visitors after the Visit

6.1 We “the LINk” were made to feel very welcome and the Home Manager spent time answering our questions.

6.2 The home was difficult to locate, and the main entrance to the home was difficult to access from the main road (Bathwick Hill). There was limited parking outside.

6.3 Unfortunately, due to time, there wasn’t an opportunity to talk with residents and staff.

Report

on

Bath & North East Somerset LINk's visit to the Charlton House Care Home, Keynsham Community Resource Centre, Hawthorns Lane, Keynsham, Bristol.

9 May 2012

Charlton House Care Home Visit Report

9th May 2012 at 10.30 am

Address of Care Home:

Charlton House Care Home
Keynsham Community Resource Centre
Hawthorns Lane
Keynsham
Bristol BS31 1BE

1. Background to Visit

1.1 The Bath & North Somerset Local Involvement Network ("LINk") decided to conduct a series of visits to care homes in Bath & North East Somerset. Although the LINk has formal, statutory powers (given under Part 14 of the Local Government and Public Involvement in Health Act 2007) to "enter and view" any premises in which health or social care is provided, it decided to conduct these visits on an informal basis, rather than invoke these powers.

1.2 The purpose of the visit was to acquire an overview of the services that are provided by talking to the residents, their carers and the home's staff. The areas of care that we decided to focus on were:

- Independence, choice and flexibility for residents;
- Facilities and activities available;
- Dignity, respect and privacy of residents;
- Management, staffing, medicines, GP care, etc;
- Communication
- Involvement of Carers;
- Engagement with the local community.

1.3 The LINk's Host (its support organisation) contacted the manager of the home prior to the visit, to inform her of the LINk's wish to informally visit the home, to explain the purposes of the visit, and to advise her of the number and identity of visitors. We asked her to send us some information on the home in advance of the visit, and she sent us the *Sirona* prospectus provided to prospective residents and their families

1.4 The LINk visitors were the B&NES LINk Deputy-Chair Jill Tompkins, LINk Committee Member Veronica Parker, and Host Development Worker Carole Pullen. They carried out their announced and informal visit to Charlton House Care Home on Wednesday 9th May at 10.30am.

1.5 We met with Sue Breakah, The Registered Manager, Charlton House who was expecting us, and made us feel very welcome.

1.6 In the introductory discussion and tour of the Centre, the Registered Manager emphasised that Charlton House is the residents' home, and that the focus of care is on facilitating the residents to make their own choices, on fostering the residents' life skills and preferred life-styles, and on encouraging them and helping them to act in their own best interest.

1.7 The LINk visitors asked to see a Care Plan and arrangements were made to view a plan for a Dementia Resident and a General Nursing Resident.

2. Overview of Charlton House Care Home: information we were given

2.1 Charlton House is a Care Home situated within the Keynsham Community Resource Centre in Keynsham which opened in 2008. It is spread over three floors - a Day Centre, assisted bathroom, main kitchen and laundry is on the ground floor. Floor one cares for people with dementia and floor two cares for older, frail people. The home is predominately social services funded

2.2 Charlton House, like the overall Resource Centre, is provided and run by *Sirona*, a new Community Interest Company, under contract to Bath & North East Somerset Council. The company was formed in October 2011 as an independent non-profit distributing organisation providing publicly-funded health and social care services. Sirona is responsible for the delivery of the community healthcare and adult social care services previously provided by Bath & North East Somerset PCT and Council respectively.

2.3 The home is registered for 30 residents over 50 years of age. The first floor provides 15 places for people diagnosed with dementia, and the second floor has 15 places for people who are frail and require general care. (We were advised that there are 14 permanent beds on each floor and a further bed on each floor is for respite).Both floors have an assisted bathroom. All rooms have *en suite* toilet and washing facilities/wet room, and resident-couples can be accommodated in adjacent, connected rooms which they can use as a separate living room and bedroom. All rooms are full at present; the home always has a waiting-list of would-be residents.

2.4 We asked about the independence and self-determination of residents, and we were told that they are encouraged to make their room homely and bring their own furniture and belongings to furnish their rooms, and to spend as much time in their rooms as they wish. Residents are not allowed to smoke in their rooms, or anywhere else inside the home. There is a small open-air smoking area directly accessible from inside the home. Small pets such as birds are allowed and dogs can visit. The home is very person centred and flexible towards the residents needs.

2.5 The Resource Centre emphasises its community provision and sharing of facilities, it is well utilised.

Age UK come in regularly and offer a free toe nail clipping service. There is a large assisted bathroom available to the community and their carers at a current cost of £5.00.

Hairdressing is provided at the home in a dedicated salon: this service is chargeable to residents and members of the Community, Chiropody is available on the same basis.

The home works with “Project Search” (The project helps disabled people secure and keep permanent jobs. It is particularly suited to people with moderate and severe learning disabilities or autism, and others who can benefit from partnership working to help them into work). The visitors met one young lady on this project who was working in the laundry room alongside a permanent member of staff.

3.0 Staffing of Charlton House House

Overall staffing consists of:

Manager
7 Senior Support Workers
20 Support Workers
9 Night Support Workers
5 Housekeeping Assistants
5 Catering Assistants

3 Cooks
Centre Administrator
Handy Man

3.1 The level of staffing is assessed on a monthly basis, agency staff are used if needed although they have a good team of casual staff that would be contacted first. We were told that staff-retention is very good.

3.2 The staff room was viewed and there was a staff suggestion board which was clearly being used with positive ideas on how services can be improved. Sue pointed out that it was really important to encourage staff to come up with ideas which the Care Manager can, if appropriate, take forward. It is about staff involvement and staff ownership and encouraging staff to take responsibility.

3.3 Small scale staff meetings are held every 6-8 weeks (the Seniors on each floor have a meeting then this is disseminated to their staff in a separate meeting). All staff-members have a joint meeting every quarter. Staff have individual one-to-ones every 4-6 weeks and an annual appraisal. The Manager is keen on staff development and support workers "act up" if appropriate. There is a staff training matrix and all staff information is stored on a computer "Excel" spreadsheet.

3.4 Staff are around 24/7 and staff handovers are done via e-mail, Seniors on both floors have access to the information, this can also be picked up at anytime via the Home Manager's Blackberry.

3.5 All staff receive an induction programme, this includes mandatory training such as Health and Safety and forms part of the diploma criteria.

3.6 Some of the staff take part in the Health Initiative funded by BANES Council, the main objective being to keep the health force healthy, and many staff have been very successful at losing weight through the Slimming World Diet Plan.

3.7 Sue informed us that the home has close links with the local Wellsway School. A level Health and Social Care students come in every Wednesday as part of their course, thus gaining valuable real life experience.

4. Visitors and Relatives

4.1 Visiting is allowed at any time acceptable to residents. Visitors are welcome to eat with their relatives if they are there during mealtimes (a small charge is made for this).

4.2 There is a relatives group and relatives meeting are held every quarter. Sue confirmed that it was important that the relatives were "on board", for there to be transparency, to see it as a home, to feel at home and be part of the resident's present and future care.

Sue advised that a special residents' families meeting was set up after the Panorama documentary to discuss and raise any issues/concerns.

4.3 If relatives have travelled some distance there is a 2 bedroom guest room available at Hawthorns Court which is chargeable, if it is an “end of life” situation and there is spare room there is no charge.

5. Observations of the LINk Visitors during visit

5.1 The dementia floor has an outside garden which won a silver award at the “Keynsham in Bloom “event. Residents and relatives participate in the gardening. There is access to several outside terraces and balconies, meals can be taken outside if wished.

There is an activities board where there are usually two activities available every day, the staff are actively involved and provide a considerably amount of one-to-one support.

A pianist comes in to play most evenings. A memory box is at the side of residents’ bedrooms, and a photo of themselves if they want displayed on the door.

There is a large communal lounge and a quiet room.

A reminiscence corner has been created, where photographs and memorabilia are displayed.

The Home subscribes to the “*Daily Sparkle*”, this is a daily reminiscence and activities newspaper produced by an outside agency. The *Daily Sparkle* is full of articles, quizzes, old news stories, gossip, puzzles and entertainment geared towards stimulating the mind and improving memory.

5.2 There is a Church service “All Churches Together” every Sunday. Surrounding bungalows, family, staff and residents at Hawthorns are invited to the weekly Church service.

5.3 The LINks visitors were able to view the kitchen where all meals are prepared and cooked fresh on the premises. Meals are also provided for Hawthorn Court (part of the Resource Centre). Members of the local community are also able to have a meal which is chargeable.

Meals can be taken in the residents’ own rooms if they so wish.

5.4 As there is no budget for “nice homely” furniture, the staff are very much involved in fundraising for the Home and are currently using the money raised to decorate and make the Home more “homely”. They have previously purchased a large TV and now have DVD/Movie nights.

The next fundraising event will be to purchase an IPAD so each resident can have their own personal file and store photographs etc.

5.5 Telephone points are in all rooms, if a telephone is required it is chargeable to the resident.

5.6 We were advised that residents can keep their own GP if local or choose, there are three GP surgeries in Keynsham.

5.7 Any administration of medicine in house can only be done by Seniors and strict procedures have to be followed.

6. Reflections of the LINk Visitors after the Visit

6.1 We, “the LINk”, were made to feel very welcome and the Home Manager spent time answering our questions. We were very impressed that there were posters up in many areas including the lifts/notice boards confirming that the LINk were coming to visit and why.

6.2 It is apparent how much the staff take pride in their jobs and into making the Home a home. The Home has a lovely warm atmosphere. There is good interaction and respect between the staff themselves and the residents and staff.

6.3 Unfortunately, due to time, there wasn’t an opportunity to talk with residents and staff in any detail.

7. Response to this Report from Care Home

“Thank you for the report I was really pleased that you had a positive experience of our service. There was just one item regarding the Church services every Sunday. These services are not organised by Churches together they come in once a month on a Wed. The Sunday Services are organised by one of our support workers. Everything else was factually fine”.

Bath & North East Somerset Council	
MEETING:	Wellbeing policy and development scrutiny panel
MEETING DATE:	July 27th 2012
TITLE:	Healthwatch position update
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: **Appendix 1 Vision for local Healthwatch** **Appendix 2 Operating model for local Healthwatch**	

1 THE ISSUE

Policy developments outlined within the Health and Social care Act currently before parliament outline a new duty on local authorities to ensure the provision of Healthwatch. Healthwatch is a development in public involvement and will be the body that replaces the existing Local Involvement Networks (LINK). In Bath and North East Somerset activity has been taking place since spring 2011 to prepare for the commissioning of Healthwatch working towards an implementation date of April 2013. The panel received a report at its meeting in July 2011 at which point the ideas for Healthwatch were being finalised. Additional position updates have been included within the LINK committee reports. A formal update is being presented today to ensure the panel has comprehensive and current information on the firm plans for Healthwatch and the development taking place towards its pending implementation.

2 RECOMMENDATION

Members are asked to consider the information presented within the report and to note the key issues described.

3 FINANCIAL IMPLICATIONS

A sum of £71,000 is available in the Council's budget for the funding of Local Healthwatch in Bath and North East Somerset. The Cabinet has also agreed a non-recurring budget, allocated from the Performance Reward Fund, to enable the development of an engagement infrastructure for Healthwatch and wider community engagement infrastructure for the Health and Wellbeing Board. This development will support and sustain Local Healthwatch provision.

4 THE REPORT

4.1 Background

The current health and social care reforms are centred on the fundamental principle that patients and the public must be at the heart of everything our health and care services do. Healthwatch is described as an evolution from the existing structures and is expected to give people real influence over decisions made about local services. It can best be described as a consumer champion whose role is to champion the views and experiences of patients, people using services, carers and the wider public and to influence service development decisions. It should be noted that the term Healthwatch covers both health and social care and it will support individuals as well as engaging communities.

The Health and Social Care Act specifies two elements to the proposed structure. These are Healthwatch England a national body providing leadership to local Healthwatch and advising the NHS commissioning Board and local Healthwatch acting as consumer champion for local people regarding health and social care.

Healthwatch is different from LINk and has new responsibilities. Healthwatch will need to do all that LINk currently does and has the same powers that LINk currently enjoys but It also has new duties to provide information to people and support them in making choices. Additionally Healthwatch has the important responsibility of having a representative as a member of the H&WB board.

4.2 Functions for local Healthwatch

Local Healthwatch has 3 principle functions:

- To Influence: helping shape the planning of health and social care services;
- To inform: providing information about health and social care services and supporting people in making choices
- To assist: acting as a consumer champion and advocate pursuing people's interests with local providers.

4.3 vision

The local vision for Healthwatch is well developed. The vision, strategy and plan was confirmed through a public engagement exercise undertaken in 2011 and reported to the panel at its previous meeting. The engagement gathered input from the partnership board, LINk, the health and wellbeing network (including service users and carers), voluntary sector providers, GPs, council and NHS officers and included 3 public meetings and a communications cascade in various media. The vision was approved by the partnership board and was supported by all stakeholders. The outcome has set the principles upon which procurement will now take place. There is a growing awareness that in developing Healthwatch there is a necessity to combine its development and the opportunities that brings into a bigger picture of whole system community engagement and this is commented on further below. The plans and vision for Healthwatch will retain sufficient flexibilities to be adaptable to this wider context and fit effectively within it as this programme of work moves forward. The Vision for Healthwatch is included at Appendix 1.

