Bath & North East Somerset Council

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Date: 13th September 2012
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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, 21st September, 2012

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 21st September, 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, 21st September, 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

   Mr Greg Hartley-Brewer will address the Panel with his statement on NHS Dentistry..

7. MINUTES 27TH JULY 2012 (Pages 7 - 30)

   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. URGENT CARE REDESIGN PROJECT (15 MINUTES) (Pages 31 - 48)

To inform the Panel about the Urgent Care Redesign Project and proposed engagement process.

11. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK (LINK) UPDATE (15 MINUTES) (Pages 49 - 118)

The Panel are asked to consider an update and LINk's Annual Report for year 2011-12.

12. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) - DEMENTIA (20 MINUTES) (Pages 119 - 126)

This report covers a summary of data held in the Joint Strategic Needs Assessment on the subject of dementia. This is following an explicit request from Wellbeing PDS Panel to keep the JSNA as a standing agenda item on a subject-by-subject basis.

13. WINTERBOURNE VIEW FINDINGS UPDATE (10 MINUTES) (Pages 127 - 156)

To provide the Wellbeing PDS Panel with an update following the publication in August 2012 of:

- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview.

The Wellbeing PDS Panel is asked to:

- Note the content of the report; and
- Receive a further update following the publication of the overview report, which is anticipated at the end of October 2012.

14. CARE QUALITY COMMISSION UPDATE (20 MINUTES) (Pages 157 - 162)

The Panel are asked to consider an update paper from Karen Taylor (Care Quality Commission).

LUNCH AT 11:50/12:00 UNTIL 12:20

15. PERSONAL BUDGETS: REVIEW OF POLICY FRAMEWORK & RESOURCE ALLOCATION (PROGRESS REPORT) (30 MINUTES) (Pages 163 - 176)

The report summarises work undertaken since March 2012 (and before) to review and revise the Personal Budgets policy framework and Resource Allocation System (RAS) currently used to deliver social care services in Bath & North East Somerset.
This review and revision is necessary in order to:
(1) Achieve financial sustainability and meet the Council's efficiency targets for adult social care.
(2) Achieve the central Government target to deliver PBs to 100% of all adult social care users by April 2013.
(3) Address a range of equalities issues which have been identified in the current social care system.
A project group has been established to assess the benefits of adopting the National RAS in Bath & North East Somerset. This is a tool commissioned by the Department of Health, currently in use by the majority of local authorities (122) as the primary mechanism for allocating funding to meet the social care needs of individual service users.

The Wellbeing Policy Development & Scrutiny Panel are asked to agree that:

- Based on the modelling contained in the main report, the percentile model for calibrating the national RAS locally is further explored and tested.
- Based on the above recommendation, further engagement and consultation with service users, carers and social care staff takes place.
- Based on the modelling contained in the main report, scenario 4 of the five transitional scenarios is adopted when roll out of the national RAS begins.
- Implementation of the national RAS should take place in early 2013 following a period of statutory consultation.

16. SPECIALIST MENTAL HEALTH SERVICES UPDATE (20 MINUTES) (Pages 177 - 192)

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

- Progress in implementing the Care Home and Community Hospital Liaison service (as previously agreed).
- The implementation of the Adult of Working Age community services redesign in line with local and national strategic intentions.
- Progress to date on further environmental improvements to Hillview Lodge.
- Avon and Wiltshire Mental Health NHS Trust (AWP) response to recent CQC

and Strategic Health Authority reviews and reports – Fit for the Future.

17. TERMS OF REFERENCE FOR ALCOHOL HARM REDUCTION STRATEGY SCRUTINY INQUIRY DAY (5 MINUTES) (Pages 193 - 200)

On 18th May 2012, the Wellbeing Policy Development and Scrutiny Panel received a report on Bath & North East Somerset Council's Alcohol Harm Reduction Strategy. The briefing also outlined powers that are set to be introduced as part of the Government's Alcohol Strategy that was published in March 2012. The briefing recommended that the Panel consider undertaking a Scrutiny Inquiry Day to help refresh the Alcohol Harm Reduction Strategy in light of these new powers.

The Wellbeing Policy Development and Scrutiny Panel is asked to:

- Note the terms of reference and agreed to undertake a Scrutiny Inquiry Day
- Agree to appoint a Steering group (usually 2-3 Members of the Panel) to plan the Scrutiny Inquiry Day
- Make any initial suggestions for invitations to the Scrutiny Inquiry Day

18. HOUSING ALLOCATIONS (20 MINUTES) (Pages 201 - 264)

Each Local Housing Authority (the Council) must have an allocation scheme which articulates how priority for social housing is determined. The Bath & North East Somerset scheme, known as the Homesearch Scheme, is operated on the principles of choice-based lettings which combine the elements of housing need, time on scheme and client choice. At present, and in accordance with the legislation current at the time of adoption, the scheme allows anyone, with a few statutory exceptions, to join the scheme. This is known as an "open scheme".
The Localism Act 2011, supported by new Allocations guidance, provides the Council with greater freedoms in determining local priorities. In particular the Council can now chose to exclude certain households from the scheme, such as, those households who do not have a local connection to the district or whose income is above a specific level. This is known as a "closed scheme". The Council will need to determine how it wants to use these freedoms.
Following consultation, including both to this Panel on the 16th March and the Housing & Major Projects Panel on the 27th March, the attached draft policy has been produced and has returned to this Panel as requested for further consideration.

19. WORKPLAN (Pages 265 - 270)

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, 27th July, 2012

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Lisa Brett, Eleanor Jackson, Anthony Clarke, Bryan Organ, Kate Simmons, Sharon Ball and Douglas Nicol

19 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

20 EMERGENCY EVACUATION PROCEDURE

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

21 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Janet Rowse (Sirona Chief Executive) had sent her apology to the Panel.

22 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

Councillor Eleanor Jackson declared personal and non-prejudicial interest at this point of the meeting as she is Council's representative on Sirona Care & Health Community Interest Company.

Councillor Vic Pritchard declared personal and non-prejudicial interest at this point of the meeting as he is Council's representative on Sirona Care & Health Community Interest Company.

Councillor Anthony Clarke declared personal and non-prejudicial interest on the agenda item 'NHS and Clinical Commissioning Group update' as he is Council's representative on the Council of Governors of the Mineral Water Hospital (RNHRD).
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23 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none. The Chairman informed the meeting that he agreed to bring forward the agenda item 'Healthwatch position update' which will be presented to the Panel straight after confirmation of the minutes from last meeting.

24 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 15 on the agenda (How the PCT monitors quality of NHS Dentistry in BANES).

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25 MINUTES 18TH MAY 2012

The Panel confirmed the minutes of the previous meeting as a true record and they were duly signed by the Chairman.

26 HEALTHWATCH POSITION UPDATE

Derek Thorne (Consultant) introduced the report.

The Panel made the following points:

The Panel noted that the Council has decided not to make an award under the current procurement process for Local Healthwatch and asked about the implications on that decision.

Derek Thorne responded that the Council decided to restart the process in October 2012 in order to meet the deadline of April 2013. The Council has also been working to ensure continuity for the work of Local Involvement Network host service, which is Scout Enterprises.

The Panel asked about the Healthwatch governance and whether there was an opportunity to have Council representative on Local Healthwatch.

Derek Thorne welcomed the idea of having Council representative on Local Healthwatch.

The Panel commented that the engagement of the public must be via traditional communication (leaflets, newsletters, etc.) and also by using the latest communication technology (internet, social media, etc.) in order to inform people of all ages on the latest developments.

Derek Thorne took this comment on board.

It was **RESOLVED** to note the report and that comments made by the Panel in terms of the governance and communication be forwarded to the appropriate officers via Derek Thorne.

27 CABINET MEMBER UPDATE

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

Councillor Bryan Organ said that older people are mainly interested in the quality and cost of care. Councillor Organ also said that Social Care and Funding is quite difficult issue to deal with considering increasing number of older people in the country and increasing cost of care.

Councillor Vic Pritchard commented that the White Paper on Social Care and Funding (summary briefing and commentary by the Local Government Association is attached as Appendix 2 to these minutes) has some quite significant changes and asked if those will be implemented or they are there to stimulate the debate.

Jane Shayler responded that her understanding is that we are not expecting proposals in the White Paper to be implemented until 2014, which is part of the usual legislative process. This is the next stage in quite lengthy process.

Councillor Katie Hall agreed with Councillor Organ on this matter and asked about whether the White Paper includes clarification of social care eligibility criteria and what should be considered a “substantial” level of need and what should be considered a “critical” level of need within national framework.

Jane Shayler replied that she was not aware that proposals rule out on Local Authorities’ view on what was considered critical/urgent only although there are proposals on tighter national guidance on what critical looks like, what substantial looks like and what moderate looks like. There are quite a lot of variations as in some areas what might appear to be “moderate” level of need might be in other local authority seen as either “substantial” or even “critical”.

Councillor Hall asked how we, as authority, compare with other authorities on this matter.

Jane Shayler responded that our criteria are not as detailed as some areas’ criteria so it is more open to the practitioners’ judgement. Jane Shayler also said that she does not have more detail on what the national picture is likely to look like.

Councillor Eleanor Jackson said that it was regrettable not to have Cabinet Member for Wellbeing to hear his views on this matter. Councillor Jackson also regretted that White Paper is far too over-cautious and there is need for a radical thinking on this matter.

Councillor Lisa Brett asked if this authority will be feeding their views in the Care and Support Bill consultation and how the panel could be engaged on this matter.

Jane Shayler responded that it would be expected from Bath and North East Somerset to provide a response. Jane Shayler also said that she would be happy to work with the Panel and the relevant Cabinet Member and agree a response via email.

The Panel unanimously **AGREED** to be involved in consultation on the Care and Support Bill via email.

Councillor Pritchard felt that Cabinet Member for Homes and Planning should be also present to discuss the appointment of the West of England Care & Repair (WE

C&R) as the future provider of home improvement services in Bath and North East Somerset. Councillor Pritchard asked what will happen with services that Mendip Care & Repair provided so far.

Jane Shayler responded that new provider will provide the services set out in the specification and it will actually deliver more service to greater number of people. There are some things that are let to the current provider under a different contract, such as services funded through the "Section 256" funding. Some of these pilot services that were facilitated by the Mendip Care & Repair might become permanent services. If that is the case then they would need to go through a full commissioning process.

Jane Shayler also said that she will check what will happen with gardening services for people with learning difficulties in Radstock which was initiated by Mendip Care & Repair.

Councillor Pritchard said that it would be welcome if the Panel get information about the future of those services.

Councillor Organ said that Action for Pensioners were pleased with services from the Mendip Care & Repair and hopefully the new provider would be as good as the previous.

The Chairman thanked Jane Shayler for an update and asked that comments from the Panel be taken on board.

Appendix 1

Appendix 2

28 NHS AND CLINICAL COMMISSIONING GROUP UPDATE

The Chairman invited Dr Ian Orpen (Clinical Commissioning Group – CCG) to give an update to the Panel.

Dr Ian Orpen updated the Panel with the current key issues with BANES CCG (attached as Appendix 3 to these minutes). Dr Orpen also updated the panel on the current situation with the Royal National Hospital for Rheumatic Diseases in Bath (also known as 'The Min'). Transition Board has been established and the meeting of that Board and representatives from the CCG, NHS and the RUH Bath will take place in the week commencing Monday 30th July. The subject of the meeting is to discuss how to go forward. Dr Orpen said that the RUH needs to become a foundation trust in order to join The Min with the RUH.

Councillor Katie Hall commented that her parents had quite bad experience with the new NHS 111 service in County Durham and Darlington. Councillor Hall asked what will be put in place to provide good service in BANES. Councillor Hall also asked what qualification/s 111 operator will be required to have.

Dr Orpen replied that the CCG is aware that nationally there are mixed views on 111 services. The CCG is also very concerned about the impact so, for that reason, one of the CCG leads, on behalf of BANES and Wiltshire CCG, will be involved in the process and give some clinical input into the way this is rolled out. Dr Open also said that Wiltshire Medial Services (WMS) currently provide services for out of hours. They are not medically qualified but they are competent. Staff that work at the moment in the WMS are likely to be TUPE-transferred across to provide 111 operator services.

The Chairman said that he participated in the selection and Harmoni were clearly the best providers, which should give people confidence.

Councillor Tony Clarke said that all issues surrounding 'The Min' should have an element of transparency with the public. Dr Orpen agreed with this comment and said that the RUH Bath is the only hospital in the country that doesn't have rheumatology services.

The Chairman thanked Dr Ian Orpen for the update.

Appendix 3

29 BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE

The Chairman invited Mike Vousden to take the Panel through the update as printed in the agenda papers.

The Chairman also invited Jill Tompkins to take the Panel through their reports on visits to four Care Homes in BANES.

Following the updates from Jill Tompkins and Mike Vousden the Chairman congratulated the Local Involvement Network Team on quite comprehensive reports for each of four Care Homes. The Chairman said that he was pleased that there was no profound criticism in any of the report. The Chairman concluded by saying that he will be support the LINk if they have intention to continue with visits.

The Panel unanimously **AGREED** with Chairman's comments.

30 JOINT WORKING ARRANGEMENTS WITH THE NHS BEYOND APRIL 2013

Mike Bowden (Divisional Director for Service Development) introduced the update to the Panel.

The Panel welcomed the update and expressed their hope that partnership between the Council and future health bodies, such as the Clinical Commissioning Group, is as good as it was between the Council and the PCT in the past few years.

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

31 HOUSING ALLOCATIONS VERBAL UPDATE

The Chairman invited Mike Chedzoy (Housing Services Manager) to give a verbal update on Housing Allocations.

Mike Chedzoy highlighted the following points in his update:

Housing Services are currently reviewing the housing allocation scheme. The housing allocation scheme is called Homesearch at the moment. Homesearch aims to give more choice in deciding where people want to live. Properties that are available for rent will be advertised each week in a weekly advertising cycle. At present there are more than 12,000 applications waiting on the Homesearch register. The service is only able to advertise approximately 750 properties per year. Private rented properties are now advertised on the Homesearch website so that local accredited private landlords and lettings agents can advertise their available accommodation. These landlords will consider people who are receiving Local Housing Allowance (Housing benefit). Consultation, with the general public, on the future of housing allocation has been going on for a year and people are asked if they support the following criteria:

1. Priority to people who want to downsize
2. Priority to people who are overcrowded in their units
3. The housing register be restricted to people who work and live in BANES; and
4. Priority to people/household who provided contribution to the community.

The first three criteria received strong support from those who participated in the consultation whilst the fourth criterion did not get strong support and it is unlikely that it will be used in the new policy.

Following the new guidance on social housing, the Housing Services are also proposing are proposing to give extra help to members of the armed forces, people who care for others or who foster children by giving them additional priority and more flexible housing need assessment.

New policy will be released in April 2013.

The Panel made the following points:

Councillor Lisa Brett gave her support to criteria 4 - priority to people/household who provided contribution to the community.

The Panel asked about the strong public support for downsizing and about the additional priorities for people who foster children.

Mike Chedzoy replied that downsizing will be very much a choice and not enforcement, which should not affect older people. The service will be asking for the evidence that the applicants are existing foster-carers or have been approved to be foster carers and this will be closely monitored.

The Panel asked how the service would ensure the quality of the private housing. The Panel also asked what will happen to fathers who are separated from wife/partner and children – will they have any chance for separate rooms when visiting.

Mike Chedzoy replied that Council will receive guidance from the Government about the use of private sector in housing. Mike Chedzoy also said that there will be no change in the policy related to separate households but that the service can always make allowances for joint custody.

The Panel asked how people without the PC and access to internet can submit their housing applications.

Mike Chedzoy replied that the service is encouraging people to use online application forms. However, people can also use Council offices in Bath, Keynsham and Midsomer Norton to submit their applications. People can also receive assistance in submitting their applications and/or "bids" for specific properties.

It was **RESOLVED** that draft Homesearch Policy be reviewed by the Wellbeing PDS Panel before it is submitted to the Cabinet for adoption.

It was also **RESOLVED** to invite Cabinet Member for Homes and Planning to comment on the Homesearch Policy.

32 CARE HOMES QUARTERLY PERFORMANCE REPORT (APRIL - JUNE 2012)

The Chairman invited Jane Shayler to introduce the report.

The Panel made the following points:

The Chairman said that the Panel had an extremely good report from the Local Involvement Network who looked in depth in four of our care homes. However, in the latest edition of the 'Midsomer Norton, Radstock & District Journal' (known as Journal) it says that *"25% of care homes in BANES are not compliant".* This is in conflict with the report that the Panel had before them. The Chairman asked how the press got hold of this information that is adverse.

Jane Shayler said that the article is unfortunate and potentially misleading as it misinterpreted the information put in the report. The use of the word 'not compliant' relates to the framework within which the Care Quality Commission (CQC) regulates providers. In the table on page 69 of the report there is a summary of the 44 homes in BANES that have been inspected by the CQC. 28 homes met all standards but it is not unusual for care providers not to be completely compliant with all standards. It is partly because the standards are quite challenging but also because that full compliance represents the level of excellence that not all providers can achieve consistently.

The Chairman said that the professional evaluation from Jane Shayler does not translate through to this article. The public will read this article and not the document that is in the report, which they probably may not understand. What the public might understand is the dramatic headline that 25% of care homes are un-safe or of a poor quality, which may not be the case. This will cause unnecessary apprehension for someone who is scheduled to go to a care facility that is not fully compliant. We

need to somehow counter this article with immediate effect and say that the information has been misconstrued.

Mike Vousden from LINk said that they have regular meetings with the CQC about these issues. Although the standards are extremely important to be followed there are some small minor technicalities that are less significant within those standards. So, non-compliance might be on trivial issues.

The Chairman said that these issues may not be translated correctly in the article and that he would want this to be rectified so the public understand the picture.

Jane Shayler said care homes that are not compliant with all of the CQC standards were taken seriously by the Council. However, the Council also have to use the judgement around that in terms of the risk associated. If the Council used only those homes that are fully compliant with the CQC standards then we would stop using a number of much loved and much valued care services in this and other areas.

The Panel **RESOLVED** that immediate reply from the Council should come from the Communications and Marketing Team in order to rectify this issue hopefully in the next edition of Journal.

33 HOW THE PCT MONITORS QUALITY OF NHS DENTISTRY IN B&NES

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

Mr Hartley-Brewer highlighted the following points in his statement:

- Dental Reference Officer's report for a visit undertaken to Oldfield Park on 27th May 2010
- ADP Oldfield Park not recording clinical data accurately
- Provision, or non-provision, of scale & polish in BANES
- Residents of Radstock and Chew Valley have to travel to access an NHS Dentist
- Use of the Dental Contract Management Handbook by the PCT
- The residents of BANES have had to put up with poor treatment in some practices for far too long and had to pay privately for treatments that should be available on the NHS

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

The Panel thanked Mr Hartley-Brewer for his statement and for his contribution on tis matter.

The Chairman invited Julia Griffith (BANES NHS) and Nathan Brown (Dentist from the Parks Dental Practice in Keynsham) to introduce the report.

The Panel made the following points:

The Panel asked about the PCT's dependency on self-assessments.

Julia Griffith explained that the self-assessment process depends on dentists reporting accurately. The PCT would compare all of the self-assessments to see if there are any areas of weakness and where the support is needed. The dentists were meant to be honest as they could be. If the PCT identified areas of weaknesses then they would write to dentists and ask them to report back on actions they have taken to improve. If there was a concern that the action plan was not carried out then the PCT would investigate further. Every practice was visited by the Dental Reference Service.

The Panel asked about an issue that some people were denied access to the NHS dental treatment.

Julia Griffith said that there are number of areas in dental contract that were always grey areas. For example scale and polishing – it is the role of the dentist to ensure that the patient is dentally fit and if the patient needs scale and polish for health reasons then it will be covered by the NHS. If not then it will be private treatment.

The Panel asked about root canal treatment.

Julia Griffith responded that this is also an area that is challenging. The NHS would provide the fee for that service and there are some procedures that will be covered with that. The PCT realises that within the pay band some treatments are more costly or cheaper to carry out than others. Overall this should balance out.

The Panel said that patient has little or no knowledge on what is wrong and what to expect so they heavily depend on the dentist to tell them.

Nathan Brown said that dentists have ethical responsibility and that they have to give patients options and choices.

The Panel asked what percentage of BANES population has regular dental treatment and if there is dental plan for gypsies and travellers.

Julia Griffith responded that the PCT target of percentage of people having regular dental treatment is 59% and so far 58% of people regularly have access. The PCT commissioned the community dental service for patients with special needs and also dental access centre which is for patients in pain (based in Riverside in central Bath).

Members of the Panel continued the debate with Julia Griffith and Nathan Brown and what should be a dental service covered by the NHS and what would be beyond NHS care.

As a result of the debate it was **RESOLVED** that the PCT request from all NHS Dentists to provide a clear guidance on treatments that are covered by the NHS and those treatments that are outside NHS care.

34 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The Chairman invited Paul Scott (Acting Director of Public Health) and Jon Poole (Research and Intelligence Manager) to give a presentation on Joint Strategic Needs Assessment (JSNA) in Bath and North East Somerset.

Paul Scott and Jon Poole highlighted the following points in their presentation:

- Objectives
- What is JSNA and what does it say?
- Needs Assessment – Local Approach
- Framework for an 'Enabling' Needs Assessment
- Who is it for?
- Website address – www.bathnes.gov.uk/jsna
- Introduction
- Aging population
- Long Term Conditions (Physical & Mental)
- Lifestyle risk
- Social & Environmental factors
- How are we using JSNA?
- Locally
- How can you use it?

A full copy of the presentation is available on the minute book in Democratic services.

The Panel made the following points:

Members of the Panel debated with officers some of the topic areas of the main document and came to the conclusion that each topic would require considerable debate at the meeting.

For that reason the Chairman suggested that the JSNA be a regular item on the agenda with intention to break down the main document into areas which will be presented at the future meeting (i.e. aging population at September meeting, complex families for November, etc.)

The Panel **AGREED** with Chairman's suggestion.

It was **RESOLVED** to note the presentation and for the officers to take on board Panel's wishes.

35 GOVERNMENT CONSULTATION ON STANDARDISED PACKAGING OF TOBACCO

The Chairman invited Paul Scott to introduce the report.

On a motion from Councillor Eleanor Jackson, and seconded by Councillor Douglas Nicol, it was unanimously **RESOLVED** to inform the Government that the Wellbeing Policy Development and Scrutiny Panel supports the introduction of standardised (plain) packaging for all tobacco products in the UK.

It was also unanimously **RESOLVED** that Panel's resolution be communicated to The Right Honourable Don Foster (Member of the Parliament for Bath) and to Mr Jacob Rees-Mogg (Member of the Parliament for North East Somerset).

36 WORKPLAN

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

- Draft Homesearch Policy (date to be confirmed)
- Joint Strategic Needs Assessment – standing agenda item with different theme each meeting.

Some Panel Members felt that agendas are too crowded and because of that Wellbeing PDS meetings are too long. The Chairman said that he might call an extra meeting of the Panel in October (if required).

The meeting ended at 2.10 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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

Wellbeing Policy Development & Scrutiny Panel – July 2012

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1. PUBLIC ISSUES

Publication of White Paper on Social Care and Funding

On July 11th, the Government published its White Paper on the reform of adult social care - *Caring for our future: reforming care and support*, a full copy of which can be downloaded from the Department of Health's website: www.dh.gov.uk

A summary briefing and commentary by the Local Government Association is attached to this briefing.

2. PERFORMANCE

There are no key performance issues to highlight that are not covered by the .Care Homes Quarterly Performance Report item later on the Panel's Agenda.

3. SERVICE DEVELOPMENT UPDATES

Home Improvement Agency

Following a competitive process, the West of England Care & Repair (WE C&R) has been appointed to be the future provider of home improvement services in Bath and North East Somerset. The new service will be available from Autumn this year.

Service user benefits of the new service will include:

- WE C&R has a strong track record of maximising income for clients through benefit assessment and charitable donations.
- Provision of peer support for older people and other service users.
- Proposals to work with rural champions to improve services to people living in rural areas
- A focus on local identity, local delivery of services and knowledge of local stakeholders.

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White Paper on Social Care and Funding Update
LGA On the Day Briefing

11 July 2012

Briefing

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Summary

The Government published the long awaited White Paper, *Caring for our future: reforming care and support*, today on the reform of adult social care. It is accompanied by a draft Care and Support Bill and a suite of other documents including a progress report on its response to the Dilnot Commission, summary of the *Caring for our future* engagement exercise, and response to the Health Select Committee's reports on these matters.

The Care and Support Bill provides enabling legislation for these reforms. This is published for pre-legislative scrutiny. It will be introduced into Parliament in late 2013 with a view to completing its passage by Autumn 2014. Most changes requiring legislation will be implemented from April 2015 at the earliest.

LGA key messages

- The LGA is disappointed the White Paper does not address the reality of the funding pressures councils face. The small pockets of additional funding are welcome but an essential precondition of serious progress must be an honest appraisal of what a modern social care system costs and how it is to be funded.
- The White Paper provides a good platform for a reformed social care system. It builds on the sector-wide consensus about the recommendations of the Law Commission and the Dilnot Commission. There is plenty for councils to work on with Government through the draft Care and Support Bill.
- However, the funding statement takes us no further forward in how a modern, stable and predictable social care system can be properly resourced. We fear that on this timetable users and carers could face at least a further 5 years of uncertainty and hardship.
- The LGA welcomes the Government's commitment to adopt the principles of the Dilnot Commission that an individual's lifetime contribution should be capped. We endorsed his view that such a system had to be universal to work and suggest the proposed consultation on voluntary opting in or out may not be workable.

Background

The Coalition's Programme for Government highlighted in May 2010 the "*urgency of reforming the system of social care to provide much more control to individuals and their carers, and to ease the cost burden that they and their families face*". Andrew Dilnot's Commission on the Funding of Long Term Care reported in July 2011, and the Law Commission completed its review of social care legislation in May 2011. In response, the Government launched an engagement exercise, *Caring for our future*, from September to December 2011 with a number of strands including integration with health, information and insurance. During

2011/12, the Health Select Committee published reports on funding social care and integration. A White Paper and an update on funding reform were originally promised in April.

Andrew Dilnot called for a cap, suggested at £35,000, for an individual's lifetime contribution towards their social care costs, after which they would be eligible for full state support. He recommended an increase in the means tested threshold, above which people should pay full care costs, from £23,250 to £100,000. He proposed that national eligibility criteria and portable assessments should be introduced to ensure greater consistency and that younger adults should be eligible for free state support immediately, rather than be means tested. Implementation costs were estimated to be around £1.7 billion.

The Law Commission recommended a single, clear, modern statute and code of practice that would pave the way for a coherent social care system. Under their proposals users and carers would have clear legal rights to care and support services and councils would have clear and concise rules to govern when they must provide services.

The Commission recommended:

- putting an individual's wellbeing at the heart of decisions, using statutory principles
- giving carers new legal rights to services
- placing duties on councils and the NHS to work together
- building a single, streamlined assessment and eligibility framework; and
- giving adult safeguarding boards a statutory footing.

The LGA set out its expectations for social care reform in its recent publication, *Ripe for reform: the sector agrees, now the public expects*. This was based on three key tests:

Test one: Does the White Paper set out proposals for a reformed system that is likely to achieve our aims of:

- improving the individual's experience through a simpler system that enhances choice and control; fosters quality services founded on dignity and a commitment to safeguarding; supports the needs of an expanding workforce; and promotes an integrated response from services to their needs.
- providing stability, predictability and transparency and encouraging the long-term view**.**
- providing sufficient funding that is appropriately directed now, until the reformed system is in place; to meet demographic pressures; meets the full costs of reform; and incentivises prevention.
- using the totality of local resources through a focus on wellbeing, quality of life, aligning of public and individual resources, integrated services, and support for carers.

Test two: Does the White Paper set out a timetable for reform that recognises the urgency of the challenge and commits to immediate action where possible?

Test three: Does the White Paper articulate a clear role for local government in a reformed system and recognise the importance of a local approach to care and support?

Commentary

Today's announcements meet many of the expectations the LGA set out in *Ripe for reform* but **fall a long way short of the second test of confidence** in seeing

this through to conclusion.

In adopting all of the key recommendations of the Law Commission and framing draft legislation, the Government has taken **significant steps towards bringing to life a new, modern social care system**. We set out a vision based on community and individual assets, support for carers, and support to users and carers to make good decisions about their future care needs. This should be based on clear, national and portable entitlement to services, coupled with individuals having the flexibility to design support to meet their needs in their local context.

We wanted an emphasis on prevention, a more integrated approach to how housing and health contribute to good care, and on developing local markets and ensuring continuity of care provision. We also stressed the need to recruit, train and support an expanding workforce. The LGA has supported putting Adult Safeguarding Boards and requirements to cooperate on a statutory basis.

Our second test was about confidence; **confidence that the White Paper would pave the way for real action** and confidence that the Government will indeed see this agenda through. We have a draft Bill but it is unlikely to complete its passage before 2014. All the key funding decisions on implementing Dilnot reforms and addressing the true costs of a reformed care system are postponed until the next Comprehensive Spending Review. There are worrying signals that these issues may have to take their place in consideration of measures to stimulate growth and other public spending pressures.

The Dilnot proposals under consideration are mainly focused on older people. He recommended care and support for adults should be free. These groups are, therefore, disproportionately affected by councils' rationing services in response to funding shortfalls. **Unless this wider issue is addressed the system cannot be considered fair or stable**.

Our third test was that the reforms articulated a clear role for local government, that appropriate links were made with Health and Wellbeing Boards, and clearly defined relationships for councils with key partners. There are clear new duties proposed that are intended to promote cooperation. **The LGA will be keen to ensure that social care and health reform are not taken forward on separate tracks** and that no opportunity is lost to develop integrated care and support and health responses to the needs of people and communities.

The Government has made much of the benefits of extending deferred payments. However, the ADASS budget survey 2012 showed that councils have already made deferred payments to around 8,500 people to a total value of £197m (an average of £23,000). Councils are not banks and the **implication of this level of debt in an already overstretched system needs urgent attention**.

Details

The headline features of the **White Paper** are as follows:

- The Government intends to legislate to give councils a clear duty to incorporate **preventive practice and early intervention** into commissioning. This will be built into the social care and public health outcomes framework.
- A range of measures is proposed to **promote community development and social action** as part of a preventive approach. These include stimulating the development of initiatives to help people share their time, talent and skills. Trailblazers are proposed from April 2013 as well as

encouraging the use of Social Impact Bonds.

- There will be a new duty to ensure **adult social care and housing** work together. The Government will work with the national improvement body for Home Improvement Agencies to extend their service to more people who fund their own adaptations and make sure people obtain timely support in securing home modifications.
- Legislation is planned to give adult social care services a power to assess young people under 18, to **assist their move from children to adult services**.
- A **capital fund of £200m over 5 years** from 2013/14 will help further develop specialist housing for older and disabled people. This probably equates to around 4 schemes per year.
- A national information website will be established. To aid the development of **local online services**, £32.5 million will be available in 2014/15. There is encouragement too for comparison websites for people to give feedback and compare provider quality.
- Access to **independent advice** will be improved to help people eligible for financial support from the local authority to develop a care and support plan.
- The **Care and Support Bill** addresses the Law Commission recommendations for a new, simplified statute incorporating among other things:
    - National minimum eligibility threshold.
    - The entitlement will be portable if users and carers move to another council area, with councils required to maintain services until a reassessment is completed.
    - Extend the right to an assessment to more carers (currently only those with substantial caring responsibilities) and give carers a clear entitlement to support for their own wellbeing.
    - People will have a legal entitlement to a personal budget.
    - Provide clarity on ordinary residence.
- Councils will be urged to rule out **contracting by the minute**.
- The Government plans to consult on further steps to ensure **service continuity** for users if a provider goes out of business.
- Dignity and respect will be at the heart of a **new code of conduct** and minimum training standards for care workers. There is no mention of any plan to introduce any registration scheme; in this respect the Government's position is unaltered.
- A new **Leadership Forum** will be established by March 2013 to bring together leaders from all parts of the sector to lead these reforms.
- The Government also plans to work with care providers, users and carers to develop a **sector-specific compact** top promote culture change and skills development.
- There are plans to **train more care workers**, mainly through doubling the number of care apprenticeships to 100,000 by 2017.
- A **Chief Social Worker** will be appointed by the end of 2012. This role covers children's and adult services and was included in the Munro report recommendations.
- Pilots will be developed to test the benefits of **direct payments for people in residential care**.
- Additional resources will be **transferred from the NHS** to local government (through the same mechanism as the previous transfer): £100m in 2013/14 and £200m in 2014/15 to help better integrate care and support. 10% of this will be used to meet reform implementation costs.
- There will be a requirement that the NHS works with councils and local carers organisations to agree plans and budgets to **identify and support carers**. A working group will consider issues how carers can carry on

working.

- There will be legislation to ensure that all agencies work together at a local level to **prevent abuse**. This places local Adult Safeguarding Boards on a statutory basis.
- There will be new funding system for **palliative care** in 2015. Investment in the pilots will be doubled to £3.6m. Under this all health and social care would be free to people once they are on the end of life locality register.
- Steps will be taken to clarify who is responsible for **care and support in prisons**.
- Payments to **veterans** under the Armed Forces Compensation Scheme will not be required to be used to pay for social care arranged by councils.

A Care and Support Transformation Board and Care and Support Implementation Board will oversee the reforms. The LGA expects to be represented at both levels and to play its part in the working groups proposed to work through the details of implementation.

Progress report on funding

The separate progress report on funding accepts the following principles of the Dilnot Commission:

- Financial protection through a cap on costs
- Extended means test
- National minimum eligibility criteria
- Deferred payments available to all, with a consultation on how interest is levied by councils

The Government will not commit to a new funding model at this stage. That will be considered as part of the next Comprehensive Spending review. As part of this the Government wants to explore further options they believe are consistent with the Dilnot report but at a lower cost namely:

- Level of the cap (say at £75,000 rather than £35,000). The Government has no firm view on the level.
- Choice about whether to have financial protection through voluntary opt-in or opt-out schemes to give protection in return for specified payments.

A working group will be set up with the financial and insurance sector to consider the requirements of a new system, tax implications and how to help people plan.

Summary of financial announcements

£100m in 2013/14 and £200m in 2014/15 to be transferred from NHS to councils under Section 256 with similar conditions to previous transfer. 10% likely to be for reform implementation costs

£200m capital spread over 5 years for specialist housing schemes

Start up funding of £32.5m from 2014/15 to develop local online information services

Investment by NHS in end of life care pilots to be doubled from £1.8m to £3.6m

Next steps

The Care and Support Bill is now open to consultation and pre-legislative scrutiny. The Bill will be formally introduced in the third session of Parliament in 2013. There will be the opportunity for councils to comment in detail on clauses on line,

which is a first for Government.

Membership of the proposed Boards will be confirmed shortly. A number of working groups will study the detailed implications of the White Paper and the Bill between now and 2015 when much of this is expected to take effect.

The White Paper refers to the LGA's Efficiency Programme that is supporting 44 councils with a range of themes.

The LGA will provide further briefings at key stages of the legislative process and will continue to lobby Government on funding through our *Show us you care* campaign.

Wellbeing Policy Development and Scrutiny Panel
27.7.12
Key issues briefing note

1. B&NES Clinical Commissioning Group (B&NES CCG) update

Appointments

Dr Simon Douglass has successfully completed the formal national assessment process and this means he is now considered able to be appointed as B&NES CCG Accountable Officer designate. The formal process for appointment is now being drawn up. The CCG is now working towards appointing the rest of its senior team into designate positions. This will provide certainty for the CCG as well as for senior commissioners as capacity is retained throughout the transition period. Once the CCG becomes a statutory body on 1st April all designate posts will automatically become substantive.

Authorisation

Before CCGs become legally constituted bodies they will go through a rigorous and extensive assessment process called authorisation. There are four waves for submission to authorisation from July to November 2012. B&NES CCG will go in the third wave (October 1). Work continues at a pace to complete the detailed, technical submission covering all 119 criteria across six domains.

Consultation on CCG plans

As part of authorisation the CCG has consulted with GPs, healthcare professionals and the wider public on its three year strategic plan. Key highlights were:

- Council members, council officers, senior commissioners Strategic planning event on 31st May
- Health and Wellbeing board presentation of draft plan (June 13)
- GPs: presentation of the CCG's strategic three year plan (July 10)
- Practice managers session: presentation of the CCG's strategic three year plan (July 11)
- Stakeholder meeting: presentation of the CCG's strategic three year plan Keynsham Fry's Conference Centre (July 12)
- Public meeting: presentation of the CCG's strategic three year plan at The Centurion Hotel, Midsomer Norton (July 19)

CCG constitution

CCGs are a membership body and practices are the members. Under guidelines set out by the Department of Health the CCG was requested to engage with GPs.