4.4 Summary of intent

We do not want Healthwatch to be a separate entity which is stand alone. To do so would duplicate existing involvement structures and would not achieve the potential for collaboration and added value.

The provider of Local Healthwatch will, building on the existing excellent relationships and infrastructure in Bath & North East Somerset, develop and operate an innovative, modern and engaging network of community participation and involvement.

Local Healthwatch will bring together the best parts of the existing Local Involvement Network (LINk) legacy, the Health and Wellbeing Network and current third sector organisations. Local Healthwatch will extend this network by linking in with patient participation groups, hospital groups and councils of members, social care providers, voluntary organisations, neighbourhoods and communities.

Local Healthwatch will operate through excellent modern communications fully embracing social media and interactive web based tools to engage interactively and accessibly with all interested members of the population. Through these communication and networking methods Local Healthwatch will coordinate the consumer voice for health and social care, champion that voice and liaise in partnership with commissioners and providers of services towards improved health and wellbeing objectives. Local Healthwatch will also elevate patients' voices to the Health and Wellbeing Board ensuring that consumers are given the opportunity to participate in decision making and influence decisions. The model for Healthwatch is included at Appendix 2.

5 Current position

5.1 Procurement

Bath & North East Somerset Council agreed to undertake an early procurement exercise for Local Healthwatch, given the local appetite for early implementation as well as contract considerations. As a result, the Council has been working in recent months on a procurement process for a Local Healthwatch body. However, the Council has decided not to make an award under the current procurement process for Local Healthwatch but instead has taken a decision to restart the process. Decisions on arrangements for this will be taken shortly in order that the deadline of April 2013 is met. The Council has also been working to ensure continuity for the work of the Local Involvement Network host service.

5.2 Maintenance

In the interim period up to the establishment of Healthwatch Bath and North East Somerset LINK continue to operate supported by their host organisation Scout Enterprises. Discussions are underway to ensure the contract for Scout can cover the transitionary period to the point when the news Healthwatch provider is assigned. LINK will continue to address their identified work programme and will continue to present their reports to the panel.

5.3 Development

Funds awarded from the performance reward grant will now support the start up development phase of Healthwatch. The plans for this are bold and involve creating the linkages within the community that will enable the consumer voice to be accessed and influential in shaping health and social care choices. A full set of objectives and

milestones have been identified to deliver the development phase by April 2013. Key tasks within the development phase are

- Involving patient participation groups in all of the 27 GP practices within the Healthwatch hub.

- Connecting the current voluntary sector and advocacy groups within the Healthwatch hub

- Create the virtual web and social media platform for whole population communications that will be the central portal for Healthwatch activity

- Identifying the community locations and neighborhood opportunities to liaise with Healthwatch hub

5.4 Health and wellbeing board

A significant role of Healthwatch is to work within the Health and Wellbeing Board to contribute to and influence decision making. The composition of the board includes at least one Healthwatch representative as a member. This connection and the principle role of Healthwatch acting as consumer champion provides opportunity for the new arrangement to play a wider role in the community engagement structure for the H&WB board. Work is now taking place to establish this structure and maximise the opportunity for Healthwatch to play a central role

5.5 Wider community involvement

The development of Healthwatch is taking place at a time when the health and wellbeing board is being established and work is underway to clarify how the board can listen to and interact with its community. A strategy for community engagement is being developed within which Healthwatch needs to fit and play a key part. Whilst Healthwatch is concerned with health and social care the remit of the Board is wider than this and potentially extends to all public service connected with wellbeing. A seminar and report is being prepared for the H&WB board to progress this debate and shape a community engagement strategy. As previously mentioned Healthwatch will adapt to this profile so that the key aims of the direct service provision are achieved and proper positioning within the community engagement architecture is also achieved.

6 RISK MANAGEMENT

There is a reputational and operational risk to the council if Healthwatch is not clearly understood, its potential is not fully realised and if a service is not procured to the stated deadline. The actions currently underway and highlighted within this report are controlling these risks and mitigating them.

7 EQUALITIES

Healthwatch aims to engage all sections of the community to be influential in shaping services and working towards reducing inequalities. The consultation on Healthwatch has included equalities perspectives and on-going development work will continue this.

8 CONSULTATION

A public consultation has been undertaken as described within the report.

9 ISSUES TO CONSIDER IN REACHING THE DECISION

Social Inclusion; Customer Focus; Sustainability;

10 ADVICE SOUGHT

The content of the report has been developed through consultation with council officers within policies and partnerships and made available to the councils monitoring officers for review.

Contact person	Derek Thorne 07530263415
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

VISION FOR LOCAL HEALTHWATCH

Local Healthwatch is being created to build on the role of existing LINks and to exceed it through the introduction of an innovative modern and proactive service for people. It will be an effective and powerful local consumer voice for all aspects of health and social care. It is important to note that although the organisation will be called Local Healthwatch, it will be equally concerned with social care issues. The B&NES Local Healthwatch will:

1. Undertake 3 core operational functions:
   - **Influencing** – helping to shape the planning of health and social services by:
     - co-ordinating and representing local voices
     - scrutinising the quality of service provision
     - having a seat and championing the consumer voice on the local Health and Wellbeing Board
     - informing the commissioning decision-making process
     - providing local, evidence-based information
     - participating with commissioners in evaluating service change
     - ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA).

   - **Signposting** – providing information to help people access and make choices about services by:
     - empowering people by helping them understand choice
     - providing advice to enquirers on where and how they can access information about choice
     - assisting people in identifying help and support to pursue NHS complaints advocacy.

   - **Assisting** – advocating and holding commissioners and providers to account by:
     - championing quality and supporting people or groups to pursue and resolve issues
     - approaching commissioners and providers of services on people's behalf and seeking responses to particular concerns raised
     - alerting HealthWatch England to concerns about specific care providers.

2. Act as a network working proactively to bring together and enhance the existing infrastructure of local engagement and support drawing input and participation from it and coordinating common outputs.

3. Proactively outreach to communities utilising methods that are inclusive and accessible to all groups e.g. adults, children, minorities, users, carers and patient groups.

4. Deliver information and stimulate choice through signposting information to the public.

5. Work in collaboration with health and social care commissioners to promote self-care and the preventative message.

6. Establish a common agenda of priorities and work alongside partners achieving excellent professional relationships and working systems.

7. Establish methods for working regularly with commissioners on developing plans for service change and evaluating plans from the consumer perspective.

8. Operate within the Health and Wellbeing Board establishing a credible and proactive representation of the consumer voice and influencing the Board in its decision making.

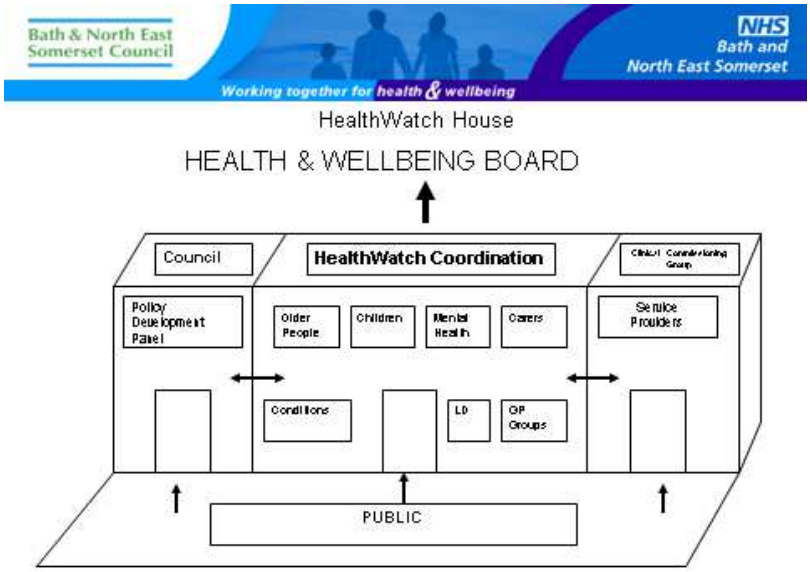
Appendix 2

Operating Model for Local HealthWatch

Our operating model to deliver this vision is depicted in the diagram below (the Local HealthWatch House). The model seeks to build as much as possible on existing work whilst providing a clear and simple "way in" for the public to access the core elements of the Local HealthWatch service.

The service provider will be expected to continue to operate those activities which are already currently carried out relevant to the role of LINk and build on those activities to secure the vision for Local HealthWatch and develop its implementation. Specifically the provider will:

1. Work further with our Clinical Commissioning Group and GP community through establishrd links in each GP practice through practice based patient participation groups, coordinating and supporting the input from these groups to be an integral part of Local HealthWatch.
2. Coordinate key stakeholders including the third sector, advocacy groups, providers and local communities to work together under the Local HealthWatch network.
3. Identify the priority aspects of LINk activity, the beneficial elements of the LINk legacy and the positive and contributory skills of LINk leaders and carry those chosen elements forward into Local HealthWatch.
4. Further develop our operating model to link with the Health and Wellbeing Board, commissioners, service providers and the Council's Wellbeing and Policy Review Scrutiny panel in a clear way.
5. Work with NHS commissioners throughout the current NHS reforms and be responsive to future and changing models of NHS leadership as they emerge throughout 2012 – 2014.



The result of this will be that Local HealthWatch will become:

- a strong local consumer voice on views and experiences to influence better health and social care outcomes
- a respected, authoritative, influential, credible and highly visible body within the health and social care community and on the Health and Wellbeing Board.

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny
MEETING DATE:	27 July 2012
TITLE:	Joint Working Arrangements with the NHS beyond April 2013
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Cabinet report 11 July 2012	

1 THE ISSUE

1.1 To provide an opportunity for the panel to discuss the proposals for future joint working arrangements with health, as described to the cabinet on 11 July and to receive any verbal updates as appropriate.

Contact person	Mike Bowden 01225 395610
Background papers	As attached
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:	**Cabinet**	
MEETING DATE:	**11 July 2012**	EXECUTIVE FORWARD PLAN REFERENCE: E 2432
TITLE:	**Joint Working Arrangements with the NHS beyond April 2013**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: None		

1 THE ISSUE

1.1 To update the cabinet on the development of joint working arrangements with the NHS from April 2013, when some key elements of the Health and Social Care Act 2012 come into effect.

2 RECOMMENDATION

The Cabinet agrees to:

2.1 Note the work underway to enable the continuation and further development of joint working arrangements with the NHS beyond April 2013;

2.2 Receive more detailed proposals for approval by Full Council in September 2012.

3 FINANCIAL IMPLICATIONS

3.1 There are no financial implications directly arising from this report. The more detailed proposals being developed will include a financial framework to ensure proper governance of aligned, pooled and delegated budgets between the two organisations.

4 CORPORATE OBJECTIVES

4.1 The development of joint working arrangements between the Council and Primary Care Trust (PCT) has enabled more integrated commissioning and delivery of heath and social care services, resulting in improved outcomes for our population, as well as ensuring efficient and effective use of our combined resources. Continued joint working after NHS reform in April 2013 will help both organisations to ensure we are **promoting independence and positive lives for everyone.**

5 THE REPORT

5.1 Bath and North East Somerset Council and NHS have a history of integrated working, developed through many years of collaboration to improve health and social care services for our residents. The Council approved the development of joint working arrangements with the PCT in May 2009, which covered the commissioning and delivery of health and social care services. These arrangements have enabled a number of positive developments, including the launch of the Community Interest Company, 'Sirona Care and Health' to deliver a range of local services on our behalf as well as helping us to achieve improved outcomes and effective use of our resources.

5.2 The Health and Social Care Act 2012, which gained Royal Assent in March this year, means that GPs working as a Clinical Commissioning Group (CCG) will take on responsibility for commissioning most health services from 1 April 2013 and local Public Health will become the Council's responsibility. The Council has created a single People and Communities Department including adult social care commissioning and children's services. It is therefore both timely and necessary to review and refresh the Joint Working Arrangements to reflect the organisational arrangements that will be in place from 1 April 2013 and to ensure that they are fit for purpose to deliver best outcomes in future.

5.3 Senior officers from the PCT and Council, together with the Executive Member for Wellbeing and GPs from the CCG, met recently to discuss the benefits of partnership working, to consider lessons learnt from the operation of the existing arrangements and to map out the next steps to cement joint working arrangements between the Council and CCG for April 2013.

5.4 The proposal is to develop a new model for joint working which brings together the commissioning of all of the Council's key services for Adults and Children with the Public Health Department and the CCG, to ensure we are maximising our ability to promote positive lives for everyone in our communities and working together to ensure that people receive the services they need, provided in a joined up way around them and their families.

5.5 It is likely that this would be based on the use of 'section 113' of the Local Government Act 1972, which was used in the existing partnership arrangements to allow designated NHS staff to be 'seconded' to undertake tasks for the Council

and vice versa. It would mean that for most staff involved their employment by either the NHS or Council would be unaffected. The joint management team would consist of the Strategic Director and Divisional Directors for People and Communities, Director of Public Health together with the Accountable Officer(GP) and senior managers of the CCG. This would enable all of the strategic and commissioning functions of these teams to be aligned as far as is possible and beneficial, with the opportunity to improve pathways of care across children's services, adult social care, public health and health care services

5.6 Existing pooled budgets would also be replicated under the new arrangement, with a clear aspiration to extend and further develop the joint working arrangements over time, which could lead to broadening the scope and/or pooling more funding to deliver better outcomes for our population.

5.7 We have established the main constraints within which the arrangements must be developed, including making sure that each organisation can fulfil its statutory obligations and continue to collaborate with other key partners.

5.8 A Joint Working Framework is being drawn up and subject to further engagement with Council members, the PCT Board and the wider membership of the CCG, the aim is to agree this ahead of the CCG's application for authorisation, at the beginning of October.

6 RISK MANAGEMENT

6.1 The report author and Lead Cabinet member have fully reviewed the risk assessment related to the issue and recommendations, in compliance with the Council's decision making risk management guidance.

7 EQUALITIES

7.1 An EqIA has not been completed at this stage, as the joint working arrangements already exist and the proposal is to continue with these. An EqIA will be completed as part of the process to finalise the joint working framework, when more detail is available about how it is proposed that it will operate.

8 RATIONALE

8.1 The existing joint working arrangements between the Council and PCT have enabled more integrated commissioning and delivery of heath and social care services, resulting in improved outcomes for our population, as well as ensuring efficient and effective use of our combined resources.

8.2 From 1 April 2013, the PCT's Public Health commissioning functions will transfer to the Council and the majority of its local health service commissioning functions will pass to the Clinical Commissioning Group.

8.3 Continued joint working after this significant NHS reform will help both organisations to ensure we are promoting independence and positive lives for everyone.

9 OTHER OPTIONS CONSIDERED

9.1 The option of discontinuing joint working arrangements was rejected as it would potentially lead to fragmentation of strategy and service commissioning, resulting in poorer outcomes for our population and less effective use of our resources.

10 CONSULTATION

10.1 *Cabinet members; Trades Unions; Staff; CCG and PCT; Section 151 Finance Officer; Chief Executive; Monitoring Officer*

10.2 Discussion at Informal Cabinet meeting; staff and trade union consultation on proposals for future structure of People & Communities Department; seminar with GPs and senior officers of CCG and PCT.

11 ISSUES TO CONSIDER IN REACHING THE DECISION

11.1 Customer Focus; Young People; Impact on Staff; Other Legal Considerations

12 ADVICE SOUGHT

12.1 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	*Mike Bowden 01225 395610*
Sponsoring Cabinet Member	*Councillor Simon Allen*
Background papers	*Council Meeting papers 14 May 2009*
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:	27th July 2012
TITLE:	Q1 Care Homes Quarterly Performance Report (April – June 2012)
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Quarter One Performance Report	

1 THE ISSUE

Further to the report to panel of the 18th May 2012 which set out the Quality Assurance Framework for social care services generally, this report is the first in a series of quarterly reports which focuses specifically on the quality of care and performance of residential and nursing homes under contract in Bath & North East Somerset.

2 RECOMMENDATION

The Wellbeing Policy Development & Scrutiny panel is asked to:

2.1 Note the contents of the report.

2.2 Contribute relevant feedback and articulate clearly the role of the panel in relation to the QAF.

3 FINANCIAL IMPLICATIONS

3.1 The Council's financial plan for 2012/13 sets out year three targets in relation to residential and nursing care provision for all of the main service user groups including older people, people with learning difficulties, people with mental illness and people with physical and sensory disabilities.

3.2 As stated in the previous report,

'Over the past two to three years, the financial viability of some providers of care services has come into question as they have been severely tested by the economic downturn and, also, by pressure from commissioners (both Local Authority and NHS) to deliver efficiency savings. This has led to a growing concern that providers may seek to reduce their operating costs by compromising on the quality and/or safety of care service provision by, for example, employing fewer and/or less skilled/experienced care staff.

4 THE REPORT

4.1 The quality and performance of care homes can be understood from a range of perspectives for example feedback from those who use services, carers and/or other advocates, from judgements issued by national regulatory body the Care Quality Commission (CQC), from local contractual monitoring/performance management and from the level and type of safeguarding activity recorded. The report provides a high level summary across all these areas and also details progress to date on Council financial targets.

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

An EIA has not been completed because this report is provided for information and to assist the panel in articulating its role rather than for decision making or policy development

7 CONSULTATION

7.1 No specific consultation has been undertaken on the contents of this report

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Customer Focus; Health & Safety; Other Legal Considerations

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	*Sarah Shatwell, Associate Director Non-Acute & Social Care*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Care Homes Quarterly Performance Report

April – June 2012

Baseline Data

At the time of writing there were 57 residential and nursing homes under contract in B&NES including those providing services to people with learning disabilities and people with mental illness.

As at 29th June 2012 1139 individuals were recorded as being 'permanently placed' in residential/nursing care, supported living or extra care settings although this figure also includes a number of individuals who are placed out of area i.e. not with a contracted provider in the B&NES local authority area.

The total weekly cost of the above placements at the time of writing was £743,680 although this figure has not been netted off in respect of income received from NHS B&NES for individuals placed under Continuing Health Care (CHC) arrangements i.e. health funded.

Care Quality Commission Data

The Care Quality Commission came into being in April 2009 and required all adult social care and independent health care providers to register by October 2010. Part of the role of CQC is to carry out inspections of care homes and to assess compliance against twenty eight quality standards, known as the 'essential standards'.

In B&NES 13 of the 57 homes under contract have yet to be inspected by CQC and 1care home provider has failed to register with CQC (this home is currently embargoed). The performance of the 44 homes in B&NES that have been inspected by CQC is summarised in the table below.

All standards met	28 homes
One standard requiring improvement	8 homes
Two standards requiring improvement	1 home
Three standards requiring improvement	2 homes
Currently under review	6 homes

When one or more essential standards are not met *and* there are serious concerns regarding the quality of care provision in a home, CQC may issue compliance notices which require providers to respond within specific timescales, after which follow up inspections take place. At the time of writing 2 homes in B&NES were under compliance action.

All other homes with outstanding compliance issues are required to produce action plans setting out how, and in what timescales full compliance will be achieved.

A report published by Age UK on 28th June 2012 suggests that around 73% of adult social care provision is fully compliant with CQC standards and this figure is corroborated by the analysis above which indicates that 72% of homes inspected in B&NES are fully complaint.

Service User & Stakeholder Feedback

Information regarding the quality of care homes is collected at each individual service user review and collated on a 'feedback database' by commissioners. The database is also used to store 'adverse incident' reports received from health colleagues. During the period April to June 2012 concerns relating to 5 care homes were received via the feedback database, these are summarised in the table below.

Nursing home	Concern regarding pressure area care
Nursing home	Poor manual handling Concerns regarding behaviour of staff member towards resident
Residential home	Concern regarding appropriate use of compression bandages
Nursing home	Range of concerns relating to general cleanliness, manual handling, meal choices and social activities
Residential home	Concern regarding pressure area care

Commissioning & Contracts Review

Of the above homes 2 have been reviewed by Commissioning & Contracts Officers, 2 are in the process of being reviewed and 1is scheduled for review before the end of July (all reviews will have been completed by the time this report is presented to panel).

One of the homes where concerns have been raised by service users is currently not registered with CQC and has been embargoed for placements for several months because of this and because of quality concerns arising from Commissioning & Contract review activity. All 5 residents placed in the home by B&NES have been reviewed which has resulted in 2 individuals moving on to more appropriate care settings and the remaining 3 choosing to stay put pending the outcome of the home's registration application to CQC.

Two of the above homes have been recently inspected by CQC and found to be fully compliant whilst one home currently has outstanding compliance actions following CQC inspection. One home has been inspected by CQC and found to be compliant however Commissioning & Contract Officers found that the home was failing to meet a number of outcomes detailed in the B&NES Care Homes Specification. This is an unusual scenario which has been flagged with CQC and will be discussed in more detail at the next liaison meeting.

Officers liaise closely with CQC and with health and social care colleagues to triangulate intelligence and to agree collaborative responses to all concerns identified. This information sharing process is relied on to prioritise inspection and review activity, thus making most effective use of limited capacity in the commissioning team. The team currently has a vacancy and the option of filling the post with a reviewing officer role is being considered to increase capacity for care home reviews. Other officers in the team are also being trained for this type of review work so that their skills can be put across a wider range of contracts.

Safeguarding Alerts & Investigations

At the time of this report information on the number of individual safeguarding referrals is available for April and May 2012 only. During this period there have been 80 new safeguarding alerts of which 32 are for residents in residential care homes and 6 are for residents in nursing homes i.e. 47% of all safeguarding alerts during April and May were in relation to residents in care homes. The majority of these cases have not been concluded at present.

Analysis of the data set needs further refining to look at individual safeguarding alerts in care homes and the outcome of these cases. This is possible, however currently the analysis is limited to care homes where more than one alert has been received. The analysis of these takes place on a quarterly basis and includes care homes and other settings for example other registered services such as domiciliary care and supported living. The next set of quarterly data will be available at the end of July in preparation for the August meeting with the Care Quality Commission.

Analysis of the 2011 – 2012 whole year data shows that for 25 care homes more than one alert of suspected abuse was received. For 16 of these 25 homes, 68 alerts were received and of these, 34 alerts were not substantiated and 34 were concluded as either substantiated, partly substantiated or it could not be determined whether the abuse occurred or not. In all of these cases protective actions were taken to minimise the risk of re-occurrence to the individual concerned and other residents.

The table below shows the type of abuse for all cases were abuse was substantiated, partially substantiated or not determined. It should be noted that in a small number of cases more than one type of abuse was found which is why the figures to not add up to 34.

Abuse type/ outcome	Neglect	Financial	Sexual	Emotional	Physical	Institutional
Substantiated	5	2	1	0	9	1
Partly substantiated	6	2	0	1	1	0
Not Determined	4	1	1	0	1	1

In cases that were abuse was substantiated or partially substantiated, the most common type of abuse was neglect, for example poor care practices such as

failure to manage skin integrity or poor manual handling, or physical abuse for example two service users hitting each other or rough handling by a member of staff.

Of all the safeguarding cases received and managed within the year where abuse was substantiated, only 2.78% involved care home staff.

Homes under Embargo

During this reporting period three homes have been embargoed for placements by B&NES due to quality and/or safeguarding concerns or registration/compliance issues. The embargo on one home was lifted during the quarter following significant improvements being made and this has been robust substantiated through CQC inspection and Commissioning & Contract Officer review.

Financial Monitoring

Cross authority work has been completed to establish a regional cost model for care homes based on locally collated data covering six main cost drivers including:

- Nursing/care staff costs
- Other staff costs
- Capital costs/rent
- Fixtures/fittings
- Food/laundry
- Utilities/rates

The weekly rates for residential and nursing home placements currently operational in B&NES have been set using the regional cost model and prices within each individual cost driver can be reviewed separately under these arrangements.

The Council's June 2012 revenue forecast for adult social care summarises performance against financial plan targets for 2012/13. The net end of year forecast shows that we will be on target. However there continues to be significant pressures on the Council's budget for purchasing care services, this is currently mitigated by the use of "Section 256" monies.

Section 256 funding is allocated by the Department of Health in response to increased demand for health and social care services arising from demographic growth and "winter pressures" and its use to subject to nationally set criteria. In agreement with the Primary Care Trust, the Council has targeted a proportion of this money at funding additional capacity in social care services in response to increases in demand from demographic growth. The appropriate distribution of this funding between the different commissioning budgets will be determined later in the financial year.

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	Friday 27 July 12
TITLE:	How the PCT Monitors Quality of NHS Dentistry in B&NES
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix - Mr HB report and PCT response. Also an open public item.	

1 THE ISSUE

1.1 How the PCT Monitors Quality of NHS Dentistry in B&NES.

2 RECOMMENDATION

The Wellbeing PDS is asked to note the report.

3 FINANCIAL IMPLICATIONS

3.1 There are no financial implications.

4 THE REPORT

Quality Monitoring Process

4.1 The PCT took over commissioning NHS Dental Services from 1 April 2006. The PCT commissioned the Dental Reference Service (DRS) to inspect all NHS dental practices in B&NES on a three yearly cycle. This covered the physical premises, equipment, policies and procedures, record keeping and an examination of a sample of patients. If the DRS had any concerns about a practice they would visit them more frequently. After the visit the DRS would send a copy of the action plan resulting from the report to the PCT via the Avon Dental Commissioning team. Six months after receipt of these reports the PCT would write to practices asking them for assurance that the actions were complete.