However, B&NES CCG felt it was important to involve the wider public in this important process. A three week consultation, from July 2 – 21, was undertaken. The process included:

- A web based consultation for the constitution on Citizen space has been used for GPs, stakeholders and the public to provide feedback
- Invitations to engage through local press articles and radio interview
- A small working group of GPs and practice managers has been established to explore the constitution as it's developed.
- GPs meeting on 18th July to formally review the constitution ahead of ratification in early September. All GP practices will then be asked to confirm their acceptance of it.

Arrangements

B&NES CCG is firming up arrangements with the commissioning support service (see note 2) on final arrangements. A memorandum of understanding has been agreed and financial allocations are imminent, which will assist the complicated process.

2. Commissioning support service

At scale commissioning support across the country will be provided by 23 organisations known as commissioning support services. In essence commissioning support organisations will provide much of the backroom function which isn't directly provided by the CCG.

B&NES and Wiltshire are part of the Central Southern Commissioning Support Service. This comprises the following PCTs: Buckinghamshire, Berkshire, Oxfordshire, Gloucestershire, Swindon as well as B&NES and Wiltshire. The Central Southern Commissioning Support Service is also going through a process of validation/accreditation and has recently been approved to progress through checkpoint three and provide viable service in 2013. Central Southern will be hosted by the National Commissioning Board through Local Area Teams from October 2012 which will offer more stability for staff.

A three month staff consultation is now being planned to start this month (July). This will begin to give staff some certainty of their final destination.

3. National commissioning infrastructure

The National Commissioning Board (NCB) continues to work with Primary Care Trusts, Strategic Health Authorities and the Department of Health to co-design a proposal for the final model of the NCB's Local Area Teams. There is likely to be up to 30 Local Area Teams set up from existing trusts which have clustered. 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.

4. RUH Doctors & nurses terms & conditions

There has been much coverage in the press this month about 'leaked proposals' to re-negotiate the terms and conditions of staff from 19 NHS acute trusts in the south west, including the RUH and all the Bristol hospitals. NHS acute trusts are largely independent organisations with their own governance and accountability processes. This is not an area that the PCT or CCG can directly influence.

5. NHS 111

The contract for the call handling and clinical assessment elements of the new NHS 111 service in Bath and North East Somerset has been awarded to Harmoni. Doctors and nurses from B&NES Emergency Medical Service Out-of-Hours (BEMS) will continue to visit patients in response.

Nationally The Secretary of State for Health has agreed to extend (by six months) the national roll-out completion deadline from April 2013 to October 2013. This is to allow those areas that need it, additional time to ensure that local Clinical Commissioning Groups and other stakeholders are fully engaged in the implementation of the new service. This is not intended to delay the roll-out of the service in those areas that are ready move ahead with the implementation. This includes B&NES where the service will go live in April 2013.

How will NHS 111 work?

When a patient calls 111, an operator - trained in the same way as a 999 operator - can send out an ambulance, put someone straight through to a nurse, book an out-of-hours GP appointment, or direct the caller to a pharmacist or dentist.

In contrast, the existing NHS Direct service is also initially answered by trained non-clinical staff, but they do not have the capacity to request ambulances or book appointments - and patients receive a separate call back if they need to speak to a nurse or doctor.

What is it?

- NHS 111 is a new telephone service being introduced to make it easier for you to access local health services, when you have an urgent need
- If you need to contact the NHS for urgent care there are only three numbers to know; 999 for life-threatening emergencies; your GP surgery; or 111
- When you call 111 you will be assessed, given advice and directed straightaway to the local service that can help you best – that could be an out-of-hours doctor, walk-in centre or urgent care centre, community nurse, emergency dentist or late opening chemist
- NHS 111 is available 24 hours a day, 365 days a year. Calls from landlines and mobile phones are free

- NHS 111 is currently available in County Durham and Darlington, Nottingham City, Lincolnshire, Luton, the Isle of Wight, North Derbyshire and Derby City, Lancashire (excluding West Lancashire), and the London Boroughs of Croydon, Hillingdon, Kensington and Chelsea, Hammersmith and Fulham, and Westminster.

Compiled by Craig MacFarlane, NHS B&NES Communications and Engagement
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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy & Development Scrutiny Panel
MEETING DATE:	Friday 21st September 2012
TITLE:	Urgent Care Redesign Project
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Improving Access to Urgent Care in B&NES – a patient & public engagement document (draft)	

1. THE ISSUE

To inform the Panel about the Urgent Care Redesign Project and proposed engagement process.

2. RECOMMENDATION

The Panel is asked to note this paper. An impact assessment will be completed and presented to the November meeting of the Panel.

3. FINANCIAL IMPLICATIONS

No financial implications for the Council.

4. THE REPORT

Background
Since 2004 NHS Bath & North East Somerset has commissioned Out of Hours GP Medical services (evenings, overnight, weekends and Bank Holidays) from Bath & North East Somerset Emergency Medical Services (BEMS), a non-profit making organisation made up of mainly B&NES GPs.

In March 2011 the PCT's Board agreed to extend the current contract with BEMS until 30th September 2013 in light of the Bath Urgent Care Network and B&NES Clinical Commissioning Committee's support to broaden the scope of the OOHs procurement to bring further improvements to urgent care in B&NES, Wiltshire and Somerset. The future role of the GP-led Health Centre is also being considered as the contract for this service ends in March 2014.

At the same time the local NHS needs to become more efficient to meet the challenges it faces over the next few years. That includes avoiding duplication of services, and helping patients to make the right choices to get the right care when they need it.

The three main reasons for looking at urgent care services as a whole are:

- To ensure patients are be clear about where to get the best treatment
- The need to balance the affordability of the different services offered
- The number of patients who use urgent care services is growing and will carry on growing in the future

Reason 1 – Confusion over where to go
All patients should get the right care, first time, and the aim is to ensure that they use the service best-placed to help them. Having listened to local people it is clear they are not sure which service they should use when they or a family member have an urgent care need despite the publicity campaigns such as Choosing Well.

At the moment patients can choose between NHS Direct, GPs, walk-in centres, GP-led health centres, minor injury units, pharmacies, dentists and emergency departments. Choice is important, but it can be confusing, especially outside usual working hours and when someone is feeling unwell. This uncertainty undermines the delivery of timely and appropriate care.

NHS 111 the new national urgent care number should help with getting people to the right service, first time, but some people will still choose to go directly to a service without phoning beforehand.

Reason 2 – Value for money & affordability
The GP-led Health Centre duplicates the services already offered by GPs. This is because the majority of patients who use the Centre are already registered with a GP locally who are already funded to provide urgent care. There are 15 practices in Bath with eight in a one-mile radius of the GP-led Health Centre.

The PCT is therefore paying for the GP, the GP-led Health Centre and in some cases for an Emergency Department attendance. The result is that taxpayers' money is not being used effectively and in these financially challenging times this needs addressing.

Reason 3 - Increasing demand
The Office of National Statistics (ONS) project that the population of B&NES will increase from 180,000 (estimate in 2010) to 198,800 by 2026, a 12% increase. This increase is expected to mainly be in older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026. People are also living longer often suffer with more than one long term condition increasing the demand for urgent care and other health care services.

The increasing demand for urgent care services is at a time when the NHS is faced with no growth in health funding. In real terms this means the CCG will have to live within its existing budget. This poses some tough challenges for the future which is why the CCG is considering changes to urgent care services. The reality is that if changes are not made money will have to be taken from other crucial services in order to fund this urgent care demand.

When the GP-led Health Centre opened in April 2009, it was staffed to see 30,000 patient attendances per year with the aim that it would help reduce demand at the Emergency Department, which has not been the case.

However, it is now evident that the majority of people attending the GP-led Health Centre are people who could be seen at their GP practice which means services are being duplicated and being paid for twice.

The options that have been considered
B&NES CCG along with the neighbouring CCGs of Wiltshire and Somerset have been involved in considering the future provision of urgent care services in light of the three reasons outlined above. Various service options have been considered by the CCG along with hospital consultants, emergency medicine and primary care professionals and managers. The aim in considering the options has been to ensure high quality, clinical safety, the best use of available resources, and simplified access.

Four options have been assessed against these criteria and it was clear to the CCG that one option was the best fit against these criteria which is set out below.

A new model for urgent care in B&NES
Increasingly people are being encouraged people to go to their GPs wherever possible for their urgent care needs as this is very important for a number of reasons including patient continuity of care and access to medical records. However, from the engagement work undertaken to date some patients do have a problem with getting a same day appointment at their practice.

Work is therefore progressing with local GP practices to improve their ability to see urgent care patients. This involves ensuring that telephones are answered promptly and between the hours of 8 am and 6.00 pm with no closure during lunch time periods. It also involves improving the time taken for GPs to visit patients at home who are unwell instead of waiting to do the traditional home visits at the end of the morning or afternoon surgery.

The proposed new model would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre.

The CCG believes this is the best model of care for the future as it not only addresses the reasons for change, but creates a model which is financially sustainable. The CCG also believe having GPs based at the Emergency Department will improve the care of older people, which will become an increasingly important role for primary care.

5. RISK MANAGEMENT

A risk register has been established as part of the project.

6. EQUALITIES

An impact assessment and equalities impact assessment will be completed as part of the engagement process and presented to the November meeting of the Panel.

7. CONSULTATION

The Bath Health Community Urgent Care Network has existed for a number of years to provide the strategic oversight and development of services across the network area. The network area includes Bath & North East Somerset, West and North East Wiltshire and the Mendip area of Somerset and comprises of health and social care providers, commissioners and lay and LINk members. It is chaired by Dr Simon Douglass, Clinical Accountable Officer (Designate) of B&NES CCG.

The PCT and CCG have started an engagement process to seek patient and public views and comments on the new model of care. A draft patient and public engagement document for the urgent care redesign project is attached as appendix 1 and subject to finalisation will be type-set and printed to support the public and stakeholder meetings as well as being made available on the PCT's website.

The engagement process is being supported by B&NES Local Involvement Network (LINk).

8. ISSUES TO CONSIDER IN REACHING THE DECISION

Not relevant.

9. ADVICE SOUGHT

It wasn't necessary to seek advice from either the Council's Monitoring Officer (Council Solicitor) or the Section 151 Officer (Strategic Director – Resources & Support Services) on the contents of this report.

Contact person	Corinne Edwards, Associated Director for Unplanned Care & Long Term Conditions, Tel: 831868
Background papers	Guidance for Commissioning Integrated Urgent & Emergency Care – A Whole System Approach, Royal College of General Practitioners, August 2011 Breaking the Mould without Breaking the System – New Ideas & Resources for Clinical Commissioners on the Journey Towards Integrated 24/7 Urgent Care, Primary Care Foundation & NHS Alliance, November 2011
Please contact the report author if you need to access this report in an alternative format	

Review of Urgent Care in Bath & North East Somerset

Patient & Public Engagement

Foreword
By Dr Ian Orpen, Chair, Bath & North East Somerset Clinical Commissioning Group

Welcome to our patient and public engagement about the future of urgent care in Bath & North East Somerset.

As the Chair of Bath & North East Somerset Clinical Commissioning Group (B&NES CCG), I'm pleased to explain how you can get involved in our engagement work.

As you probably know, the Government has asked GPs to take a much greater role in commissioning or buying local health services. Groups of GPs have formed Clinical Commissioning Groups (CCGs) to do this and the B&NES CCG will be responsible for services in this area from April 2013.

Since forming last year, we have been working with our neighbouring CCGs who use the Royal United Hospital in Bath, to review urgent medical care services and how they all work together. Urgent care services are those designed to meet emergency health care needs. In B&NES the services include:

- Bath & North East Somerset Emergency Medical Service (GP out-of-hours) – when your GP surgery is closed at night and over the weekends, a GP is available to provide advice, arrange to see you at one of two locations or visit you at home
- The Minor Injury Unit at Paulton Hospital
- GP-led Health Centre at Riverside in Bath
- The Emergency Department at the Royal United Hospital in Bath

The contracts for the GP out-of-hours service and the GP-led Health Centre come to an end in March 2014 and this gives us an opportunity to look at the urgent care services in B&NES. Furthermore in these financially challenging times, we have to make judgements on how to make the best use of the public money we have at our disposal so we want to know what you think about our plans.

At the same time, we are working with our local GP practices to improve their access so that in future you can see them more easily for urgent problems as we recognise that this is a barrier for many people.

Please take a few moments to read this document, and then fill in the questionnaire and let us know what you think. If you can, you may also like to attend one of the public meetings we are holding – details are at the end of this booklet.

We look forward to hearing from you.

Best wishes,
Dr Ian Orpen

Introduction
This document gives you the background to our patient and public engagement about how we believe urgent care services should be provided in the future and we need to hear what local people think about these proposals. Please take a few moments to read through this document, and then to answer the questions at the end. The information and questionnaire are also available on-line at www.banes-pct.nhs.uk

What is urgent care?
Urgent care services are those designed to meet emergency health care needs.

Background
We have a number of urgent care services who see patients in different locations in B&NES including:

- 27 GP practices
- Bath & North East Somerset Emergency Medical Service (the GP out-of-hours service)
- The Minor Injury Unit at Paulton Hospital
- GP-led Health Centre at Riverside in Bath
- The Emergency Department at the Royal United Hospital in Bath

We are particularly focussing on the future of the GP-led Health Centre based at Riverside in Bath and the GP out-of-hours service. Firstly we have to commission these by 2014, secondly they both centre around primary care and thirdly their services compliment each other.

Your local NHS needs to become more efficient to meet the financial challenges it faces over the next few years. That includes avoiding duplication of services, and helping patients to make the right choices to get the right care when they need it.

There are three main reasons for looking at urgent care services as a whole:

- We want all patients to be clear about where to get the best treatment
- We need to balance the affordability of the different services we offer
- We know that the number of patients who use urgent care services is growing and will carry on growing in the future.

What are the current services?
They can be summarised as follows:

GP Practices
There are 27 practices across Bath & North East Somerset, 15 in Bath City, seven in the Norton-Radstock area and five in the Keynsham and Chew Valley area. Around 195,000 patients are registered with these practices, but the number of people registered with each one does vary, from 2,900 patients to 12,500 patients. Practices are funded to be open from 8 am to 6.30 pm, Monday to Friday. All practices offer extended hours, eg early mornings, late evenings and Saturday mornings, but this will vary between practices.

Practices not only see patients with urgent care needs, but also those patients who have more routine or planned care needs such as a review or treatment of their long term condition.

Bath & North East Somerset Emergency Medical Out-of-Hours Service
The GP out-of-hours service was formed in 2004 to provide out-of-hours urgent GP services for patients who are unwell and cannot wait to be seen by their own practice the next day or after a weekend.

GPs are available from 6.30 pm to 8 am and at weekends. They see patients at the RUH and at Paulton Hospital as well as seeing patients at home who are too unwell to travel following an assessment on the telephone. They only see patients at Paulton Hospital from 6.30 pm to 11.30 pm only.

Paulton Minor Injury Unit
The Minor Injury Unit at Paulton Hospital is open seven days a week 8 am to 9.30 pm. Patients with minor injuries or illness attend the unit and can walk-in without the need for an appointment.

RUH Emergency Department
The Emergency Department is open 24-hours a day, seven days a week, every day of the year. People either self-present or are referred by GPs and nurses or are brought in by ambulance.

Bath GP-led Health Centre
Prior to the opening of the GP-led Health Centre in April 2009, Bath had a nurse-led walk-in centre for seven years. GP-led Health Centres were created as part of a national initiative by the Government to provide convenient access to basic primary care services without the need for an appointment. The GP-led Health Centre is based at Riverside in St James Street in Bath and is open seven days a week, 8 am to 6.30 pm.

There are also other services based in the Riverside building, including the Contraception & Sexual Health Service and the Dental Access Service. These will not be affected as a result of our proposals.

The reasons for change
The review is based on the key principles of achieving value for money and high quality care.

Reason 1 – Confusion over where to go
We believe that all patients should get the right care, first time, and we want to ensure that they use the service best-placed to help them. We know from listening to local people that they are not sure which service they should use when they or a family member have an urgent care need despite the publicity campaigns such as Choosing Well.

At the moment patients can choose between NHS Direct, GPs, walk-in centres, minor injury units, pharmacies, dentists and emergency departments. Choice is important, but it can be confusing, especially outside usual working hours and when you're feeling unwell. This uncertainty undermines the delivery of timely and appropriate care.

NHS 111 the new national urgent care number should help with getting people to the right service, first time, but we know some people will still choose to go directly to a service without phoning beforehand.

Reason 2 – Value for Money & Affordability
The GP-led Health Centre duplicates the services already offered by GPs. This is because the majority of patients who use the Centre are already registered with a GP locally who is already funded to provide urgent care. There are 15 practices in Bath with eight in a one-mile radius of the GP-led Health Centre.

We therefore pay for the GP, the GP-led Health Centre and in some cases for an Emergency Department attendance. The result is that taxpayers' money is not being used effectively and in these financially challenging times we need to address this.

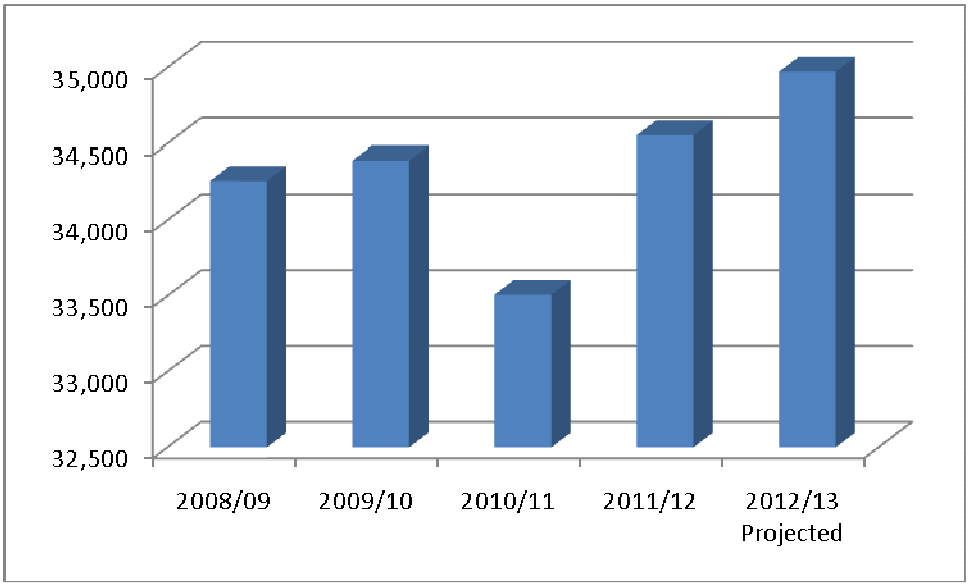
Reason 3 - Increasing demand
The Office of National Statistics (ONS) project that the population of B&NES will increase from 180,000 (estimate in 2010) to 198,800 by 2026, a 12% increase. This increase is expected to mainly be in older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026. We also know that people living longer often suffer with more than one long term condition increasing the demand for urgent care and other health care services.

We are seeing increasing demand for urgent care services at a time when we are faced with no growth in health funding. In real terms this means we will have to live within our existing budget. We are therefore faced with some tough challenges for the future which is why we are considering changes to urgent care services. The reality is that if we don't we will have to take money from other crucial services in order to fund this urgent care demand.

When the GP-led Health Centre opened in April 2009, it was staffed to see 30,000 patient attendances per year with the aim that it would help reduce demand at the Emergency Department, which has not been the case as can be seen from the graph below.

However, it is now evident that the majority of people attending the GP-led Health Centre are people who could be seen at their GP practice which means we are duplicating services and effectively paying twice.

B&NES Emergency Department Attendances at the RUH



What options have been considered?
B&NES CCG along with the neighbouring CCGs of Wiltshire and Somerset have been involved in considering the future provision of urgent care services in light of the three reasons outlined above. Various service options have been considered by us along with hospital consultants, emergency medicine and primary care professionals and managers. Our aim in considering the options has been to ensure high quality, clinical safety, the best use of available resources, and simplified access.

Four options have been assessed against these criteria and it was clear to us that one option was the best fit against these criteria which is set out below. Details of the other options considered can be found in annex 1. The strengths and weaknesses for each option, including the proposed new model are set out in annex 1.

A new model for urgent care in B&NES
Increasingly we are encouraging people to go to their GPs wherever possible for their urgent care needs. We believe this is very important for a number of reasons including patient continuity of care and access to medical records. However, we know from our engagement work to date that some patients do have a problem with getting a same day appointment at their practice.

We are therefore working with local GP practices to improve their ability to see urgent care patients. We want to ensure that telephones are answered promptly and between the hours of 8 am and 6.30 pm with no closure during lunch time periods. We also want to improve the time taken for GPs to visit patients at home who are unwell instead of waiting to do the traditional home visits at the end of the morning or afternoon surgery.

Our proposed new model would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre.

We believe this is the best model of care for the future as it not only addresses the reasons for change, but creates a model which is financially sustainable. We also

believe having GPs based at the Emergency Department will improve the care of older people, which we know will become an increasingly important role for primary care.

We also now know that one of the main reasons for originally creating the GP-led Health Centre is less relevant today – that is the aim to reduce emergency department attendances.

How we have included our B&NES community to date
Over the past few years, the Primary Care Trust (PCT) has taken opportunities to improve access to urgent care services. However, as a result of a need for the PCT to re-tender the out-of-hours GP service, the PCT and CCG agreed to look at the opportunity to include other urgent care services. The PCT and CCG then embarked on an engagement process starting in April 2012. An event with stakeholders, patients and public was held where the proposals to redesign the urgent care system were presented. Attendees were posed three questions to consider:

- What are the most important patient experience issues for people when using the urgent care system?
- What are the key principles to hold on to when planning any changes?
- How can we help people understand the different parts of the urgent care system and how best to use it?

The key messages from these questions were as follows:

- Good accessibility and waiting times for all services, including car parking and transport
- Customer and quality focussed
- Need for joined up and integrated services
- Good triage systems
- Maximising the use of technology
- Communication and education

Subsequent to this, a specific event was held with health and social care professionals and lay members to consider in more detail the potential options for redesigning the services which looked at:

- The demand for services
- The size and needs of the population served
- Options of the type and location of urgent care services
- The costs of providing the current services
- The fact that patients should be seen safely in the most suitable environment for their needs, whilst ensuring that public money is spent wisely

All the above, together with patient survey results, has helped shaped our ideas hence why we have decided to go ahead with patient and public engagement to present our ideas and the benefits we believe this would bring.

We believe our plan for urgent care within B&NES will give a better service to our community. We believe there will be greater clinical support and benefits to patients

from hospital and GP staff working together along with the availability of diagnostic services on site. Equally important is that local GP practices have a greater urgent care role to meet their community needs, giving patients a chance to have a more rounded communication with their practice and its staff.

We know this will mean changes, but we believe this is the best way forward and we hope our B&NES community will work with us to help to shape this project.

Next steps

We would like you to think about our ideas, and then let us know what you think and provide any other comments. Please complete the questionnaire and return to us by 31st October 2012. You can either fill it in by hand, or complete it on-line at www.banes-pct.nhs.uk

There will also be four meetings in B&NES (two in Bath, one in Keynsham and one in Norton/Radstock) where you can meet us and talk to use about our plans. They are listed on page 8.

We have asked B&NES Local Involvement Network (LINk) to help us with our engagement work.

Once we have done this, we will gather all the feedback, and use it to help us develop the specification for the new model of care.

Public meetings

We are running a series of public meetings during the engagement as follows:

Date & Time	Place

Questionnaire – your feedback
Before completing the questionnaire below, we would suggest you read annex 1 where we have set out the strengths and weaknesses of each option.

1. Do you think the new model proposed is a good idea?

Yes
No
Not sure
If no please state why:

2. Do you have any concerns about the new model?

Yes
No
Not sure
If yes please make a comment:

3. Do you agree that the majority of minor illnesses should be dealt with by a GP practice to avoid duplication?

Yes
No
Not sure
Please make a comment:

4. Would you like to make any other comments about access to GP services in Bath & North East Somerset?

5. Would you like to make any other comments about access to the GP out-of-hours service in Bath & North East Somerset?

6. Would you like to make any other comments about access to the GP-led Health Centre in Bath?

7. Would you like to make any other comments about access to Emergency Department services at the Royall United Hospital?

8. Do you live in Bath & North East Somerset?

Yes
No
If not where do you live?

9. Do you work in Bath & North East Somerset, but live outside of Bath & North East Somerset?

Yes
No

If yes please could you indicate where you live:

10. Have you ever used the GP-led Health Centre in Bath?

Yes
No
If yes, how many times in the past 12 months?

11. Have you ever used the Emergency Department at the Royal United Hospital?

Yes
No
If yes, how many times in the past 12 months?

12. Are you representing an organisation?

Yes
No
If yes, please give the name

About you

13. Gender

Male
Female
Transgender
Prefer not to say

14. Age group

16 years & under
17 to 25 years
26 to 35 years
36 to 45 years
44 to 55 years
56 to 65 years
66 to 75 years
75 to 85 years
86 year & over
Prefer not to say

15. Ethnic group

White – British Irish Gypsy/Traveller Any other white background, please specify

Mixed – white & black Caribbean white & black African white & Asian Any other mixed background, please specify

Asian/Asian British
Indian Pakistani Bangladeshi Any other Asian background, please specify

Black/Black British
Caribbean African Any other black background, please specify

Chinese

Other Ethnic Group – please specify

Prefer not to say

16. Disability
Do you consider yourself to have a disability or long-term health condition?
Yes
No
Prefer not to say

If yes, please tick all which apply:
Physical Partial or total loss of vision Learning disability
Partial or total loss of hearing Mental health condition or disorder
Long standing illness or disease Speech impediment or impairment
Other medical condition or impairment, please specify

17. Sexual orientation
Heterosexual Bisexual Gay Lesbian
Other please specify
Prefer not to say

18. Religion & belief
No religion Christian Muslim Jewish
Hindu Buddhist Sikh
Other, please specify
Prefer not to say

19. First four letter/numbers of your postcode (we will not be able to identify your address from this, but it helps us understand approximately where replies are from)

If you would like to receive the final engagement report, please provide your contact details below:

Name:
Postal address or email address:

Please reply on-line or return your completed questionnaire by 31st October 2012.

New Model for Urgent Care

Strengths	Weaknesses
• It is affordable and makes more efficient use of resources as it reduces duplication. Patients arriving at the Emergency Department with primary health care needs can be directed to the Centre. This will cost less	• An urgent care centre at the RUH could mean its harder to access for some patients who live and work in the city leading to a poorer experience
• There will be 24 hour, seven day GP presence	• The RUH location may pose transport issues for some patients
• GP presence will help the prompt assessment and treatment of frail elderly patients and ensure that they are safely transferred to an appropriate setting as GPs have better knowledge of the services available in the community	• The GP-led Health Centre provides more primary care access
• Better integration of GPs and nursing staff with the Emergency Department will mean there is support if a patient requires more help than first thought. This will potentially enhance the quality of care	• Students who are not registered with a GP practice will need to do so
• Location is good for some people	• Patients may dislike being re-directed back to their registered GP
• Provides good access to diagnostics and other specialist staff and services	• Availability of car parking at RUH
• Provides opportunity for developing pathways of care and clinical links between primary and secondary care clinicians	• Car parking charges at RUH
• Provides a single primary care focus which can offer a consistent message to patients	
• Retains the 'walk-in' aspect that is a valued feature of the GP-led Health Centre	
• All B&NES patients know where the Emergency Department is located	
• Encourages patients with primary care needs to use their GP in the first instance	
• Enables high quality data collection of activity to monitor performance of service and future planning of services	
• Provides the clinical and managerial	

hub for other urgent care services such as Paulton Minor Injury Unit, homeless service and the community based deep vein thrombosis service	
• There are good transport links from the city centre to the RUH	

No Change
This option assumes no change to the existing services, which would remain in current locations. A review of the type of patient conditions the GP-led Health Centre dealt with over the past year shows that an overwhelming majority of people could have been assessed and treated by staff in general practice

Strengths	Weaknesses
• No disruption to existing services	• Not affordable with poor use of clinical resources – duplication of services available in general practice
• No need to communicate change	• Poor use of financial resources as NHS is potentially paying for some patients care more than once across GPs, the GP-led Health Centre and the Emergency Department
• Additional convenience remains for those living in a two to three mile radius of the Centre and those working in Bath	• The GP-led Health Centre has not reduced demand at the Emergency Department
• Provision of additional access to primary care	• Financially not sustainable given the increasing demand for urgent care services and an ageing population
• Offers services to some patients who would not otherwise use them at all	• Fragmented services leading to patients having to be transferred to another service and clinical governance risks
• Retention of skilled staff in existing settings	• Extended GP opening hours have reduced need for the extra access offered by the GP-led Health Centre
	• The GP-led Health Centre has no on-site diagnostics such as X-rays. This means some patients have to visit the Emergency Department, disrupting care and increasing cost

Expand the GP-led Health Centre
The GP-led Health Centre could be expanded to include additional diagnostic services which could mean investment in X-ray equipment. This could for example enable fracture clinic services to allow the treatment of patients with more complex conditions.

Strengths	Weaknesses
• Retains all benefits identified in option 1 – local and accessible	• Not affordable as it would require significant investment and duplicates

	services
• Treats more complex cases closer to those able to access the service	• Additional accommodation, staff and equipment required to deliver new services
• May reduce demand on the Emergency Department	• No back up of specialist doctors to diagnose more complex problems
• Further development of skilled workforce	• There is an increased risk for patients if services are delivered away from specialised facilities with additional support
• Improve access to healthcare for local communities	• Comparatively small number of patients could leave staff unable to retain their skills
	• Transportation of patients to the Emergency Department if needed
	• No access to enhanced diagnostics and specialist opinion

Closure of the GP-led Health Centre
Complete removal from B&NES of the service provided by the GP-led Health Centre.

Strengths	**Weaknesses**
• Would save £1.3 million annually to reinvest in other health care services	• Closure could mean a poorer experience for some patients
• Allows resources to be redirected to those most in need and to those areas where there is increasing demand, eg dementia care, diabetes care	• Overall reduction in primary care service on offer
• Can support the reduction in health inequalities	• Break up of skilled clinical team
	• Demand will increase elsewhere because some patients attend other health services such as the Emergency Department instead
	• The GP-led Health Centre is popular with patients who use it

Bath and North East Somerset

Local Involvement Network

Report to B&NES Wellbeing Policy Development & Scrutiny Panel, 21 September 2012

1. Impact Assessment - Paediatric Audiology Service

This impact assessment related to the proposed relocation of Paediatric Audiology services from the Royal United Hospital to new-built premises at the St Martin's Hospital site. The community-based service provides hearing assessment of children from 16 months to 16 years of age at 15 venues across B&NES, West and North Wiltshire, and Mendip. Children are referred by GPs, Health Visitors, Paediatricians and Speech Therapists. The service also provides a newborn-children's hearing screening service, and school-entrance hearing screening.

The service's current premises at the RUH are inadequate for purpose, and create risks of misdiagnosis through the lack of sound-proof facilities in which specialised equipment can be properly used. The overall risk from these present inadequacies is that 50% of the hearing assessments conducted carry an unacceptable risk that conditions that could lead to permanent loss of hearing will not be diagnosed.

Diana Hall Hall and Jill Tompkins attended the impact assessment on behalf of the LINk. They felt that the proposed change would benefit users of the Paediatric Audiology services considerably. In implementing the proposals, particular attention was to be given to provision for parents, and to parking and transport problems. They reported this to the LINk Committee at its August meeting, and the Committee enthusiastically supported the proposed change.

2. LINk's Annual Report, 2011-12 *[attached]*

The LINk's Annual Report for 2011-12 gives a detailed account of our work during the year. We feel that this is a creditable record of the achievement of volunteers. The Chair of the LINk will be happy to answer any questions on the Report and to receive the Panel's comments.

Diana Hall Hall

Chair, B&NES Local Involvement Network

10 September 2012

OUR COMMUNITY, OUR HEALTH, OUR SOCIAL CARE

Bath & North East Somerset Local Involvement Network

Annual Report

2011-2012

Host Support Organisation

Scout Enterprises Ltd

B&NES LINk Office -

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Contents

Chair's Introduction

This foreword was compiled at the end of the fourth year of our brief life as a Local Involvement Network. In last year's report we noted the coming change in the arrangements for public involvement in health and social care, and the replacement of LINks with new Local HealthWatch organisations. During the last year there has been much uncertainty and speculation over what these changes would be and how they would be implemented. The new Health & Social Care Act was finally given Royal Assent on 27 March 2012, and we now know that LINks will be replaced by Local HealthWatch organisations in April 2013.

As in 2010-11, LINk members have spent much of their time participating in the discussions around the planning and design of the new organisations that will emerge from the new Health and Social Care Act . We hope that involvement will continue through 2012-13 as we approach the formal establishment and launch of the B&NES Local HealthWatch organisation.

In spite of all the uncertainty and speculation over the future of public involvement in health and social care, and the uncertainty over the LINk's place in this future, Members of the LINk have been very busy in carrying out its formal workplan, and in responding to opinions, proposals and events that it feels are important for the population of Bath and North East Somerset. In this Annual Report, you will find details of the major representations we have made on such issues. These include .

Signage at the Royal United Hospital, Bath;

Participation in the development of a new Health & Wellbeing Board for B&NES;

Participation in the interview Panel for Board members of the new Social Enterprise for the provision of Community Services in B&NES, and representation of the public through membership of the Board;

Representation to the Health Minister via Don Foster MP on the retention of Cancer Networks;

Contribution to the NHS B&NES legacy document for handing over to future Commissioners;

Input to Commissioners' Clinical Priorities Policy;

Work with Council's Overview & Scrutiny Committee to achieve thorough impact assessment for closure of part of a mental health unit;

Representation of B&NES patients in problems of accessing GP Out-of-Hours services;

Expression of concerns to the Strategic Health Authority on behalf of the public over the possible threat to Joint Commissioning in B&NES from the PCT's amalgamation with Wiltshire PCT in a new PCT "cluster";

Expression of concern to B&NES Council over the commissioning of an Avon-wide provider for the Home Improvement Agency;

Representation to the Council on the proposal to close Mortuary Services facilities in Flax Bourton - used by many people from B&NES. This proposal was subsequently rescinded.

All the above are merely examples of the wide-ranging work that the LINk has done on behalf of the people of B&NES, and this Annual Report contains more details of all of them, and of many other areas of our work.

In closing this introduction to our Annual Report, there are several records of my thanks that I would like to make.

Firstly, my thanks must go to Councillor Malcolm Hanney, who as Chair of NHS B&NES and of the Partnership Board until 2012 has been a good friend to the LINk, and has always ensured that its views were heard at the meetings he chaired.

Secondly, we say goodbye to our present Host at the end of October 2012. They have been with us since the LINk was created in 2008, and my thanks go to them for their support to me as Chair and to the LINk generally.

On a brighter note, former councillor Adrian Inker, always our supportive friend as Chair of the Healthier Communities and Older People Overview and Scrutiny Panel, has, following his retirement as a councillor in March 2011, become an active member of the LINk, and, amongst other activities, is one of the LINk's representatives on the Members' Group of the new B&NES Community Services social enterprise, *Sirona*.

I do hope that you will find our Annual Report interesting. The LINk is always keen to hear from the people who use health and social care services in B&NES - to represent you and to make your problems and concerns known is the very reason for our existence. We have been given the legal powers to make our voice for you heard by those who make decisions.

Diana Hall Hall
Chair

June 2012

1. Local Involvement Networks

Local Involvement Networks

Local Involvement Networks (LINks) were created by Parliament in April 2008. There is a LINk for the area of every local authority in England with social services responsibilities.

Although there are some legal requirements, which all LINks must follow, they have a wide discretion in how they set themselves up, and in the way they arrange to carry out their work.

Each LINk has a "Host" organisation to provide it with support and guidance. The Host for Bath & North East Somerset LINk is Scout Enterprises Ltd.

The LINk's formal role is to -

- Promote and support the involvement of the people of Bath & North East Somerset in planning and shaping the development of local health and social care services.
- Ask the people of Bath & North East Somerset what they think about local health and social care services, and provide a chance to suggest ideas to help improve services.
- Investigate specific issues of concern to the community relating to their health and social care.
- Use its legal powers to hold those who provide health and social care services to account for the range and quality of those services.

To enable it to do this, the LINk has legal powers to -

- ask those responsible for planning and providing care services for information, and to get an answer in a specified amount of time;
- carry out visits to places where services are provided, to assess the nature and quality of services and obtain the views of the people using those services, and to see if they are working well;
- make reports and recommendations to improve services, and receive a response from those responsible for the services.
- refer issues to the Overview and Scrutiny Panel of Bath & North East Somerset Council.

The LINk is made up of both Members who want to be actively involved, and Participants who only want to receive information on the LINk's work. Individuals and local voluntary/community sector organisations and groups can become Members or Participants. Each March, Members of the LINk elect the LINk Committee, which is made up of six individual and six organisational members. The Host and the LINk work together on targeted engagement to achieve a LINk that is representative of the local community. See Appendices 1 and 2 for membership background, and membership of the LINk Committee and Sub-Committees.

Local HealthWatch Organisations

Local authorities will be required to set up local HealthWatch organisations for their areas from April 2013. They will have all the functions and powers of LINks, and will have a number of additional features -

- They will have an important relationship with the new HealthWatch England organisation, and will feed in local information to contribute to its national-level work, as well as receiving advice and guidance from HealthWatch England;. They will also have the power to make recommendations to the HealthWatch England Committee of the Care Quality Commission, or, where the circumstances justify this, directly to the Care Quality Commission. They will also give the HealthWatch England Committee such assistance as it may require.
- They will have a statutory place on the new Health and Wellbeing Boards, which are being created for each local authority area. They will have representatives on these Boards, who will be equal partners alongside the new Clinical Commissioning Groups, Local Authorities, and other startegic representatives.
- They will have a new "Signposting" function, through which they will advise, and direct members of the public to help and to sources of information relating to health and social care.

The statutory provisions for HealthWatch England and Local Healthwatch organisations were contained in the Health and Social Care Act 2012. After a very long and contentious passage through Parliament, this Act finally became law on 27 March 2012. It has had one of the most agonised and protracted passages through Parliament of any recent piece of legislation. Its complexity and size are formidable - it is said to be the largest piece of legislation ever to come before Parliament. The most significant amendments to the arrangements for HealthWatch England and Local Healthwatch were introduced at the very end of the Bill's passage through Parliament. They were thus never fully debated in detail by the House of Commons, and were published only a matter of days before the Lords held their final debate on this section of the legislation. Perhaps the most significant change introduced at this stage was that Local HealthWatch organisations would not, after all, be statutory bodies. Another major change was that local authorities, who will be responsible for setting up LHW's and for managing their performance, will be able to split up and contract separately for the various statutory functions of LHW's. The fact that they will have considerable latitude in the arrangements for LHW's, will probably mean that there will be a large number of different models across England. At the time of writing, the Statutory Instruments and formal Directions that will put more operational flesh on the legislation have not been published.

The Bath & North East Somerset local authority has been among the first in England to start its tendering process for a Local HealthWatch provider. The provider appointed for Local HealthWatch will also be required to continue support for the LINk until the creation of a Local HeathWatch organisation in April 2013.

2. How the LINk Manages Itself

The LINk has governance arrangements which are intended to make involvement for everyone as easy as possible. At the same time, they ensure that the LINk operates in a way that is accountable to the public, and that it uses the public funds provided for it by the Government in a responsible and accountable way. The LINk's 'Governance Principles and Procedures' (its Constitution) and its key policies are published on our web site, and are also available from our Host.

Anyone can participate in the vast majority of LINk activities - not just members. We know that not everyone has the time or the inclination to become deeply involved in our work, so we have made it easy to be involved in the LINk as much or as little as people want.

Membership of the LINk is open to people and organisations who live, work, receive health and social care services, or have any other appropriate connection with health and social care matters in B&NES. All you have to do to become a member is to fill in a short form - with the help of the Host, if needed. Membership is free and allows you to have a say in how the LINk is run. It also allows you to stand for election to the LINk Committee, and to vote in the annual election.

If, on the other hand, you just want to hear what the LINk is doing, or to become involved only when you have a particular concern, then you can easily do that.

When we set the LINk up, we decided that it would be most effectively managed by a small group of people, elected by the Members of the LINk, and that this group should have an equal balance of individuals and organisations - six of each. This "LINk Committee" is intended to be an enabler of activity. The main work of the LINk is done by individuals and working groups, and many of them are not members of the LINk Committee. They are given resources and authorisation by the committee, and supported by the Host. For the Year 2011-12, the Chair of the LINk Committee was Diana Hall Hall. The Deputy Chairs were Jill Tompkins and Jayne Pye.

We noted in our last report that the LINk has three formal Sub-Committees, which were set up when it's Constitution was originally drawn up. We also noted that the work of these Sub-Committees is confined to purely formal matters when required. This situation has not changed, and the Sub-Committees have not needed any meetings during 2011-12. They are:

- the Strategies & Priorities Sub-Committee
- the Governance & Appointments Sub-Committee
- the Engagement Sub-Committee

The LINk's normal work is organised and managed by its three Working Groups (see next Section of this Report).

Authorised Representatives

The LINk has the specific statutory power to carry out Enter and View visits to health and social care premises, for the purpose of evaluating services. It exercises this power through its "Authorised Representatives", who carry out the visiting role on behalf of the

LINk. Each Authorised Representative has to undertake specific training for the role, as well as having to undergo a Criminal Records Bureau check. As at March 2012, there are eight members who are Authorised Visitors:

Diana Hall Hall	Ann Harding
Jill Tompkins	Veronica Parker
Jayne Pye	Howard Wreford-Glanvill
Dr Pat Jones	Ben Rogers

3. The LINk out and about in the Community

During the first quarter of 2011, B&NES LINk continued contacting groups in the community that were identified as under-represented by the December 2010 Gap Analysis survey review. Disappointingly, we received replies from less than half of those contacted and only a few accepted the offer to become involved in a LINk survey. The most common reason given for organisations being unable to get involved was a lack of resources. The groups that did respond to the engagement email were visited to raise awareness of the LINk, and some surveys were completed to gather views and experiences. Groups visited were, MOSAIC (run by Bath MIND), The Big Issue and The Rainbow Café (run by Gay West). A report was produced following each visit and any concerns highlighted were followed up. In doing this work, we were reminded of the importance of visiting hard-to-reach groups to enable those who are under-represented in our engagement work to have a voice and be involved in the work of the LINk. The LINk has developed strong working relationships with the groups visited, and our thanks go to all those that made us welcome and have contributed to the work of the LINk. See **Appendix 4a** of this Annual Report for the second Gap Analysis Report February 2011-July 2011.

Appendix 4b relates to engagement activity during 2011/12 and this is covered in more detail in the following sections.

Following on from the 'Hidden Carers' drop in session early in 2011, a questionnaire was sent out with the LINk's April 2011 newsletter to gain a better picture of the experiences of "hidden carers" in B&NES (these are people with caring responsibilities for relatives or friends, who are unknown to and unrecognised by any organisations who could give them support). The response was much improved, with several key issues highlighted, including the need for better information regarding the rights and responsibilities of carers.
Joan Travis, the lead of the LINk's Carers Working Group, completed this piece of work in July 2011 by compiling a "Hidden Carers" database, to provide details of voluntary organisations to help inform carers in B&NES.

In December 2011, the Carers Working Group began to look at 'Care Provision Options' in B&NES, and a survey was used to measure public awareness. Again the LINk received a reasonable response and a report of our findings was produced, in which Joan Travis commented -

> *"Following an analysis of the returns of completed questionnaires the indication was that carers have an increasing awareness of what is available to them and how to access relevant information.*
> *They are aware of the range of services provided by the Statutory Organisations but are less aware of the Voluntary Organisations and the wide and varied range of services they offer.*
> *There was a disappointing response from potential carers, which indicates that care issues are not given much consideration until the need arises.*

The recent economic climate is causing some carers concern about future care provision or the possible cut- back in the support they receive.

Research shows that care at home, whenever possible, is the most desirable outcome, and so support and reassurance for carers should be a top priority".

Engagement work carried out by the LINk in 2009, highlighted the high usage of Ketamine by young people in B&NES, and the long term damage that it can cause to the bladder. The LINk had advised the Primary Care Trust of its findings in 2009, and we were informed that Ketamine awareness training for GPs took place in May 2011. This was an extremely positive outcome for the LINk

We continued to keep contact and maintain our relationship with *Hop Skip and Jump*, a day-care centre for Children with Special Needs in Kingswood, South Gloucestershire. Although situated just outside the B&NES border, it is not attended by many people from B&NES and so on request, we provided advice on how the centre could reach out and raise awareness of the people in B&NES that might benefit from the services they provide.

During the summer months of 2011-12, we identified a number of networking opportunities in B&NES. In June, we attended the open day of *Community@67* to increase links with groups in Keynsham and engaged with many new organisations and individuals, gaining new additions to our membership. In July, Carole Pullen, the LINk Development Worker, and Deputy-Chair Jill Tompkins worked in partnership with the Wiltshire LINk and visited the Lymphoedoema Support Group to gather views and experiences and inform the group about the LINk and its future evolution into Local HealthWatch.

The LINk supported a positive piece of work completed over several months by a member of the community. He compiled useful advice and suggestions on how to support those with Alzheimer's to use the facilities and services at Bath Spa railway station. This was then fed back to the station manager.

Developing public awareness of the coming HealthWatch arrangements formed a large part of the engagement work, especially in the second half of the year. Information leaflets were hand delivered and posted to many organisations across B&NES, including, libraries, the RUH, The Guildhall, Universities and Colleges - **See Appendix 4c.** Letters and leaflets were also sent to all GP Practice Managers in B&NES to raise awareness of the transition of LINk into Local HealthWatch, and particularly to invite partnership working between the Practices' Patient Participation Groups and the LINk. Disappointingly, we did not have any responses at all to these letters.

As lead of the LINk's Disability Working Group, Jayne Pye represented the LINk on the South West Development Programme for Long Term Conditions. Jayne co-ordinated the dissemination of a six-question survey of 100 people with Long Term Health Conditions living in B&NES. The responses were collated and the information fed back in October 2011.

During the Autumn months, a visit was made to the "Rural Recovery Hub" run by *Developing Health and Independence* (DHI) in Midsomer Norton, which specialises in support for people with drug and alcohol issues. We spoke with a number of these service-users to get their views and hear about their experiences.

The LINk worked with the National Autistic Society and the Family Information Service on facilitating public involvement in the shaping of the B&NES Autism Strategy. Two meetings were held, one in October 2011 and one in February 2012, to raise awareness of the strategy and to enable people to share their views and experiences, which were passed on to the Autism Strategy Partnership Board. The LINk will continue to liaise with NAS to ensure public awareness of the Autism Strategy Consultation, and to facilitate community involvement in the consultation.

The LINk attended both of the B&NES *Healthy Conversation* meetings that were held in 2011-12. At the15 June 2011 meeting, the workshop sessions focused on the delivery of the three functions of a local HealthWatch - the roles of Influencing decision-makers, providing Information on health and social care, and acting as a "Watchdog" on behalf of the public. The LINk facilitated the Influencing workshop. The topic at the second *Healthy Conversation* on 16 November 2011 was Clinical Commissioning & Planning Priorities. The LINk attended with a stand and publicity material to raise awareness of the LINk.

Towards the end of 2011, the LINk began planning a long-term piece of work, to gain a picture of the variety of care and services provided at care homes in B&NES. It was agreed that this would be done through a series of informal visits to care homes. The first visit took place in February 2012, and an interim report was completed after the fourth care home visit in May, This was later in 2012 presented to the Council's Wellbeing Policy Development and Scrutiny Panel, which received it with enthusiasm and encouraged us to continue with this work. The LINk plans to carry out further visits during 2012-13.

The LINk has monthly meetings in public, and we often invite speakers to talk to us about aspects of health and social care. One of our most interesting topics this year was *The Big Issue*, which came out of engagement we had done with the homeless. Two speakers from *The Big Issue* Foundation came to talk to the LINk Committee, to describe the work of the Foundation and the way that "Vendors" were helped and supported. It was, by common consent, one of the most informative and rewarding, and thought-provoking presentations we have had.

The LINk continues to build relationships with the Care Quality Commission, Avon and Wiltshire Mental Health Partnership, and Great Wester Ambulance Trust. Our Development Worker, Carole Pullen, has also continued to meet with Development Workers for the other LINks in the Avon area to share best practices, swap ideas, and be involved in joint working when relevant.

Throughout the year, LINk newsletters and e-bulletins for Members and the public provided regular updates on issues related to health and social care, and have, in particular, given information about local HealthWatch and the progress of the Health and Social Care Bill through Parliament.

Recognising the need to engage and involve through social media, the LINk joined *Facebook* in December 2011 to reach out to the wider public, and to encourage younger people to join our membership. The B&NES LINk website www.baneslink.co.uk is also a source of information and is regularly updated with information relating to health and social care.

4. Working with our Strategic Partners

A key function of the LINk is its work with its strategic partners (such as NHS B&NES and B&NES Council) to represent the people of B&NES in the decisions that are made about their health care and their social care.

As in 2010-11, much of our work with partners has been in the area of the implementation of the Health and Social Care Act 2012, and particularly in the preparation for the new Local HealthWatch organisations, whose start has now been delayed until April 2013. However, the LINk has continued to monitor local strategic issues, and has also worked with its partners on a number of these.

B&NES Healthier Communities and Older People Overview and Scrutiny Panel

The LINk views its relationship with the B&NES Council Wellbeing Policy Development and Scrutiny Panel as one of its most important strategic alliances. The Chair of the LINk and the Host Manager (and other LINk members) regularly attend Panel meetings, and are always given a formal slot on the agendas to report on the LINk's work and concerns. These reports cover the activities that are noted in other parts of this Annual Report. The sharing of concerns with this influential Panel gives the LINk's work much increased profile and credibility, and a number of issues have been taken forward as joint concerns. Foremost among these have been the consideration of new arrangements for the Home Impovement Agency, and shared concerns over the implications for joint health and social care commissioning of the new PCT clustering arrangements.

We are grateful to the Members and Chair of the Panel for the warm welcome they always extend to the LINk when it participates in the Panel's business, and for the support they have given us during 2011-12 in pursuing the concerns we bring to them on behalf of the people of B&NES.

New B&NES Health & Wellbeing Board

The Health & Social Care Act 2012 gives Local Healthwatch organisations a formal place on the new Health & Wellbeing Boards that will be established from April 2013. Like many other local authorities, Bath & North East Somerset Council have established a shadow Board for the purposes of the Act. The Chair and the Host Manager together attended an initial planning meeting for this shadow Board in April 2011. Since then, the LINk Chair has been attending meetings of the shadow Board as a full *ex officio* member.

Strategic Transition Board

The LINk's Deputy-Chair, Jayne Pye, sits on the Strategic Transition Board, as a part of her work in the field of Disabilities.

Reform of the NHS

A general picture of the Government's plans for Local HealthWatch is given in Section 2 of this Annual Report, and our Annual Report for 2010-11 gave an account of developments last year. During 2011-12, the target date for the commencement of Local HealthWatch was revised twice, first to July 2012, and then to April 2013. The LINk has continued to work with its partners during the year to prepare for the new system, and has participated in consultation events and in the Council's selection process for a contractor for Local HealthWatch. Since this took place, the Council has announced that it intends to re-commence its procurement following a challenge to its original procurement process.

The LINk has also engaged with other key areas of the NHS Reforms, such as the development of Clinical Commissioning Groups and the development of the new B&NES Health and Wellbeing Board. We have participated in the consultation on the CCG's Clinical Priorities Policy, particularly in respect of Homeopathic Medicine services, and the LINk's Chair is an ex officio member of the shadow Health and Wellbeing Board, regularly attending its meetings.

Care Quality Commission

The LINk has continued its working relationship with the Care Quality Commission during 2011-12, through quarterly meetings with the CQC officers covering the B&NES area. This has given the LINk useful insights into the CQC's findings in its inspection visits to hospitals and care homes, and it was particularly useful to be able to plan our work in visiting care homes with reference to the inspections made by the CQC and to their knowledge of individual homes.

Regional Working

The LINk and its Host organisation have attended regular meetings between all LINks and Hosts in the south west. These meetings cover a variety of topics, and, as in 2010-11, much of the shared work has related to the development of the new Local HealthWatch organisations, and the new relationships that they will need to forge.

Member of Parliament - Don Foster MP

During 2011, many cancer services users and professionals expressed concerns that the failure to guarantee the future of Cancer Networks under the new commissioning arrangements would lead to their demise as the new commissioners sought savings. The Secretary of State had refused to intervene, seeing this as a matter for prioritisation by the new commissioners.

In May, the LINk received information on this from Macmillan Cancer Support, arguing that there should be specific statutory protection for Cancer Networks during the changes to commissioning arrangements, and the LINk Committee decided that it should take action in support of this. The LINk wrote to Don Foster, MP for Bath, asking him to intervene with the Secretary of State. Mr Foster replied, supporting the LINk's view, and saying that he had forwarded our correspondence with him to the Secretary of State. He wrote again in June, enclosing the reply to him from Andrew Lansley. Referring to the LINk's correspondence, the Secretary of State replied that in response

to wide concerns, he would be providing protection for Cancer Networks for 2012-13, and that the new National Commissioning Board would continue to support “strengthened” Cancer Networks in the longer term.

5. Working with Other Local Organisations

The LINk has formal representatives on a number of local health and social care organisations, and works with commissioners, services providers and users to look into concerns and to feed-in ideas for improvement. Updates on this from these representatives have been given below.

Commissioning - NHS Bath & North East Somerset

The Chair continued to represent the LINk at meetings of the PCT Board during 2011-12. From April 2012, the PCT will come together with the Wiltshire PCT to form the NHS B&NES and Wiltshire Cluster PCT, although each PCT will retain its statutory identity and responsibilities.

Work done by the LINk relating to NHS Bath & North East Somerset included:

- Expressions of concern at the "Clustering" arrangements to be introduced for the PCT and Wiltshire PCT. We wrote to the Strategic Health Authority with the view that this clustering would have a detrimental effect on the very well-developed and successful joint commissioning arrangements that have been developed between the PCT and the Local Authority in B&NES. These arrangements are not, we believe nearly as advanced in Wiltshire. The clustering arrangement was, nevertheless, put in place.
- In August, NHS B&NES asked the LINk to draw up a "legacy" document detailing the LINk's work since it was created in 2008. This will be an important part of the PCT's overall legacy document, which will be handed over to the new commissioners when the PCT is abolished in April 2013. It was presented to the PCT Board at its November meeting, and is a useful account of the LINk's work over three years. The document can be found on the LINk website.
- The LINk was given in-depth introductions by PCT officers to the new Care Summary Record system, to the new non-emergency NHS telephone contact number "111", and to the changes being implemented nationally to Public Health.
- A member of the public wrote to the LINk, outlining the problems she had encountered in accessing GP out-of-hours care. She lived alone, had no personal transport, and could not afford the cost of taxis. Late at night, she had been asked to attend either the RUH or Paulton Hospital. She could not get to either. She told us that the GP did, with some reluctance, visit and treat her at her home, but that she was made to feel guilty about this. We raised this issue with NHS B&NES, and pointed out that this was a problem that was likely to get more common as services became more centralised and distant from where people lived, and as an aging population became less able to drive.

  NHS B&NES replied that this was a recognised problem, but one that only affected a very small number of people. It would be difficult to commission a regular service for a need that, they felt, would amount to no more than one case per day. They also pointed out that the NHS is only able to meet needs that arise from medical conditions, and that such problems arise not from these, but from social and local infrastructure considerations. If the patient's inability to travel had been

the result of a medical condition, then the doctor would have visited as a matter of routine, but there was no medical reason for her being unable to travel.

NHS B&NES has agreed to keep this issue under review, but the LINk feels that the increasing tendency to centralise services to save the NHS money might be simply shifting the costs of access from the NHS to the public.

Commissioning - Clinical Commissioning Group

The LINk has continued to engage with the shadow Clinical Commissioning Group, which still formally operates as a committee of NHS B&NES. Members attend its meetings, although without any formal presence on the Group.

During the year, the LINk worked with the CCG on its Clinical Priorities Policy, and took part in a formal Impact Assessment of proposed commissioning changes for Homeopathy Services in B&NES. Members also felt strongly that there should have been full formal consultation on the commissioning policy being proposed by the CCG.

Commissioning - Bath & North East Somerset Council

In addition to its role as our funder and as our Host's contract performance manager, B&NES Council is also subject to our independent scrutiny as a LINk.

Home-Improvement Agency tendering

The LINk's Deputy-Chair, Jayne Pye, visited *Care and Repair* in late-November, and there learnt that there was a consultation under way for re-tendering of the Council's Homes Improvement Agency contract. The LINk had not previously heard about this. We made further enquiries, and in mid-December, the LINk received information that the consultation, which had commenced at the beginning of October, was due to finish at the end of December. The LINk was concerned that, not only had it not been consulted on the tendering, but also had not been involved in the design of the consultation process or the specification for the service. We were also worried that the high level of service given by the current holder of the contract, who operated on a very popular and effectve social model of service, might be lost in favour of a larger, less local provider offering a lower price. We wrote to Councillors expressing this concern, and received a comprehensive reply from Councillor Simon Allen, who holds the portfolio for Wellbeing.

Councillor Allen apologised for the fact that the LINk had not been involved earlier in the procurement process, and explained why the service was being re-tendered.

During the year, the LINk Committee was also given presentations on the Council's Personalisation programme, and the Independent Living Service provided by Somer Community Housing Trust.

Sirona Care and Health

Sirona Care and Health is the new Community Interest Company which, from October 2011, took over NHS B&NES' and B&NES Council's previous responsibilities for providing publicly-funded health and social care services in the community. It was set up to take over the PCT's role in providing community health services when the PCT is abolished in April 2013, and also to move towards the integration of all care services in

the community by removing the confusing, and sometimes obstructive division between the provision of health and social care.

In June 2011, the Chair and Deputy-Chairs of the LINk sat on the interview Panel for Executive and Non-Executive Board members for Sirona, and a Deputy-Chair, Jayne Pye, attended a Sirona Membership Workshop.

The LINk was kept well informed through the year on developments at Sirona, with a presentation in August on "Opportunities for Membership", and an update on Sirona's progress in February, both from its Chief Executive. In August, the LINk Chair also joined the Chief Executive of Sirona in an interview on Radio 4 on the subject of the the creation of the new Community Interest Company.

LINk Members participated in an Equalities Impact Assessment for one of Sirona's services, relating to the proposals to reduce the opening hours of Paulton Hospital Minor Injuries Unit from 24 hours each day to 13½ hours. This assessment was followed by a Health Impact Assessment early in 2012-13.

Two members of the LINk, Adrian Inker and Jayne Pye, are Members of Sirona CIC ("Community Interest Company").

Royal United Hospital, Bath

Deputy Chair, Jill Tompkins, has attended the RUH Trust Board meetings, throughout the year on behalf of the LINk. Jayne Pye, the other Deputy Chair attends the meetings of the *Respect, Dignity, Privacy* team.

We have been kept up to date with developments in the Trust's progress towards Foundation Trust status, and in June the Chief Executive and the Chairman of the Trust attended the LINk Committee meeting to give us a full update on this. We also had clarification from the Trust on the training in Dementia care given to non-specialist nurses - an issue that concerned us, since patients with dementia may have treatment under any specialty at the Trust.

Another issue that concerned us was a proposal to close the Mortuary Services department at the RUH, with re-location of all services for B&NES and a large part of Wiltshire to Flax Bourton in North Somerset. A significant issue with the consultation around this change was that the consultation conducted had not included an Equalities Impact Assessment, and that people in Wiltshire (a major usr of the service) had not been consulted. The LINk aligned itself with the many other organisations opposing this change, which was aimed at saving a very small amount of money in overall budgetary terms, and the proposal was abandoned.

Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

Connie Wright is the LINk's representative for RNHRD matters, and she has given the following account of her activities during 2011-12:

Infection Control and Environment Committee

I attend bi-monthly meetings for Infection Control and Patient Environment where I can question and contribute to discussions. Reporting and updating is very detailed,

CDiff is a concern in all Trusts at present. The RNHRD has a very good record for infection control figures.

Council of Governors Service Development and Delivery Committee

I chose to be a member of this committee. We discuss the progress of services and consider patient feedback on quality of services. We meet with a CQC inspector twice a year to discuss progress and concerns or new services being developed. A new service is now underway to support Cancer Survivors.

Our group comment on the Annual Quality Report which is published on the Trust's website.

There is now a reported financial pressure placing the Trust in significant difficulty while the standards of service delivery are still of a high quality and must continue in the interest of patients. The CQC is aware of the situation and has no concern about the delivery of quality services.

New Service development at the RNHRD NHS FT

As B&NES LINk Representative and a Cancer Survivor I am a member of the Steering Group funded by Macmillan cancer support in developing an educational intervention for cancer-related fatigue at the Trust. Using the National Survivorship Agenda and Criteria for Cancer Survivorship a rehabilitation programme is now operational at the trust developed by RNHRD CFS/ME Team. This ground breaking, innovative development has been complicated and dynamic in developing an operational policy, working with Macmillan advisor, consultants , researchers, GPs,cancer advisors and Patient Representatives. In this role I attended a Macmillan Conference in Plymouth with the RNHRD Team, which emphasised the patient need for more services. Cancer patients were well represented.

RUH presentations for patients and public to become members of their Foundation Trust

The RNHRD were invited by the Chief Executive of RUH, to appoint some members of the Council of Governors who would be willing to talk about their experience as Governors to those applying for RUH membership. I was one of five people invited and found the experience interesting as the opportunity for working together, sharing experience and involving people in the community is at the heart of LINks and Healthwatch. However, when questioned on the role of LINks and Healthwatch, the Chief Executive seemed to have reservations over this, particularly in the light of the current lack of understanding about how LINks would evolve into Local HealthWatch organisations, and about how Local HealthWatch would work. After the presentations we were informed that many people signed up for membership.

Staff at RUH are working very hard to achieve efficiency.

University of West of England and South West Strategic Health Authority

Joint service Lead for CFS/ME Service RNHRD, Anne Johnson, invited me to join her team of lecturers to teach Allied Health Professionals in a degree programme to modernise AHP career's to deliver high quality care for all, transform community services and clinical practice through leadership and clinical development. My role is to show how developing Patient and Public Involvement groups has a historical basis which has been formed and reformed over decades. In recent years putting this innovation into practice has been to take note of patient experience(giving power to patients), which can influence clinical practice and deliver safer care. Health,

work and wellbeing has relevance to AHPs, as growing research evidence demonstrates through rehabilitation. Students have to show how they involve patients and public in their planning and the importance of institutional checks to improve access to services , reducing inequalities and ensure social inclusion for all.

Research Groups

Government now demands that health researchers in hospitals and universities must use PPI in all research projects, the following presentations were given at the Hilton Hotel in Bath. A patient who had hugely benefited from research restoring her from a crippling musculo-skeletal disorder at an early age, now studying for a postgraduate degree, spoke of how she was involved in her treatment as a research project and how she and the team benefited.

University of Bath Research Groups Conference: Road Map for Patient and Public Involvement.

Presentations:- 25th May 2012:
How best to involve the public when designing a research project - *INVOLVE,* a national advisory group funded by and part of National Institute for Health Research, supports active public involvement in NHS, public health and social care research.

National Institute for Health Research ; Helps to build successful grant applications, methodologies, designs studies and all research needs. Sees patient/public involvement as important in research as they are experts in their conditions
Relevant to the research
Lived experience
Networks into a wider community
Know what will and won't be acceptable.

Nigel Harris University of Bath/ Bath Institute of Mechanical Engineering & Team.
Design and research projects for those with Alzheimer's disease and their carers.
Registered charity
Deals with all the problems of dementia, works with engineers, therapists ,designers, mechanics, technologists and carers to produce different models for improvement.

The LINk's representatives also provided a formal response to the RNHRD's Quality Account for 2011-12.

Great Western Ambulance Service NHS Trust

The Great Western Ambulance Trust ("GWAS") provides emergency and urgent care and patient transport services across the local authority areas of Bristol, South Gloucestershire, North Somerset, Bath & North East Somerset, Gloucestershire, Wiltshire and Swindon. For this reason, the seven LINks for those areas have formed a joint GWAS working group to ensure coordinated dealings with the Trust.

The GWAS Trust was formed in 2006 from the three former ambulance services of Avon, Gloucestershire and Wiltshire. At that time, other ambulance Trusts across England were being combined into much larger organisations covering very large areas.

As a result of all this, GWAS was left as by far the smallest ambulance Trust in the country. All ambulance Trusts are now required to become Foundation Trusts, and it has become clear that GWAS is not large enough to be sustainable as such a Trust. It therefore decided to seek to become a part of the very much larger South Western Ambulance Services Foundation Trust, which covers the rest of the south-west penisula. This will result in the dissolution of GWAS as a Trust, and the transfer of its services and assets to the South Western Ambulance Services Trust ("SWAST"). None of this will change the services used by the public, and users will see no difference apart from the name on ambulances and buildings. The final confirmation of this change will be made by November 2012, and services will be taken over by SWAST from April 2013.

Much of the work that LINk members have done with GWAS during 2011-12 has been concerned with this reconfiguration, and with the consultation that is required with representatives of the public when such changes are being proposed.

The Joint LINks' Working Group also decided to carry out visits to Accident & Emergency Departments at all the District General Hospitals in the GWAS area, to inspect the services available for patients, and the procedures in place. It was decided that this should be done on an informal basis, rather than by using the LINks' legal powers to "Enter and View" health service premises, and all the hospitals agreed to this. Each of the constituent LINks visited the hospital(s) in their own areas, and the B&NES LINk representatives on the Working Group visited the Royal United Hospital Bath on 16 January 2012. As well as asking questions about some standard operational matters (agreed in advance as questions to be asked at all the visits conducted by the LINks across the area), the B&NES team asked some specific questions relating to the manner of recording ambulance "turn-around" times at the hospital, and to the provision made in the A&E Department for patients with mental illness who need emergency care. It was explained that any discrepancies between turn-around times recorded by ambulance crews and those recorded by hospital staff were reconciled through regular liaison meetings between these staff to reconcile any discrepancies. The LINk members who carried out this visit were impressed with what they saw, and produced a report for inclusion in the wider report being produced for the whole GWAS area by the Joint Working Group.

The LINk has also worked with the other LINks in the GWAS service-area to formally respond to the Trust's Quality Account for 2011-12.

During 2011-12, Jill Tompkins has been the formal LINk representative on the Joint Working Group. Veronica Parker has also contributed to the work and attended meetings.

Avon & Wiltshire Mental Health Partnership NHS Trust

LINk Members Jill Tompkins and Veronica Parker have continued their involvement in the work of the Mental Health Trust, attending its meetings on behalf of the LINk to represent the public. The Trust hopes to achieve Foundation Trust status during 2012-13. The Trust's service area includes six LINks, and they all contributed to a joint response to the Trust's Quality Account.

In March, the LINk Committee was given a detailed account of the work being done by the Trust in the area of Early-Onset Dementia at its *Forget-Me-Not* Centre in Swindon.

There was a valuable contribution to this by users of the service, which provides support to both patients and their families.

An important issue for the Trust's service-users that was brought to the attention of the LINk in July 2011, was the planned closure of the acute high-dependency ward for mental health patients at Hillview Lodge. This was raised by a representative of *MIND*, one of the LINk's Organisational Members. This had originally been presented as a temporary closure, but there was a fear locally that the closure could become a permanent one, resulting in patients from B&NES having to travel long distances to units in Bristol or Salisbury for very short-term crititical care. The LINk was particularly concerned that these more remote care-settings could change the thresholds for entry and exit to care for vulnerable patients, affecting the safety and quality of their care, and also removing them from the communities within which their recovery could be more naturally achieved.

The Chair of the LINk wrote to the Chief Executive of the Avon & Wiltshire Partnership Trust, expressing these concerns, and also raised the issue at the B&NES Overview and Scrutiny Panel at its October meeting, saying that it did not feel that the correct procedure for consultation had been followed. Following the concerns expressed at the OSC, AWP conducted a full Impact Assessment which included representatives from the LINk, and returned to the January meeting of the OSC with the results of this, and with clear proposals to mitigate the effects of the proposed changes, including the establishment of a "de-escalation" facility to fill the gap left by the closure of the High-Dependency Unit. The OSC and the LINk were both pleased with this outcome, which they felt provided assurance that the needs of users would be well met.

The LINk's representatives worked with the other LINks in the AWP services-area to provide the statutory response from LINks to the Trust's Quality Account.

Urgent Care Redesign Project and Urgent Care Network

The Urgent Care Redesign Project Group was established in 2010, and followed a Department of Health review of local Urgent Care Services in November 2009, which had highlighted the confusion for patients and staff when trying to access urgent care. The Project Group's membership includes NHS B&NES, NHS Wiltshire, B&NES Emergency Medical Services, Wiltshire Medical Services, B&NES LINk, the provider of the Riverside Health Centre in Bath, the provider of community health and social care services in B&NES, Wiltshire PCT Community Health Services, and the RUH A&E Department.

The aim of the Group is to simplify urgent care, to provide consistency, to enhance the role of GP Practices in urgent care, and to achieve value for money.

The LINk has been working as a part of this this group since 2010 through the close involvement of one of its Deputy Chairs, Jayne Pye. This year changes have been seen in the way urgent care has been approached within the B&NES community. The change of opening hours of the Bath Walk-in-Centre, the RUH change in ED administration with GPs on site and front-door triage for trial periods , after hours GP cover and changes of opening hours at Paulton Minor Injuries Unit.

The new 111 telephone service, now commissioned by NHS B&NES, has also been part of the above project. LINk were invited to hear all of the organisations competing for the tender and discuss with the tender group their opinions.

In April 2012, Jayne Pye joined the Urgent Care Network as its community member. The group is basing its principles on the "*Breaking the Mould without Breaking the System*" document, and is looking to have various commissioning decisions around urgent care put in place by Autumn 2013 to complete the Urgent Care Pathway.

Equality B&NES Health Group

The LINk's Deputy Chair, Jayne Pye, has continued with the work she reported in our Annual Report for 2010-11, and acts at the health lead on the Equality B&NES Steering Group. She has worked with them on many consultations regarding Access issues in B&NES for people with disabilities. Jayne feels that this work and involvement provides a useful "sounding board" for her other work for the LINk on Long-Term Conditions.

Bath Area Play Project

This organization works with children and young people, families, and the statutory authorities within B&NES in the area of disability. LINk member, Jayne Pye, is a trustee of the Bath Area Play Project, and, following an invitation from the Children and Young People's Network, also sits on the Project's Strategic Transition Committee on the Network's behalf.

National Autistic Society

During 2011, following discussions with the National Autistic Society, the LINk worked with the Society to enage with people with autism and their families to establish their views and concerns about the health and social care they received, and to establish what support there would be for a B&NES Autism Group.

This work resulted in two public meetings held in 2011-12. The first of these was held on 24 October at the Guidhall in Bath to listen to and gather the views and experiences of adults with Asperger/Autism Spectrum conditions, and those of their families and carers. Another aim of this meeting was to encourage the setting-up of a B&NES Autism group to take forward work from the meeting. The meeting was well-attended, and information was provided on the Autism Act 2009, and on the development of the B&NES Autism Strategy. Important issues raised by those at the meeting were:

- problems of diagnosis of these conditions;
- the management of the transition from children's to adults' services, and then help into employment;
- the service requirements for mental health in regard to the wellbeing of young adults.

A further meeting was held jointly by the LINk and the National Autistic Society in February at Keynsham Town Hall, and this was specifically focused on young people (aged 14-25 years), and the transition for them from children's to adults' health and social care services. The meeting started with presentations from the National Autistic Society on national and local Autism strategies, and on work being done locally on care transition through the *Person Centred Approach* from B&NES Council. This was followed by a participatory discussion with service-users on "What is Working and What is not Working". The main issues that arose in this discussion were:

- information on the condition and services available;
- the transition from children's to adult services;
- consistency and reliabilty of points contact with services;
- the lack of understanding of these conditions in mental health teams;
- the difficulties faced in higher education, employment and housing;
- difficulties in diagnosis;

Copies of the full reports on both the meeting of 24 October and the meeting of 17 February can be obtained from the LINk office.

We are pleased to have been able to help in taking forward this work in the interests of people with autistic conditions. The National Autistic Society has been asked to organise a consultation event on the new B&NES Autism Strategy, although, due to its reduced resources, the LINk will have to step back from the significant level of support that it has been giving.

LINk member, Jayne Pye, is also a member of the B&NES Autism Strategy Board.