4.2 The staffing of the DRS was reduced significantly in April 11. So the Dental Reference Officers (DRO) are only able to support PCT in dealing with PALS enquiries and complaints, providing second opinions for dentists and patients and advising the PCT on dentists whose performance gives cause for concern.

4.3 Since 2006, the PCT, in addition to the DRO service reviewed contract compliance with dental practices via a self assessment process. This included compliance with NICE guidelines, quality assurance, complaints system, treatment plans, referral notices, data protection, patient information, patient charges and patient choice. If there were common areas of non compliance across the B&NES dental practices then the PCT sent out suitable resources e.g. providers of CRB checks; or set up an incentive scheme e.g. funding provision of fluoride varnish and fissure sealants; or access to training e.g. support to stop smoking. All these measures were put in place to improve compliance.

4.4 The PCT held an event in February 11 which aimed to establish a local learning network, this covered decontamination, legionella advice, infection prevention and control and data protection. There were representatives of most practices across B&NES with approx 120 attendees.

4.5 When a dentist applies to join the B&NES Dental Performers list a number of checks are carried out. These are undertaken by the Primary Care Support agency on behalf of the PCT and include CRB checks, references, English language test attainment scores, qualifications, experience etc. All applications are then signed off by the Clinical Governance Lead at the PCT. This process provides assurance on the quality and competency of the dentists that we commission services from in the area. If a dentist does not meet the agreed minimum criteria at application, then they will either be refused application to the list or given a conditional inclusion which usually involves supervision of their practice for a determined period of time.

4.6 If concerns regarding the clinical competence/ practice of a dentist come to light, the PCT has a robust process for investigating the concerns and taking action if required against the dental performer's list regulations. All cases are then presented to the PCT Performance Decision Making Group for formal decision making against the dental performers list regulations. These are also summarised and scrutinised by the Board in the Confidential Session.

4.7 The PCT also reviews controlled drug prescribing for all prescribers in B&NES, including dentists. Where there are any concerns regarding prescribing investigations are carried out lead by the PCT Accountable Officer.

4.8 The PCT has a NICE Commissioning Group which ensures that all relevant NICE Guidance is disseminated and implemented by providers including dentists.

4.9 The PCT has strong links to a dental advisory support group where clinical quality issues can be discussed anonymously.

4.10 If a new piece of legislation or guidance relating to NHS Dental Services is produced the PCT commissions specialist advisors to assess practices and advise them on how to be compliant e.g. in 2011 the PCT decontamination lead asked all NHS dental practices in B&NES to complete a self assessment on the basis of their return. A further risk assessment was carried out and practices of concern received a visit from the decontamination lead.

Detail of process carried out in 2011/12

4.11 The PCT carried out a risk assessment of all dental practices in B&NES and then choose certain practices to concentrate on. The PCT looked at location – so all geographies were covered, BSA exception reports, vital signs reports (see appx1) showing the size of the contract,

activity levels and whether the practice is meeting their contractual activity levels, the number of new patients seen, access trend analysis and quality markers. The quality markers measure whether patients are being recalled too frequently, that not too many patients need urgent care, not too many repairs are needed, not too many continuations (where extra treatment is provided for a charge-paying patient within two months of completing a course of treatment), patients satisfaction with the care they received and patients satisfaction with the time they had to wait for an appointment (see appx 2 for more details). A clinical advisor also looked at low % of band 3 treatments and very low band 2 to ensure that practices were providing the full range of treatments on the NHS. The PCT also reviewed any PALS enquiries/ complaints.

4.12 This resulted in the PCT (PCT lead commissioner and local clinical advisor who is a B&NES dentist) meeting with some practices across B&NES.

4.13 The practice visit (draft agenda appx 3) included looking at their vital signs report for the previous year (appx 1) and year to date for the current year. The PCT also discussed the End of year statement (appx 4) with each practice that included the clinical dataset. The PCT also discussed any PALS issues notified to the PCT and any complaints that the practice had received from patients in the previous year. As a result of this visit the PCT drew up an action plan which all the practices signed up to achieving.

4.14 This process was reported to the PCT PEC and Board within the integrated performance report.

Patient feedback

4.15 Since 2008, the PCT has reviewed any complaints or PALS inquiries that were copied to the PCT that related to dental care. Dental practices have a legal obligation under the Complaints Regulations to respond directly to the complainant but as a matter of course the PCT requested copies of the responses and reviews these and follows up any that were of cause for concern. Analysis of PALS/ Complaints are carried out each quarter by the PCT, practices with a higher number of complaints/ PALs issues are identified and the Quality Leads attend specific contract meetings and in one instance carried out a practice quality visit where the complaints process was reviewed.

4.16 Healthy Conversations are regularly held by the commissioners to seek public and voluntary sector views on service change/ development. One of these events was held to discuss patient experience of dental services.

4.17 The PCT is alerted to any comments that patients post on NHS Choices about any dental practices in B&NES and when negative comments are received these are taken up with the practice.

Additional Process in 2012/13

4.18 From 1 April 2011 NHS dental practices in B&NES have been registered with the Care Quality Commission (CQC). Each dental practice has submitted a self assessment form across 16 outcomes. As a result of these self assessments and other data that CQC receives the CQC chose to visit a number of practices in B&NES. The reports of these visits are published on the CQC website and are available to the public. The dental practice then has 14 days after the publication of the report to send CQC an action plan detailing the improvements that need to be made. CQC will be informed in writing when these compliance actions are complete.

4.19 If a practice has any areas of non compliance with the CQC Essential Standards of Quality & Safety, the PCT will be writing to them to request a copy of their action plan to CQC and also when they confirm to CQC that the actions are complete.

4.20 The PCT is waiting for 2011/12 outturn data for the clinical dataset. The PCT meets with 4 dentists across B&NES on a quarterly basis for to discuss issues with commissioning dental services from a clinical perspective. We have agreed as part of this years work programme (2012/13) that the dentists will go through all the clinical datasets for 2010/11 and 2011/12 to see if they can see any areas of concern, whether this is data quality issues, or an unusual clinical practice. The PCT will then write to dental practices asking them for feedback.

Conclusion

4.21 The PCT does take into account the quality of the dental services that it commissions but accepts that the process is not perfect. The PCT is working with local dentists to continue to refine the process to enable a smooth transfer to the new working arrangements between the Local Area Team of the NHS Commissioning Board and Local Professional Networks.

Appendix 1

NHS
Dental Services

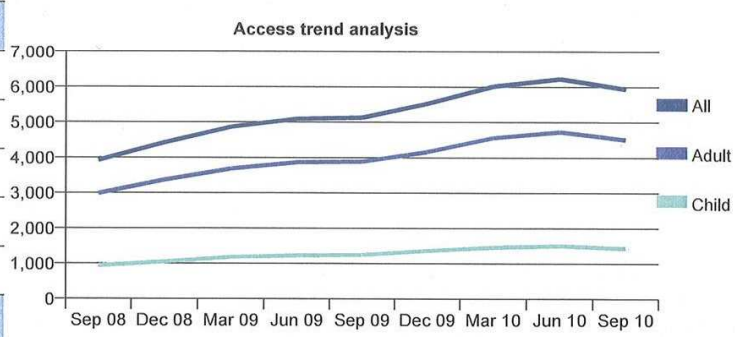
5FL - Vital Signs At a Glance Contract Report for - September 2010

Name or company name	
Contract type name	GDS Contract
Purpose of contract	General
Contract start date	01/04/2006
Contract end date	

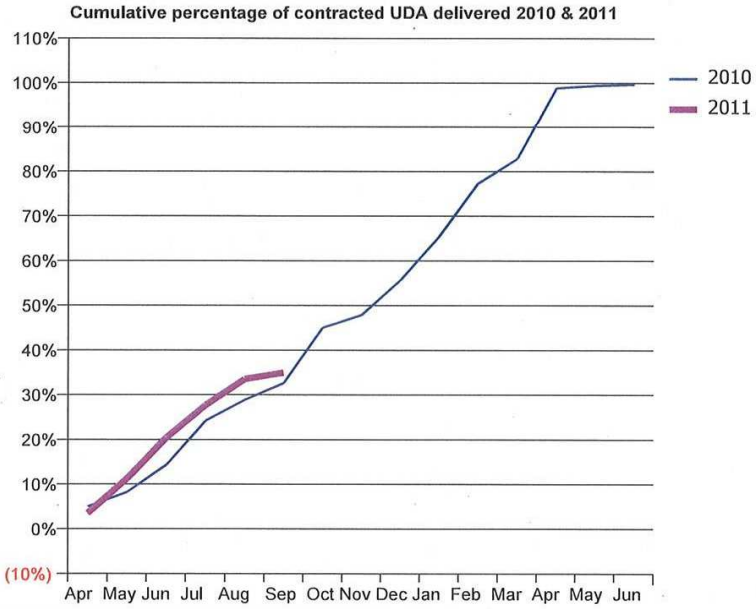
10/11 Contracted general activity (UDA)	12,661
Carry forward general activity (UDA)	0
10/11 Contracted orthodontic activity (UOA)	63
Carry forward orthodontic activity (UOA)	0
Baseline contract value	

ACCESS

Patients seen in 24 months	Total	Change since previous quarter
Quarter ending September 2009	5,130	
Quarter ending December 2009	5,525	↑
Quarter ending March 2010	6,017	↑
Quarter ending June 2010	6,227	↑
Quarter ending September 2010	5,939	↓
Variance since September 2009	15.8%	↑



ACTIVITY



Month	Adjusted Scheduled Activity (UDA) 2010	2011
April	622	443
May	1,015	1,420
June	1,767	2,588
July	2,985	3,505
August	3,559	4,248
September	4,026	4,433
October	5,549	
November	5,902	
December	6,864	
January	8,073	
February	9,533	
March	10,213	
April	12,193	
May	12,263	
June	12,299	

QUALITY

	Quantity	Base Number	Contract**	PCT	SHA	England
% of FP17s for the same patient ID Re-attending within 3 months	692	3,957	17.5%	16.5%	19.2%	19.4%
% of FP17s for the same patient ID Re-attending between 3 and 9 months	1,433	3,957	36.2%	54.7%	52.6%	48.6%
% of FP17s for Band 1 Urgent Courses	183	2,189	8.4%	6.7%	7.7%	8.2%
% of FP17s Relating to Free Repair or Replacements	60	2,189	2.7%	1.1%	1.1%	1.0%
% of FP17s Relating to Continuations	51	2,189	2.3%	2.3%	2.6%	2.2%
% of Patients satisfied with the dentistry they have received	49	54	*90.7%*	93.1%	93.0%	91.6%
% of Patients satisfied with the time they had to wait for an appointment	48	54	*88.9%*	90.1%	89.0%	86.3%

* This is based on patients treated on this contract for their most recent course of treatment.
** Figures in italics indicate the base number of FP17s or Patient Questionnaire responses are less than 100. N/A is shown where the base number of responses is less than 10 during the period.
% is calculated as Quantity/Base number*100

Appendix 2

(d) Quality

A World class commissioner will give strong focus to the quality element of the NHS Dental Services report and use this as the basis for debate with practices and with public health and dental practice advisers about how to improve performance and improve access.

- Expect this figure to be higher if commissioning urgent access slots
- High proportion of Band 1 urgent courses may indicate an issue with the quality of diagnosis or treatment planning
- Very low proportion of Band 1 urgent courses may indicate that patients are not able to access urgent treatment

- High level may indicate an issue with the quality of treatment being provided
- Low level over a period of time may indicate that patients are not able to access urgent treatment

Quality						
% of FP17s for same patient ID re-attending within 3 months	% of FP17s for same patient ID re-attending between 3-9 months	% of FP17s for Band 1 urgent courses	% of FP17s relating to free repair or re-placements	% of FP17s relating to continuations	% of patients satisfied with the dentistry they have received	% of patients satisfied with the time they had to wait for an appointment
16.4%	58.8%	5.3%	0.8%	2.7%	93.7%	89.5%

- What is the PCT range?
- How does your % compare to that of other PCTs and SHAs?
- How does your combined total for these two columns compare to that of other PCTs and SHAs?
- What does this imply for use of NICE guidance on recall intervals?

- What is the PCT range?
- How does the practice figure compare with the PCT average?

- Measures derived from results of routine monthly random patient questionnaires sent to 25,000 patients (response rate 50%)
- Look at this information alongside:
  - feedback from PALS
  - feedback from local dental helpline

Appendix 3

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Meeting with	
Date:	
Venue:	
Time	

Agenda

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1. **Introductions**
2. **NHS Developments : Health and Social Care Bill**
3. **Contract Performance 2010/11**
   - **Year End Vital Signs Report**
   - **End of Year Statement**
4. **Contract Level 2011/12: Vital Signs Report April - June 2011**
5. **Complaints & PALS**
6. **AOB**

Appendix 4

Contract: ..