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6. Issues we have Investigated as Part of Our Work Plan

Much of the LINk's work is done in response to issues emerging from its work with its strategic partners, and this is described in other sections of this Annual Report. However, the LINk also decided that it wanted to investigate particular themes coming out of its interaction with the public or from its views of how emerging issues would impact on people using health and social care services. The LINk Committee selected a small number of areas that they wished to investigate alongside the wider work described in this Report, although they recognised that there would inevitably be much overlap between the two.

The specific themes chosen for 2011-12 were:

- Quality of Care in Care Homes
- Disability
- Carers

Quality of Care in Care Homes

Jill Tompkins, the LINk lead for this work writes:

"This year, quite recently, we have been visiting local residential homes. As yet we have only been able to look at four. Under our 'Enter and View' terms we have visited to familiarize ourselves, usually three of us, to look at the services they provide. On every occasion we were welcomed, and given answers to all our questions. A review of this programme will be completed in the near future."

Disabilities

The LINk's Deputy-Chair, Jayne Pye, has been leading on this work-stream, and has written the following report -

"For this year my work has centred on the Long-Term Conditions Development Programme. The LINk was asked to join the B&NES group in July 2011. In August 2011, I organised a Long-Term Conditions feedback exercise with Clinical Commissioning Group and other Commissioning colleagues, and had a very good response. This work is ongoing, and will be the backbone of CCG commissioning for the next few years."

As Long-Term Conditions cover many disabilities, during the year I have become involved with many groups, both statutory and voluntary, to try to understand the "cradle to grave" philosophy that I feel is needed to understand this group's needs.

1. Work around children and young people: I am a member of the Children and Young People's Network, have completed my lead professional training. I sit on the Common-Assessment Quality Assurance Group, and I am a trustee of the Bath Area Play Project. I also sit on the Strategic Transition Board. For me, this is the beginning of the Long-Term Conditions "ladder" for many, and I

needed to understand how the children and young peoples services work for this group

2. During 2011, the LINk has been working with the National Autistic Society regarding engaging with adults who are diagnosed on the autistic spectrum. Our impetus at this time for action was the document *Fulfilling and Rewarding Lives',* the statutory guidelines for implementing the national Autism Strategy. Our first meeting was in October 2011, and since then another meeting has been held to gather views of how this particular group sees its place within the B&NES community, finding the positives and negatives of living in our area. We are now awaiting a consultation event on the strategy proposed by the statutory commissioners. I now sit on the Autism Strategy Group.
3. I have worked with *Equality B&NES* on many practical consultations regarding access around B&NES, looking at all areas of disability and being included in core strategy and public realm consultations. I lead on health for *Equality B&NES,* and find this disability-wide group a good sounding board for Long-Term Conditions work.
4. To understand particular difficulties within secondary care around disability groups, and to put forward the needs of the Long-Term Conditions Group, I joined the multidisciplinary team in the Dignity, Respect and Privacy group at the RUH. The LINk also has a comment section in the RUH quality accounts, and throughout the year we meet regarding their ongoing quality goals.
5. A consultation was undertaken regarding the experiences of Dental Practices by the disabled community within B&NES. The LINk contributed after engagement with disabled groups regarding appropriate questions. The commissioner involved found this very informative and got a very good response .
6. We were also invited by the Clinical Commissioning Group to hold meetings with them regarding their strategy, and particularly the forming of GP Practice Patient Participation Groups in B&NES. There has now been funding given particularly for the PPG's to be formed, and a meeting has been held to which the LINk was invited to announce their strategy.
7. In September 2011, I was appointed as a service-user member of *Sirona Care and Health*. This appointment was made due to my breadth of experience, skills and networks within B&NES. My Long-Term Conditions work for the LINk obviously is a basis for this. As a member, my responsibilities are as the owner of the company taking a special interest in ensuring the organisation acts in accordance with its Community Interest Statement. The LINk is asked to comment on the organisation's Quality Account, and to take part in impact assessments."

Carers

Joan Travis, who is the member leading on this work, writes:

"Following an analysis of the returns of completed questionaires the indication was that carers have an increasing awareness of what is available to them and how to access relevant information. They are aware of the range of services provided by the Statutory Organisations but are less aware of the Voluntary Organisations and

the wide and varied range of services they offer. There was a disappointing response from potential carers which indicates that care issues are not given much consideration until the need arises. The recent economic climate are causing some carers concern about future care provision or the possible cut- back in the support they receive.Research shows that care at home, whenever possible, is the most desirable outcome and so support and reassurence for carers should be a top priority."

7. The Future

The New HealthWatch system

The statutory implementation date for Local HealthWatch has finally been set at 1 April 2013. The Health and Social Care Act, which gained Royal Assent on 27 March 2012, contains provisions for HealthWatch, both Healthwatch England (which will be a part of the Care Quality Commission), and Local HealthWatch organisations.

> *"The Health and Social Care Bill 2011 proposes that Healthwatch will be the new consumer champion for both health and social care. It will exist in two distinct forms – local Healthwatch, at local level, and Healthwatch England, at national level."*

Local HealthWatch Organisations will have all the functions of LINks, and will have, in addition, the role of providing the public with advice and information about access to local care services and about the choices that they have about using those services. They will also provide information on local views to Healthwatch England, and will be able to make recommendations to HealthWatch England about investigations that it should carry out.

> *"Local Healthwatch will gather local views on the health and social care system to provide feedback, which will enable Healthwatch England to advise on the national picture, in turn influencing national policy, advice and guidance."*
>
> *"Local Healthwatch will gather views on the social care as well as the healthcare system. The aim of local Healthwatch therefore will be to gather views of patients and the public on both health and social care at the local level, but it will have the additional benefit of having a national level body to act as consumer champion."*

The decisions about the form Local HealthWatch organisations should have, and their funding and performance management will be the responsibility of Local Authorities. However, we now know that it is a statutory requirement that Local HealthWatch organisations will be social enterprises, and that they will not be statutory bodies in their own right. These requirements resulted from last-minute changes to the legislation in Parliament. As we write this Report, we are waiting for the publication of the Statutory Instruments that will put some flesh on the bones of the broad requirements of the Health and Social Care Act.

Preparing for Local HealthWatch

The LINk has already been involved during 2011-12 in paving the way for Local HealthWatch, and for the other major changes being introduced into the NHS. It has produced various "legacy" materials for the new system, including a major piece of work on the LINk's work and achievements over the last four years for incorporation into NHS Bath & North East Somerset's work in handing over to the new Clinical Commissioning Group and the new Health and Wellbeing Board. The LINk also has representatives on the shadow Clinical Commissioning Group and the shadow Health and Wellbeing Board, and these arrangements will continue through 2012-13.

APPENDIX 1

DEMOGRAPHIC COMPOSITION OF THE LINK 2011-12

Membership

Total number of members at 1st April 2011	64
Total number of members at 31st March 2012	67
Made up of:	
• Individual Members	37
• Organisational Members	30

Participants

Total number of participants at 1st April 2011	545
Total number of participants at 31st March 2012	595
Made up of:	
• Individual Participants	222
• Organisational Participants	373

The total of members and participants on 31st March 2012 is 662.

Equality and Diversity Monitoring Data

Equality and Diversity Monitoring has been carried out for individual members and participants. By the end of March 2012, 84 forms had been received, but 300 had not been returned. Monitoring data for these 84 individuals are provided below:

	No. of individual Participants and Members
Age groups:	
Aged up to 17	0
18 - 24	2
25 - 34	5
35 - 44	11
45 - 54	11
55 - 64	20
65-74	34

	No. of individual Participants and Members
75 and over	1
Gender:	
Male	25
Female	58
Transgender	0
Not Declared	1
Sexual Orientation:	
Bisexual	9
Gay man	1
Lesbian	2
Heterosexual	58
Not declared	14
Ethnic Origin:	
White British	77
White Welsh	0
White Isle of Man	0
White Irish	2
French	0
Estonian	0
Traveller/Gypsy	0
Any other White Background	0
Traveller/Gypsy	0
Black or Black British African	1
Caribbean	0
Asian or Asian British	2
Any other Asian background	0
Chinese or other ethnic group	0
Dual or Multiple Heritage	0
Other ethnic group	1
Not declared	1
Religion/ Faith:	
Buddhist	1
Christian	59
Hindu	2
Jewish	0
Muslim	1
Sikh	0
No religion	13
Other	7

	No. of individual Participants and Members
Not declared	1
Declared Disability:	
Yes	14
Declared Mental Health/Ill Health	
Yes	11

APPENDIX 2

COMMITTEE and MEMBERSHIP at 31 March 2012

The LINk Committee is elected by the membership and is the overall governing body for the LINk. As provided for in its Constitution, some of its powers and responsibilities are delegated to Sub-Committees for day to day working.

Membership of the LINk Committee and its three Sub-Committees for 2011-12 is listed below:

LINk Committee

Individual Committee Members
Diana Hall Hall **(Chair)**
Jill Tompkins **(Deputy Chair)**
Jayne Pye **(Deputy Chair)**
Veronica Parker
Connie Wright
Ben Rogers

Organisational Committee Members
Joan Travis **(Action for Pensioners)**
Pauline Swaby-Wallace **(Bath & Ethnic Minority Senior Citizens' Association - BEMSCA)**
Pat Mawhood **(B&NES Older Learners Forum)**
Pat Jones **(Breathe Easy Bath & District)**
Ronnie Wright **(The Care Forum)**
Theresa Hegarty **(RUH Bath)**

Strategies & Priorities Sub-Committee
Diana Hall Hall
Howard Wreford-Glanvill
Pat Jones
Veronica Parker
Jill Tompkins
Jayne Pye

Engagement Sub-Committee
Jayne Pye
Joan Travis
Jill Tompkins
(Plus other members as and when appropriate)

Governance & Appointments Sub-Committee
Jill Tompkins
Jeremy Key-Pugh
Veronica Parker
Connie Wright

Transition Stream
Diana Hall Hall
Jill Tompkins
Jayne Pye

Engagement Stream
Jill Tompkins
Jayne Pye
Joan Travis

APPENDIX 3

USE OF THE LINK'S LEGAL POWERS, 2011-12

Formal Requests for Information

How many requests for information were made by your LINk during 2011-12?	4
Of these, how many of the requests for information were answered within 20 working days?	4

Formal Enter and View Visits

How many enter and view visits did your LINk make?	0
How many enter and view visits related to health care?	n/a
How many enter and view visits related to social care?	n/a
How many enter and view visits were announced?	n/a
How many enter and view visits were unannounced?	n/a

Formal Reports and Recommendations

How many reports and/or recommendations were made by your LINk to commissioners of health and adult social care services?	*2*
How many of these reports and/or recommendations have been acknowledged in the required timescale?	*2*
Of the reports and/or recommendations acknowledged, how many have led / or are leading to service review?	1
Of the reports and/or recommendations that led to service review, how many have led to service change?	1
How many of these reports/recommendations related to health services?	Not known
How many of these reports/recommendations related to social care services?	Not known

Referrals to OSCs

How many referrals were made by your LINk to an Overview & Scrutiny Committee (OSC)?	0
How many reports were made by your LINk to an Overview and Scrutiny Committee (OSC)?	5
How many of these referrals did the OSC acknowledge?	n/a
How many of these referrals led to service change?	n/a

APPENDIX 4

ENGAGEMENT WITH THE PUBLIC DURING 2011-12

Meeting and Engaging with the Public, 2011-2012

12/04/2011	Equality Act Event
19/04/2011	Hospital Discharge Working Group meeting
16/05/2011	CQC/LINk meeting
23/05/2011	Visit to The Big Issue
15/06/2011	Facilitated at Healthy Conversation meeting
27/06/2011	Bath Association for Disabled People AGM
30/06/2011	Community@67 Open Day – Networking
05/07/2011	LINk stand at Healthy Conversation meeting
14/07/2011	Visit to the Lymphoedoeda Support Group with the Wiltshire LINk
18/07/2011	Meeting with NAS re B&NES Adult Autism Group
20/07/2011	Visit to MOSAIC – Bath MIND
01/08/2011	CQC/LINk meeting
03/10/2011	Visit to DHI Rural Recovery Hub
19/10/2011	Development Workers meeting
16/11/2011	LINk stand at Health and Wellbeing Board meeting
21/11/2011	Workplan meeting
24/11/2011	NAS/LINk meeting re B&NES Adult Autism Group
28/11/2011	CQC/LINk meeting
04/01/2012	Care Home visits meeting
16/01/2012	Care Home visits meeting
24/01/2012	Care Home visits meeting
01/02/2012	1st Care Home visit and debrief
06/02/2012	Planning meeting for 17 Feb B&NES Adult Autism meeting
24/02/2012	2nd Care Home visit and debrief
27/02/2012	CQC/LINk meeting
20/03/2012	3rd Care Home visit and debrief

Distribution of Information about the LINk, 2011-12

Tri Fold	A5 Flyer	News-letter			Q/Survey	Q/Survey completed	Web Link	Press Article or mention	Event/ Meeting / Place	Date	Date
20									As and when	07/04/2011	07/04/2011
		318								18/04/2011	18/04/2011
		307								18/04/2011	18/04/2011
								1	Bath Chronicle	21/04/2011	21/04/2011
										01/05/2011	01/05/2011
										01/05/2011	01/05/2011
1		1			1				Refugee Action	11/05/2011	11/05/2011
1		1							Gay West	18/05/2011	18/05/2011
10	10								Equality Workshop	19/05/2011	19/05/2011
1		1			1				MOSAIC	20/05/2011	20/05/2011
20	20	20			9	9			Big Issue	23/05/2011	23/05/2011
1					1		1		EACH	26/05/2011	26/05/2011
1		1			1				Living Springs MCC	27/05/2011	27/05/2011
										01/06/2011	01/06/2011
										01/06/2011	01/06/2011
10		10							Hop Skip & Jump	03/06/2011	03/06/2011
1		1			1				LGBT	08/06/2011	08/06/2011
25	15								Healthy Conversations	15/06/2011	15/06/2011
20	20	10							BADP AGM	27/06/2011	27/06/2011
20	15								Bath LC	29/06/2011	29/06/2011
20	10	10							Community@67 Keynsham	30/06/2011	30/06/2011
1		1							Keynsham Police Station	30/06/2011	30/06/2011
1		1							Keynsham South Forum	30/06/2011	30/06/2011
									WPA	30/06/2011	30/06/2011
1		1							Avon Fire Rescue Service	30/06/2011	30/06/2011
1		1			1				YAGA/Childrens Society	30/06/2011	30/06/2011
1		1			1				Keynsham Youth		

Tri Fold	A5 Flyer	News-letter			Q/Survey	Q/Survey completed	Web Link	Press Article or mention	Event/ Meeting / Place	Date	Date
									Service		
1		1							Natural Food School	30/06/2011	30/06/2011
157	**90**	**686**			**16**	**9**	**1**	**1**			
20		7				7			Gay West	02/07/2011	02/07/2011
1									Francesca Thompson, RUH	12/07/2011	12/07/2011
10						3			MOSAIC	20/07/2011	20/07/2011
16	16	10							Lymphoedoema Support Group	14/07/2011	14/07/2011
26									The Carers Centre	12/08/2011	12/08/2011
20	10	1							The Women's royal army Corps Ass' Bath	09/09/2011	09/09/2011
32	32	677								1 July-30 Sept	1 July-30 Sept
125	**58**	**695**				**10**					
20		40	20		20	2			DHI Recovery Hub MSN	03/10/2011	03/10/2011
7									Autism Meeting	24/10/2011	24/10/2011
14	14	653								Various	Various
41	**14**	**693**	**20**		**20**	**2**					
20				1					Bath Library	24/01/2012	24/01/2012
20				2					RNHRD	24/01/2012	24/01/2012
20				1					PALS RUH - outside office	24/01/2012	24/01/2012
10									RUH café - main entrance	24/01/2012	24/01/2012
				1					RUH B12-B13 corridor	24/01/2012	24/01/2012
15				2					RUH - Adult Care & Childrens Social Care	24/01/2012	24/01/2012
30									Council Connect - Bath	24/01/2012	24/01/2012

Tri Fold	A5 Flyer	News-letter			Q/Survey	Q/Survey completed	Web Link	Press Article or mention	Event/ Meeting / Place	Date	Date
30									The Guildhall Bath	24/01/2012	24/01/2012
30				2					Bath NHS Healthcare Centre (Formerly The Riverside Health Centre)	24/01/2012	24/01/2012
30				3					City of Bath College via SU	24/01/2012	24/01/2012
15									Susan Moran PM West View Surgery	02/03/2012	02/03/2012
15									Mr Roger Stead PM Fairfield Park Health Centre	02/03/2012	02/03/2012
15									Michelle Creed PM St. Michael's Surgery	02/03/2012	02/03/2012
15									Martin Pickbourne PM Newbridge Surgery	02/03/2012	02/03/2012
15									Stuart Cowper PM The Pulteney Practice	02/03/2012	02/03/2012
15									Sue Fell PM Keynsham Health Centre	02/03/2012	02/03/2012
15									Sharon Taylor PM Elm Hayes Surgery	02/03/2012	02/03/2012
15									Helen Harris PM Number 18 Surgery	02/03/2012	02/03/2012
15									John Moon PM St. Augustine's Surgery	02/03/2012	02/03/2012
15									Mrs. Elizabeth Best PM Oldfield Surgery	02/03/2012	02/03/2012
15									Charles Richardson PM St. Chad's Surgery	02/03/2012	02/03/2012
15									Mrs. Heather Du Plessis PM Batheaston Medical Centre	02/03/2012	02/03/2012
15									Mrs Judy Robinson PM Harptree Surgery	02/03/2012	02/03/2012

Tri Fold	A5 Flyer	News-letter			Q/Survey	Q/Survey completed	Web Link	Press Article or mention	Event/ Meeting / Place	Date	Date
15									Mrs Susan Matthews PM Widcombe Surgery	02/03/2012	02/03/2012
15									Karen Slade, PM Combe Down Surgery	02/03/2012	02/03/2012
15									Ann Davis PM Hope House Surgery	02/03/2012	02/03/2012
15									Rachael Eade PM Grosvenor Place Surgery	05/03/2012	05/03/2012
15									Lucy Hitchcock PM Weston (& Rush Hill) Surgery	05/03/2012	05/03/2012
15									Kate Davenport PM Chew Medical Practice	05/03/2012	05/03/2012
15									Lizzie Doman PM University Medical Centre	05/03/2012	05/03/2012
15									Pat Giles PM Monmouth Surgery	05/03/2012	05/03/2012
15									Martin Pickbourne PM St. James' Surgery	05/03/2012	05/03/2012
15									Ms Caron Standerwick PM Somerton house Surgery	05/03/2012	05/03/2012
15									Lea Trevor PM Catherine Cottage Surgery	05/03/2012	05/03/2012
15									Mrs Jackie Yates PM St Marys Surgery	05/03/2012	05/03/2012
15									Anne Davies PM Hillcrest Surgery	05/03/2012	05/03/2012
15									Dawn Davies PM Westfield Surgery	05/03/2012	05/03/2012
15									Mr Philip Kelley PM Bath NHS Healthcare Centre	05/03/2012	05/03/2012
20									Keynsham Library	06/02/2012	06/02/2012

Tri Fold	A5 Flyer	News-letter			Q/Survey	Q/Survey completed	Web Link	Press Article or mention	Event/ Meeting / Place	Date	Date
20									Keynsham Health Centre (Temple House Surgery is part of)	06/02/2012	06/02/2012
20									Riverside Keynsham B&NES Council Connect	06/02/2012	06/02/2012
15									Keynsham Lloyds Chemist	06/02/2012	06/02/2012
20									Keynsham Town Hall	06/02/2012	06/02/2012
30									Carers Centre-Carers Forum	07/03/2012	07/03/2012
20									Information Take Away	26/03/2012	26/03/2012
10									Circle Bath	23/03/2012	23/03/2012
780	**0**	**0**	**0**	**12**	**0**	**0**					

APPENDIX 5

Diversity of Engagement - Gap Analysis Report Follow-Up Project, February 2011- July 2011

A baseline Gap Analysis review was completed in December 2010 to monitor the diversity of the engagement work carried out by the B&NES LINk during that year. From this, it was identified that there was an under-representation of males, the under 65's (including those under 19), the employed (males and females) and individuals from the gay, lesbian and transgendered communities. In addition, a slight under-representation was shown in black and ethnic minority groups of *White Other*, *Asian*, *Black*, *Mixed-Heritage* and *Travellers – other*. It was also noted that representation from Faith organisations was relatively low. The 2010 Gap Analysis is included as **Annex 1** to this Appendix.

In February 2011 we began a Gap Analysis engagement project, the aim of which was to engage with members of the community in B&NES that we had found to be under-represented, and to increase their involvement in the LINk.

We created a short survey Questionnaire (included in **Annex 2** below), to gather people's views and to ask if there was any support we could give to help them to become involved with the work of the LINk. We reviewed the engagement database and selected relevant organisations to contact in order to engage with target groups. We also researched organisations previously not contacted to target harder to reach groups such as males and the employed, e.g. The Police and The Ministry of Defence. We offered to visit groups with surveys, or to send out via email or post. We also asked those who completed the survey to fill in an *Equality and Diversity Monitoring* form so that we could check whether we were engaging effectively (see **Annex 3** below).

We initially focussed on contacting large local employers whose workforce would match our biggest under-represented groups, i.e. the MOD, The Police, the Royal Mail and The Fire Service. Following this we targeted organisations, employers and groups in B&NES to reach other under-represented groups. We were surprised at the considerable amount of time and resources required to identify the correct person to take onus and embrace our community involvement project and coordinate the completion of the surveys. **Annex 4** of this Appendix gives full details of who we contacted and what the outcomes were.

As **Annex 4** shows, we contacted each of the 49 organisations by email or letter, and requested their support in asking their staff or members to complete our survey. We diarised to email or write to each of the organisations for a second time, if they did not reply the first time, so that we maintained contact and momentum. We understand that most organisations are busy and receive many emails/letters, so we felt that sending a gentle reminder would be helpful and give people another opportunity to respond and be involved in our survey.

Disappointingly we received replies from less than half of those contacted and only a few accepted our offer to become involved in the survey. The most common reason given for organisations being unable to get involved was lack of resources. However, those that have asked to complete the survey have been very keen to be involved and have provided us with lots of information and useful feedback that we can take forward. We have made visits and completed surveys face to face at The Big Issue, Mosaic, (run by Bath MIND) and the Rainbow

Café, (run by GayWest). We received good feedback from all three and praise for our friendly approach. What worked well worked really well and we are very proud and appreciative of the positive foundations that we have started to build with these organisations and hope to develop these further in the future. It is important to us that we have a good rapport with our partner organisations and that we foster a mutually beneficial working relationship. We completed individual reports for each of the three visits that we made, and these can be read at **Annex 5** below..

The review of the Gap Analysis also suggested that we would benefit from increased engagement with Faith groups and so we have begun to address this by contacting several groups and hope to carry out some partnership work in the future.

Conclusions

Although we were not successful in meeting with many of the under-represented groups, those we did meet with were very happy for us to engage with their members and we identified many useful things to consider when engaging with the public.

We discovered that:

- Completing surveys/forms face to face can be very effective as it allows for human connection and people feel they are really being listened to.
- Some people are more comfortable if they are presented with questions face to face as this allows for the aim of the survey to be explained and support can be given when completing the form.
- Completing surveys/forms is less of a chore whilst chatting to a LINk representative.
- Visiting groups to complete the survey gives the LINk a face and makes it real.
- Some people would rather complete face to face but in private, as they feel more comfortable this way - some issues may be confidential and/or sensitive issues.

One of the main groups of the community that we continue to struggle to engage with is the employed. It is difficult to engage with the employed since they are working the same hours as the Host and we conclude that the only way of gaining their views is by having real and proactive support from employers, some ideas of achieving this are;

- By circulating our survey with a condition to respond, via email or post
- By enabling the LINk to visit the workplace and allowing employees the time to complete a survey, either with us 1:1 or time to complete themselves
- By tasking a member of staff with being a member if the LINk with the responsibility of attending LINk Committee meetings and keeping up with the work of the LINk and then reporting back to the organisations to keep them informed.

What are we going to do with the information that we have gained?

1. The individual engagement reports have been sent to relevant service providers, e.g. The PCT and The RUH, to inform on peoples experiences of health and adult social care services and to provide guidance when planning services.
2. The lessons that we have learnt about effective ways to engage and the barriers that still pose a problem, will help us when we proceed with any future public engagement.
3. This information will be passed on to Local HealthWatch, so that they may benefit from what we have learnt and move forward more effectively with this knowledge.

[Appendix 5]
Annex 1

B&NES LINk
Gap Analysis Review of Membership and Engagement
December 2010

In September 2009, a gap analysis was carried on the B&NES LINk membership to identify how representative the individual membership was in relation to the population of B&NES. It was discovered from the members that had returned forms, that the membership had a good representation of those declaring an impairment or disability, that the LINk was over-represented by those who had experienced problems with mental health, the over 65 age group, carers, women and retired people.

Areas of under-representation were males, the under 65s (particularly those under 19), the employed and just slightly for the unemployed. Under-representation was shown in the Black and Minority Ethnic groups of white other, Asian, black, mixed heritage and travellers-other and there was also under-representation of gay men and lesbian women. The number of members on B&NES LINk means that a representative figure for transgender would be less than one person and currently no-one has indicated being transgender from our monitoring forms.

Since the end of December 2009 the LINk membership has an overall increase of 28 individuals (8%) and 72 organisations (56%).

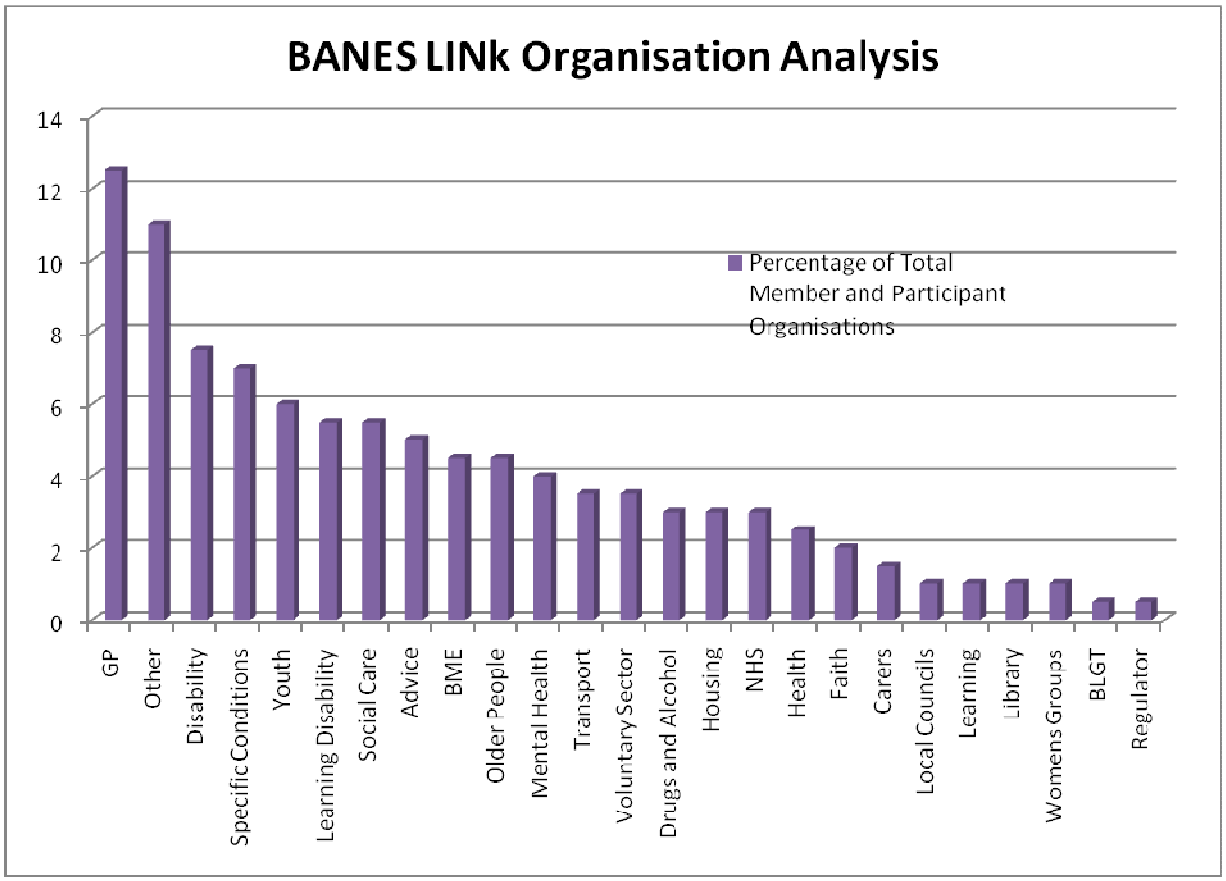
To review the representation of LINk individual member and participants, a re-monitoring exercise is required. We use an anonymous monitoring system, but this means that if people leave the LINk, we have not been able to remove their monitoring statistics. Since April 2010 we have had 19 leavers, but as there are plans to replace LINks with Healthwatch, it was not felt appropriate to carry out a re-monitoring exercise at this time. This will be reviewed in June 2011.

As preparation for the LINk Annual Report 2010/11, a full review of Engagement events will be carried out to identify any potential gaps in the diversity of engagement. In summary, an event was held in April 2010 to increase member, participant and community involvement in the LINk. A diverse number of voluntary sector events and group meetings are also attended by the LINk team. The website was also redesigned by a local design and events consultancy, and this went live early in 2010, to help make LINk more accessible. The B&NES LINk has also continued to work closely with the Bath and North East Somerset Health and Wellbeing Network and promoted the LINk at many of their “Healthy Conversation” events.

Review of the diversity of organisational members and participants

In December 2010, all LINk organisation members and participants were categorised according to their primary area of work, to gauge the diversity of organisations involved with the LINk or on its circulation. The attached chart shows the organisations categorised into equality and diversity areas. There were a total of 200 organisations, 25 of which were members and 175 participants. Groups that are not represented on the membership by organisations are males, working age adults, the employed (specifically through private sector

businesses), although public sector and voluntary sector organisations will be covered through the organisational membership.
Based on the 2009 gap analysis information for individuals, the continued gaps on the LINk membership are males, the employed, 19-64 year olds, gay men and lesbian women. Individuals with a black or minority ethnicity were slightly under-represented, but it is noted that representation of BME organisations forms 5% of all organisations on the LINk. This is a significant increase on 2009. Younger people under 19 were also under-represented on the individual membership, but the organisational breakdown shows a good representation from Youth organisations. Representation from Faith organisations is relatively low and the LINk could benefit from further engagement in this area.



[Appendix 5]
Annex 2

THE QUESTIONNAIRE

Community Involvement in Shaping Health and Social Care Services

Please can we ask for 5 minutes of your time to complete this short survey.
Please answer accordingly.

1) Have you heard of the LINk (Local Involvement Network)? YES/NO

2) What issues have affected you or do you have an interest in? Please add comments below:

Carers - Caring for somebody or being cared for

Hospital Discharge – Services and issues relating to release from hospital

Disability – In particular, access to services

Other issues relating to Health and Social Care

3) Do you feel it is important for your views on Health & Social Care Services to be heard? YES/NO

4) Would you like to get involved in helping us to improve services? YES/NO

5) If 'Yes' please provide contact details:

6) Are there any barriers that would stop you from getting more involved, if so what are these?

7) How can we as a voluntary organisation enable you and others to become more involved?

So that we can check that we are engaging effectively, please can you complete our Equality and Diversity form. Thank you for your time, the information you have given is important to us and will help us to understand how we can involve more of the community in shaping their local services.

[Appendix 5]

Annex 3

Equality and Diversity Monitoring Questionnaire

Please tell us about yourself by ticking the appropriate boxes and return the form by post or by e-mail to contact@baneslink.co.uk, if you receive this electronically.

What age group do you belong to?

17 or under ☐ 18 – 25 ☐ 26 – 39 ☐ 40 – 49 ☐ 50 – 59 ☐ 60 – 69 ☐ 70 or over ☐

Gender

Male ☐ Female ☐ Transgender ☐ Prefer not to specify ☐

Sexual Orientation

Bisexual ☐ Gay Man ☐ Heterosexual ☐ Lesbian ☐ Prefer not to specify ☐

Working Status

Work part time (less than 35 hours per week) ☐

Work full time (35 hours or more per week) ☐

Retired ☐ Unemployed ☐ Unable to work due to long term sickness ☐

Student ☐ Carer ☐

How would you describe your ethnic origin?

White		**Black or Black British**	
British	☐	**African**	
Irish	☐	Ghanaian	☐
Any other White Background		Kenyan	☐
Albanian	☐	Nigerian	☐
Greek/Greek Cypriot	☐	Somali	☐
Kosovan	☐	South African	☐
Turkish/Turkish Cypriot	☐		
Other (please specify below)	☐	**Caribbean**	☐
		Any other black Background (please specify below)	☐

sian or Asian British		**Dual or Multiple Heritage**	
Indian	☐	White and Asian	☐
Pakistani	☐	White and Black African	☐
Bangladeshi	☐	White and Black Caribbean	☐
		Any other dual or multiple heritage (please specify below)	☐
Cont. pg2.			
Any other Asian background		**Traveller/Gypsy**	
Sri Lankan	☐	Gypsy/Roma	☐
Mauritian	☐	Traveller	☐
Other (please specify below)	☐	Other (please specify below)	☐
Chinese or other ethnic group			
Chinese	☐		
Any other ethnic background (please specify below)	☐		

Faith

Yes ☐ No ☐ Prefer not to answer ☐

If Yes, please specify

Disability

Do you consider yourself to have a disability as defined by the Disability Discrimination Act 1995. The Act defines disability as: "a physical or mental impairment which has substantial and long-term effect on a person's ability to carry out normal day to day activities".

Yes ☐ No ☐

Do you have a mental health issue or are you a user of mental health services?