General clinical data set

Item on FP17	Unit	Band 1 Rate per 100 FP17s	Band 1 England rate per 100 FP17s	Band 2 Rate per 100 FP17s	Band 2 England rate per 100 FP17s	Band 3 Rate per 100 FP17s	Band 3 England rate per 100 FP17s	All FP17s Number	All FP17s Rate per 100 FP17s	All FP17s England rate per 100 FP17s
Scale and Polish	FP17s	22.5	39.5	11.2	34.9	*17.9*	32.3	249	19.3	33.3
Fluoride Varnish	FP17s	1.9	3.6	1.9	3.0	*0.0*	1.2	23	1.8	3.0
Fissure Sealants	Teeth	0.0	0.4	1.2	1.9	*0.0*	0.1	4	0.3	0.6
	FP17s	0.0	0.2	0.6	0.9	*0.0*	0.1	2	0.2	0.4
Radiographs	Rads	16.4	30.2	14.0	41.2	*36.5*	62.7	206	16.1	28.4
	FP17s	9.0	11.1	5.1	22.7	*25.6*	34.3	117	9.1	16.2
Endodontic Treatment	Teeth	0.0	0.0	2.2	3.7	*2.6*	5.6	8	0.6	1.6
	FP17s	0.0	0.0	2.2	3.5	*2.6*	5.2	6	0.5	1.5
Permanent fillings and sealant restorations	Teeth	0.0	0.1	105.5	114.1	*61.5*	48.7	426	33.2	37.8
	FP17s	0.0	0.1	65.1	76.4	*33.1*	26.8	283	21.9	25.3
Extractions	Teeth	0.0	0.0	30.2	25.7	*41.0*	35.7	81	6.3	10.2
	FP17s	0.0	0.0	14.0	16.1	*17.9*	15.9	52	4.0	5.7
Crowns	Teeth	0.0	0.0	0.0	0.0	*53.8*	36.1	21	1.6	2.1
	FP17s	0.0	0.0	0.0	0.0	*53.8*	35.8	21	1.6	2.0
Acrylic upper dentures	Teeth	0.0	0.0	0.0	0.2	*212.8*	224.2	63	6.4	12.6
	FP17s	0.0	0.0	0.0	0.0	*30.5*	27.4	6	0.6	1.5
Acrylic lower dentures	Teeth	0.0	0.0	0.0	0.1	*210.3*	147.0	62	6.4	9.2
	FP17s	0.0	0.0	0.0	0.0	*23.1*	16.6	9	0.7	0.9
Metal upper dentures	Teeth	0.0	0.0	0.0	0.0	*0.0*	14.9	0	0.0	0.8
	FP17s	0.0	0.0	0.0	0.0	*0.0*	2.6	0	0.0	0.1
Metal lower dentures	Teeth	0.0	0.0	0.0	0.0	*0.0*	7.6	0	0.0	0.4
	FP17s	0.0	0.0	0.0	0.0	*0.0*	1.3	0	0.0	0.1
Veneers	Teeth	0.0	0.0	0.0	0.0	*0.0*	1.7	0	0.0	0.1
	FP17s	0.0	0.0	0.0	0.0	*0.0*	1.5	0	0.0	0.1
Inlays	Teeth	0.0	0.0	0.0	0.0	*2.6*	10.1	1	0.1	0.6
	FP17s	0.0	0.0	0.0	0.0	*2.6*	9.9	1	0.1	0.6
Bridges	Units	0.0	0.0	0.0	0.0	*0.0*	9.0	0	0.0	0.5
	FP17s	0.0	0.0	0.0	0.0	*0.0*	3.9	0	0.0	0.2
Examination *	FP17s	96.9	52.3	75.2	52.6	*66.7*	57.5	1,144	88.7	67.7
Antibiotic items prescribed *	FP17s	0.0	0.2	0.0	0.6	*0.0*	0.6	0	0.0	0.9
Other treatment *	FP17s	59.6	5.3	2.8	6.9	*7.7*	11.9	576	44.7	11.6
No clinical data	FP17s	0.4	7.0	0.0	1.2	*0.0*	1.7	4	0.3	6.5
Patient referred for advanced mandatory services	FP17s	0.0	0.1	0.0	0.4	*0.0*	0.2	0	0.0	0.2
Patient treated on referral	FP17s	0.0	0.1	0.0	0.6	*0.0*	0.1	0	0.0	0.3
Free repairs/replacements	FP17s	0.0	0.0	0.6	2.9	*0.0*	0.6	2	0.2	1.0
Further treatment within two months	FP17s	0.0	1.3	0.6	3.7	*0.0*	1.4	2	0.2	2.2
Domiciliary visits	FP17s	0.0	0.3	0.0	0.1	*0.0*	0.7	0	0.0	0.3
Sedation Services	FP17s	0.0	0.0	0.0	1.0	*0.0*	0.4	0	0.0	0.4
FP17s for contract		**904**		**322**		**39**			**1,290**	

* These treatments relate to FP17s with a date of acceptance on or after 1st April 2010. Figures in *italics* indicate the base number of cases is less than 100.

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. The PCT does have the risk of limited management capacity in this time of transition on the main PCT risk register.

6 EQUALITIES

6.1 The PCT is in the process of carrying out an Equality Impact Assessment on the Avon Dental Commissioning Strategy.

7 CONSULTATION

7.1 This paper was written as a result of a member of the public expressing their concerns at a Wellbeing PDS meeting.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Decision not requested.

9 ADVICE SOUGHT

9.1 The panel is asked to note the contents of the report.

Contact person	Julia Griffith 01225 831628
Background papers	None.
Please contact the report author if you need to access this report in an alternative format	

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18 May 2012 10am. Guildhall, Bath

Greg Hartley-Brewer (greghartleybrewer@yahoo.com/ 01225 464251)

Statement to the Wellbeing Policy Development & Scrutiny Panel of B&NES Re. Dental Access (Item 11 on Agenda) via the Public Speaking Scheme

PCT responses are in bold.
ADP responses are in italics and bold.

I began looking into NHS dentistry in B&NES in November 2010 after receiving two episodes of extremely poor treatment from ADP Oldfield Pk which required remedial work at the Riverside Centre. When I mentioned to the Riverside I was going to complain about ADP's treatment they told me to make sure that I did because they were fed up of having to complete unfinished work or rectifying failed treatments provided by ADP Oldfield Park.

1. ***Mr H-B's original complaint was thoroughly investigated by ADP and responses sent to Mr H-B from the clinician and the practice. Practice procedures have been reviewed, and updated where relevant, following the investigation of the issues raised in the complaint.***

Riverside raised verbal concerns about some local high street (GDS) dentists when the PCT met with the previous clinical lead. JG advised them of the process of raising concerns via the lead commissioner of this service which is NHS Bristol. The PCT attends quarterly meetings with the other commissioners of this service and no complaints were raised either at this meeting or with the PCT direct.

I began asking the PCT how they monitored practices in B&NES to be told they monitor dentists using three criteria; Access -patients seen in the last 24 months; Quality-using criteria such as patients re-attending within 3 or 9 months, complaints, DRS reports and thirdly Activity. Activity though was only measured using the cumulative total of UDAs delivered, there was no analysis of treatments ie. identifying the provision of particular types of treatment and their number.

2. The PCT carries out a risk assessment of all dental practices in B&NES each year and then chooses certain practices to concentrate on. The PCT looks at location – so all geographies are covered, BSA exception reports, activity levels and whether the practice is meeting their contractual activity levels, the size of the contract, a clinical advisor looks at low % of band 3 treatments and very low band 2 to ensure that practices are providing the full range of treatments on the NHS, and whether the PCT has received any PALS enquiries. In February 2012 this resulted in the PCT (PCT lead commissioner and local clinical advisor who is a B&NES dentist) meeting with 13 practices across B&NES. In addition the PCT decontamination lead asked all NHS dental practices in B&NES to complete a self assessment. On the basis of their return a further risk assessment was carried out and practices of concern received a visit from the decontamination lead.

3. The practice visit included looking at their vital signs report for last year (2010/11) and year to date this year(2011/12). The PCT also discussed the End of year (2010/11) statement with each practice that includes the clinical dataset. The PCT also discussed any PALS issues notified to the PCT and any complaints that the practice had received from patients in the previous year. As a result of this visit the PCT drew up an action plan which all the practices signed up to achieving. This process was reported to the PCT PEC and Board within the integrated performance report.

4. The risk assessment process was carried out because the PCT was unable to visit all dental practices due to capacity issues. This was logged formally on the PCT risk register.

As you all know the new dental contracts act as a disincentive to dentists to undertake the more complicated work, such as root canals, because they are paid a fixed rate which takes little account of how complicated the treatment is in terms of the labour or material costs. This is why it is essential that the PCT and the new CCGs monitor the type and quantity of treatments to ensure that dentists don't 'cherry pick' or 'game' the system. The PCT has not been doing this.

5. As stated above the PCT does monitor the type of treatment provided such as root canals. It will not be the role of CCG to commission dental services in the future as this will be part of the National Commissioning Board's responsibility.

I asked the PCT through an FOI request to provide me with a copy of the most recent Dental Reference Officer's inspection report for ADP Oldfield Park which was undertaken in June 2010 to be told, on 22 Feb 2011, that they had not received the report. I also asked the PCT whether they monitored treatments by type and number to be told and I quote;

" Some PCTs may monitor this level of detail with their practices but we do not in B&NES."

6. Please see above. The PCT at this time did not routinely check every dental practice clinical dataset but used the risk assessment process described above.

After some basic checking by phoning the Dental Services Division the PCT then agreed that in fact they would have received the Dental Reference Officer's report online from the Dental Services Division two or three days after the Dental Reference Officer's visit but the report had not been studied because Val Janson and one other had visited the practice in person and found no issues of concern.

7. The DRO has stopped visiting dental practices in England as part of this work is carried out by CQC now. Normally the PCT receives the DRO reports from colleagues in NHS Bristol PCT who lead on commissioning dental services across old Avon. But there was long term sickness and maternity leave in this team so in this instance the PCT did not receive the report in a timely way. Normally when the PCT had received the DRO report the PCT sent a request 6 months later to ask the practice if they had carried out the actions as agreed by the DRO. This did not happen in this instance. As a result of a higher than average number of PALS/complaints received at the PCT the clinical governance lead clinician and the quality lead manager attended a contract meeting to discuss complaints and general quality management systems and processes with ADP. They also visited the practice in February 2011 to discuss a particular

complaint and at that time received assurance from the ADP Clinical Director that clinical competency and clinical record keeping were assessed on a regular basis and it was felt that the practice could improve its complaints record management and implement a more effective system for learning from complaints. On the basis of the issues discussed and the actions agreed the PCT was satisfied that progress would be made.

Furthermore the PCT then denied they received the General Clinical Data Set from the Dental Services Division, either the quarterly 'vital signs' reports or the annual reports for every NHS dentist in B&NES. The criteria the PCT said they DID use to monitorAs an attachment to this document I have included the General Clinical Data Set for ADP Oldfield Park for 2010/11 with causes for concern regarding activity highlighted
access, activity and quality can only be found in this data! What were they trying to hide? Was it the complete lack of monitoring taking place and/or trying to obscure what the data would show?

8. The PCT was not trying to hide any information. The PCT does not receive these reports direct but can download them from a website. At the time of Mr HB request there was no-one in the PCT who could access this website. (As a key member of staff had just left). As stated previously stated the PCT does review these reports as part of the risk assessment process.

I have submitted to Lauren Rushen the full General Clinical Data sets for each NHS practice in B&NES for 2009/10 and 2010/11 and the Dental Contract Management Handbook 2010 which gives advice on how to interpret this data. It gives guidelines for figures that should raise concerns. I believe the PCT was unaware of this document or didn't use it if they were. This document also gives specific guidelines in chapter 9 regarding "Questions for the Overview and Scrutiny Committee."

For example-
"Does the PCT protect patients by ensuring the quality of dental services?"
"Does the PCT have audited processes for monitoring efficiency and effectiveness of dental contracts?"

9. The PCT is aware of the Dental Contract Handbook 2010 which gives very helpful advice for dental commissioning. This was reviewed to form the basis of the risk assessment process.

Also, the report used by this committee for today's meeting, "Developments in NHS Dentistry" Section 7 page 4 states that PCTs have a responsibility to improve oral health through prevention as well as by access to treatment. One of the treatments it lists is the application of fluoride varnishes to children at high risk of dental decay. The figure for this treatment for Oldfield Pk for 2010/11 is zero per 100 FP17s; fissure sealants is zero per 100 FP17s; scale and polish is 5.6 per 100 FP17s Band 1 when the national average is 39.5 per 100 FP17s. They treated a total of 13,518 patients and specifically 3,032 under 18's during this period. Prevention, what prevention?

10. ***In the contract year 2011-2012 the percentage of child course of treatment receiving Fluoride treatment was 9.25%. The current computer systems use the pre-2006 fee scale in order to record what treatment is performed and unless a dentist assiduously uses these codes it is not possible to accurately measure activity. It has historically been common to simply write a note indicating that these areas have been covered. The use of metrics has increased as the 2006 contract has progressed but the interpretation of this kind of data can be unreliable. ADP can now produce clinical datasets at practitioner level and is now able to discuss the importance of correct recording of this information. The Pilots for the new dental contract are specifically trialling methods to assess the effectiveness of preventative measures by looking at treatment outcomes.***

The PCT has noted that rate of fissure sealants and fluoride varnishes were low for this practice according to the dataset. The clinical director of IDH who now own this practice agreed to look into this further at a future contract review meeting with the PCT. This may be a data recording issue.

This is a practice that has an unending, permanent contract, awarded without competitive tendering to provide just under 60,000 UDAs which was increased from 39,000 UDAs 18 months/two years ago. This is more than double the next largest provider in B&NES.

11. When the PCT inherited commissioning dental services from the DH in 2006 all dentists providing General Dental Services (GDS) were given permanent contracts. This was a DH decision to stabilise dental services. 18 months/two years ago in order to improve access to dental services the PCT procured £1.4M worth of services from 11 practices in B&NES. There were two other practices awarded a similar level of increase in this process. The process used by the PCT included a review of quality standards and health promotion.

The damning report from the CQC into Oldfield Park , published two days ago, raises major concerns regarding patient safety with regard to infection control, Legionella risk and fire risk. The issues raised by the CQC highlight factors that were in place at the time of the previous inspections by the PCT and DRO. For example no sink for staff to wash their hands in the equipment decontamination room with staff stating that “we just didn't wash our hands.”

12. ***The practice has produced an action plan to addresses any areas of concern following the CQC inspection. Progress to implement this action plan is under review by both the Practice and the Company and all areas of concern flagged by the CQC have already been addressed. A new decontamination room has been created in the practice and is fully HTM01-05 compliant. A legionella test was completed in March 2011 but the evidence for this was not available for inspection at the time of the CQC inspection. PAT testing is arranged for the end of July 2012.***

CQC have only recently instigated a review of dental services. Prior to this starting in the B&NES area CQC contacted the PCT to discuss areas of concern. The PCT advised CQC of the information that has been reviewed as part of the risk assessment process and the decontamination self assessment. The quality manager advised CQC that the PCT has had cause to carry out a quality visit to ADP Bath as a result of complaints/PALS enquiries. CQC alerts the PCT when the reports are in the public

domain. We know that after a CQC visit the practice has 14 days to respond to the report. Dentists with agreement by the Avon LDC will send the PCT a copy of their report for information. The PCT will then follow up on any issues of concern.

ADP Oldfield Park's reputation precedes it. If I speak to people about it very rarely does anyone have anything good to say about it. If the PCT was unaware of this it is because it is was not asking the right questions. The CQC report, I believe, shows that the practice was not being monitored sufficiently. ADP's business model is profits first with patients coming a poor second. The decision to give so many UDAs to ADP Oldfield Pk was simply about getting a provider operating in B&NES that would always take on NHS patients, this was at the expense of quality. The PCT, due to the historic problem in Bath of limited NHS dental capacity, has concentrated on access at the expense of what happens when a patient is through the door. Access, access, access seems to have been the mantra for the provision of NHS dentistry in B&NES. As an attachment to this document I have included the General Clinical Data Set for ADP Oldfield Park for 2010/11 with causes for concern regarding activity highlighted

13. See previous comments. The PCT is being performance managed by the Strategic Health Authority on Access to NHS Dental Services as this was a priority in the NHS Commissioning Framework in 2011/12.

The current vital signs data (March 2012) indicates that 87.8% of patients were happy with the dentistry they have received. This is more than amplified by the recent Patient Satisfaction Survey (PSS). This clearly shows that the large majority (90% +) of patients are happy with the service provided. The only PSS question scoring in the blue is the 3.4% who had to wait more than 15 minutes. These results are being considered by the practice and an action plan is produced as a result.

The General Clinical Data sets for dentists in B&NES highlight areas as causes for concern if the Dental Contract Management Handbook 2010 is used as a guide. The levels of scale & polish across B&NES are low compared to national averages. In two cases they are far too high, again a cause for concern. I have been asked to pay for a hygienist at ADP Oldfield Park when the treatment was deemed clinically necessary. I have had clients at the Citizens Advice Bureau who have said the same.

14. The levels of scale and polish are low across B&NES because a number of practices in B&NES only see children. Children should not need scale and polish. Scale and polish should not be needed for patients who have good oral hygiene. NHS hygiene services are made available to patients but only for those patients that clinically require treatment to maintain their oral health.

ADP is currently undertaking a review of the provision of hygienist services to ensure that clear information is available to patients around the provision of NHS periodontal treatment. This will ensure that patients understand the clinical need for periodontal treatment, what treatments are available to patients under the NHS and any private options.

The CQC report, page 12, talks about fees and states that,

" If an individual requests a scale & polish for cosmetic reasons, it was the practice's custom to refer the patient to the dental hygienist. This was then charged for privately."
The scale & polish figures are very low so it may be that dentists are not routinely offering this treatment when clinically necessary on the NHS which is why patients are having to ask for this treatment. The report states that the PCT has now raised concerns with the provider and I would ask the Committee to follow this up and check the specific data for 2011/12 and 2012/13 to make sure the figures for scale and polish have risen and that the PCT or CCG is regularly using the General Clinical Data Set to monitor on a continuous basis.

15. The clinical dataset is produced quarterly and a summary of the whole year on an annual basis. We are waiting for 2011/12 outturn data. The PCT meets with 4 dentists across B&NES on a quarterly basis for to discuss issues with commissioning dental services from a clinical perspective. We have agreed as part of this years work programme that the dentists will go through all the clinical datasets for 2010/11 and 2011/12 to see if they can see any areas of concern whether this is data quality issues or an unusual clinical practice. The PCT will then write to dental practices asking them for feedback.

I then moved practice to 1a Queen Sq, twice I was told I needed to see the hygienist and would have to pay £35. I pointed out twice that I was an NHS patient. No offer of treatment on the NHS was forthcoming. I complained to be told that the dentist concerned had offered me both options. This was a total untruth. The General Dental council states that dentists must put their patients ahead of any personal or business interest. Why is it that two completely different dental models; one a national company and one a family run partnership, felt confident enough to breach the General Dental Services contract by asking me to pay privately for mandatory preventative treatments that should be available on the NHS?

16. ***A Basic Periodontal Examination (BPE) is the accepted screening tool used to assess the presence of periodontal disease. A BPE of 3 or higher suggests that a diagnosis of periodontal disease should be considered, a lower score does not diagnose periodontal disease and therefore, on the NHS, scaling is not appropriate.***

The reason, I believe, is because the PCT has given a green light to dentists and through their lack of effective monitoring they've said "Don't worry become an NHS provider so that we can improve access and once the patient is through the door we wont bother you!"

17. see previous comments outlining that the PCT does monitor quality.

I had a meeting with the practice manager at 1a Queen Square to raise my concerns. She was very honest. She stated that she thought their figures for scale and polish would be low because many of their NHS patients paid privately for the hygienist. She had never seen the General Clinical Data Set figures for any of the practice's dentists. Finally she told me she had had no contact with the PCT for several years. There is no guidance being given to NHS providers in B&NES. Does the PCT have any knowledge of what's happening at the NHS/private interface?

18. The practices in B&NES received the general clinical dataset figures directly from the BSA in June 11 as shown by the report that Mr HB sent you. The PCT can assure the committee that the PCT has been in regular contact with Queen Square. The dentists in this practice have separate contracts with the PCT and they correspond

directly with the PCT on a regular basis. This practice manager has contacted the PCT on a number of occasions.

I have spoken to Karen Taylor of the CQC who stated that there is an issue with regard to the accuracy of the data because there is a lack of uniformity on recording protocol. But the Dental Services Division does have explicit instructions on it's website on how to record data using the FP17s and dentists do after all get paid from this data so it's inaccuracy cannot be significant. If the PCT believes the data to be less than accurate then it should ensure reporting is consistent via oversight.

19. The PCT piloted the use of clinical datasets with dentists as part of the practice visit process. See previous comment about work programme this year for the 4 B&NES dentists.

Has any dentist in B&NES in the last three years had a remedial or breach notice issued against it? What are the bench mark figures the PCT uses when action will be instigated?
NHS dentistry in the UK is in state of flux. Dentists find it hard to provide all the treatments available on the NHS and make a living because of their contracts. So the patient pays the price through a blurring of the NHS/private relationship.

20. Some dentists in B&NES have been issued with remedial notices that relate to not achieving activity targets. But these issues have been resolved as part of the year end reconciliation process. There are no outstanding remedial notices.

The difference in quality between NHS and private treatment is significant. This disparity is not something we would put up with from our local GP and yet we have to accept a two tier health service when it comes to oral health.

21. The PCT does not have access to the quality of private dental treatment so is not able to comment.

This point onwards the report is making recommendations to the Wellbeing PDS
.
I don't expect the Committee to make recommendations based solely on what I have said today and I would be happy to be proved wrong. But I would ask that you recommend an investigation into the NHS/private relationship in B&NES and set up a system to monitor the type and number of treatments using the General Clinical Data Set.

I have spoken to Karen Taylor of the CQC who stated that there is an issue with regard to the accuracy of the data because there is a lack of uniformity on recording protocol. But the Dental Services Division does have explicit instructions on it's website on how to record data using the FP17s and dentists do after all get paid from this data so it's inaccuracy cannot be significant.

This could be investigated by:

1. Sending a letter reminding dentists of their statutory duties to provide mandatory services under the General Dental Services contract and not to direct patients to private care where that treatment is clinically necessary.

2. Compel dentists to place the document “Guide to NHS Dental Services in England”, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097431 (see pages 11 & 13) which is about NHS dental rights, in their waiting rooms with signs informing patients they should read it.

3. Lastly 6 months after that has been done undertake a patient questionnaire survey listing the treatments available on the NHS and ask the basic question “Have you ever been asked to go private for any of these treatments available on the NHS or told that the treatment would be better if done privately?”

4. Monitor the number and types of treatment being offered so that the PCT/CCG knows that ‘gaming’ or 'cherry picking' is not occurring.

At the present time if you need root canal work that’s moderately complicated on the NHS you loose your tooth because it's not economically viable for a dentist to spend two hours treating a patient. Look at the General clinical data set and see how low the figures are for this treatment. Why not do what Wiltshire have done and provide a dentist with an endodontic specialism one afternoon per week?

One of this Committee's remits is reducing health inequalities. In B&NES if you can afford private treatment you save your tooth, if you are an NHS patient you lose it. To me that is a glaring example of a health inequality.

I would also recommend watching Channel 4's Dispatches programme ‘The Truth About Your Dentist’ broadcast on the 18 May 2011 and still available on Channel 4 OD.

Finally, I would agree with today’s proposition that access has improved, but now let’s also concentrate on what happens when a patient gets through the door.

NB. As a separate attachment to this document I have included the General Clinical Data Sets for 2010/11 for B&NES. Please look at the first two practices on the list (page 5 of both) which are ADP Oldfield Park and ADP Walwyn Close, Twerton for 2010/11. In particular see 'scale & polish' and 'fluoride varnish'. Remember the PCT only monitors 'activity' by the cumulative total for UDAs not the breakdown of that activity ie. the number of 'scale & polishes' or the number of 'fluoride varnishes'. This is what needs to be monitored.

Below is the criteria the PCT will state they use to monitor for 'quality', 'access' and 'activity'. Ask the PCT to provide evidence of this monitoring not just a list of what it states it uses!

Access
Patients seen in 24 months
Activity
Cumulative percentage of contracted UDA delivered

Quality
% of FP17s for the same patient ID Re-attending within 3 months
% of FP17s for the same patient ID Re-attending between 3 and 9 months

% of FP17s for Band 1 Urgent Courses
% of FP17s Relating to Free Repair or Replacements
% of FP17s Relating to Continuations
% of Patients satisfied with the dentistry they have received
% of Patients satisfied with the time they had to wait for an appointment

PALS and complaints & DRS reports

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Bath & North East Somerset Council	
MEETING:	Health and Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	27/07/2012
TITLE:	Joint Strategic Needs Assessment (JSNA)
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report:	

1 THE ISSUE

1.1 There is a new statutory requirement for the local authority to conduct research activity. This is called the Joint Strategic Needs Assessment (JSNA). The JSNA and aims to provide the big picture about current and future needs of the Bath and North East Somerset population. Our JSNA has been produced in partnership between the Public Health Team and Policy and Partnerships. This report and accompanying presentation outlines the process undertaken and highlights key findings.

2 RECOMMENDATION

The Health and Wellbeing Policy Development & Scrutiny Committee is asked to:

2.1 Note the process and findings of the JSNA.

2.2 Consider how the JSNA can be used as an evidence to effectively support future scrutiny activity.

2.3 Consider who else needs to be told about the JSNA and sources of information which should be included in future updates.

3 FINANCIAL IMPLICATIONS

3.1 The JSNA has been produced by re-tasking existing council and NHS resources.

3.2 The document underpins the Clinical Commissioning Groups Plan and the emerging Health and Wellbeing Strategy which will both have an impact on long term budget setting and prioritisation. In the longer term we are planning to promote the document as a reference point for service and financial planning.