Yes ☐ No ☐

[Appendix 5]

Annex 4

2011 Gap Analysis "Plug the Gaps"

Contact	Date letter/e-mail sent	Reply received after initial letter/email	Action/follow up	Reply Received after follow up letter/email	Action/Follow up
TARA (The Abbey Residents Association) (FoBRA) Mem	28/02/2011	05/03/2011	waiting for decision if they will distribute and collect our survey		No reply- NFA
Bath Bus User's Group (FoBRA) Affiliate Mem	28/02/2011		Follow up email sent 11/04/2011 to ask why no reply	15/04/2011	NFA - not the capacity to be involved in the survey
Bath City FC	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
Bath Rugby Club	14/02/2011		Follow up email sent 17/03/2011to ask why no reply		No reply - NFA
Bath Spa Uni	15/02/2011		Follow up letter sent 17/03/2011to ask why no reply	30/03/2011	NFA - lack of resources & reached survey limit
Bathwick Estate Residents' Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011 to ask why no reply	11/04/2011	They expressed interest -emailed updated survey. No reply -NFA
Bathwick Hill Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011 to ask why no reply	11/04/2011	NFA - not their area, poor uptake of surveys by members

Beech Avenue Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011		No reply - NFA
Contact	**Date letter/e-mail sent**	**Reply received after initial letter/email**	**Action/follow up**	**Reply Received after follow up letter/email**	**Action/Follow up**
Big Issue (The)	07/04/2011	Tel call & email 07/04/2011	CP & Jo - coffee morning 23 May with vendors completed 9 surveys 1:1		CP & Jo completed a report & hand delivered 8/06/11
Bristol Law Society	17/03/2011			22 & 31/03/2011	NFA - not enough B&NES members to warrant putting our survey on their website
Camden Association (FoBRA) Mem	28/02/2011	01/03/2011	awaiting committee meeting decision 10 March if they will distribute and collect our survey		No reply- NFA
City of Bath College	15/02/2011		Follow up letter sent 17/03/2011to ask why no reply	25/03/2011	NFA -lack of time to be involved, 1 survey completed
EACH	Met at Workshop on 19/05/11- sent email 26/05/2011				No reply - NFA
Fire Station- Chew Magna	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
Fire Station -Paulton	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
Fire Station-Bath	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA

Fire Station-Keynsham	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
Contact	**Date letter/e-mail sent**	**Reply received after initial letter/email**	**Action/follow up**	**Reply Received after follow up letter/email**	**Action/Follow up**
Fire Station-Radstock	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
Federation Of Bath Residents Association (FoBRA)	15/02/2011	27/02/2011	Advised to contact each Resident Association individually		Contact each Res Assoc.
GayWest	18/05/2011	18/05/2011	visit to the Rainbow Café 2 July - Jo & Jill Tompkins – completed 7 surveys		
Genesis Trust	15/07/2011				No reply -NFA
Green Park Residents Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011		No reply - NFA
Keynsham RFC	15/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
LGBT University of Bath	08/06/2011				No reply, however this is probably due to the holidays. NFA
Living Springs MCC	27/05/2011	02/06/2011	Kieren is considering involvement in the survey & will be in touch		No reply -NFA

London Road Area Residents' Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011to ask why no reply	12/04/2011	NFA - already taken part in National NHS survey.
Contact	**Date letter/e-mail sent**	**Reply received after initial letter/email**	**Action/follow up**	**Reply Received after follow up letter/email**	**Action/Follow up**
M&S	11/02/2011		Follow up letter sent 17/03/2011to ask why no reply		NFA - no response
MOD	11/02/2011		Follow up email sent 17/03/2011to ask why no reply	25/03/2011	08/06 tel call - Kevin advised of a delay in sending out our survey due to other surveys circulating. 26/07/11 due to organisational changes the survey has not been distributed. NFA
MOSAIC	20/05/2011	20/05/2011	Carole & Jo visited on 20 July- 3 surveys completed		

Police Station- Bath	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply	23/03/2011	05/04/2011Chief Inspector Ellis authorised Serg. Beatrice Hayes to send survey to all police in B&NES, but to say not compulsory. Serg. Hayes completed a survey - no other responses received. NFA
Contact	**Date letter/e-mail sent**	**Reply received after initial letter/email**	**Action/follow up**	**Reply Received after follow up letter/email**	**Action/Follow up**
Police Station- Keynsham	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply		* see Bath Police
Police Station-Radstock	14/02/2011		Follow up letter sent 17/03/2011to ask why no reply	23/03/2011	* see Bath Police
Pulteney Estate Residents' Association (FoBRA) Mem	28/02/2011		Follow up email sent as to why no reply 11/04/2011		No reply - NFA
Refugee Action	11/05/2011				No response - NFA
(The) Royal Crescent Society	28/02/2011		Follow up email sent 11/04/2011to ask why no reply		No reply - NFA
Royal Mail Bath	11/02/2011		Follow up letter sent 17/03/2011to ask why no reply	24/03/2011	NFA – reply to us lack of time/ resources
Sion Hill Place Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011to ask why no reply		No reply - NFA

Student Union City of Bath College	11/02/2011		Follow up letter sent 17/03/2011to ask why no reply	23/03/2011	NFA – not able to be involved this time – invited to contact in future re other surveys if relevant
Student Union University of Bath	11/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply- NFA
Contact	**Date letter/e-mail sent**	**Reply received after initial letter/email**	**Action/follow up**	**Reply Received after follow up letter/email**	**Action/Follow up**
Student Union Uni of Bath Spa	15/02/2011		Follow up email sent 17/03/2011to ask why no reply		No reply - NFA
Sydney Buildings Association (FoBRA) Mem	28/02/2011		Follow up email sent 11/04/2011to ask why no reply	11&19/04/2011	NFA - did not feel qualified to answer the questions
Unison - Avon and Somerset Police Branch	17/03/2011				NFA - since Bath HO Police helping us already
Unison - Bath Health Branch - RUH	17/03/2011		Follow up sent 10/05/11 to ask why no reply		NFA - no response
Unison - Bath Spa University College Branch	17/03/2011		Follow up sent 10/05/11 to ask why no reply	10/05/2011	Liz Rack to send survey to Welfare Officer to be emailed to their members – no responses - NFA
Unison - Bath & North East Somerset Council Branch	17/03/2011		Follow up sent 10/05/11 to ask why no reply		No response - NFA
Unison - University of Bath Branch	17/03/2011		Follow up sent 10/05/11 to ask why no reply		No response - NFA

University of Bath	15/02/2011		Follow up letter sent 17/03/2011to ask why no reply		No reply - NFA
Wellsway School	15/02/2011		Follow up email sent 17/03/2011to ask why no reply		No reply - NFA
Widcombe Association (FoBRA) Member	28/02/2011	28/02/2011	8 March Committee meeting discussed our survey - their membership will not plug our gaps. Thanked for reply.		NFA

[Appendix 5]
Annex 5

B&NES LINk - Engagement Report – The Big Issue

Introduction

Carole and Jo visited The Big Issue on Monday 23rd May 2011; the target audience were Big Issue vendors. (Posters were circulated prior to the visit, see poster attached)

The aim was to:

Engage with individuals identified as under-represented by our December 2010 Gap Analysis; listen to their views and to ask them to complete our survey (appendix a) and our Equality and Diversity Form (appendix b).
Network with other relevant organisations.

Achievements

- 9 completed surveys
- 9 Equality and Diversity Monitoring forms
- 2 new Individual Participants

Spoke with Spike and a volunteer from DHI, who gave us the name of Jo Gibbins as a person to for us to contact at DHI to do some future work with regarding people with drug and alcohol issues.
Met and talked with volunteers at The Big Issue.
Our visit was mentioned in The Big Issue newsletter

Information Gathered

Equality and Diversity Monitoring (for those who agreed to complete form)

Age Group		Ethnic Origin		Gender		Sexual Orientation	
17 or under	=	White British	= 6	Male	= 7		
18 – 25	= 1	White Irish	= 1	Female	= 2	Heterosexual	= 7
26 – 39	= 3	White Scottish	= 1	Transgender	=	Bisexual	= 1
40 – 49	= 2	Hungarian	= 1			Gay man	=
50 – 59	= 3					Lesbian	=
60 – 69	=					Prefer not to specify	= 1
70 or over	=						

Mental Health Issue		Religion/Faith		Disability		Working Status
Yes	= 2	Christian	= 3	Yes	= 2	Work full time = 4
No	= 7	Spiritual	= 1	No	= 7	
		Buddhist	= 1			Self employed = 5
		None	= 4			

Community Involvement in Shaping Health and Social Care Services Survey – Information gathered

Have you heard of the LINk?

Yes = 0
No = 9

What issues have affected you or do you have an interest in?

Carers

- Informal Carer to boyfriend – do not need any support.
- I looked after a friend for a long time. I had lots of help from GP's etc.

Hospital Discharge

- Good after care for my friends Hep C condition

Disabilities

- No comments given about services

Other Issues and comments

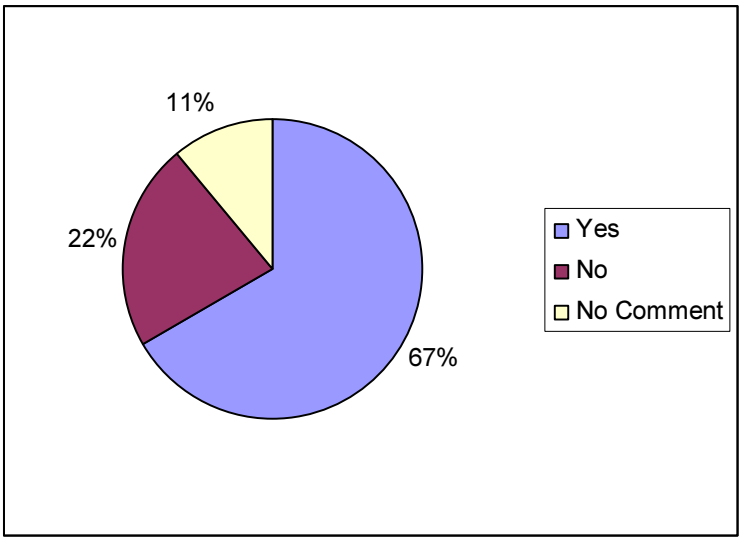
- I have not been treated with respect or the same as other patients at the RUH and at Pulteney Bridge Dental Practice. I believe this is because I am on Methadone. I went to the walk in clinic and was given a pregnancy test and told to visit my GP, which I did. My GP said that he was going to do a pregnancy test and examine me, but as soon as he looked at my file which says I am on Methadone, he suggested that I had a termination, gave me a pack and told me to see the midwife in a week. He did not examine me or do a pregnancy test. I do not like to complain because I do not want people to think worse of me. In hospital, they think that you are a waste of resources if you are on Methadone, and that the money is better used on someone else.

- Doctor is ok, registered ok. Regular check ups with dentist.

- RUH and GP do not treat me the same as other patients because I am on Methadone, they do not give me the time.

- Good support provide in B&NES for the homeless (food provided at night).

- Do you feel that it is important for your views on health and social care services to be heard?



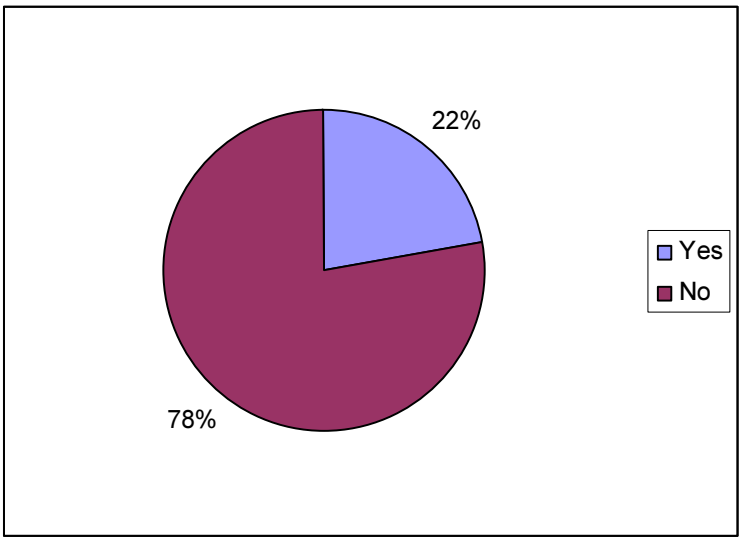
Yes = 6

- But, there is no point as nobody listens.
- I am just as important as anyone else.
-

No = 2

No Comment = 1

Would you like to get involved in helping us improve services?



Yes = 2
No = 7

Are there any barriers that would stop you from being involved?

Yes = 3

- People judging me and thinking that I should not have a view
- I don't have the time
- My criminal record

No = 6

How can we as a voluntary organisation enable you and others to become involved?

- Food is a good incentive
- Don't know
- Advertise in the Big Issue
- Reach out on a 1:1 basis – meet at the Big Issue office
- Offer an incentive

Conclusions and things to take forward

- Look into the possibility of placing a B&NES LINk advert in the Big Issue – contact has been made with Alex Hobbis to take this forward.
- Send a LINk Committee meeting poster to the Big Issue Office before every meeting to be posted in the window – email address has been added to the mailing list.
- Invite members of The Big Issue staff and vendors to give a presentation at a LINk Committee meeting. This has been discussed, and the 4th October meeting has been noted as the probable date.

B&NES LINk - Engagement Report - GayWest

Introduction

Jill Tompkins and Jo Leighton visited The Rainbow Café run by GayWest on Saturday 2 July 2011; to engage with the visitors to the café. The aim was to:
Engage with individuals identified as under-represented by our December 2010 Gap Analysis; listen to their views and to ask them to complete our survey (appendix a) and our Equality and Diversity Form (appendix b).
Network with other relevant organisations.

Achievements

7 completed surveys
7 Equality and Diversity Monitoring forms
3 new Individual Participants
20 leaflets given out
7 newsletters given out

Information Gathered

Equality and Diversity Monitoring (for those who agreed to complete one)

Age Group		Ethnic Origin	Gender		Sexual Orientation	
17 or under	=	White British = 7	Male	= 7	Heterosexual	=
18 – 25	=		Female	=	Bisexual	=
26 – 39	= 1				Gay man	= 7
40 – 49	=				Lesbian	=
50 – 59	= 2				Prefer not to specify	=
60 – 69	= 2					
70 or over	= 2					

Mental Health Issue		Religion/Faith		Disability		Working Status	
Yes	= 4	Yes	= 2	Yes	= 1	Work full time	= 2
No	= 3	No	= 3	No	= 6	Self employed	= 1
		Other	= 1			Retired	= 4
		Prefer not to answer	= 1				

Community Involvement in Shaping Health and Social Care Services Survey – Information gathered

Have you heard of the LINk?

Yes = 1
No = 5
No answer given = 1

What issues have affected you or do you have an interest in?

Carers

- It was reported by a carer that they would have benefited from being able to access respite care, more practical support and more knowledge of relevant support agencies.
- Better liaison with carer was needed to explain details of the many medication changes because the patient was an older lady who had difficulty understanding. It was not checked if the patient had someone to support them at home with medication and other care needs.

Hospital Discharge

- A patient was moved from the RUH to St. Matins, but their family were not informed. They only discovered the move when they arrived at the hospital to visit.
- There was not a continuity of staff and the family spoke to a different person each time they called or visited.
- Everything was explained well.
- On two visits to the RUH for Diabetes Type 1 my needs were not met. Once I was not told my blood glucose level. A second time, I was refused to go home because my glucose level was 22, but as soon as I left it was below 10.
- A patient was discharged from the BRI on the day of a 3 hour operation. No checks were made on his post hospital arrangements and he lives in Cardiff, he had no transport and nowhere to stay in Bristol. This has been passed on to the Bristol LINk.

Disabilities

- An older lady was assessed at home due to a mobility issue and although a walking stick was provided, the assessment was only brief and more practical support would have been helpful.

Other Issues and comments

- Excellent service and treatment for skin cancer at the RUH.
- Excellent day treatment.
- It was said that the service and support was good at the RUH.
- Wonderful service at the RUH.
- Dr. Davidson at Grosvenor Place Surgery is a very good and sympathetic doctor.
- The sexual health clinic at the RUH is very good.
- Problems with collection of medical waste. Yellow bags for sharps and hazardous waste. Dangerous for children and older people.
- Some improvement needed in referral of people needing AA guidance.
- A GP advised a patient that an appointment would be arranged for an ultra sound scan and 2 weeks later there was no news. The patient felt that this was rather a long delay in hearing about an appointment.
- Generally happy with GP services.

Do you feel that it is important for your views on health and social care services to be heard?

Yes = 7
No = 0

It was thought that it is important that good feedback is given as well as the negatives.

Would you like to get involved in helping us improve services?

Yes = 3
No = 2
Possibly = 1
No answer = 1

It was thought that it is important that good feedback is given as well as the negatives. Happy to make statements if visited and asked, but not the time to be more involved.

Are there any barriers that would stop you from being involved?

Yes = 3

- I don't have the time x 2
- Not good in meetings

No = 2
No answer = 2

How can we as a voluntary organisation enable you and others to become involved?

- By attending the GayWest Rainbow Café on Saturday mornings and asking the members.
- Going out to different groups to let them know who the B&NES LINk is and explaining what we do.
- More publicity - placing posters and leaflets in various locations.

Some notable findings

- 100% of those that we spoke thought that it was important for their views on their local health and social care services to be heard.
- Only 2 out of 7 said that they would not like to be involved in helping us to improve services.
- 5 out 7 of the people said that a good way for the LINk to listen to people's views would be to visit them at group meetings, for example GayWest at their Saturday morning Rainbow Café.
- 3 out of 7 people independently reported good service at the RUH

Conclusions and things to take forward

The visit was a success and was felt to be a good way, by the members of GayWest that were spoken to, for the LINk to listen to and gather their views on local health and

social care services. It was agreed for the LINk to maintain contact with GayWest and to visit the Rainbow Café again in the future.

A copy of this report will be sent to GayWest, The RUH, St. Martins, The Carers Centre, PCT, the GP Consortium Committee and Dr. Davidson at Grosvenor Place.

The issue regarding the BRI will be sent on to the Bristol LINk.

A LINk Committee poster will be sent to the building that houses the Rainbow Café every month to help increase awareness of the LINk and encourage new members of the public to attend meetings.

Leaflets can be hand delivered regularly.

B&NES LINk - Engagement Report - Mosaic

Introduction

The Development Worker Carole Pullen and Jo Leighton the Assistant Development Worker visited MOSAIC, run by Bath MIND on Wednesday 20 July 2011. Mosaic is a social group and one to one support for service users and their carers from all ethnic minority and/or cultural backgrounds.

The aim was to:
Engage with individuals identified as under-represented by our December 2010 Gap Analysis; listen to their views and to ask them to complete our survey (appendix a) and our Equality and Diversity Form (appendix b).
Network with other relevant organisations.

Achievements

3 completed surveys
3 Equality and Diversity Monitoring forms
1 new Individual Participant

Information Gathered

Equality and Diversity Monitoring (for those who agreed to complete one)

Age Group	Ethnic Origin	Gender	Sexual Orientation

17 or under =	Anglo Indian = 2	Male = 1		Heterosexual= 2
18 – 25 =	Sri Lankan = 1	Female = 2		Prefer not to specify = 1
26 – 39 =				
40 – 49 =				
50 – 59 = 1				
60 – 69 = 1				
70 or over = 1				

Mental Health Issue	Religion/Faith	Disability	Working Status
Yes = 3	Catholic = 2	Yes = 2	Unemployed = 1
No =	Other = 1	No = 1	Retired = 2

Community Involvement in Shaping Health and Social Care Services Survey – Information gathered

Have you heard of the LINk?

Yes = 1
No = 2

What issues have affected you or do you have an interest in?

Carers

- I have carers to help me do some things, all ok.
- Only get 1-2-1 support for help with a computer.

Hospital Discharge

- Has been in the RUH twice this year and all ok, no issues.

Disabilities

- No issues reported

Other Issues and comments

- Uses the support services at BEMSCA and MOSAIC, no other support offered.

Do you feel that it is important for your views on health and social care services to be heard?

Yes = 3
No = 0

One person said that they do not think that anybody listens.

Would you like to get involved in helping us improve services?

Yes = 1
No = 2

Are there any barriers that would stop you from being involved?

All three listed barriers, which were, not got the time, not much time as looking for work and feel too old to get involved.

How can we as a voluntary organisation enable you and others to become involved?

- Good to visit local support groups.
- Better 1-2-1, possibly at home without interruptions, so you are able to talk privately. More publicity - placing posters and leaflets in various locations.

Conclusions and things to take forward

The day was a good first visit for the members and staff at MOSAIC to get to know a little bit about LINk and for us to get to know what happens at the drop in held every Wednesday. We were made to feel very welcome and we able to join in with the music activity that was happening and chat to people over coffee and lunch. However, many did not feel comfortable to fill in a questionnaire with us and several people expressed that they would prefer to speak 1-2-1 in private. The group is set up to offer relaxed environment and most members go regularly, so it is well established. We were new to the group and were very mindful to be respectful of people's space and to fit in with the group as much as possible. We both felt that it was not appropriate to bother or interrupt people that attend the group because of its hassle-free and familiar environment. We feel that in future it would be more suitable and less intrusive to support members of the group to voice their views on local health and social care services in a way comfortable for them. It was agreed for the LINk to maintain contact with MOSAIC and to possibly visit again in the future.

We have been reminded that we need to be flexible when visiting groups to gather their views and that we must be able to adapt how we engage to suit the people and the situation. We also learnt that the questionnaire we have been using needs to be changed so that it is more relevant to the work that the LINk is currently undertaking.

A copy of this report will be sent to MOSAIC.

A LINk Committee poster will be sent to the building that houses MOSAIC every month to help increase awareness of the LINk and encourage new members of the public to attend meetings.

APPENDIX 6

INCOME AND EXPENDITURE 2011-12

	Expenditure (£)	***Income (£)***
Local Authority Funding		87,620
Salaries Host Staff	56,752	
Staff Travel	3,022	
Staff Training	0	
Host Management Charge	5,000	
Capital - Information Technology	0	
Stationery/Postage	2,203	
Printer/ copier leasing	2,021	
Publicity	718	
Criminal Records Bureau disclosures	72	
Meeting Support	3,203	
Audit	1,599	
Members' Training	0	
IT & Website	67	
Members' Expenses	3,444	
Quality Assurance	687	
Professional Indemnity	0	
Contingency Reserve	0	
Office Premises (incl. furniture rental)	7,015	
Electricity/Gas	86	
Water	71	
Telephone	1,156	
Insurance	500	
	Total Income	**£87,620.00**
	Total Expenditure	**£87,616.00**
Surplus of Income over Expenditure		**£4.00**

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	21/09/2012
TITLE:	Joint Strategic Needs Assessment (JSNA) – Dementia
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: JSNA Topic Summary : Dementia	

1 THE ISSUE

1.1 This report covers a summary of data held in the Joint Strategic Needs Assessment on the subject of dementia. This is following an explicit request from Wellbeing PDS Panel to keep the JSNA as a standing agenda item on a subject-by-subject basis

2 RECOMMENDATION

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

2.1 Note the findings of the briefing

2.2 Consider whether the format/layout/content of the briefing is suitable

2.3 Consider the broader implications/impacts of these findings on the work of the panel

3 FINANCIAL IMPLICATIONS

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

3.2 The JSNA 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. Findings will also be used to support the Equalities Impact Assessment of council service and financial plans.

3.3 Projected increases in the number of people with long term health conditions, such as dementia, will place increased pressure on local services; a separate report has been commissioned to investigate the likely financial pressures of this increase.

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.

4.2 At the HWPD&S meeting on 27 July 2012 a request was made for more in-depth presentations on JSNA data to be made to the panel to support their policy development and scrutiny role. At the request of the chair the topic of dementia was chosen to trial this process

Content

4.3 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’.

4.4 The summary document provided as Appendix 1 covers the current JSNA content on the subject of dementia and includes input from local commissioners.

4.5 Full JSNA documents and underlying materials are currently available through the council web-site at www.bathnes.gov.uk/jsna

4.6 The JSNA is an ongoing project and we are always looking for new intelligence about our communities, if you feel we should be told about anything, please contact research@bathnes.gov.uk

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. Dementia is a condition which specifically affects the older population and due to the profile of older people it is seen more in women than in men, however when age is taken into account the rates are similar.

6.2 There is a small relationship between hospital admissions for dementia and socio-economic inequalities, suggesting areas with lower incomes have a greater number of admissions. However there is a lower level of diagnosed cases, this may suggest that there is an issue of under-diagnosis in some of these communities.

6.3 For many of the data sources used in the JSNA data is not available with regards other equalities characteristics, particularly ethnicity.

CONSULTATION

6.1 Cabinet Member; Staff; Other B&NES Services; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Monitoring Officer

6.2 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.

7 ISSUES TO CONSIDER IN REACHING THE DECISION

7.1 Social Inclusion; Older People; Human Rights; Corporate; Other Legal Considerations; Wellbeing

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	Jon Poole, Research & Intelligence Manager Helen Tapson, Public Health Intelligence Analyst
Background papers	www.bathnes.gov.uk/jsna
Please contact the report author if you need to access this report in an alternative format	

V1.2

This document contains a summary of the content included in the Joint Strategic Needs Assessment relating to the topic of dementia and is accurate as at 04 Sep 2012.

Introduction

The aim of the JSNA is to provide the big picture of need in Bath and North East Somerset. It is produced between Public Health and the Policy and Partnerships division. It covers a wide range of data (from health trends, to crime, employment and the natural environment), includes a review of data from local community engagement activity and a review of performance data to assess the extent we're doing what we said we'd do.

The term 'dementia' describes a set of symptoms that include loss of memory, mood changes, and problems with communication and reasoning. There are many types of dementia; the most common are Alzheimer's disease and vascular dementia[i]. Dementia is mostly a disease of older age with the majority of cases found in over 65 year olds (although early onset dementia can occur before this), the chance of having dementia doubles every 5 years over the age of 65[ii].

Local and National Strategic Context

The National Dementia Strategy

The National Dementia strategy (2009) [iii] recognises the increasing prevalence of dementia and sets out 21 objectives in a 5 year strategy address issues. More recently the Prime Minister's Dementia Challenge (2012)[iv], put forward three key themes to improve dementia care including; driving improvements in health and care, creating dementia friendly communities, and better research.

B&NES Dementia Care Pathway Group

The Dementia Care Pathway Group in B&NES oversees the delivery of the local action plan with the Associate Director for Unplanned Care & Long Term Conditions and the Associate Director for Mental Health having dual commissioning responsibility for the delivery of the plan and care pathway.

The local plan has 8 dementia challenge priorities including: better diagnosis, improved care in hospitals, Improving standards in care homes & domiciliary care, Better information for people with dementia & their carers, Better support for carers, providing support in the community, supporting people with dementia at end of life and reducing use of antipsychotics. Progress towards these goals is being monitored.

What the data says

Current situation

- In B&NES 867 people are registered as having dementia on GP practice records (0.4% of the adult population). This is lower than the national average (0.5%) [v]
- Nevertheless, estimates of expected levels suggest that rates recorded in GP practices are lower than the rate of people experiencing dementia in the community, both in B&NES and nationally. In B&NES the actual number of people experiencing dementia is estimated to be nearer 2,400 (2008/09) [vi]
- The diagnosis of dementia (the match-up between the numbers expected and the numbers recorded) varies widely between GP Practices, suggesting that some are much better/poorer than others at identifying people with this condition.

    - In particular, practices in lower income areas are shown to have lower rates of dementia identified but higher rates of hospital admissions for dementia, suggesting an inequality in diagnosis (although as the data on identified dementia is not age specific this result may be confounded by the age profiles of practice populations.)[vii]
- Practices with higher prevalence are distributed throughout the area with no obvious correlations [viii]
- Aerobic physical activities which improve heart and lung fitness is beneficial for cognitive function in healthy older adults and can interrupt the disease processes of dementia [ix]
- Evidence suggests that residents in nursing homes have multiple complex medical needs and over 50% have dementia or other mental health needs as the primary clinical need or in addition to complex physical disabilities [x]
- Vulnerable groups identified by Clinical Commissioning Group consultation.
    - People living alone with dementia
    - Black & Minority Ethnic (BME) groups where uptake of services are variable (There are lower levels of awareness of problems such as dementia within BME communities)[xi]

Future projections

Dementia cases are expected to increase by 23% for females and 43% for males between 2010 and 2025 in B&NES (34% and 58% respectively nationally) [xii]

Table 1. Projected dementia cases in women and men

Projection Year	Population		Dementia cases	
	Women	Men	Women	Men
2010	17700	13900	1549	853
2015	19100	15400	1608	955
2020	20000	16400	1715	1075
2025	21300	17600	1916	1225

What the community says

The South West Care Services Improvement Partnership's regional consultation on dementia brought out three themes from carers, users, and the general public.

- Improving information and raising awareness
- Promoting early diagnosis and intervention
- Improving care for people with dementia [xiii]

All respondents with dementia responding to the Long Term Conditions survey 2011 suffered from another long term condition. Further accurate understanding of multiple conditions has been identified as an area for further research.

Quality and Performance

The majority of people with a dementing illness are not cared for by specialist services but managed in primary care and by generic social work teams.

The Health and Well-Being Partnership has identified that engagement with people with dementia and their carers is an area of weakness and needs to be strengthened going forward [xiv]

Medication for Alzheimer's disease, if it is effective, on average delays progression by about 6 months. For the patient this may mean being able to live independently for longer (which is what most patients want to do), but does not stop the inevitable progression of the disease, and therefore the need for services and ultimately care home admission [xv]

Implementation plan for the NHS covering four priority objectives as follows:

- Good-quality early diagnosis and intervention for all
- Improved quality of care in general hospitals
- Living well with dementia in care homes
- Reduced use of antipsychotic medication

All staff working with older people in the health, social care and voluntary sectors should be trained for dementia care. Mental health services and substance misuse services need integrating better
It is unlikely that the NICE Clinical Guideline for dementia is being followed fully for all patients[xvi]

Enabling communities

NICE guidance

Need to assess the gaps against the NICE Guidance. Specifically for dementia suffers and their carers:

- Non-discrimination: people with dementia should not suffer discrimination
- Securing valid consent
- Carers should have their needs assessed and met
- Health and social care should be coordinated and integrated and delivered accordingly
- Memory services should be the single point of referral for all people with a possible diagnosis of dementia
- Structural imaging for diagnosis should be used in the assessment of people with suspected dementia
- Behaviour that challenges should be helped early and systematically
- All staff working with older people in the health, social care and voluntary sectors should be trained for dementia care
- Acute hospitals should ensure the mental health needs of dementia users are catered for. **Error! Bookmark not defined.**[xvii]

www.bathnes.gov.uk/jsna
research@bathnes.gov.uk

References

[i] Alzheimers Society (2011) About Dementia. http://www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200120

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[iii] Department of Health. 2009. National Dementia Strategy. http://www.dh.gov.uk/health/2011/07/dementia-strategy/

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[v] Network of Public Health Observatories (2011) APHO GP Profiles - Dementia: QOF prevalence (all ages) http://www.apho.org.uk/PracProf/Profile.aspx

[vi] NHS Comparators (2008/9) Bath and North East Somerset PCT - Dementia Reported vs Expected Prevalence

[vii] Dementia and Deprivation (2009-2011) in house analysis.

[viii] Network of Public Health Observatories (2011) APHO GP Profiles - Dementia: QOF prevalence (all ages) http://www.apho.org.uk/PracProf/Profile.aspx

[ix] Milner, P. & Morgan, K. (2008) Health Needs Assessment for Older People with Mental Health Problems in Bath and North East Somerset, Bath and North East Somerset Council and PCT http://www.B&NES.nhs.uk/SiteCollectionDocuments/About%20Us/Strategies%20and%20Plans/JSNA%204.Older%20People%20with%20mental%20health%20problems%20180608.pdf

[ix] SUS data (2004-2011) Hospital admissions for self-harm, in-house analysis

[x] Wellbeing Policy Development and Scrutiny Panel (November 2011) Update on Dementia, Bath and North East Somerset Council http://democracy.bathnes.gov.uk/documents/s8494/Dementia%20update.pdf

[xi] Wellbeing Policy Development and Scrutiny Panel (November 2011) Update on Dementia, Bath and North East Somerset Council http://democracy.bathnes.gov.uk/documents/s8494/Dementia%20update.pdf

[xii] North East Public Health Observatory (2008-2025) Estimating the future number of cases of dementia in PCTs and local authorities in England (downloaded 14/3/2012) http://www.apho.org.uk/resource/item.aspx?RID=77391

[xiii] Network of Public Health Observatories (2011) APHO GP Profiles - Dementia: QOF prevalence (all ages) http://www.apho.org.uk/PracProf/Profile.aspx

[xiv] Bath and North East Somerset Health and Well-being Partnership (November 2011) Local Action Plan – Implementation of the National Dementia Strategy (NDS) – November 2011 Update, Bath and North East Somerset Council http://democracy.bathnes.gov.uk/documents/s8495/BNES%20Dementia%20Local%20Action%20Plan%20Update%20Nov%2011.pdf

[xv] Milner, P. & Morgan, K. (2008) Health Needs Assessment for Older People with Mental Health Problems in Bath and North East Somerset, Bath and North East Somerset Council and PCT http://www.B&NES.nhs.uk/SiteCollectionDocuments/About%20Us/Strategies%20and%20Plans/JSNA%204.Older%20People%20with%20mental%20health%20problems%20180608.pdf

[xvi] Milner, P. & Morgan, K. (2008) Health Needs Assessment for Older People with Mental Health Problems in Bath and North East Somerset, Bath and North East Somerset Council and PCT http://www.B&NES.nhs.uk/SiteCollectionDocuments/About%20Us/Strategies%20and%20Plans/JSNA%204.Older%20People%20with%20mental%20health%20problems%20180608.pdf

[xvii] North East Public Health Observatory (2008-2025) Estimating the future number of cases of dementia in PCTs and local authorities in England (downloaded 14/3/2012) http://www.apho.org.uk/resource/item.aspx?RID=77391

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	21st September 2012
TITLE:	Winterbourne View Findings Update
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – "Winterbourne View Initial Findings" Appendix 2 – Collated Summary of Recommendations	

1 THE ISSUE

1.1 To provide the Wellbeing PDS Panel with an update following the publication in August 2012 of:

- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview

2 RECOMMENDATIONS

The Wellbeing PDS Panel is asked to:

2.1 Note the content of the report; and

2.2 To receive a further update following the publication of the overview report, which is anticipated at the end of October 2012.

3 FINANCIAL IMPLICATIONS

3.1 There are no specific financial impacts.

4 THE REPORT

4.1 This paper provides an update following the publication in August 2012 of

- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview

4.2 In addition to a summary of the key recommendations, this paper also outlines the immediate actions being taken by B&NES as part of a coordinated local and regional response to provide local commissioning assurance.

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.

5.2 The Bath & North East Somerset Local Safeguarding Adults Board (LSAB) has committed to holding a “lessons learned” workshop in October 2012 to ensure that local practice is of the required standards arising from Winterbourne View and subsequent published reports.

6 EQUALITIES

An EqIA has not been completed because this report is provided for information and there are no direct equalities issues.

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	Jane Shayler, Telephone: 01225 396120 Mike MacCallam, Telephone: 01225 396054
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Appendix 1

Winterbourne View Initial Findings

1 Summary

The physical and verbal abuse of patients with learning disabilities at Winterbourne View has been extensively reported on previously, following the original Panorama broadcast on 31st May 2011.

This paper provides an update following the publication in August 2012 of a number of reports:

- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview

These in turn follow the earlier publication on the 26th June 2012 of the report:

- Department of Health Review: Winterbourne View Hospital – Interim Report

Key recommendations from the interim report are attached as Annex A.

In addition to a summary of the key recommendations from all these reports (attached as Annex B) this paper also outlines next steps and future reporting processes, including detail on the publication of the findings of a number of investigations that have been carried out

2 Key Recommendations

A summary of the collated recommendations from all reports is attached as a Annex B to this report. There are, in total, 115 recommendations in respect of the actions to be taken by the NHS; Local Authorities, CQC; NHS Commissioning Board, Department of Health; drawing on the conclusions reached from all of the reports above.

3 Next steps

The NHS South of England Learning Disabilities lead has established a series of regular briefings with commissioners to manage planned responses to the recommendations contained within the reports above, local commissioning assurance, media responses and requests for information. Bath and North East Somerset is working with neighbouring commissioners and NHS South of England to develop a local action plan to address the recommendations.

All 11 members of staff who were charged with offences relating to Winterbourne View eventually entered a guilty plea, meaning that a trial, set for August 2012 was not needed. Sentencing is scheduled to take place on 22 October 2012

It is anticipated that the DH will publish a final report in October 2012. This review will draw on a number of investigations including:

- Police investigations and criminal proceedings against staff at the hospital;
- Reviews commissioned by the Castlebeck Care Board and shareholders;
- Inspections by the Care Quality Commission (CQC) of all Castlebeck Care units and a wider review of 150 learning disability hospitals and care homes (NHS, independent healthcare and social care facilities);
- The report of the NHS Review of commissioning of care and treatment at Winterbourne View; and
- The Serious Case Review (SCR) established by South Gloucestershire Council.

The Bath and North East Somerset Local Safeguarding Adults Board (LSAB) has committed to holding a 'lessons learned' workshop in October 2012 to ensure that local practice is of the required standards arising from Winterbourne View and subsequent published reports. The LSAB are also reviewing local policies around whistleblowing and provider position regarding whistleblowing and their responses to individual whistleblowing concerns.