4 THE REPORT

Background

4.1 The requirement to conduct a Joint Strategic Needs Assessment has been placed on local authorities under the Health and Social Care bill, however the requirements on exactly what a Joint Strategic Needs Assessment is are quite broad. As a result, a local approach has tried to take best practice from elsewhere and take the local audience into account. As a result it is not a static, many-page document, but instead a process covering a range of topics, issues and is available in a range of documents.

Content

4.2 The JSNA contains a wide range of local statistical data gathered from national sources and local databases; local opinions gathered from existing consultations and engagement exercises and also data gathered from performance management systems. It is designed to highlight positive features of the area as well as more traditional medical 'needs'.

4.3 In order to make the data accessible we have started to produce short annual summaries of JSNA information and a continually updating "Technical Summary" including more detail on sources,

4.4 The main document looks at data according to headings based on how services are arranged or by broad topic areas, these are:

- Population and demographic change
- Mortality and life expectancy
- Long term conditions and disability
- Mental health
- Safeguarding
- Carers
- Service use & quality
- Health Improvement & protection
- Lifestyle Determinants
    - Pregnancy and Maternity
    - Child Health
    - Obesity, physical activity & diet
    - Smoking
    - Poisoning
    - Alcohol
    - Illicit substance misuse
- Social determinants and wider wellbeing
    - Education

- Not in education training or employment (NEET)
- Child Poverty & Social Inequalities
- Benefits and Employment
- Housing
- Stronger Communities
- Crime and Disorder
- Cultural Activities
- Climate Change
- The Natural and Build Environment
- Air Quality

4.5 In addition, the summarising process identified a number of cross-cutting issues or 'themes' which sit across a number of topics:

(1) Ageing Population

(2) Complex Families

(3) People Experiencing Multiple Needs

(4) Social and economic differences (inequalities)

(5) Rural areas

Next Steps

4.6 We will be making the JSNA documents and as much of the underlying data as possible available on-line at our web-site www.bathnes.gov.uk/jsna, which will be up and running with the new Council web-pages. We can also attend meetings and conduct briefings on particular subjects of interest.

4.7 We will be producing ongoing updates to the main document and will be producing annual summaries on or around April each year.

4.8 We also acknowledge that there are gaps in our knowledge and the JSNA will never be able to hold everything, but if there are studies we're missing, or if something doesn't feel right, then the JSNA team can be contacted on research@bathnes.gov.uk (01225 477230).

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. An EqIA has not been completed as the JSNA is not a corporate strategy document and does not make direct recommendations for action. However an equalities specific summary has been prepared to support the organisation in grounding EqiAs in local evidence.

7 CONSULTATION

7.1 Cabinet Member; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer

7.2 Information gathered from public engagement is a critical element to the JSNA, and the new Healthwatch engagement member will have a statutory responsibility to input. As the JSNA process develops we will be investigating more ways of getting existing public engagement information fed into the process. In addition, an aim of the web-portal is to ensure that local information can reach the communities who have need of it.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Young People; Human Rights; Corporate; Other Legal Considerations

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	Paul Scott, Acting Director of Public Health Jon Poole, Research & Intelligence Manager
Background papers	Joint Strategic Needs Assessment 2 Page Summary Joint Strategic Needs Assessment 15 Page Summary Joint Strategic Needs Assessment Technical Summary www.bathnes.gov.uk/jsna
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 and Scrutiny Panel
MEETING DATE:	27th July 2012
TITLE:	Government Consultation on Standardised Packaging of Tobacco
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Equalities Impact Assessment	

1 THE ISSUE

The Department of Health has launched a consultation on whether standardised (plain) packaging of cigarettes and other tobacco products should be introduced in the UK[1]. The consultation is open until 10th August 2012.

Due to increasing restrictions on tobacco advertising in recent years, tobacco packaging has become one of the tobacco industry's leading promotional tools. Research suggests that plain packaging would increase the impact of health warnings, reduce false and misleading messages that one type of cigarette is less harmful than another, and reduce the attractiveness of products to young people.

Australia will become the first country in the world to require all tobacco products to be sold in plain packaging, from December 2012. The UK government has committed to consulting on options to reduce the promotional impact of tobacco packaging, including plain packaging.[2]

2 RECOMMENDATION

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

Inform the Government that it supports the introduction of standardised (plain) packaging for all tobacco products in the UK through a collective response to the consultation.

3 FINANCIAL IMPLICATIONS

There are no financial implications for the Council or the PCT in responding to the consultation. If the Government decide to legislate for standardised packaging of tobacco products there will be no financial implications at a local level as implementation will be at a national level

[1] Department of Health Consultation documents: http://consultations.dh.gov.uk/tobacco/standardised-packaging-of-tobacco-products/consult_view

[2] Action on Smoking and Health (ASH) 2011 Plain Packaging Briefing

Reducing the desirability and attractiveness of tobacco products to children is a key element of local and national Tobacco Control Strategy which aims to reduce the number of young people taking up smoking.

Whilst tax on tobacco contributes £10 billion annually to the Treasury, the true costs to society from smoking are far higher, at £13.74 billion.[3] This cost is made up of the cost of treating smokers on the NHS (£2.7 billion) but also the loss in productivity from smoking breaks (£2.9 billion) and increased absenteeism (£2.5 billion); the cost of cleaning up cigarette butts (£342 million); the cost of fires (£507 million), and also the loss in economic output from the deaths of smokers (£4.1 billion) and exposure to second hand smoke (£713 million).

Each year in B&NES it is estimated that smoking costs society £39.9 million. Annually smokers in B&NES spend approximately £45.3 million on tobacco products, approximately £1,700 per smoker per year. This contributes roughly £34.5 million in duty to the exchequer leaving an estimated annual funding shortfall of £5.5million.[4]

4. THE REPORT

Every year, another 340,000 children and young people are tempted to try smoking[5]. Very few people start smoking as adults. Two thirds of smokers say they began before they were legally old enough to buy cigarettes and 9 out of 10 started before the age of 19 years. Nicotine addiction starts in adolescence.

Due to the death rates of current smokers and the ever growing number of ex-smokers who have successfully quit, the tobacco industry must find innovative ways of recruiting the next generation of smokers to replace those who quit or die. This means targeting young people to become the next generation of smokers, and subsequently the future generation of patients suffering diseases such as lung cancer, COPD and heart disease. 300 people die of smoking related diseases every year in B&NES[6]. Research from local secondary school pupils (Yr 8 and 10) tells us that 24% have tried smoking or are smoking now[7]. The highest rates of smoking nationally are amongst the 16 – 24 year olds (26%).

Smoking is becoming increasingly engrained in more disadvantaged communities, with 32% of people in routine and manual jobs in B&NES currently smoking and high levels of smoking in pregnancy amongst young women (35%) and women in lower socio economic groups.

Both further education colleges in B&NES have identified high rates of smoking amongst students. More girls in B&NES are smoking than boys. 12% of Year 10 boys and 21% of Year 10 girls said that they smoke ‘occasionally’ or ‘regularly’. 33% of 11 – 15 year olds in B&NES say at least one person regularly smokes indoors in their home. This figure is lower than the national comparator (40%) but still represents a significant number exposed to second hand smoke and smoking behaviour.

[3] Featherstone H & Nash R (2010) Cough Up; Balancing tobacco income and costs in society. Policy Exchange
[4] http://ash.org.uk/localtoolkit/R9-SW.html
[5] Department of Health 2011 Healthy Lives Healthy People; A Tobacco Control Plan for England
[6] Local Authority Health Profiles; Bath & North East Somerset 2011 www.lho.org.uk
[7] Schools Health Education Unit Secondary Schools Survey; B&NES 2011

In recent years the pack has become the most important marketing tool for the tobacco industry, known in the trade as the 'silent salesman'. The power of brands is well known to all parents, with young people heavily influenced by branding. Printing and pack technology has advanced considerably over recent years, leading to innovative new pack and cigarette designs which use colour, graphics and method of pack opening to appeal to different segments of the population. Examples will be shown at the meeting and include pastel colours and super-slim sticks to appeal to young women and girls, and slide packs featuring graphics that appeal more to men and boys, such as motorbikes and music equipment.

It is important to note that plain packs are not actually plain – they will have detailed text, graphics and health warnings, as well as covert security measures to reduce illicit trade. Plain packaging means internal and external colours will be prescribed, fonts and labelling will be the same on all packets. Standard shape and opening will be required and no advertising, promotion, logos or additional text will be permitted.

The Governments' consultation paper is accompanied by an independently conducted systematic review of the evidence base on plain packaging[8]. This review concludes that there is strong evidence to support the propositions set out in the WHO Framework Convention on Tobacco Control relating to the role of plain packaging in helping to reduce smoking rates; that is,

I. that plain packaging would reduce the attractiveness and appeal of tobacco products;
II. it would increase the noticeability and effectiveness of health warnings and messages, and
III. it would reduce the use of design techniques that may mislead consumers about the harmfulness of tobacco products.

The Government has three policy options under consideration:

- Option 1: Do nothing (ie, maintain the status quo for tobacco packaging).

- Option 2: Require standardised tobacco packaging of cigarettes and hand rolling tobacco (HRT). In line with the approach set out in the consultation document, this could involve the standardisation of pack colour and shape and removal of all branding except brand name which would appear in a standardised typeface. Relevant legal markings such as health warnings and tax stamps would be retained as well as covert markings to reduce trade in illegal tobacco products.

- Option 3: A different approach to tobacco packaging to improve public health, if suggested by consultation responses. Options 1 and 2 are considered in this. The potential of Option 3 will be explored following consultation, if responses to the consultation suggest an alternative approach to reduce the promotional impact of tobacco packaging.

There are a number of counter arguments to plain packs put forward by the tobacco industry. Some of these relate to arguments about intellectual property and freedom of

[8] University of Stirling (2011) Plain Tobacco Packaging: A Systematic Review

trade, some of which are currently before the courts in Australia and are likely to go before the World Trade Organisation. Most legal opinion suggests that such arguments are unlikely to succeed, as public health interests can provide a justifiable reason for interfering in free markets. The other counter arguments and responses are summarised in the following paragraphs.

- ***Tobacco smuggling will increase because plain packs are easily counterfeited.***

There is no evidence that plain packaging will lead to an increase in the illicit trade in tobacco. Plain packs may not have the brand logos and colours, but they will still be required to have all the health warnings and other covert security markings – so they will actually be no easier to counterfeit.

- ***Plain packs will cause confusion and extra costs for small businesses.***

The main impact will be on reducing uptake amongst young people and not on current smokers. Which means sales will decline gradually and not overnight, allowing shops time to adapt. Research measuring over 5,000 'retail transactions' (the time shop staff take to find the right pack and hand it over), found that plain packs, if anything, reduced transaction times and selection errors.

- ***Tobacco is going to be put out of sight, so we don't need plain packs.***

Tobacco packaging will only be hidden in shops. Once outside, it will continue to work as the industry's 'silent salesman' advertising brands and promoting smoking to children.

- ***Isn't this going too far? Are other 'unhealthy' products going to be branded plain too?***

Tobacco is not like any other product. It is the only legal consumer product on the market which is lethal when used as the manufacturer intended. Plain packs for tobacco will not set a precedent for other consumer products.

Effective tobacco control can only be achieved through co-ordinated action at local, regional, national and international level. Regulation of tobacco products, taxation and restricting the promotion of tobacco are key strands in controlling demand. There is significant public support for tobacco control measures, with a recent national public opinion survey showing that 37% of people think the Government is not doing enough on tobacco policy and 37% thinking it's about right.[9]

From April 2013 local authorities will have responsibility for achieving the public health outcomes for smoking which include reducing smoking prevalence amongst 15 year olds, reducing smoking prevalence in adults (over 18's) and reducing smoking at time of delivery. In order to ensure smoking prevalence continues to decline locally a strategic multi agency approach is needed which ensures all elements of tobacco control are being addressed including:

- restricting supply of tobacco, including illicit tobacco and underage sales

[9] ASH 2011 Tackling Tobacco; Public Opinion in the South West http://ash.org.uk/localtoolkit/docs/R9-SW/PO-R9-SW.pdf

- reducing exposure to second hand smoke – smoke free environments
- producing effective communications, education and social marketing to denormalise smoking
- helping people to quit

RISK MANAGEMENT

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

5. EQUALITIES

An EqIA has been completed and some adverse or other significant issues were found. The full EqIA is attached.

The issues mirror those highlighted by the National Tobacco Policy team at the Department of Health who carried out an Equality Impact Assessment on the proposed policy objective of introducing plain packaging[10]. It is important to note the difficulty in fully scoping the impact of this policy development as it has not been implemented anywhere in the world to date. Australian policy will be implemented from December 2012. Possible adverse findings of the EqIA were;

Potential negative impact on small businesses due to a decrease in tobacco sales, with potential impact on equality in relation to ethnicity, where businesses are owned by minority ethnic groups.