Mike MacCallam
Associate Director – Learning Disabilities and PSI

Annex A – Summary of key actions – DH Interim Report

Improve the capacity and capability of commissioning across health and care
Contracts: The Department will work with the NHS Commissioning Board Authority to agree by January 2013 how best to embed Quality of Health Principles in the system, using NHS contracting and guidance
Service specification: The Department will work with the NHS Commissioning Board Authority and the Association of Directors of Adult Social Care (ADASS) to develop National Service specifications
Resources: NICE will develop Quality Standards on learning disabilities and the autism Quality guidelines will be published in July 2012.
Collaborative commissioning: the NHS Commissioning Board Authority will support CCGs to work together in commissioning services for people with learning disabilities and behaviour which challenges. Health and Wellbeing Boards (HWBs) will bring together local commissioners of health and social care in all areas, to agree a joined up way to improve services.
Improve the quality of services which empower people with learning disabilities and their families to have choice and control.
Voice: The Department is establishing Health Watch both locally and nationally. It will act as a champion for those who use services and for family carers, ensuring the interests of people with learning disabilities are heard and understood by commissioners and providers of services across health and social care.
Personalisation: The Department expects the NHS and local authorities to demonstrate that they have taken action to assure themselves and the public that personalised care and choice and control is available in all settings, including hospitals
Providers: The Department expects providers to deliver high quality services and prevent abuse. This includes: • Actively promoting open access for families and visitors, including advocates and visiting professionals • Making sure recruitment practices recruit the right people.
Quality: By autumn the National Quality Board will publish a report setting out how the new system architecture will identify and take action to correct potential or actual serious failure
Care Quality Commission; the Department will look at how CQCs registration requirements could be changed to drive up the quality of services on offer and ensure that unannounced inspections can take place any day and any time of the week
Clarify roles and responsibilities and promote better integration
Integrated workforce; the professional bodies that make up the Learning Disability Professional Senate will carry out a refresh of CHALLENGING BEHAVIOUR; A UNIFIED APPROACH to support clinicians in community learning disability teams to clearly describe how different services fit together to deliver the best outcomes by December 2012.
Professional standards: The Academy of Royal Colleges and the professional bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the new health and care system by April 2013.
Concordat: The Department is working with key national partners to sign up to a concordat in the autumn committing each signatory to the actions they will take to deliver the right model of care and better outcomes for people with learning disabilities of autism and behaviour which challenges.
Promote innovation and reduce use of restraint
Restraint: the Department will work with the Department for Education (DfE), Care Quality Commission (CQC) and others to drive up standards and promote best practice in the use of positive behavioural support and ensure that physical restraint is only ever used as a last resort
Measuring progress: The Department of Health will work with the NHS Commissioning Board Authority to agree what information and data we need to collect to measure progress

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Annex B

South of England Strategic Health Authority

DRAFT

Collated recommendations from the following reports:

- **Winterbourne View Hospital: A Serious Case Review**
- **Report of the NHS Review of commissioning of care and treatment at Winterbourne View**
- **Care Quality Commission, Internal Management review of regulations of Winterbourne View**
- **Care Quality Commission, Learning Disability Services, Inspection Programme, National Overview**
- **Out of Sight, Mencap and Challenging Behaviour Foundation**

No	From	For action by	Recommendations
1	NHS Review Page 68 6.13.2	Commissioners of Winterbourne View	Carefully review the actions of staff involved in the commissioning and care coordination process in order to identify if any of the failures to act that have emerged warrant disciplinary action or referral to professional regulatory bodies.
2	NHS Review Page 68 6.13.1	Commissioners of Winterbourne View	Continue to ensure that patients who were at Winterbourne View are supported over the long term to ensure that the effect of any abuse received or witnessed while at Winterbourne View is minimised as far as possible.
3	NHS Review Page 68 6.14.1	NHS	Insist on the use of a standards NHS Contract for all 'spot purchased' patient placements which includes prominently both quality and safety measures, and in particular a requirement for the commissioner to be informed directly of any untoward incident.

No	From	For action by	Recommendations
4	NHS Review Page 68 6.14.2	NHS	Assess the performance of the provider against the contract on a regular basis.
5	Serious Case Review Page 127 Recommendation 12	NHS and Local Authorities	Commissioners funding placements should ensure that they have up to date knowledge of service e.g.
6	Serious Case Review Page 127 Recommendation 12(a)	NHS and Local Authorities	Adverse incidents / serious untoward incidents, including the injuries of patients and staff.
7	Serious Case Review Page 127 Recommendation 12(b)	NHS and Local Authorities	Absconding
8	Serious Case Review Page 127 Recommendation 12(c)	NHS and Local Authorities	Police attendance in the interests of patient safety
9	Serious Case Review Page 127 Recommendation 12(d)	NHS and Local Authorities	Criminal investigations
10	Serious Case Review Page 127 Recommendation 12(e)	NHS and Local Authorities	Safeguarding investigations
11	Serious Case Review Page 127 Recommendation 12(f)	NHS and Local Authorities	The occurrence of Deprivation of Liberty Safeguards applications and renewals.
12	NHS Review Page 68 6.14.3	NHS and Local Authority	Clarify the relationships and respective roles of organisations in relation to the commissioning and care coordination arrangement in place for learning disability and mental health specialist placements. In particular, ensure that there is a formal schedule setting out the arrangements and

No	From	For action by	Recommendations
			consistent thresholds for communications between care coordination teams and the commissioner.
13	NHS Review Page 69 6.14.4	NHS and Local Authority	Specify the expectations placed on care coordinator teams and commissioners with regard to their input to the Care Programme Approach process and ongoing communication with families, carers and advocates.
14	NHS Review Page 69 6.14.5	NHS and Local Authority	Ensure that there is clinical expertise available to care coordination teams and that this is being deployed as necessary in order to provide appropriate clinical input to decision making.
15	NHS Review Page 69 6.14.6	NHS and Local Authority	Clarify the routes available for families, carers and advocates to make known any concerns about care being provided directly to the commissioner of care.
16	NHS Review Page 69 6.14.7	NHS and Local Authority	Together with social care partners, review policy and strategies surrounding those whose behaviour challenges services, and in particular ensuring that there is a clear focus on preventing escalation within community settings and develop criteria for situations in which specialist placements outside of mainstream services are required.
17	NHS Review Page 69 6.14.8	NHS and Local Authority	Monitor the length of stay in assessment and treatment units and ensure a clear focus on discharge planning is part of the Care Programme Approach.
18	NHS Review Page 69 6.14.9	NHS and Local Authority	Ensure that the Deprivation of Liberty of Safeguards are being applied systematically in relation to all relevant patients.

No	From	For action by	Recommendations
19	Serious Case Review Page 135 Recommendation 20	NHS and Local Authority	Commissioners should ensure that all hospital patients with learning disabilities and autism have unimpeded access to effective complaints procedures – in the case of NHS-funded care, these arrangements must meet the statutory requirement laid down in the 2009 Local Authority and National Health Service Complaints (England) Regulations 2009.
20	Serious Case Review Page 135 Recommendation 23(a)	NHS and Local Authority	Commissioners responsible for funding placements should be proactive in ensuring that patients are safe.
21	Serious Case Review Page 135 Recommendation 23(b)	NHS and Local Authority	If responsibility for monitoring a placement or the ongoing coordination of care is delegated to nurses or social workers, then commissioners ensure that they are informed about safeguarding concerns and alerts.
22	Serious Case Review Page 135 Recommendation 23(c)	NHS and Local Authority	Decisions about funding placements should be based on outcome data.
23	Serious Case Review Page 135 Recommendation 23(d)	NHS and Local Authority	Arrangements should be in place to share information about safeguarding incidents and alerts between those responsible for monitoring patient safety, the provider and commissioners and this should be routinely monitored through contracts.
24	Serious Case Review Page 142 Recommendation 38	NHS and Local Authority	Organisations providing NHS funded care should be required to demonstrate accountability for effective governance to commissioners and Council Adult Safeguarding.
25	Serious Case Review Page 142 Recommendation 39	NHS and Local Authority	Commissioners should encourage hospitals and assessment and treatment units for adults with learning disabilities and autism to ensure that their employees are signed up to the proposed Code of Conduct and minimum induction / training standards for unregistered health and social care assistants commissioned by the Department of Health.

No	From	For action by	Recommendations
26	Serious Case Review Page 142 Recommendation 41	NHS and Local Authority	Commissioners of assessment and treatment services should ensure that there are pharmacist led medicines reviews both for individual patients and for the service as a whole.
27	Mencap Out of Sight Page 7 Action needed 8	NHS and Local Authority	Commissioners must make sure that provides of care and support demonstrate that they are capable of meeting the needs of people who show behaviour that challenges and that they can provide the right environment and skilled staff.
28	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 1	NHS and Local Authority	Commissioners need to urgently review the care plans for people in treatment and assessment services and identify and plan move on arrangements to the next appropriate service and care programme.
29	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 3	NHS and Local Authority	Commissioners also need to review the quality of advocacy services being provided, particularly in those locations where we identified non-compliance with the standards.
30	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 7	NHS and Local Authority	Providers and commissioners should ensure that there are appropriate quality assurance systems in place. This includes having appropriate: 1 Complaints procedures, assess to and use of: 2 Advocates, welcoming 3 Approaches to visitors and a fundamentally sound and appropriate support 4 and supervision structure of all staff.

No	From	For action by	Recommendations
31	Serious Case Review Page 124 Recommendation 1	NHS, Local Authority and NHS Commissioning Board	Clinical Commissioning Groups, local authorities and the NHS Commissioning Board should be commissioning services with regard to the needs identified in the Joint Strategic Needs Assessment, the priorities agreed in Joint Health and Wellbeing Strategies and where appropriate, the health aspects of the National Planning Policy Framework. The presumption should be to address the needs of the whole population within the geography of the local area, with the aim of reducing the number of people using in-patient assessment and treatment services in line with the policy set out in the Department of Health (2012) Interim Report.
32	Serious Case Review Page 124 Recommendation 2	NHS, Local Authority and NHS Commissioning Board	The principle of investing in and promoting good quality, local services… providing intensive community support **with only limited use of in-patient services** (Department of Health 2012) should be adopted and monitored by Clinical Commissioning Groups and the NHS Commissioning Board.
33	Serious Case Review Page 124 Recommendation 3	NHS, Local Authority and NHS Commissioning Board	Clinical Commissioning Groups should require generic mental health services, as part of their annual contract monitoring, to identify the steps taken to enable citizens with learning disabilities and autism to be supported in their own communities and familiar localities.
34	Serious Case Review Page 127 Recommendation 9	NHS, NHS Commissioning Board and Local Authority	Adults with learning disabilities and autism, who are currently placed in assessment and treatment units, should have the full protection of the Mental Capacity Act 2005.
35	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 2	NHS, NHS Commissioning Board and Local Authority	The emerging Clinical Commissioning Groups and the NHS Commissioning Board, as well as the local authorities in England need to work together to deliver innovative commissioning at the local level to establish person-centred services. This is much more likely to lead to people being able to stay in their local communities and so maintain

No	From	For action by	Recommendations
			important relationships.
36	Serious Case Review Page 135 Recommendation 22	NHS and Department of Health	Clinical Commissioning Groups should explore how Accident and Emergency can detect instances of re-attendance from the same location as well as by any individual. The Department of Health may wish to highlight this to A & E departments, including it in their annual review of Clinical Quality Indicators.
37	Serious Case Review Page 124 Recommendation 4	NHS and NHS Commissioning Board	In it direct commissioning responsibilities and perhaps as part of contractual arrangements, the NHS Commissioning Board should take appropriate steps to enquire hospitals and assessment and treatment units for adults with learning disabilities and autism to publish information concerning:
38	Serious Case Review Page 124 Recommendation 4 (a)	NHS and NHS Commissioning Board	Direct patient related costs.
39	Serious Case Review Page 124 Recommendation 4 (b)	NHS and NHS Commissioning Board	Their service costs.
40	Serious Case Review Page 124 Recommendation 4 (c)	NHS and NHS Commissioning Board	The specific rehabilitation gains of individual patients.
41	Serious Case Review Page 124 Recommendation 4 (d)	NHS and NHS Commissioning Board	The detention status of patients at the point of discharge, and whether or not discharge is to a within-service transfer to a facility owned by the same company, an associated company or an NHS Trust.

No	From	For action by	Recommendations
42	Serious Case Review Page 126 Recommendation 7 (a)	NHS and NHS Commissioning Board	Commissioners should commission the model of care as set out in the Department of Health (2012) Interim Report, to ensure that people only go into in-patient services for assessment and treatment where they cannot get the support that they need in the community.
43	Serious Case Review Page 127 Recommendation 7 (b)	NHS and NHS Commissioning Board	Local Authorities should only commission such services where they are the lead commissioner and there are valued services and pooled budgets in place.
44	Serious Case Review Page 127 Recommendation 11	NHS Commissioning Board	The NHS Commissioning Board should seek ongoing assurance that the practice of commissioning of NHS services for adults with learning disabilities, autism, behaviour which challenges and mental health problems is explicitly attentive to reducing inequalities.
45	Serious Case Review Page 137 Recommendation 33	NHS, Local Authority and Care Quality Commission	The Care Quality Commission and the commissioners should ensure that a service is providing care, which is consistent with its Statement of Purpose, i.e. in the case of Winterbourne View Hospital, assessment and treatment, and rehabilitation.
46	Care Quality Commission Internal Management Review Page 46 Recommendation 1	Care Quality Commission	The Care Quality Commission should highlight in our quality and risk profiles (QRP) that services defined as providing regulated activities in residential institutions for people with learning disability, challenging behaviour and mental health needs are inherently higher risk institutions. This is consistent with the Department of Health guidance on models of service delivery for this group of patients. This higher risk status will act as an alert system to our staff when looking at data and information and when carrying out inspections of these institutions. This change should be implemented immediately.

No	From	For action by	Recommendations
47	Care Quality Commission Internal Management Review Page 46 Recommendation 2	Care Quality Commission	The Care Quality Commission should take account of the inherent risk of different types of service provision and the different characteristics of the people using those services throughout it work. This will include collated intelligence about corporate providers as well as individuals locations which will help to identify risks across a provider group as well as at individual location level.
48	Care Quality Commission Internal Management Review Page 46 Recommendation 3	Care Quality Commission	Compliance inspectors should record the outcome of the investigations from safeguarding alerts and compliance mangers should sign off the agreed actions from those investigations. Where Care Quality Commission cannot agree the outcomes from the investigation this should be communicated back to the Safeguarding Adult Team and if necessary to the Adult Safeguarding Board.
49	Care Quality Commission Internal Management Review Page 46 Recommendation 4	Care Quality Commission	Although the Care Quality Commission now have a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.
50	Care Quality Commission Internal Management Review Page 46 Recommendation 5	Care Quality Commission	The Care Quality Commission should built new protocols about working with local Safeguarding Adult Teams and Safeguarding Adult Boards to ensure there is timely investigation and intervention of relevant safeguarding alerts, and to ensure that all relevant parties are involved in the investigation of the incident(s) leading to the alert(s).

No	From	For action by	Recommendations
51	Care Quality Commission Internal Management Review Page 46 Recommendation 6	Care Quality Commission	The Care Quality Commission should develop its analysis of safeguarding alerts, to look at particular trends at individual locations, and across service providers. This is particularly important in looking at concerns across chains of providers which cross the Care Quality Commission's geographical boundaries.
52	Care Quality Commission Internal Management Review Page 46 Recommendation 7	Care Quality Commission	The Care Quality Commission should evaluate and embed the process it has commenced of integrated, routine and ongoing exchanges of information between the Compliance Inspectors and Mental Health Act Commissioners and, where appropriate, or joint inspections to take place. This needs to be managed through the supervisory arrangements between the Compliance Managers and their inspectors and the Mental Health Act Commissioner Managers and their commissioners.
53	Care Quality Commission Internal Management Review Page 47 Recommendation 10	Care Quality Commission	The Care Quality Commission should review how it collates information and looks at risks at provider level as well as at location level. This is particularly important for chains of providers where systemic issues could be overlooked because of a focus on location level information.
54	Care Quality Commission Internal Management Review Page 47 Recommendation 11	Care Quality Commission	The Care Quality Commission's Board should receive a report on the whistle blowing arrangements that are in place on a six monthly basis. This should be a public report setting out in detail the scope, volume and actions taken by the Care Quality Commission in response to the concerns raised by whistle blowers.
55	Care Quality Commission Internal Management Review Page 47 Recommendation 12	Care Quality Commission	The Care Quality Commission should audit, on an annual basis, the effectiveness of the case management arrangements in place to ensure that supervision is systematically considering the services with the most serious concerns as part of a quality assurance process. The outcomes of this audit should be reported to the board, and the report should be

No	From	For action by	Recommendations
			made public.
56	Care Quality Commission Internal Management Review Page 47 Recommendation 13	Care Quality Commission	The Care Quality Commission should now develop a protocol about the way in which we will work the Safeguarding Adult Boards and Teams across England. The protocol should take account of what the proposed legislation may set out and also take account of what has worked effectively in Children's Safeguarding Boards.
57	Serious Case Review Page 137 Recommendation 27	Care Quality Commission	The requirements concerning a service's Statement of Purpose and the supporting guidance should be strengthened to aid clarity. The Care Quality Commission, through its Mental Health Act monitoring responsibilities, should consider giving particular focus to:
58	Serious Case Review Page 137 Recommendation 27(a)	Care Quality Commission	The way in which hospital managers (as defined in the MHA 1983) discharge their responsibilities and
59	Serious Case Review Page 137 Recommendation 27(b)	Care Quality Commission	Evidence that hospitals are engaged in their activities they are registered to provide.
60	Serious Case Review Page 137 Recommendation 29	Care Quality Commission	The Care Quality Commission should collaborate with the Health (and Care) Professionals Council, plus the Sector Skills Councils for both Health and Care, in providing advice and guidance on the qualifications and continuing professionals development requirements for Registered Managers and for the practitioners they supervise. It is of concern that managers, registered to operate services across residential, nursing home, hospital and home care, are not required to be distinct registered professionals individually accountable through a governing body and code of ethics.

No	From	For action by	Recommendations
61	Serious Case Review Page 137 Recommendation 30	Care Quality Commission	The Care Quality Commission should take appropriate enforcement action where registered managers are not in place.
62	Serious Case Review Page 137 Recommendation 31	Care Quality Commission	Inspection is a term that the public understands and expects to be in pace for an establishment such as Winterbourne View Hospital. The Care Quality Commission's Compliance Inspectors did not identify the abuse.
63	Serious Case Review Page 137 Recommendation 31(a)	Care Quality Commission	Care Quality Commission should ensure that inspections are carried out by sector specialists and experts by experience so that warning signs may be identified earlier (i.e. the approach effectively implemented for the inspection of 150 services for adults with learning disabilities in England.
64	Serious Case Review Page 137 Recommendation 31(b)	Care Quality Commission	Inspectors should be qualified and competent to carry out inspections, and demonstrate that they have sufficient knowledge and (i) the service that they inspect and (ii) the abuse of vulnerable adults, including the crime of assault.
65	Serious Case Review Page 137 Recommendation 32	Care Quality Commission	The Care Quality Commission must encourage whistleblowers to raise the alarm and then securely receive, log and take action when concerns are raised. They should report on actions arising from whistle blowing notifications in its annual State of Care report.
66	Serious Case Review Page 141 Recommendation 35	Care Quality Commission	The Care Quality Commission through its Mental Health Act monitoring responsibilities should consider giving particular focus to the way in which hospital managers (as defined in the Mental Health Act 1983) discharge their responsibilities.
67	Serious Case Review Page 141 Recommendation 36	Care Quality Commission	The Care Quality Commission, in discharging its responsibilities to monitor the use of the Mental Health Act, should ensure that all the requirements of the Act are applied when a patient moves from being an

No	From	For action by	Recommendations
			informal patient to being detained under the Act in the same hospital.
68	Serious Case Review Page 142 Recommendation 42	Care Quality Commission	The Care Quality Commission should consider including pharmacist led medication reviews in future inspections.
69	Mencap Out of Sight Page 7 Actions Needed 6	Care Quality Commission	The Care Quality Commission must conduct rigorous inspections, involving people with a learning disability and their families, and not shy away from taking action to deregister or enforce their recommendations.
70	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 8	Care Quality Commission	Care Quality Commission should determine when it is most appropriate to visit and inspect services at weekends and evenings, rather than Monday to Friday between 09.00 – 17.00. Visits at these times can sometimes provide the additional evidence needed to assess visitor assess, and judge the quality of care, staff, support and supervision.
71	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 9	Care Quality Commission	We acknowledge that the sample of learning disability providers inspected outside this thematic programme (52) was small by comparison. However, the differences in judgements about compliance and non-compliance warrant further evaluation, to help understand and explain the difference.
72	Serious Case Review Page 141 Recommendation 37	Care Quality Commission and Health Professionals Council	The Care Quality Commission and Health Professions Council should work together to describe in guidance what effective systems of clinical supervision look like in hospitals for people with learning disabilities and autism. The guidance should identify the roles of registered managers and nominated individuals in developing such systems in practice.
73	Care Quality Commission Internal Management Review Page 47	Care Quality Commission and Local Authority	When the Care Quality Commission Mental Health Act Commissioners set out their comments and suggestions for the provider following a visit these should be monitored through an action plan submitted to the Care Quality Commission, and linked with the QRP for the location. There

No	From	For action by	Recommendations
	Recommendation 9		should be follow up to ensure that the agreed actions are being implemented as agreed. Where there is failure to do so the Adult Safeguarding Team should be notified.
74	Care Quality Commission Internal Management Review Page 47 Recommendation 8	Care Quality Commission and Medical Staff	The information and intelligence that the Second Opinion Appointed Doctors may capture regarding concerns that they have for patient safety as part of their statutory remit should be systematically and routinely recorded and made available as part of the intelligence and risk information used by Care Quality Commission in its work. Care Quality Commission should review the mechanisms by which SOAD's receive pre-visit relevant information and how they feed back to Care Quality Commission on concerns observed during the discharge of their statutory function.
75	Serious Case Review Page 137 Recommendation 26	Care Quality Commission and Provider Hospital Mangers	The mental health arm of Care Quality Commission should have characteristics akin to HM Inspectorate of Prisons in terms of standard. The hospital managers as defined by the Mental Health Act 1983 have the primary responsibility for ensuring that all requirements of the Act, including all the safeguarding to ensure detention is necessary in the first place (3 independent professionals assessments) and needs to continue. Care Quality Commission and the First Tier Tribunal should ensure that these responsibilities are discharged for all detained patients. All decisions taken on the use of the Mental Health Act 1983 must be guided by the Act's guiding principles, including the purpose principle and the least restriction principle.
76	Serious Case Review Page 142 Recommendation 43	Castlebeck Care Ltd	In the light of the harm sustained by former Winterbourne View Hospital patients, Castlebeck Care Ltd should consider funding (i) Independent psychotherapeutic provision for all former Winterbourne View hospital patients – in negotiation with each

No	From	For action by	Recommendations
			person and their families; and an evaluation of the effectiveness of this intervention and (ii) The costs associated with the Serious Case Review.
77	NHS Review Page 70 6.16 a	Department of Health	The extent to which lead safeguarding authorities are able to share information with other commissioners.
78	NHS Review Page 70 6.16 b	Department of Health	Whether lead commissioning arrangements would be beneficial.
79	NHS Review Page 70 6.16 c	Department of Health	Whether the guidance surrounding he Mental Health Act contains adequate safeguards against conflicts of interest arising.
80	NHS Review Page 70 6.16 d	Department of Health	Whether the guidance surrounding the Care Programme Approach could be clearer about the particular role of the commissioners and the retention of responsibility for clinical oversight in situations in which the patient has been placed outside of local services.
81	NHS Review Page 70 6.16 e	Department of Health	Whether existing standards and expectations of independent skilled advocacy support advice are sufficient.
82	NHS Review Page 70 6.16 f	Department of Health	Whether there are adequate checks and balances available in relation to situations in which patients are transferred between two facilities operated by the same provider organisation.
83	NHS Review Page 70 6.16 g	Department of Health	How to achieve clarity on the appropriate balance between checks and assurance carried out by the regulator, the necessary additional checks and assurance that should be pursued by commissioners before making any referrals.

No	From	For action by	Recommendations
84	NHS Review Page 70 6.16 h	Department of Health	What additional contribution families, self and peer advocates can make to monitoring and reporting on experiences of quality.
85	Serious Case Review Page 124 Recommendation 5	Department of Health	The guidance associated with the legislative framework for placing Safeguarding Adults Boards on a statutory footing, and any subsequent review of safeguarding guidance, should reflect the findings of all the reviews associated with Winterbourne View Hospital.
86	Serious Case Review Page 126 Recommendation 6	Department of Health	Adults with learning disabilities and autism, who are not subject to the provisions of the Mental Health Act 1983, should not, by law, be the subject of restrictions in the same way as with patients who are subject to the provisions of mental health legislation.
87	Serious Case Review Page 127 Recommendation 8	Department of Health	The Department of Health should take steps to ensure there is clarity across the health and social care spectrum about commissioning responsibilities for hospital based care for people with learning disability.
88	Serious Case Review Page 127 Recommendation 13	Department of Health	A commissioning challenge is required. There are 51 former patients of Winterbourne View Hospital, some of whom have transferred to other hospitals and secure settings. Commissioners ought to use their best endeavours in relation to ex-patients transferred to hospitals (who are not detained under the Mental Health Act 1983) to return them home or to suitable placements within their local communities. The treatment of those who are detained under the Mental Health Act 1983 should be focused on recovery and support with a view to returning them to their local communities. This will require more than keeping tabs on where they are now – political support, the engagement of generic mental health services, as well as the First Tier Tribunal – Mental Health and capable managers and staff are essential if competent and humane forms of local provision are to develop.

No	From	For action by	Recommendations
89	Serious Case Review Page 130 Recommendation 14	Department of Health	There should be a condition of employment on all health and social care practitioners (registered and unregistered) to report operational concerns to (i) the Chief Executive and Boards of Hospitals (ii) the regulator.
90	Serious Case Review Page 130 Recommendation 15	Department of Health	All registered health and social care employers should be required to advise their employees in their contracts to whom they can whilst blow, the response that the employee can anticipate from the employer and what to do if this is not forthcoming. This should include information about provision in the Employment Rights Act 1996 which gives protection to those making disclosures in the public interest.
91	Serious Case Review Page 132 Recommendation 19	Department of Health	The Department of Health should consult the National Quality Board about how to rationalise the notifications which hospitals providing services to adults with learning disabilities and autism should make, and confirm which agency should "hold" this information.
92	Serious Case Review Page 135 Recommendation 21	Department of Health	The Department of Health, Department of Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disability and autism in hospitals and assessment and treatment units. An investment comparable to the banning of the corporal punishment of children is required. The use of restrictive physical intervention "as a last resort" characterises all policies and guidance and yet made no difference to the experience of patients at Winterbourne View Hospital.
93	Serious Case Review Page 137 Recommendation 28	Department of Health	There is compelling case for mandatory visits by the Nominated Individual/Board Member reported and brought together in an annual report accompanying the accounts. The Department of Health should consider amending registration requirements to require such mandatory visits and public reporting.

No	From	For action by	Recommendations
94	Serious Case Review Page 142 Recommendation 40	Department of Health	Reducing the use of anti-psychotic medication with adults with a learning disability and autism requires attention. An outcome of the National Dementia Strategy (Department of Health 2009) was an investment in reducing anti-psychotic medication for patients with dementia (Banerjee 2009). Adults with learning disabilities require no less.
95	Mencap Out of Sight Page 7 Action needed 1	Department of Health	The government must show strong leadership and clearly set out what each player in the health and social care system is expected to do within an agreed timescale. It must also say who is accountable for the different parts of an action plan.
96	Mencap Out of Sight Page 7 Action needed 2	Department of Health	The government must start a closure programme of all large assessment and treatment units are integrated with local services.
97	Mencap Out of Sight Page 7 Action needed 3	Department of Health	The government must tell commissioners to develop local services that meet the needs of children and adults with a learning disability and behaviour that challenges, including community-based intensive support services. There must be no excuse for sending vulnerable people far away.
98	Mencap Out of Sight Page 7 Action needed 4	Department of Health	The government must carry out an urgent review to ensure that funding arrangements do not work against the incentive to get people out of assessment and treatment units and that 'economies of scale' don't force the continued development or larger units.
99	Mencap Out of Sight Page 7 Action needed 5	Department of Health	The government must ensure that the Care Quality Commission has the power to only register services that are in line with the policy recommendations in the Mansell Report.
100	Mencap Out of Sight Page 7 Action needed 7	Department of Health	The government must strengthen the law on adult safeguarding to keep people safe from abuse and ensure that rigorous action is taken against abusers and responsible organisation when abuse occurs.

No	From	For action by	Recommendations
101	NHS Review Page 69 6.15 a	Department of Health / Serious Case Review	The experience of Local Authorities as commissioners of care at Winterbourne View.
102	NHS Review Page 69 6.15 b	Department of Health / Serious Case Review	The effectiveness of communication within the safeguarding system
103	NHS Review Page 69 6.15 c	Department of Health / Serious Case Review	The extent to which the system of regulation might have provided unmerited assurance to commissioners of care and treatment about the standards at Winterbourne View.
104	NHS Review Page 69 6.15 d	Department of Health / Serious Case Review	Whether issues were considered and resolved appropriately within the safeguarding process.
105	NHS Review Page 69 6.15 e	Department of Health / Serious Case Review	The extent to which patterns and trends in incidents of concern could have been identified more clearly within the safeguarding process.
106	NHS Review Page 69 6.15 f	Department of Health / Serious Case Review	The adequacy of the systems of clinical governance and the quality of clinical care provided by Castlebeck Ltd at Winterbourne View, including the discharge of professional responsibilities by those employed by Castlebeck.
107	Serious Case Review Page 127 Recommendation 10	Department of Health and Care Quality Commission	The Department of Health should assure itself that Care Quality Commission's current legal responsibility to monitor and report on the use of Deprivation of Liberty Safeguard provides sufficient scrutiny of the use of DoLS.
108	Serious Case Review Page 132 Recommendation 18	Department of Health and National Quality Board	The National Quality Board should devise a mechanism for aggregating pertinent safeguarding information for NHS patients with learning disabilities and autism as part of its consideration of actions to correct actual or serious failure (Department of Health 2012).

No	From	For action by	Recommendations
109	Serious Case Review Page 131 Recommendation 16	Local Authority	Council Safeguarding Adults personnel must ensure that hospital patients, subject to Deprivation of Liberty Safeguards and Mental Health Act detention, who are restrained and/or make a complaint, have opportunities to access, in private, independent professionals such as social workers, local authority Deprivation of Liberty Safeguards assessors, Independent Mental Capacity Advocates or Independent Mental Health Advocates and Mental Health Act Commissioners for those detained under the Mental Health Act 1983.
110	Serious Case Review Page 131 Recommendation 17	Local Authority	When a hospital fails to produce a credible safeguarding investigation report within an agreed timeframe, the host Safeguarding Adult Boards should consult with the relevant commissioners and the regulators to identify remedies to identify remedies.
111	Serious Case Review Page 136 Recommendation 24	Local Authority and Care Quality Commission	Local Adult Safeguarding Boards, Care Quality Commission and all stakeholders should regard hospitals for adults with learning disabilities and autism as high risk services i.e. services where patients are at risk of receiving abusive and restrictive practices within indefinite timeframes. Such services require more than the standard approach to inspections and regulation. They require frequent, more thorough, unannounced inspections, more probing criminal investigations, and exacting safeguarding investigations.
112	Serious Case Review Page 137 Recommendation 25	Monitor	Monitor, as the sector regulator of all provider of NHS funded services, should consider the inclusion of internal reporting requirements for Boars of registered provider services in their provider licence conditions.

No	From	For action by	Recommendations
113	Serious Case Review Page 141 Recommendation 34	All Providers	To meet their statutory obligations all providers of residential, nursing home and hospital care should require that their registered managers' normal place of work is one where they can become known to patients/service users and are routinely visible and accessible for the staff who are working 365 day rotas.
	Care Quality Commission Learning Disability Service Inspection Report Page 9 Recommendation 4	All Providers	Providers must ensure that people using services are routinely involved and 'own' their care planning and activities. These must be available in appropriate formats and must be accessible.
114	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 5	All Providers	There are still lessons to be learned by providers about the use of restraint. There is an urgent need to reduce the use restraint, together with training in the appropriate techniques for restraint when it is unavoidable. There also needs to be systematic monitoring about the use of restraint and ongoing analysis so that lessons can be learned and patterns of use better understood, which should all lead to less use of restraint. The use of seclusion needs to be recorded as a form of restraint.
115	Care Quality Commission Learning Disability Service Inspection Report Page 8 Recommendation 6	All Providers	Providers must ensure that staff understand and can apply the deprivation of liberty safeguards.

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Care Quality Commission (CQC)

briefing for Bath and North East Somerset council

Wellbeing Policy Development and Scrutiny Panel

On 21 September 2012

Dear Mr Pritchard and scrutiny panel members

I am sorry I will be unable to attend your meeting in person on 21 September 2012. Unfortunately, I have a long standing commitment to a national CQC management conference, which is the reason why we also are unable to send another manager to meet with the panel.

There is a lot on documented information that I could have sent, some of which no doubt the panel will have already read. So I have given some thought to the most appropriate briefing in respect of Winterbourne View specifically. I will be attending your next meeting on 16 November 2012 and this will be an opportunity to discuss local issues in Bath and North East Somerset and the communications between the CQC, the panel and other local agencies.

I have set out a briefing below, as follows

1. **Extract from Dame Jo William's briefing to CQC staff following the publication of the Winterbourne View SCR**

2. **Extract from the CQC Individual Management Review (IMR) submission to the Serious Case Review (SCR) panel**

   - Actions the Care Quality Commission has taken

3. **Extract from the CQC IMR**

   - Recommendations

Karen Taylor
Compliance Manager
Care Quality Commission
Bath and North East Somerset and Wiltshire
6 September 2012

1. Extract from Dame Jo William's briefing to CQC staff following the publication of the Winterbourne View SCR

Winterbourne View was a watershed moment for CQC. It demonstrated very clearly where our systems needed to be stronger, it showed where we needed to reinforce our model, and it was a terrible illustration of the vulnerability of people in hospitals like Winterbourne View.

It also reinforced that no single organisation can stop abuse of this kind. Panorama focused on our role in the events, but as the serious case review points out, there are many organisations involved in protecting people from the kind of abuse uncovered at Winterbourne View and all of them let down the residents there in some way.

Our actions since Winterbourne View have shown how seriously we have taken our responsibilities to improve and - as Margaret Flynn, the author of the serious case review, acknowledges - how honest we were about what needed to be done.

Among other things, we now have a specialist team in the NCSC taking whistleblowing calls (up from around 50 a month before Winterbourne View to over 500 a month now) and each one is tracked until it is resolved. Our revised model acknowledges the higher risk that hospitals like Winterbourne View carry with more frequent unannounced inspections. And we were able to go to the Department of Health and ask for more inspectors - an extra 250 - so that we can visit more providers more frequently. Our own internal management review made 13 recommendations for changes which we are adopting.

Our inspections of 150 services for people with learning disabilities was a landmark piece of work. It brought to light that this sector is not nearly good enough - almost half the locations we inspected were non-compliant. Among the failings were too many people in assessment and treatment for too long, and people fitted into services, rather than having services designed around their needs.

We have already done a lot to make sure there is no repeat of Winterbourne View. We cannot guarantee that abuse like that will never take place, but we have more people, better systems and a revised model that makes us much stronger. As the serious case review makes clear, preventing abuse is not only a matter for CQC; good care starts with providers and their staff, relies on effective commissioning and safeguarding procedures, and is informed by the views of people who use services and their families. We must all work better to ensure people are protected from abuse.

2. Extract from the CQC IMR

Actions the Care Quality Commission has taken

216. The end-to-end review of the service, from the time it was first registered and regulated by the Healthcare Commission through to the closure of the service following the BBC Panorama expose, was significant in helping us make improvements to our management practices and regulatory model:

- The way in which we now weight and track the concerns of whistleblowers has been improved.
- We are sharpening up the supervisory arrangements between Compliance Inspectors and Compliance Managers and Compliance Managers and Regional Directors, so that there is always a focus and tracking on services where safeguarding concerns have been highlighted through any relevant data and information sources including from whistleblowers.
- Inspectors and mangers must sign off the outcomes arising from any actions taken in response to safeguarding alerts.
- The evidence from the Mental Health Act Commissioners and the Second Opinion Appointed Doctors is increasingly an integral component of our regulatory evidence set.
- We are actively engaged in the way in which we liaise and work with Adult Safeguarding Teams and Boards across England, including developing protocols and agreements covering information sharing, attendance and sign off of multi agency action plans.

217. Since the abuse at Winterbourne View was exposed, the Care Quality Commission has begun a programme of unannounced inspections of all those services that are delivering care to those with learning disabilities, challenging behaviour and mental health needs.
218. The work is being supported by an advisory group who have helped to shape the methodology and also provide access to experts by experience and professionals who will be part of the inspection teams.
219. This programme of inspection will be completed by January 2012 and inspection reports published soon after.
220. This approach to inspecting services will not be a one-off activity. The Care Quality Commission is proposing to carry out unannounced annualised inspection of, all independent hospitals and adult social care providers from April 2012. We are currently consulting on changes to the judgement framework and our enforcement policy19 and subject to an endorsement for those changes we will deliver a simplified inspection process.
221. Whilst the Care Quality Commission can never ensure that abuse does not take place in the myriad of regulated care settings, we are committed to making sure that our management processes and the delivery of our regulatory activity play their part in the overall system attempts to protect those who are most vulnerable.

3. Extract from CQC's IMR - recommendations

RECOMMENDATION 1
The Care Quality Commission should highlight in our quality and risk profiles (QRP) that services defined as providing regulated activities in residential institutions for people with learning disability, challenging behaviours and mental health needs are inherently higher risk institutions. This is consistent with the DH guidance on models of service delivery for this group of patients. This higher risk status will act as an alert system to our staff when looking at data and information and when carrying out inspections of these institutions. This change should be implemented immediately.

RECOMMENDATION 2
The Care Quality Commission should take account of the inherent risk of different types of service provision and the different characteristics of the people using those services throughout its work. This will include collated intelligence about corporate providers as well as individual locations which will help to identify risks across a provider group as well as at individual location level.

Although the Care Quality Commission now has a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.