Potential negative impact on those who cannot read or understand English, whether due to disability or race, if they can no longer recognise their usual brand of tobacco from name alone.

If the policy did increase availability of illicit tobacco in communities this is more likely to be in disadvantaged communities and could undermine the impact of price increases as a control measure.

The Department of Health EIA states that there is not enough evidence to say whether these impacts would arise or not and therefore they would need to be reconsidered following the consultation if the policy is developed further.

Positive impacts

A requirement for standardised packaging would be a universal intervention at population level, therefore it could improve health by deterring young people from starting smoking and supporting adults to quit. Additionally a benefit would be the reduction in exposure to second hand smoke from reduced rates of smoking, which would protect the population as a whole but children in particular as they are more vulnerable to the impacts of second hand smoke.

If overall smoking prevalence is reduced across all social groups this policy will help to narrow inequalities, due to smoking being more prevalent in disadvantaged groups and those with mental health conditions.

[10] Department of Health. Consultation on Standardised packaging of tobacco products. Equality Impact Assessment (April 2012)

Evidence shows that plain packaging is less appealing to young people and to females in particular. More girls smoke than boys therefore it may contribute to narrowing the gap in smoking rates amongst girls and boys.

Department of Health state that depending on the evidence received through the consultation, further specific consultation with stake holder groups may be needed.

6. CONSULTATION

Cabinet Member; Overview & Scrutiny Panel; Other B&NES Services; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Monitoring Officer

The proposal for Plain Packaging has been supported by the B&NES Tobacco Action Network, B&NES Clinical Commissioning Group and B&NES Children's Trust Board.

Two road-shows were run in April/May 2012 in Bath City Centre to raise awareness amongst the public of the consultation.

To date over 500 people in B&NES have signed up to support Plain Packaging through the Plain Packs Protect website www.plainpacksprotect.org.uk

7. ISSUES TO CONSIDER IN REACHING THE DECISION

Social Inclusion; Children & Young People;

The implementation of this strategy is relevant to social inclusion, young people, vulnerable people and vulnerable families and addressing health inequalities.

8. ADVICE SOUGHT

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	*Cathy McMahon, Public Health Development and Commissioning Manager, NHS B&NES cathy.mcmahon@banes-pct.nhs.uk 01225 831539*
Background papers	*none*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	Government Consultation on Standardised Packaging of Tobacco Products
Name of directorate and service	NHS B&NES Public Health Department
Name and role of officers completing the EIA	Cathy McMahon, Public Health Development and Commissioning Manager
Date of assessment	11th July 2012

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community. The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality impact Assessments (EIAs) can be carried out in relation to service delivery as well as employment policies and strategies.

This toolkit has been developed to use as a framework when carrying out an Equality Impact Assessment (EIA) or Equality Analysis on a policy, service or function. It is intended that this is used as a working document throughout the process, with a final version including the action plan section being published on the Council's and NHS Bath and North East Somerset's websites.

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	Aim of the Government Consultation is to consider whether there might be public health benefits to introducing standardisation of packaging of tobacco products. The Government also want to understand what other effects there might be with introduction of this policy. Public Health supports the introduction of standardised (plain) packaging for tobacco products and is advocating that the Council, other Partnerships and the local community support the proposal and respond to the consultation. The intended outcomes of the introduction of plain packaging for tobacco products is that cigarettes and other tobacco products will be less desirable and attractive to young people and thereby contribute to a reduction in the uptake of smoking in adolescence. Also that plain packaging will support adult smokers that want to quit.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	This would be new legislation and would apply to all Tobacco Products on sale in the UK. The following restrictions would apply: • All internal and external packaging to be in a prescribed colour/s (details would be set out by the Government in the future). • All text on the pack, including brand names, to be in a standard colour and typeface (specifications including maximum size of type would be set out by the Government in the future). • No branding, advertising or promotion to be permitted on the outside or inside of packs, or attached to the package, or on individual tobacco products themselves. For this purpose 'branding' includes logos, colours or other features associated with a tobacco brand. • Any foils within a pack to be of a standard format and colour with no text permitted (specifications would be set out by the Government in the future).

		• Packs to be of a standard shape and opening, and possibly manufactured with particular materials (specifications would be set out by the Government in the future). • Only the following information or markings to be permitted on packs (specifications would be set out by the Government in the future): • a brand name; • a product name; • the quantity of product in the packaging; • the name and contact details of the manufacturer; • one barcode to facilitate sale and stock control; • health warnings as currently required; • tar, nicotine and carbon monoxide (TNCO) yield information as currently required; • product identification marking as currently required; • fiscal mark requirements as currently required; and • markings not visible to the naked eye to assist with the identification of genuine, duty paid products, or other features to prevent fraud (details would be set out by the Government in the future). • Any wrapper around the pack to be transparent and colourless, without any other markings visible to the naked eye.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	The aims of this proposal support the aims within the Draft B&NES Tobacco Control Strategy 2012 and has links to the Sustainable Communities Strategy in terms of promoting health and wellbeing through addressing inequalities in health and improving the life chances of disadvantaged children.

2. Consideration of available data, research and information		
Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources: • **Demographic** data and other statistics, including census findings • Recent **research** findings (local and national) • Results from **consultation or engagement** you have undertaken • Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age) • Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations • Analysis of records of enquiries about your service, or **complaints** or **compliments** about them • Recommendations of **external inspections** or audit reports		
	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	The policy will not be delivered locally. If implemented it will be national legislation. The National Tobacco Policy team at DH has undertaken a Equality Impact Assessment on the proposed policy. Depending on the evidence received through the consultation, further specific consultation with stake holder groups may be needed.
2.2	What equalities training have staff received?	N/a as above
2.3	What is the equalities profile of service users?	Smoking prevalence increases with age throughout the school age years and girls are currently smoking more than boys. Regular smoking is associated with other risky behaviours such as drinking alcohol and taking drugs. Those young people who have truanted from school or been excluded at some point are more likely to be regular smokers. Children are 3 times more likely to smoke if their parents smoke. The local Secondary School age (Yr 8 and 10) survey in B&NES reported that:

		• 24% of pupils said they have tried smoking in the past or are smoking now • 8% said they smoke regularly or occasionally (compared to 9% in national sample) • 6% smoked at least one cigarette during the last 7 days (compared with 9% of national sample) • 12% of year 10 boys and 21% of year 10 girls said that they smoke 'occasionally' or 'regularly' • 13% of B&NES primary school pupils think they may smoke when they are older compared to 10% of the national survey. Research has shown that the decline in smoking rates in the UK has slowed since the start of the economic recession in 2008. Prevalence has reduced across all social gradients however the gap between the socio economic groups has stayed constant. Smoking is becoming more engrained in specific communities, particularly those in routine and manual jobs, those living in disadvantaged areas and those with mental health conditions.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	We do not know the specific views of local small businesses on this policy. Equally we have not consulted with disability groups or those who do not speak English who may be disadvantaged by plain packaging.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	B&NES PCT commissions Smoke Free South West to undertake Tobacco Control campaigning work on its behalf. Smoke Free South West are actively campaigning for plain packaging of tobacco products with the support of the 14 PCT's in the South West and a range of national partners including the British Heart Foundation, Cancer Research UK and the Royal College of Nursing. The campaign called www.plainpacksprotect.co.uk has over 120,000 signs up of support to date across the UK. Of these 12,794 have come from the South West with 556 from B&NES residents to date. The majority of B&NES sign ups have come from 2 Roadshows held in the centre of Bath in April or via active promotion through local professional networks.

2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	Depending on the evidence received through the consultation, DH have stated that further specific consultation with stake holder groups may be needed at a national level if the policy is developed.

3. Assessment of impact: 'Equality analysis'			
	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender** – identify the impact/potential impact of the policy on women and men. (Are there any issues regarding pregnancy and maternity?)	More girls smoke than boys. Plain packaging will contribute to a reduction in misleading messages and marketing targeting girls and boys and support a reduction in smoking overall. However there is some evidence that females may find plain packaging particularly unattractive.	
3.2	**Transgender –** – identify the impact/potential impact of the policy on transgender people		
3.3	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration of a range of impairments including both physical and mental impairments)		Those with reading difficulties may find it harder to distinquish their brand from written text alone.
3.4	**Age** – identify the impact/potential impact of the policy on different age groups	Marketing and branding of cigarettes in particular is targeted at young people. The majority of people start smoking before they are 18 years of age.	

		Research has shown that plain packaging is less attractive to young people , makes health warnings more visible and will reduce false and misleading messages aimed at children and young people. Young people may be more affected by plain packaging than older people.	
3.5	**Race –** identify the impact/potential impact on different black and minority ethnic groups		Where smaller businesses are run by ethnic minority groups there could be an impact in terms of equality (see below re; social economic impact)
		Examples of what the service has done to promote equality	**Examples of potential negative or adverse impact and what steps have been or could be taken to address this**
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people		
3.7	**Religion/belief –** identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.		
3.8	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood, employment status can influence life chances	Smoking is becoming more engrained in specific communities. Those from disadvantaged backgrounds are more likely to smoke, live in a household with smokers and be exposed to second hand smoke. Plain packaging will support an overall strategy to reduce smoking in these communities however it is a population approach rather than one targeted at disadvantaged communities. Therefore its likely impact	Smaller businesses could be affected by a reduction in tobacco sales. If standardised packaging had an effect of increasing illicit tobacco sales in communities this could impact on crime in poorer communities in particular. However there is not enough evidence to say that it will lead to increase in illicit trade at the moment.

		is to reduce smoking prevalence across the social gradient.	
3.9	**Rural communities** – identify the impact / potential impact on people living in rural communities		

4. Bath and North East Somerset Council & NHS B&NES
Equality Impact Assessment Improvement Plan

Please list actions that you plan to take as a result of this assessment. These actions should be based upon the analysis of data and engagement, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your service planning framework. Actions/targets should be measurable, achievable, realistic and time framed.

Issues identified	Actions required	Progress milestones	Officer responsible	By when
Those with reading difficulties may find it harder to distinquish their brand from written text alone.	Await the outcome of the consultation. DH has committed to undertaking further consultation if evidence becomes available on these issues.			
Smaller businesses could be affected by a reduction in tobacco sales. Where smaller businesses are run by ethnic minority groups there could be an impact in terms of equality (see below re; social economic impact	Await the outcome of the consultation. DH has committed to undertaking further consultation if evidence becomes available on these issues.			
If standardised packaging had an effect of increasing illicit tobacco sales in communities this could impact on crime in poorer communities in particular	Await the outcome of the consultation. DH has committed to undertaking further consultation if evidence becomes available on these issues.			

5. Sign off and publishing

Once you have completed this form, it needs to be 'approved' by your Divisional Director or their nominated officer. Following this sign off, send a copy to the Equalities Team (equality@bathnes.gov.uk), who will publish it on the Council's and/or NHS B&NES' website. Keep a copy for your own records.

Signed off by: Paul Scott, Acting Director of Public Health (Divisional Director or nominated senior officer)
Date: 13/7/2012

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Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **27th July 2012**
TITLE: **WORKPLAN FOR 2012**
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 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 18.07.12.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
27th Jul 12						
	Cabinet Member update (15)					
	NHS/CCG update (15)					
	LINk update (15)					
	HealthWatch update (20)		Derek Thorne			
	Joint working arrangements with the NHS beyond April 2013 (15)		Mike Bowden			
	Housing Allocations – verbal update (10)		Graham Sabourn			
	Care Homes quarterly performance report (20)		Sarah Shatwell			
	Report on the Quality of Dental Service with NHS dentists (30)		Julia Griffith			
	Joint Strategic Needs Assessment (45)		Paul Scott			
	Tobacco Plain Packaging Consultation (15)		Cathy McMahon			
21st Sep 12						
	Cabinet Member update					
	NHS/CCG update					
	LINk update					
	Developing Health and Independence approach to Individual/Personalised				Vic Pritchard	

Last updated 18.07.12.

	Budgets (tbc)					
	CQC update		Karen ?			
	Winterbourne View findings		Jane Shayler			
	Housing Allocations report (tbc)		Graham Sabourn			
	B&NES Tobacco Control Strategy		Cathy McMahon			
	Alcohol Harm Reduction – SID ToR (tbc)		L Rushen			
	Update on the AWP		Andrea Morland			
	Energy Efficiency Report		tbc			
16th Nov 12						
	Medium Term Plan					
	Further update on Dementia		tbc			
18th Jan 13						
	Service Action Plan					
	Strategic Transition Board update					
	Alcohol Harm Reduction SID - recommendations		L Rushen			
22nd Mar 13						
Future items						
	Half Day open session on Joint Strategic					

	Needs Assessment (date tbc)					
	Talking Therapies update		Andrea Morland			
	Alcohol Harm Reduction Strategy - Scrutiny Inquiry Day with relevant experts and stakeholders to formulate policy on approaches to key issues such as Early Morning Restriction Orders, late night levies and health bodies' involvement in licensing decisions					

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