RECOMMENDATION 3 Compliance inspectors should record the outcome of the investigations from safeguarding alerts and compliance managers should sign off the agreed actions from those investigations. Where CQC cannot agree the outcomes from the investigation this should be communicated back to the Safeguarding Adult Team and if necessary to the Adult Safeguarding Board.

RECOMMENDATION 4
Although the Care Quality Commission now has a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.

RECOMMENDATION 5
The Care Quality Commission should build new protocols about working with local Safeguarding Adults Teams and Safeguarding Adult Boards to ensure there is timely investigation and intervention of relevant safeguarding alerts, and to ensure that all relevant parties are involved in the investigation of the incident(s) leading to the alert(s).

RECOMMENDATION 6
The Care Quality Commission should develop its analysis of safeguarding alerts to look at particular trends at individual locations, and across service providers. This is particularly important in looking at concerns across chains of providers which cross the Care Quality Commission's geographical boundaries.

RECOMMENDATION 7
The Care Quality Commission should evaluate and embed the process it has commenced of integrated, routine and on going exchanges of information between the Compliance Inspectors and Mental Health Act Commissioners and, where appropriate, for joint inspections to take place. This needs to be managed through the supervisory arrangements between the Compliance Managers and their inspectors and the Mental Health Act Commissioner Managers and their Commissioners.

RECOMMENDATION 8
The information and intelligence that the Second Opinion Appointed Doctors may capture regarding concerns that they have for patient safety as part of their statutory remit should be systematically and routinely recorded and made available as part of the intelligence and risk information used by CQC in its work. CQC should review the mechanisms by which SOADs receive pre-visit relevant information and how they feed back to CQC on concerns observed during the discharge of their statutory function.

RECOMMENDATION 9
When the Care Quality Commission Mental Health Act Commissioners set out their comments and suggestions for the provider following a visit these should be monitored through an action plan submitted to the Care Quality Commission, and linked with the QRP for the location. There should be follow up to ensure that the agreed actions are being implemented as agreed. Where there is failure to do so the Adult Safeguarding Team should be notified.

RECOMMENDATION 10
The Care Quality Commission should review how it collates information and looks at risk at provider level as well as at location level. This is particularly important for chains of providers where systemic issues could be overlooked because of a focus on location level information.

RECOMMENDATION 11 The Care Quality Commission's Board should receive a report on the whistle blowing arrangements that are in place on a six-monthly basis. This should be a public report setting out in detail the scope, volume and actions taken by the Care Quality Commission in response to the concerns raised by whistleblowers.

RECOMMENDATION 12
The Care Quality Commission should audit, on an annual basis, the effectiveness of the case management arrangements in place to ensure that

supervision is systematically considering the services with the most serious concerns as part of a quality assurance process. The outcomes of this audit should be reported to the Board, and the report should be made public.

RECOMMENDATION 12 The Care Quality Commission should immediately audit the interaction that it has with Safeguarding Adult Teams and Boards across England. The audit should focus on which staff normally represent the Care Quality Commission at meetings, the circumstances which trigger our attendance at a meeting and how we sign off the actions agreed at a multi agency safeguarding meeting.

RECOMMENDATION 13
The Care Quality Commission should now develop a protocol about the way in which we will work with the Safeguarding Adult Boards and Teams across England. The protocol should take account of what the proposed legislation may set out and also take account of what has worked effectively in Children's Safeguarding Boards.

Bath & North East Somerset Council		
MEETING:	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING DATE:	**21st September 2012**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	Personal Budgets: Review of Policy Framework & Resource Allocation (Progress Report) COVER REPORT	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 - Personal Budgets: Review of Policy Framework & Resource Allocation (Progress Report) MAIN REPORT		

1 THE ISSUE

1.1 The report summarises work undertaken since March 2012 (and before) to review and revise the Personal Budgets policy framework and Resource Allocation System (RAS) currently used to deliver social care services in Bath & North East Somerset.

1.2 This review and revision is necessary in order to:

(1) Achieve financial sustainability and meet the Council's efficiency targets for adult social care.

(2) Achieve the central Government target to deliver PBs to 100% of all adult social care users by April 2013.

(3) Address a range of equalities issues which have been identified in the current social care system.

1.3 A project group has been established to assess the benefits of adopting the **National RAS** in Bath & North East Somerset. This is a tool commissioned by the Department of Health, currently in use by the majority of local authorities (122) as the primary mechanism for allocating funding to meet the social care needs of individual service users.

2 RECOMMENDATION

The Wellbeing Policy Development & Scrutiny Panel agrees that:

2.1 Based on the modelling contained in the main report, the **percentile model** for calibrating the national RAS locally is further explored and tested.

2.2 Based on the above recommendation, **further engagement and consultation** with service users, carers and social care staff takes place.

2.3 Based on the modelling contained in the main report, **scenario 4** of the five transitional scenarios is adopted when roll out of the national RAS begins.

2.4 Implementation of the national RAS should take place in early 2013 following a period of statutory consultation.

3 FINANCIAL IMPLICATIONS

3.1 A previous report to the Wellbeing Policy Development & Scrutiny Panel on 13th March 2012 set out the financial context for the proposed changes to the Personal Budgets Resource Allocation System, the implementation of which is assumed to be cost neutral overall.

3.2 The project group has identified potential transitional costs of implementation which will vary according to a) the RAS calibration model adopted and b) the mitigation measures approved by B&NES. Detailed analysis is contained in the main report.

4 THE REPORT

4.1 The main report (Appendix 1) provides details of:

(1) Background & context for Personal Budgets in B&NES
(2) Financial modelling to illustrate the Resource Allocation System currently used in B&NES
(3) Financial modelling of options for calibrating the National RAS for use in B&NES

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 considerations are detailed in the main report including impact assessment and modelling of potential implementation options. A formal EIA is in the process of being completed with support from the Equalities Team who have advised the project group throughout.

7 CONSULTATION

7.1 *Ward Councillor; Cabinet members; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies*

7.2 Statutory consultation period to commence in October 2012 including service user focus groups, mailshots and network meetings.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Sustainability; 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* *Sarah_Shatwell@bathnes.gov.uk* *01225 477162*
Sponsoring Cabinet Member	*Councillor Simon Allen*
Background papers	Wellbeing Policy Development & Scrutiny Panel Report: 16th March 2012 *'Personal Budgets: Review of Policy Framework & Resource Allocation System'*
Please contact the report author if you need to access this report in an alternative format	

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Appendix 1

Personal Budgets: Review of Policy Framework & Resource Allocation (Progress Report) MAIN REPORT

Background & Context

A Personal Budget (PB) is an allocation of money made by social services to meet an individual's assessed care & support needs. Anyone who receives a PB must be eligible under the Council's eligibility criteria (also known as FACS).

Within the FACS eligibility framework the amount of PB is calculated using a Resource Allocation System (RAS), a formula which translates assessed needs into points and then into an amount of money.

Bath & North East Somerset Council was one of thirteen pilot local authorities that contributed to the development and subsequent mainstreaming of PBs. As a pilot site B&NES developed its' own RAS which was largely based on historical spending patterns across different client groups

PBs can be used by service users to purchase a range of community care and support services to meet their identified needs. PBs are not currently offered to service users to purchase residential or nursing home placements.

More than 60% of all adult social care services users in B&NES now receive a PB with which to purchase services, and whilst many express a preference to have services commissioned by the local authority (PB commissioned), a significant number choose to manage their own budget under a Direct Payment arrangement (PBDP) and a third group opt for a mixed package (PB mixed).

The Government vision in relation to PBs is set out in *A Vision for Adult Social Care: Capable Communities and Active Citizens*[1] which states that *'Councils should: provide personal budgets for everyone eligible for on-going social care, preferably as a direct payment, by April 2013'.*

A Social Care Strategic Planning Group was established in October 2011 to address issues arising from the mainstreaming of PBs. This group has pursued a number of lines of enquiry in order to corroborate anecdotal evidence of inequality and inefficiency in the current system.

Financial Modelling of Current System

Financial analysis shows that per head expenditure on social care packages has increased since the mainstreaming of Personal Budgets in Bath & North East Somerset.[2]

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[1] Department of Health, 16th November 2010

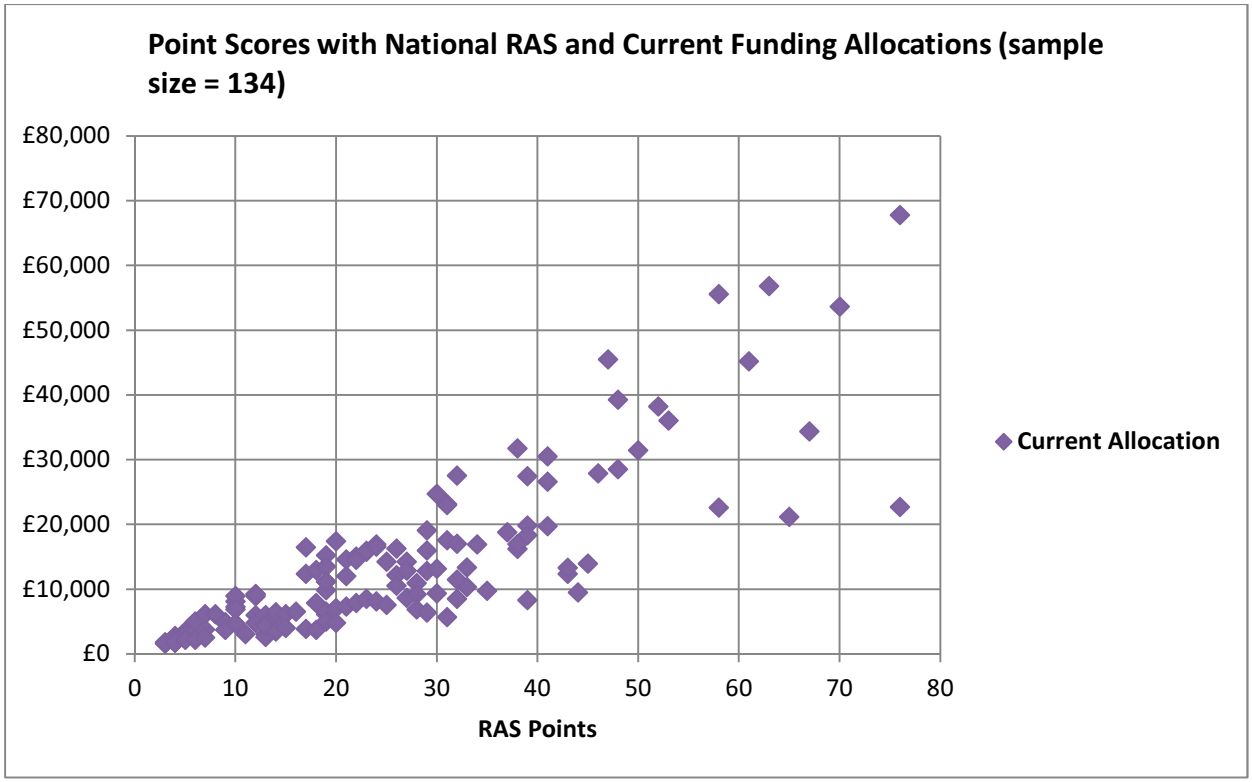
[2] Wellbeing Policy Development & Scrutiny Panel Report: 16th March 2012
'Personal Budgets: Review of Policy Framework & Resource Allocation System'

This increase appears to be over and above that which could be linked to inflationary or demand pressures though it is clear that demand for social care services continues to rise in line with the frailty and complexity of service users presenting.

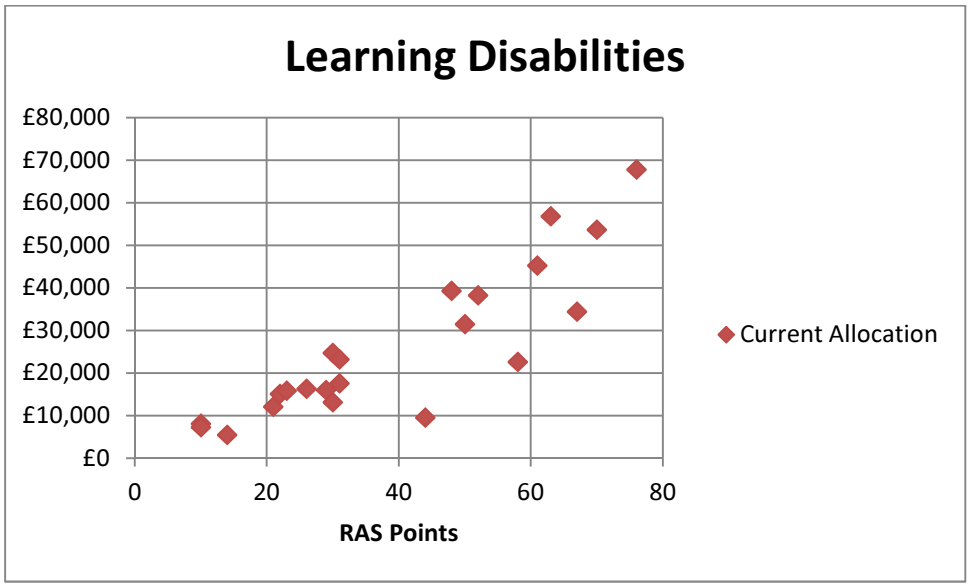
Further analysis of the current RAS has shown that in general younger people tend to receive a higher level of resource than older people. In addition, analysis of the application of FACS eligibility criteria in the process of resource allocation has revealed inconsistencies both between and within social work teams, and in some cases packages of care offered to service users are holistic, rather than focussed on addressing substantial or critical risks as set out within the current B&NES eligibility framework.

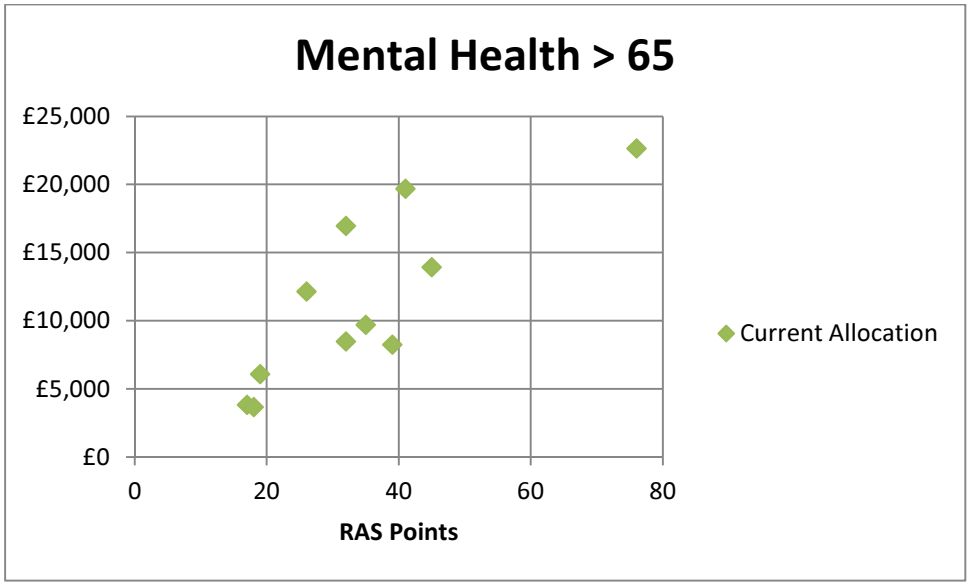
The Strategic Planning Group has begun to explore the use of the national RAS which was commissioned by the Department of Health and has been adopted by 122 other Council's. The national RAS uses a simple questionnaire to assess social care needs and translate them into points. The questionnaire has been approved by ADASS as a viable basis for statutory Community Care Assessment.

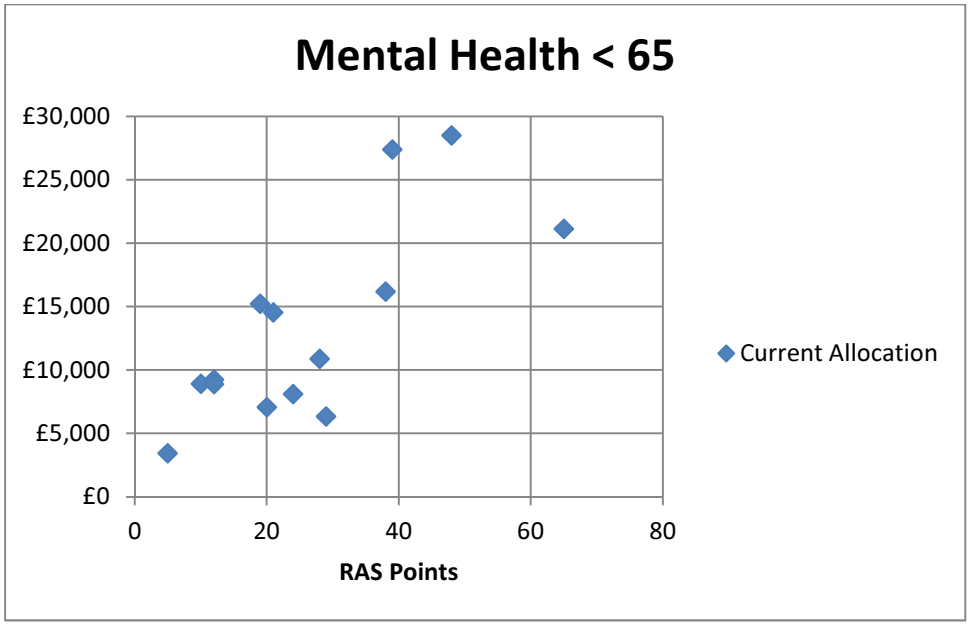
The chart below shows the distribution of national RAS points (needs assessment points) for a representative sample of 134 existing social care users in B&NES and the PB allocations these individuals currently receive. This illustrates the inconsistency of current resource allocation, even for people who have been assessed as having a similar level of need.

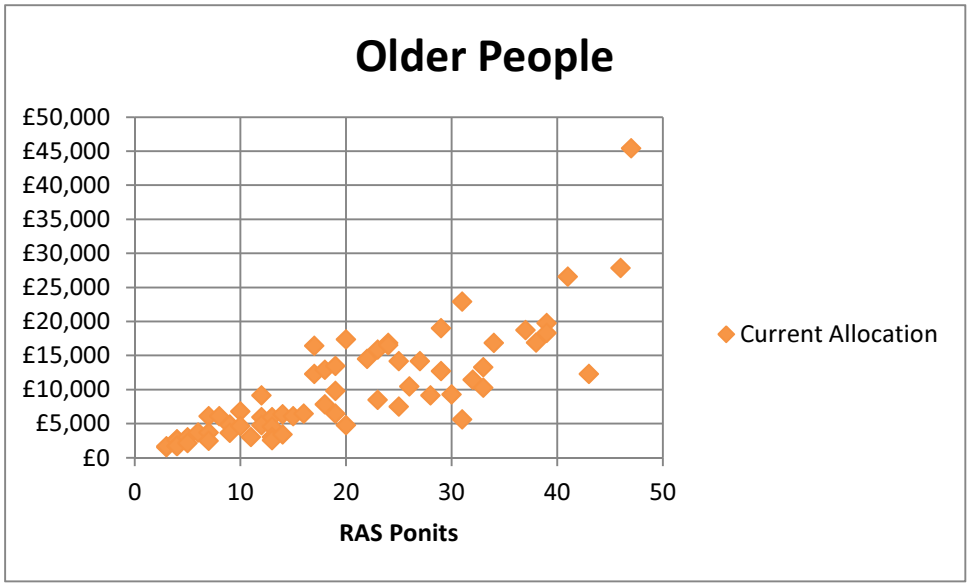


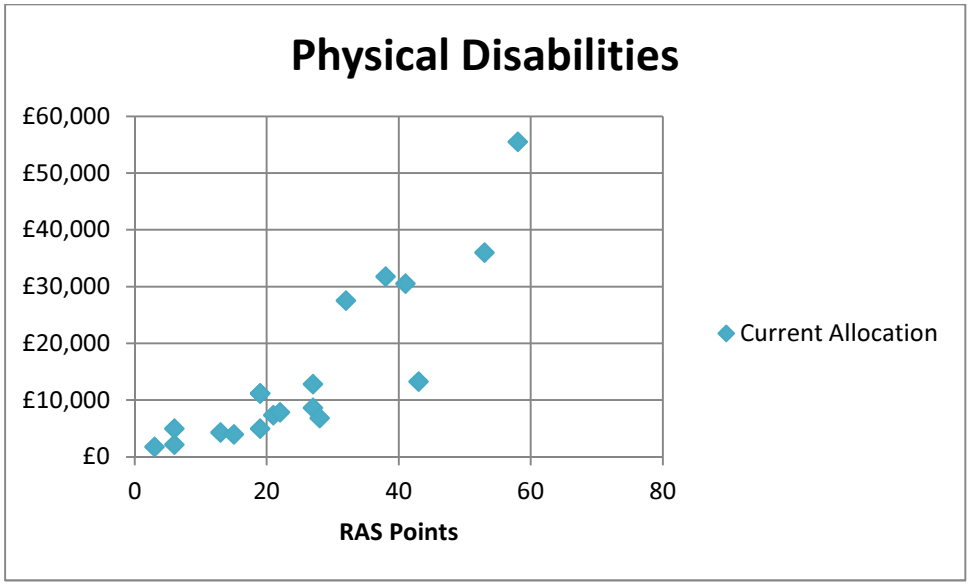
The following charts break down the data into specific service user groups to show that significant variation in resource allocation which exists, an issue which is concerning from an equalities perspective.






Mental Health < 65
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
0
20
40
60
80
RAS Points
Current Allocation


Older People
£50,000
£45,000
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
0
10
20
30
40
50
RAS Ponits
Current Allocation



Financial Modelling of Options for Calibrating the National RAS

The national RAS must be calibrated locally to ensure that spend on PBs does not exceed available budgets. There are three options for calibration, all of which involve using the representative sample of service users shown in the above illustrations as a basis for re-distributing resource allocations in a more consistent and equitable manner which is more clearly linked to assessed need.

Fixed Model - The first method divides the total number of RAS points (for all clients in the sample) by the total budget available and allocates the same amount for each point regardless of degree and complexity of need.

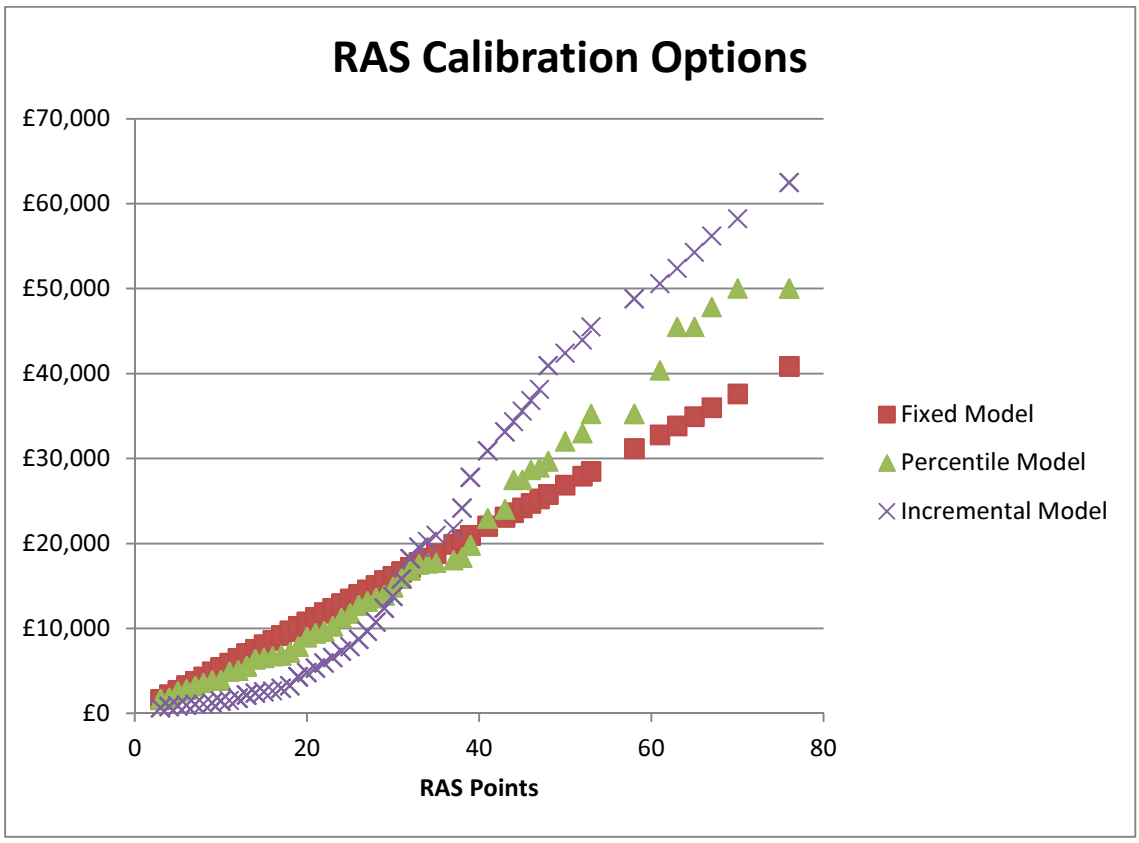
Percentile Model - The second method allocates the highest amount (based on current spend) to the client in the sample with the highest RAS point score and allocates amounts to others in the sample based on their relative RAS point position within the sample.

Incremental Method – The third method uses a sophisticated mathematical formula (linear regression) to allocate an increasing amount to individuals with higher RAS point scores to reflect increasing complexity

All three methods are adjustable and all will result in some clients being awarded both higher and lower allocations than are currently made. In addition, all three models can be either,

- Capped to apply efficiencies across the whole system
- Capped at a maximum allocation, above which alternative arrangements for resource allocation can be made e.g. for very high need/complex cases
- Inflated to respond to market forces
- Adjusted to allow for transitional/mitigation measures

The following chart below illustrates the impact of applying each of the three calibration methods to the representative sample of 134 existing social care users.



Implementing the national RAS will allow B&NES to achieve a more sustainable method of delivering PBs although the transitional period will inevitably pose some challenges.

Fixed Model – Results in broadly the same number of higher and lower allocations (68:66) with the majority of higher allocations being at the lower end of the cost range.

The lower end of the cost range is where approximately 75% of the existing client base is according to the 134 cases sampled. The lower end of the cost range is also where the majority of older clients are distributed according to the 134 cases sampled.

The fixed model also results in significantly lower allocations for clients with the greatest/most complex needs although the number of clients affected in this way would be fewer.

Percentile Model – Results in fewer higher allocations and a greater number of lower allocations (60:74) than the fixed model however the amount of variance between current and projected allocations is lower than with the fixed model i.e. new allocations would be nearer to current ones so there would be closer alignment between old and new.

Incremental Model – Results in the fewest higher allocations and the greatest number of lower allocations (37:97) than either of the other two models. The majority of lower allocations would be at the lower end of the cost range and the average variance from current costs would be more pronounced in a number of cost bandings.

Average variance from current allocations with all three calibration models varies depending on client group and on current cost range as illustrated in the table below.

Client Group	Range	No	Average Existing Cost	Fixed Model	Percentile Model	Incremental Model
Older People	£0 - £2,500	7	1,875	2,338	2,071	748
Older People	£2,501 - £5,000	16	3,749	5,422	4,486	1,582
Older People	£5,001 - £10,000	16	7,358	9,174	7,705	4,120
Older People	£10,001 - £15,000	13	12,565	14,900	13,664	12,239
Older People	£15,001 - £20,000	11	17,530	16,072	14,442	14,646
Older People	£20,001 - £30,000	3	25,798	21,462	22,197	27,690
Older People	£30,000+	1	45,436	25,645	28,790	38,049
Physical Disabilities	£0 - £10,000	10	5,702	8,730	7,494	4,211
Physical Disabilities	£10,001 - £20,000	4	12,108	14,733	13,375	12,714
Physical Disabilities	£20,001 - £30,000	1	27,496	17,461	16,921	18,014
Physical Disabilities	£30,001 - £40,000	3	32,736	24,009	25,780	33,931
Physical Disabilities	£40,000+	1	55,519	31,648	36,471	50,588
Learning Difficulties	£0 - £10,000	4	7,550	10,640	10,237	9,814
Learning Difficulties	£10,001 - £20,000	7	15,080	14,187	12,639	9,606
Learning Difficulties	£20,001 - £30,000	3	23,461	21,644	22,552	26,587
Learning Difficulties	£30,001 - £40,000	4	35,796	29,601	36,027	47,501
Learning Difficulties	£40,001 - £50,000	1	45,171	33,285	40,346	52,421
Learning Difficulties	£50,000+	3	59,384	38,014	48,429	59,891
Mental Health Under 65	£0 - £10,000	7	7,418	8,730	7,345	4,230
Mental Health Under 65	£10,001 - £20,000	4	14,200	14,460	12,567	10,969
Mental Health Under 65	£21,000 - £30,000	3	25,667	27,646	31,557	42,082
Mental Health Over 65	£0 - £10,000	5	6,123	13,641	11,957	11,158
Mental Health Over 65	£10,001 - £20,000	5	16,507	20,953	21,936	27,009
Mental Health Over 65	£21,000 - £40,000	2	28,859	30,284	33,876	42,839
Total		**134**				

Transitional Options

Calibration of the national RAS is assumed to be a cost neutral process i.e. the tool is calibrated to the social care budget set. However the broader context for this work is the significant financial challenge the Council faces in responding to the requirement for savings and efficiencies across all service areas.

Furthermore, financial modeling indicates that transitional cost pressures are likely to be incurred as the new system is rolled out to all new and existing social care clients and these costs will need to be managed, in addition to managing individual client needs and expectations in line with statutory responsibilities.

In order for the implementation process to be cost neutral a number of scenarios have been modeled in relation to mitigation/protection options for individual service users who may be affected. Further financial analysis has been completed to model transitional costs associated with the sample of 134 existing social care users, based on each of the three calibration models assuming five different scenarios as follows:

Scenario 1 – All existing clients receiving a higher allocation are awarded this figure in full despite current costs being lower. All existing clients receiving a lower allocation are allowed 12 months before any reductions are applied.

Scenario 2 - All existing clients receiving a higher allocation are awarded this figure in full despite current costs being lower. All existing clients receiving a lower allocation are required to phase down the cost of their current package to the allocated amount over a 12 month period.

Scenario 3 – All existing clients receive their new allocations (higher or lower) with immediate effect.

Scenario 4 – All existing clients receiving a higher allocation are awarded a figure in line with current costs. All existing clients receiving a lower allocation are required to phase down the cost of their current package to the allocated amount over a 12 month period.

Scenario 5 - All existing clients receiving a higher allocation are awarded a figure in line with current costs. All existing clients receiving a lower allocation do so with immediate effect.

The table below summarizes the impact of each of the above scenarios for each calibration model.

	Existing Costs	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Fixed Model	1,866	2,206	2,059	1,866	1,739	1,566
Pressure/(Saving)		**320**	**173**		**(147)**	**(320)**
Percentile Model	1,866	2,179	2,033	1,861	1,740	1,568
Pressure/(Saving)		**293**	**148**	**(25)**	**(146)**	**(318)**
Incremental Model	1,866	tbc	tbc	tbc	tbc	tbc
Pressure/(Saving)		tbc	tbc	tbc	tbc	Tbc

Contingencies

Guidance provided by ADASS recommends setting aside a contingency within each individual's PB allocation for all new clients who are 'processed' using the new national RAS. This allows further calibration of the RAS during the initial phases of implementation and ensures that clients have access to additional funds within their allocation should the amount awarded be insufficient. For example, setting aside a contingency of 20% of each allocation guards against the risk of over allocating whilst also ensuring that additional one off costs can be met if needed.

Managing Individual Re-Allocations & System Transformation

A limited amount of case modeling has been completed to establish any impacts and potential solutions and alternative care arrangements for clients who might see a change in their PB allocation as a result of national RAS implementation. To date this type of modeling has only been completed for a number of older people and further work is underway in relation to younger clients including people with learning disabilities and mental health problems.

Early indications are that direct employment of staff using a Direct Payment rather than relying on Sirona/B&NES to commission care can significantly reduce costs and allow clients to manage with lower PB allocations. A system shift towards greater uptake of Direct Payments would need to be supported by market changes such as an increase in the provision of DP support agencies and an increase in the availability of Personal Assistants as opposed to staff employed by provider agencies.

The third sector, community and voluntary sector will have a key role to play in supporting and facilitating change in the social care system and in fostering a culture of care in which service users are directed to their local communities rather than to statutory services. Implementation of the national RAS will need to be robustly managed to ensure that practitioners are supported to stay within budget however this is only likely to be possible with access to a full range of voluntary sector services.

Timescales for Implementation

Work to date indicates that implementation of the national RAS could begin in early 2013 following a statutory consultation period to take place between October and December 2012. The momentum gathered to date with staff in the project team and within Sirona would not be lost if this timescale were to be adopted.

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	September 2012	**AGENDA ITEM NUMBER**
TITLE:	**Specialist Mental Health Services update**	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 - Working draft outline for the Care Home and Community Hospital Liaison Service Specification (developmental) Appendix 2 Primary Care Liaison Activity Information		

1 THE ISSUE

1.1 This paper gives an updated progress report on specialist mental health services provided by the Avon & Wiltshire Mental Health NHS Trust (AWPT) in the context of the modernisation programme for services described previous reports to the panel in October 2011 and January 2012 and a recent CQC Community Services inspection.

1.2 The report also sets out AWP's response to the findings of the recent NHS South SHA independent review report on governance and management arrangements. This report was received and accepted at the April 27th 2012 AWP Trust Board and was then published following the SHA July 26th 2012 Board meeting. The recommendations from the independent review form the basis of the objectives in an implementation plan, Fit for the Future (Appendix 1). This plan provides the focus for action in AWP.

2 RECOMMENDATION

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

2.1 Progress in implementing the Care Home and Community Hospital Liaison service (as previously agreed).

2.2 The implementation of the Adult of Working Age community services redesign in line with local and national strategic intentions.

2.3 Progress to date on further environmental improvements to Hillview Lodge.

2.4 AWP response to recent CQC and Strategic Health Authority reviews and reports – Fit for the Future.

3 FINANCIAL IMPLICATIONS

There are no direct financial implications for the council from this update. Previous financial context from January 2012 report applies.

4 THE REPORT

4.1 AWP B&NES Service Redesign - progress

Since the previous reports that gained agreement for service redesign, commissioners and AWP have had the following aims:

- To maintain service continuity during redesign
- To ensure compliance with care management requirements (including electronic records)
- To manage safely all transitions of service users between clinicians, care coordinators and teams, and staff between services.
- To ensure that service users have named care coordinators at all times and that key service standards continue to be delivered.
- To supervise, via service manager caseload reviews, the transfer of clients from one care co-ordinator to another where there has been staff changes

4.2 Care Home Liaison Service

- The Care Home Liaison service now employs 2 x Band 6 Community Psychiatric Nurses and is managed by one of the Senior Practitioners within the Complex and Intervention Treatment Team (previously call the Older Adults Community Mental Health Team). The team has access to mental health workers, previously undertaking the Intensive Support Team role, as described in the update to panel in January 2012. The new workers started in their role on 16th July 2012.
- An outline shape of service is being used as a working draft to inform the development of the service specification between the commissioner and AWP. (Appendix 1)
- Since the service began in July there have been 38 referrals, with more coming from the Bath area than from North East Somerset and more from GPs and Care Homes than the community hospitals.
- Partnership working is at the heart of the services. An example is the team working with Dorothy House to deliver joint training to Sirona Care and Health Staff on End of Life Care and Dementia.

4.3 Primary Care Liaison Service (PCLS)

- As detailed within the previous panel papers in January, service redesign, by its nature, will change the planned care pathway for service users. The Primary Care Liaison Service (PCLS) is the 'in-hours' front door, with the Intensive service covering 'out of hours', taking referrals and carrying out assessments where required.
- The team has now been established. The current skill mix of the team is a combination of two disciplines of staff from older adult and adult of working age, meaning the team operate an ageless (18yrs +) primary point of access for mental health. Within B&NES the team composition is a dedicated consultant, team leader and a complement of 11 Community Psychiatric Nurses, and administrative support.
- The PCL service commenced its extended hours from 1st September 2012. This offers an 8am to 8pm service weekdays and 9am -1pm on Saturdays. Service users may transfer on to other services both within and external to the Trust.
- The first activity data is included as a full report in Appendix 2 (separate format). Key highlights are as follows[1]:
    - 423 out of 547 have been from GPs
    - The majority of clients are female

1 Data range is 1st April 12 to 19 August 12.

    - The age profile between the following age bands is:
        - 181 referrals for the 18 yrs to 35 yrs group
        - 202 referrals for the 36yrs to 65 yrs group
        - 160 referrals for the over 66yrs group
- The model is predicated on producing a demonstrable reduction of referrals through to secondary care teams, namely the Complex Intervention and Treatment Team (later life specialism) and the Recovery Team (adult of working age specialism). Although it should be remembered that those teams can also still receive direct referrals as well, the liaison service has demonstrated a drop in referral rates into secondary care teams.
- The PCL service has established clear routes for conversations with Sirona Care and Health's re-ablement service. Feedback from both parties is that good foundations have been laid for partnership work.

4.3.1 Next Steps for PCLS

- Support and directly advise primary care professionals/GPs by establishing link workers with each practice.
- Increase the partnerships with key stakeholders and voluntary sector organisations, such as Sirona Care and Health. Examples for the future include invitation to training events and sharing expertise across practitioners to facilitate this, sending shared letters to Primary Care regarding an individuals treatment.
- Provide commissioning information on what services could be of use to clients being seen or provided with advice.
- Seek feedback in the form of a survey & questionnaire to be sent out in September and again in January to support how the team can grow and learn as it develops in to a model which supports primary care professionals.

4.4 Intensive Service

- The adult service redesign has now been completed and the new service model is operational. Some recruitment is still required within the Intensive service where the response to advertised vacancies has not been as successful as we may have wished. The team in the meanwhile is being supported by bank staff as required. The matter of staffing in the B&NES Intensive team was reflected in a recent CQC inspection report as a potential concern. The vulnerabilities of the rota have been openly discussed with the Operational management team and commissioner and all remedial steps that can be taken have been.
- The Intensive team is now operating as a 24 hour waking service and has been since October 2011.
- A recent review of activity demonstrated that work with the Emergency Department at night was a significant component of their face-to-face work. The service offered to the Emergency department by the Intensive team has been very positively received and reported on. Some work is still taking place to align targets between services and resolve any tensions that different targets can produce.
- Joint working with the PCLS is progressing well although there have been some lessons to be learned from early bedding-in problems.
- As anticipated the relationship between the Intensive Service and the longer term Recovery service has changed and work is being undertaken to clearly establish at what points a client would transfer from one to the other. There have been some good examples of joint working thus far in B&NES.
- The Intensive service is also enhancing its service to the inpatient facility in order that people are supported to receive care at home, can leave hospital early and be admitted when they are most seriously ill. The allocation of people on the ward currently is 52% of people with recurrent psychosis with high level of symptoms and disability and 15% with severe or very severe non psychotic depression. This is a good representation of the target group who one might expect needing acute inpatient care.

- The Intensive service and the Sirona re-ablement service have also established a good understanding of how the two services 'fit' together and consolidation of care pathways can be seen in practice.

4.5 Recovery Service

- The Recovery service now has a fully established workforce with a range of disciplines including integrated social care staff. The transition of work during redesign was significant although this has now almost been completed with clients being allocated to a care coordinator.
- The team is divided up so that it links in with one or two GP clusters.
- It is developing a new model of care – the Functional Assertive Community Treatment (FACT) model. This enables staff to respond to identified clients who need an increased level of support and treatment at any given time. The team manager reports that this is starting to develop well as currently 9% of clients are receiving this assertive approach - a 1% increase on the previous team. This trend is as we would have hoped and is a promising start to the journey.
- In recent months there has been special focus on ensuring appraising staff skills and learning objectives within the Recovery service. Interventions based on evidence and NICE guidelines is now the starting point for clients to enhance their Recovery potential. A good example of the use of NICE guidelines is the use of our CBT group which is now in its sixth cycle. Participation in this group has enabled 4 service users to start work.
- The Recovery pathway for clients is also being supported by the use of the Recovery Star and the specialist worker in the team is rolling this out across all clients. Targets for completing the star have now been set and progress is being made in meeting these targets.
- The Recovery service has well established working relationships with Sirona Care and Health's Floating Support services - with whom they are mainly aligned. Discharge planning from AWP could be strengthened in terms of ensuring floating support services have the confidence to continue working with the recovery care plan once the service user is transferred to their care.

4.6 Adult Acute Inpatient services & delivery of High Dependency In-Patient Services

- Following the permanent closure of the BANES High Dependency Unit (HDU), Adult Acute Inpatient services are now delivered as described in the proposed model of service provision in January 2012.
- This has been developed by replacing the existing HDU with the appropriate use of Psychiatric Intensive Care Unit (PICU) beds and improved in-patient care management which provides care to service users within a nationally determined governance framework.
- The business case for the full development of an Extra Care Area is pending final agreement in September 2012.
- The interim measures to make the seclusion room available for Sycamore ward has been split into two phases. Phase 1: the refurbishment has been completed. Phase 2: the organisation of the area to meet fire officer requirements - to be completed by week commencing 10 September.
- The change in practice has resulted in adult acute beds and PICU beds for BANES being used as follows:
    - There has been a slight rise in the number of admissions to Adult acute wards in AWP for B&NES service users for Quarter 1 2012/13 in comparison to the same period in 2011/12. However, the length of stay in inpatient services has reduced overall.
    - There has been an increase in admissions to PICU services for BANES service users for Quarter 1 2012/13 in comparison to the same period in 2011/12. There have been 10 admissions in comparison to 7 admissions

in the same quarter of the previous year. This rise in admission is not considered to be of significant concern as there was a similar increase in Quarter 3 in 2011/12. However, this will be closely monitored during the next months.

- One of the aims of the inpatient redesign is to develop services to enhance and develop a recovery focused, therapeutic environment that facilitates shorter hospital admissions. Close working links with the intensive service is a core part of enabling people to return to their community as soon as possible.
- Access to PICU is also monitored closely and the service works with PICU services to return individuals to their area as soon as possible.
- During this time of change Sycamore ward staff have undergone a review of training. All staff have had further training in safeguarding, dignity in care and physical intervention training.
- At the current time a review of the skill mix for inpatient services is underway which is looking to increase the number of registered practitioners in order to enhance the care on the unit.

5 Fit for the Future – implementation plan

The Fit for the Future implementation plan has been produced in order to respond to the SHA South report on governance and management arrangements in AWP. The findings of this report highlighted the exacting performance culture of AWP and the feedback that this has often been at the expense of true clinical engagement and sign up. The implementation plan outlines the need to achieve the following measurable outcomes including:

- An upward trend in patient survey indicators - particularly in connection with the Care Programme Approach
- Improved staff survey indicators - including appraisal, staff satisfaction, incident reporting and recommendation of the service to others
- Meeting the internally set and measured 85% staff appraisal target, and improved supervision rates
- Ongoing performance improvement in contractual and national metrics - particularly in relation to the Care Programme Approach (CPA) and carers
- Appointment of staff, Board engagement and strategy implementation
- Future commissioning intentions and commissioner convergence on our Integrated Business Plan (IBP)

This programme of work aims to:

- put service users and carers at the centre of everything we do – every team, ward and staff member and the Trust Board
- decentralise management and increase the local service authority
- develop and implement a clinical engagement strategy to underpin local and Trust wide decision making and improve staff morale

The Trust is restructuring to ensure locally responsive operational activity and ongoing quality and performance improvement. This is already underway with the recent appointment of Carol Bowes, Service Director for BANES who is responsible for:

- owning the delivery of all the local services
- having regular liaison and meetings with PCT/LA commissioner
- ensuring the different teams locally work well together to ensure continuity of care

The programme has been developed through an iterative process starting with the April and May 2012 Trust Board seminars. They provided a clear steer on direction of travel

and the Executive Management Team (EMT) who have further developed the plan in discussion with the senior management tier of the Trust (Extended Executive Management Team - XEMT). Feedback from NHS South SHA has been incorporated in the plan as it has developed. The programme breaks into two parts:

- Short Term – April to September 2012 to ensure the change process is pump primed
- Medium Term – October 2012 – October 2013 to ensure the embedding of change

The process of transformation is not confined to just these actions or timetable - rather it starts with them and will be ongoing.

6 RISK MANAGEMENT

6.1 Risks highlighted in the paper, such as vacancies in the Intensive team, the increased use of PICU and the work on the seclusion/de-escalation facility on Sycamore Ward are all being effectively managed.

7 EQUALITIES

Equality impact assessments have been reported previously. Not applicable to this update.

8 CONSULTATION

8.1 There has been a full staff consultation and recruitment process for re-design as previously reported.

8.2 AWP are working closely with all stakeholders and commissioners on the Fit for Future implementation plan.

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

9 ISSUES TO CONSIDER IN REACHING THE DECISION

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

10 ADVICE SOUGHT

10.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have not had the opportunity to input to this report, which does not have any direct financial or legal implications and is presented for information only. The Strategic Director and Programme Director have had the opportunity to input to this report and have cleared it for publication.

Contact person	Andrea Morland, Associate Director Mental Health and Substance Misuse Commissioning 01225 831513
Background	*Equity & Excellence: Liberating the NHS (DH 2010)*, sets out ambitions to make primary care the nexus of health care planning, commissioning

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

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Can Do:

- Undertake face to face assessments using the SBAR tool/ Risk assessment and feedback to referrers
- Provide opinions/recommendations that could be used for discharge planning
- Attend/advise on complex care reviews / Individual SU reviews
- Offer telephone consultation
- Advise on environmental audit work
- Open referral criteria
- Aspire to same day telephone response
- 72 Hour urgent assessment
- 5 Day routine assessment
- Safeguarding Alerts – can advise and support around related mental health issues
- 2 Levels of interventions:
    - Standard
    - Complex

Will not do:

- Discharge Planning/ hospital transfer – this needs to be referred to appropriate discharge nurse or involved team.
- Case Management – this will need to be completed by the appropriate worker from the involved team.
- Care coordination / CPA – this will need to completed by the appropriate worker from the involved team.
- Safeguarding Vulnerable adults – we can advise and support around this but this will need to be coordinated by the adult care or CITT depending on where the case sits.
- Commissioning or appropriate care package – this will need to be completed by the involved team.
- Carers Assessments - these will need to be conducted by the appropriate team, but will identify carers and where required will recommend carers assessments are completed.
- Crisis Work – this needs to be carried out by the appropriate service.
- Provide Transport – this will need to be accessed/provided by usual routes.
- Equipment – this will need to be accessed through usual routes.

Chris Wall will primarily cover Bath and Sulis Ward

Andrew Baker will primarily cover NES and Paulton Ward

The team will be managed by Chris Prangley-Griffiths

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Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

COMMUNITY ACTIVITY for the period 01 April 2012 - 19 August 2012

Organisation Level: LIAISON & LATER LIFE >> PCLS >> L3 BANES PC Liaison >> BANES

The report shows summarised activity data for all teams in an SBU, teams of a specific type and/or location, or a specific team, depending on the parameters specified.
The reporting period defaults to financial year to date (full months only) but can be amended as required. Bear in mind that if you don't select a full month or quarter, the month and quarter aggregate figures may appear skewed.

more...

REFERRAL SUMMARY

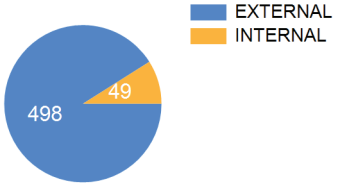
01 April 2012 - 19 August 2012

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

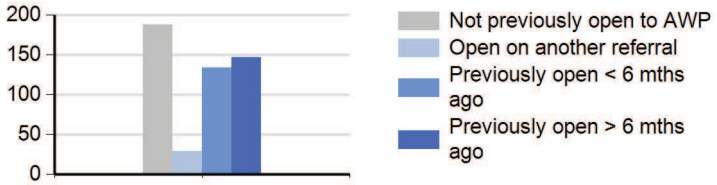
COMMUNITY ACTIVITY for the period 01 April 2012 - 19 August 2012

Organisation Level: LIAISON & LATER LIFE >> PCLS >> L3 BANES PC Liaison >> BANES

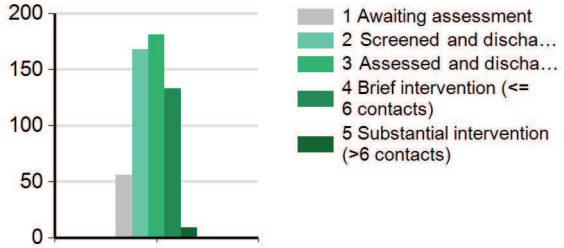
Referral Source



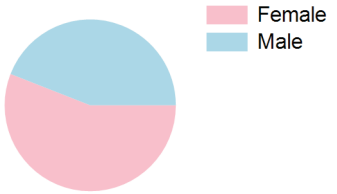
Referral Status (external only)



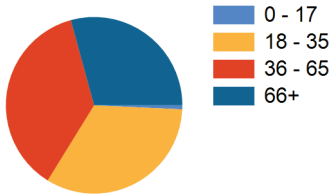
Referral Outcome



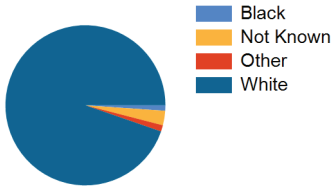
Gender



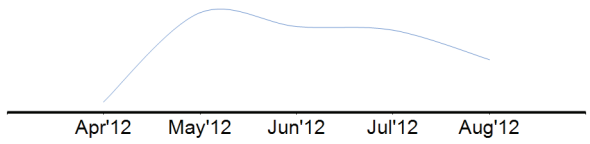
Age



Ethnicity



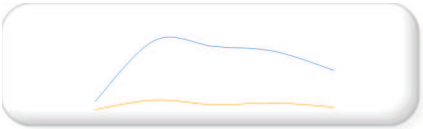
Referral Trend



Page 188

REFERRAL SOURCE (Click + to expand) **01 April 2012 - 19 August 2012**

Back to Summary



Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

COMMUNITY ACTIVITY for the period 01 April 2012 - 19 August 2012

Organisation Level: LIAISON & LATER LIFE >> PCLS >> L3 BANES PC Liaison >> BANES

Source	2012-13		Total
	Q1	Q2	
EXTERNAL **Total**	**294** (90.74%)	**204** (91.48%)	**498** (91.04%)
INTERNAL	30 (9.26%)	19 (8.52%)	**49** (8.96%)
Total Referrals in Period	**324**	**223**	**547**

REFERRAL STATUS - External Only (Click + to expand)

01 April 2012 - 19 August 2012

Back to Summary

Referral Status	2012-13		Total
	Q1	Q2	
Not previously open to AWP	116 (39.46%)	72 (35.29%)	**188** (37.75%)
Open on another referral	18 (6.12%)	11 (5.39%)	**29** (5.82%)
Previously open < 6 mths ago	78 (26.53%)	56 (27.45%)	**134** (26.91%)
Previously open > 6 mths ago	82 (27.89%)	65 (31.86%)	**147** (29.52%)
Total	**294**	**204**	**498**

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

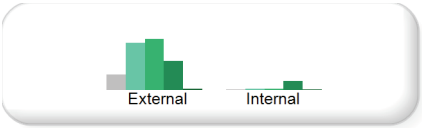
COMMUNITY ACTIVITY for the period 01 April 2012 - 19 August 2012

Organisation Level: LIAISON & LATER LIFE >> PCLS >> L3 BANES PC Liaison >> BANES

REFERRAL OUTCOME (Click + to expand)

01 April 2012 - 19 August 2012

Back to Summary



Source	Referral Outcome	2012-13 Q1	2012-13 Q2	Total
EXTERNAL	1 Awaiting assessment	0 (0.00%)	55 (24.66%)	**55** (10.05%)
	2 Screened and discharged	106 (32.72%)	56 (25.11%)	**162** (29.62%)
	3 Assessed and discharged	128 (39.51%)	47 (21.08%)	**175** (31.99%)
	4 Brief intervention (<= 6 contacts)	55 (16.98%)	45 (20.18%)	**100** (18.28%)
	5 Substantial intervention (>6 contacts)	5 (1.54%)	1 (0.45%)	**6** (1.10%)
	Total	**294** (90.74%)	**204** (91.48%)	**498** **(91.04%)**
INTERNAL	1 Awaiting assessment	0 (0.00%)	1 (0.45%)	**1** (0.18%)
	2 Screened and discharged	4 (1.23%)	2 (0.90%)	**6** (1.10%)
	3 Assessed and discharged	5 (1.54%)	1 (0.45%)	**6** (1.10%)

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

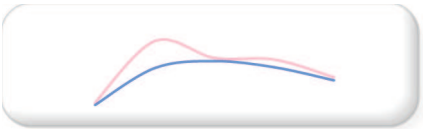
COMMUNITY ACTIVITY for the period 01 April 2012 - 19 August 2012

Organisation Level: LIAISON & LATER LIFE >> PCLS >> L3 BANES PC Liaison >> BANES

INTERNAL	4 Brief intervention (<= 6 contacts)	18 (5.56%)	15 (6.73%)	**33** (6.03%)
	5 Substantial intervention (>6 contacts)	3 (0.93%)	0 (0.00%)	**3** (0.55%)
	Total	**30** (9.26%)	**19** (8.52%)	**49** (8.96%)
Grand Total		**324**	**223**	**547**

REFERRAL DEMOGRAPHICS (Click + to expand)

01 April 2012 - 19 August 2012



Back to Summary

Demographic Breakdown

Source	Gender	Age Band	Ethnicity	2012-13 Q1	2012-13 Q2	Total
EXTERNAL	Female			168 (51.85%)	109 (48.88%)	**277** (50.64%)
	Male			126 (38.89%)	95 (42.60%)	**221** (40.40%)
INTERNAL	Female			19 (5.86%)	10 (4.48%)	**29** (5.30%)
	Male			11 (3.40%)	9 (4.04%)	**20** (3.66%)

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

COMMUNITY ACTIVITY for the period 01 April 2012 - 19 August 2012

Organisation Level: LIAISON & LATER LIFE >> PCLS >> L3 BANES PC Liaison >> BANES

Age Breakdown		2012-13		Total
		Q1	Q2	
Age Band	**Source**			
0 - 17		3	1	**4**
18 - 35		107	74	**181**
36 - 65		117	85	**202**
66+		97	63	**160**
Total		**324**	**223**	**547**

Ethnicity Breakdown		2012-13		Total
		Q1	Q2	
Ethnicity	**Source**			
Black		3	3	**6**
Not Known		2	14	**16**
Other		6	1	**7**
White		313	205	**518**
Total		**324**	**223**	**547**

Click here to export the raw data for further analysis. A new report will open, click export and select Excel.

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	21st September 2012
TITLE:	Terms of Reference for Alcohol Harm Reduction Strategy Scrutiny Inquiry Day
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1: Draft terms of reference	

1 THE ISSUE

On 18th May 2012, the Wellbeing Policy Development and Scrutiny Panel received a report on Bath & North East Somerset Council's Alcohol Harm Reduction Strategy. The briefing also outlined powers that are set to be introduced as part of the Government's Alcohol Strategy that was published in March 2012. The briefing recommended that the Panel consider undertaking a Scrutiny Inquiry Day to help refresh the Alcohol Harm Reduction Strategy in light of these new powers. The draft terms of reference (Appendix 1) sets out the initial scope, objectives and timescales for the Scrutiny Inquiry for the Panel to approve.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to:

2.1 Note the terms of reference and agreed to undertake a Scrutiny Inquiry Day

2.2 Agree to appoint a Steering group (usually 2-3 Members of the Panel) to plan the Scrutiny Inquiry Day

2.3 To make any initial suggestions for invitations to the Scrutiny Inquiry Day

3 FINANCIAL IMPLICATIONS

3.1 The cost of the Scrutiny Inquiry Day will be met by the budget allocated to the Policy Development and Scrutiny Panels

3.2 Financial considerations will also be taken into account when forming any recommendations at the Scrutiny Inquiry Day

4 THE REPORT

On 18th May 2012, the Wellbeing Policy Development and Scrutiny received a briefing on Bath & North East Somerset Council's (B&NES) Alcohol Harm Reduction Strategy and also the Government's Alcohol Strategy that was this year. The briefing outlined that a refreshed version of the B&NES strategy had been adopted and key priorities agreed by the Cabinet in April 2012. The key themes in the strategy are health and treatment, community safety, crime and disorder children and young people and partnership working. The Alcohol Harm Reduction Strategy Steering Group, a multi-agency group with Council representation, is responsible for implementing our local strategy.

The briefing also outlined that in March 2012; the Government launched its 'Alcohol Strategy' which introduced a number of new powers to local authorities including: from April 2012, licensing authorities and local health bodies became 'responsible authorities' under the Licensing Act 2003. This means that both will now be automatically notified of an application or review and can instigate a review of a license themselves. From October 2012, local authorities will also have the power to introduce Early Morning Restriction Orders to support local areas to restrict alcohol sales late at night if they are causing problems and a new late night levy for businesses that sell alcohol late into the night, which can be used to cover the cost of policing and wider local authority action. The government also plans to hold national consultation on whether to ban multi-buy drinks promotions and the levels of minimum pricing for alcohol sales.

The B&NES Alcohol Harm Reduction Strategy will need to be reviewed in light of the national strategy within the next 12 months so the Wellbeing Panel agreed to undertake a scrutiny inquiry day (SID) to assist with this review.

5 RISK MANAGEMENT

A preliminary risk assessment was discussed at a scoping meeting for the Scrutiny Inquiry Day and a further risk assessment related to the Scrutiny Inquiry Day will be undertaken, in compliance with the Council's decision making risk management guidance.

6 EQUALITIES

An Equalities Impact Assessment has not been completed but equalities issues were considered when scoping the terms of reference and will be considered as part of the preparations for the Scrutiny Inquiry Day and the recommendations that come out of the Scrutiny Inquiry Day.

7 CONSULTATION

7.1 *Overview & Scrutiny Panel; Staff; Other B&NES Services; Stakeholders/Partners;*

7.2 A scoping meeting was held between the Chair, Vice Chair, the Public Health Development and Commissioning Manager and the Policy Development and Scrutiny team to identify the reasons and benefits for undertaking the Alcohol Harm Reduction Strategy Scrutiny Inquiry Day. This meeting was also used to identify key stakeholders who will be invited to attend and input into the Scrutiny Inquiry Day and a full stakeholder analysis chart is being developed.

7.3 The draft terms of reference has been circulated to the Wellbeing Policy Development and Scrutiny Chair and Vice Chair, Alcohol Harm Reduction

Strategy Steering Group and officers in Policy and Partnerships who are working on the Joint Strategic Needs Assessment their input prior to publication.

7.4 Further steering group meetings will take place to identify stakeholders and finalise the arrangements for the Scrutiny Inquiry Day

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 *Social Inclusion; Young People; Health & Safety; Other Legal Considerations*

9 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	*Lauren Rushen (Policy Development and Scrutiny Officer) 01225 396410*
Background papers	*Bath & North East Somerset Council's Alcohol Harm Reduction Strategy* *Department of Health Alcohol Strategy (March 2012)* *Bath & North East Somerset Council's Joint Strategic Needs Assessment*
Please contact the report author if you need to access this report in an alternative format	

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Wellbeing Policy Development and Scrutiny Panel

ALCOHOL HARM REDUCTION STRATEGY

SCRUTINY INQUIRY DAY

Date TBC
Room TBC

This meeting is a public meeting, though members of the public must submit any statements in advance of the meeting – outcomes will be presented to the next public meetings of the Wellbeing Policy Development and Scrutiny Panel on (date TBC)

Background

On 18th May 2012, the Wellbeing Policy Development and Scrutiny received a briefing on Bath & North East Somerset Council's (B&NES) Alcohol Harm Reduction Strategy and also the Government's Alcohol Strategy that was this year.

The briefing outlined that a refreshed version of the B&NES strategy had been adopted and key priorities agreed by the Cabinet in April 2012. The key themes in the strategy are health and treatment, community safety, crime and disorder children and young people and partnership working. The Alcohol Harm Reduction Strategy Steering Group, a multi-agency group with Council representation, is responsible for implementing our local strategy.

The briefing also outlined that in March 2012; the Government launched its 'Alcohol Strategy' which introduced a number of new powers to local authorities including: from April 2012, licensing authorities and local health bodies became 'responsible authorities' under the Licensing Act 2003. This means that both will now be automatically notified of an application or review and can instigate a review of a license themselves. From October 2012, local authorities will also have the power to introduce Early Morning Restriction Orders to support local areas to restrict alcohol sales late at night if they are causing problems and a new late night levy for businesses that sell alcohol late into the night, which can be used to cover the cost of policing and wider local authority action. The government also plans to hold national consultation on whether to ban multi-buy drinks promotions and the levels of minimum pricing for alcohol sales.

The B&NES Alcohol Harm Reduction Strategy will need to be reviewed in light of the national strategy within the next 12 months so the Wellbeing Panel agreed to undertake a scrutiny inquiry day (SID) to assist with this review.

Purpose

The purpose of the scrutiny inquiry day is to provide the opportunity to formulate policy approaches with relevant experts and stakeholders on the key issues in the B&NES Alcohol Harm Reduction strategy and the new powers being introduced through the Government's 'Alcohol Strategy' and refresh the B&NES Alcohol Harm Reduction Strategy and its desired outcomes.

Key Objectives

1. To engage key stakeholders to develop a future policy direction for the use of new powers for local authorities and health bodies through the Government's 'Alcohol Strategy'. Specifically SID will formulate recommendations about:

    a. How best to utilise the new licensing powers which mean that local authorities and local health bodies will become 'responsible authorities' in order to reduce alcohol harm.
    b. The use of other new powers including extended Early Morning Restriction Orders and late night levies for businesses in Bath and North East Somerset

2. To examine existing evidence in order to identify the harm caused by alcohol in Bath and North East Somerset. This data will feed into the Joint Strategic Needs Assessment and refreshed Alcohol Harm Reduction Strategy.

3. To engage key stakeholders in refreshing the Alcohol Harm Reduction Strategy and its desired outcomes:

    a. *Increasing the number of people drinking sensibly within the daily safe limits; Decreasing the physical and emotional harm arising in people who misuse alcohol; Decreasing the crime and disorder arising in people who misuse alcohol; Decreasing the impairment at work arising in people who misuse alcohol; Decreasing the amount of family and community harm related to alcohol misuse and; Preventing children and young people and adults from misusing alcohol.*

4. If possible, influence national policy by formulating a joint response to government consultation on minimum pricing policies and 'multi buy' offers (timescales for the consultations are yet to be confirmed by Government)

Scope

The Scrutiny Inquiry Day could focus on:

- What work has been undertaken already and what issues have been identified? Including an introduction to the Alcohol Harm Reduction Strategy and progress made by the Alcohol Harm Reduction Strategy Steering Group and a look at existing data on harm caused by alcohol in Bath & North East Somerset.
- What are the new powers being introduced through the Government's Alcohol Strategy and (timings permitting) what is the government currently consulting on?
    - What are the issues with introducing these new powers?
    - What opportunities are there with introducing the new powers?
    - What are the interests/obligations of stakeholders attending the Scrutiny Inquiry Day?
    - Discussion/formulation of a response to any government consultation
- Formulation of joint recommendations about how to refresh the B&NES Alcohol Harm Reduction Strategy and the role will these new powers play in the strategy. Recommendations may also be made about how to deliver the strategy including consideration of partnership working and funding.

Approach

The Wellbeing Panel host the Scrutiny Inquiry Day, however it has been recognised that the subject area under investigation overlaps with other Panel remits, particularly the Economic and

Community Development PD&S Panel (who are responsible for scrutinising community safety) and the Early Years, Children and Youth PD&S Panel. The Wellbeing Panel will therefore keep these Panels regularly informed about developing the SID and members of these Panels will also be invited to attend the Scrutiny Inquiry Day.

The Panel will request for written submissions at least 5 days before the event to try to avoid duplication and to ensure that everyone has the opportunity to engage in the event.

Exclusions:

We need to prioritise areas where B&NES and key partners are likely to either have impact locally (through the Alcohol Harm Reduction Strategy) or influence nationally (by responding to government consultation). Therefore, the SID will not focus on areas that, whilst important, we have limited influence such as supermarket pricing policies.

Outline of the Day (draft)

The day will focus on:-

- Presentation/briefing about the Alcohol Harm Reduction Strategy and what progress has been made so far
- Presentation/introduction on joint ways of working with new licensing procedures, Early Morning Restriction Orders, Late Night Levies and government consultation (if available).
    - Group discussion or small group workshops to discuss new powers and joint response to government consultation on minimum pricing and restricting 'multi buy' offers
    - Refreshment break
- Workshops: Potential topics could include the following (attendees pick two out of four to participate in):
    - Engaging with businesses/workplaces
    - Working with parents, children and young people and vulnerable groups
    - Crime and disorder associated with alcohol consumption
    - Accessing treatment
- Feedback from workshops, additional points to raise in recommendations, next steps and sessions close

Attendees

(Please note a full communications plan will be developed therefore the below only provides a draft list of some of the key stakeholders that will be invited to engage at the Scrutiny Inquiry Day)

Council:

Policy Development and Scrutiny Panels: Initiations sent to all members of the Wellbeing, Economic and Community Development and Early Years Children and Youth

Cabinet Members: An invitation will be sent to all Cabinet members both those with a particular interest would include Simon Allen (Wellbeing), Nathan Hartley (Early Years Children and Youth) and David Dixon (Neighbourhoods)

Council/Primary Care Trust (PCT) Departments: Public Health, Policy and Partnerships (Community Safety), Licensing Team. This will also include an open invite to the Chief Executive and all Strategic and Divisional Directors.

Partners and Stakeholders:

Clinical Commissioning Group

Shadow Health and Wellbeing Board Members

Local Involvement Network (LINks)

Health and Social Care Organisations: Sirona, Royal United Hospital (A&E), Great Western Ambulance Service, Avon and Wiltshire Mental (AWP) Health Trust, Developing Health and Independence (DHI), Project 28

Responsible Authorities Group (RAG): Avon and Somerset Police, Avon Fire and Rescue, Avon Probation Service, Primary Care Trust, City Centre Manager (Future Bath Plus/Bath Business Improvement District), Curo (formerly Somer Housing)

Alcohol Harm Reduction Strategy Steering Group:
Public Health, Substance Misuse Treatment Service Providers, Community Safety, Public Protection, Fire Services, Probation, Police, RUH, Commissioners Adult & Children's substance misuse services, Bath Spa University, Cllr Katie Simmons (representing Wellbeing PDS)

Night Time Economy Steering Group:
Police, City Centre Manager, Licensing, Cllr Lisa Brett, Environmental Health, Business Improvement District Representative, University Student Representatives, Fire Service, Public Protection

Local Strategic Partnership Members: Chambers of Commerce, Business West, Children's Trust, Youth Parliament, Federation of Bath Residents Associations,

Town/Parish Councils

Residents Associations

Educational Establishments: University of Bath, Bath Spa University, City of Bath College, Norton Radstock College

Draft Timescales

The planning and preparation for the Scrutiny Inquiry Day will take a minimum of 3 months looking at an event date to be agreed around December/January. This would allow for a report of findings/ outcomes to be delivered to the March Wellbeing Panel meeting and to Cabinet in March.

Enquiries

For further information, contact:

Chair of Wellbeing Panel	Councillor Vic Pritchard	
Vice Chair of Wellbeing Panel	Councillor Katie Hall	
Policy Development & Scrutiny	Lauren Rushen	Lauren_Rushen@bathnes.gov.uk

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	21st September 2012
TITLE:	Housing Allocations
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1- Draft Homesearch Policy	

1 THE ISSUE

1.1 Each Local Housing Authority (the Council) must have an allocation scheme which articulates how priority for social housing is determined. The Bath & North East Somerset scheme, know as the Homesearch Scheme, is operated on the principles of choice-based lettings which combine the elements of housing need, time on scheme and client choice. At present, and in accordance with the legislation current at the time of adoption, the scheme allows anyone, with a few statutory exceptions, to join the scheme. This is known as an "open scheme".

1.2 The Localism Act 2011, supported by new Allocations guidance[1], provides the Council with greater freedoms in determining local priorities. In particular the Council can now chose to exclude certain households from the scheme, such as, those households who do not have a local connection to the district or whose income is above a specific level. This is known as a "closed scheme". The Council will need to determine how it wants to use these freedoms.

1.3 Following consultation, including both to this Panel on the 16th March and the Housing & Major Projects Panel on the 27th March, the attached draft policy has been produced and has returned to this Panel as requested for further consideration.

2 RECOMMENDATION

The Wellbeing Policy Development & Scrutiny Panel is asked to:

2.1 Note and comment on the draft Homesearch Policy contained in Appendix 1.

[1] DCLG - Allocation of accommodation: guidance for local housing authorities in England.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications arising from this report. However, should the Council decide to amend the Homesearch policy there will be financial implications. These financial implications arise from non-recurring set-up costs and any policy amendments which result in changes to the resources required to operate the scheme. This were discussed in more detail in the report provided to panel on 16th March.

4 THE REPORT

4.1 In November 2002 Bath & North East Somerset launched the Homeseekers Register. This was one of a number of Government funded pilots into the adoption of a "Choice Based Lettings" approach to the letting of social housing tenancies. This is an approach that balances customer choice and time on list with assessed housing needs as opposed to the traditional "needs only" based system. This provides a number of benefits including: transparency; improved customer satisfaction; reduced void times, particularly with low demand properties; and greater community stability and thus sustainability. Such was the success of the pilots that the Government of the day expressed a desire for all Councils to adopt such an approach. The current Government has reaffirmed their support for this approach.

4.2 In 2005 Housing Services commissioned an independent review of the Homeseekers Register. This review recommended a number of improvements, including a significant simplification of the scheme, marketing of all available properties and a significant investment in new IT systems. These recommendations were adopted and resulted in the introduction of the current Homesearch Policy in 2006.

4.3 The scheme operates in partnership with 16 local Registered Providers, also known as social landlords, who between them manage 95% of all the social housing stock in the district. Depending upon the landlord between 75% and 100% of their properties are allocated through the Homesearch scheme. In 2011 622 general needs and 150 sheltered properties were allocated through the scheme.

4.4 The current system operates with 4 Groups to which a household is placed, these being:

(1) Group A: This Group includes people who need affordable housing as a result of a specific statutory requirement or those who are at a serious risk to their health, safety and well-being due to their housing situation.

(2) Group B: This Group includes people who have a medium level need for housing and where there are no statutory requirements. It includes people whose: current housing situation is causing a risk to their health, safety and well-being; people who are eligible for the Assisted Move-on Scheme; a strategic management move; or are at imminent risk of becoming homeless.

(3) Group C: This Group includes people who want affordable housing and have a genuine need to live in the Bath & North East Somerset area.

(4) Group D: This Group includes people who do not meet the criteria for inclusion in Groups A, B or C and students who have moved to the area to study at one of the colleges in Bath and North East Somerset

4.5 When a property becomes vacant it is advertised on the Homesearch website, local papers and property bulletins. Households can then express an interest in any property which meets their needs. The household in the highest group expressing an interest is then nominated to that property. If two households in the same group express an interest then the household who has been in that Group for the longest time period secures the property. The system is relatively simple and transparency is enhanced by publishing the group & time on list details of the successful applicant. There are some specific conditions relating to local rural connection which applies to social housing properties in villages of less than 3,000 residents. In these cases households who can demonstrate a local connection to the village are prioritised above other applicants.

4.6 The Localism Act 2011 and allocations guidance provides Councils with greater freedoms in the drafting of their allocation policies to tackle local needs. The key changes are:

(1) The Council has the power to determine what classes of people are or are not qualified to be allocated housing;

(2) New requirement for a right of review of a decision on qualification and to be informed of grounds of decision.

4.7 The requirement that certain categories of applicants are given reasonable preference remains in the legislation. These are households who are: homeless; owed a housing duty by the Council; occupying insanitary, overcrowded or unsatisfactory housing; need to move on medical or welfare grounds; or where failure to move to a particular locality in the district would cause hardship.

4.8 Having regard to the legislation, guidance and consultation the following changes are proposed:

(1) Restricting access to the scheme to applicants who are resident within Bath & North East Somerset or have a need to reside here, for example, due to employment, social or medical reasons. This is a significant change and is expected to remove around 17% of current applicants. It will also mean that the Council withdraws from the current Homes Choice West partnership which relaxes the local connection policy for some properties within the West of England area.

(2) The Government are proposing to issue allocation regulations in regard to members of the Armed and Reserve Forces. The aim is to prevent local authorities from disqualifying a person on the grounds that they do not have a connection with a housing authority. Homesearch will comply with any regulation in this regards as it becomes available, however, in the meantime we will continue to operate a relaxed local connection policy for current and ex-service personnel.

(3) Applicants with sufficient financial resources available to meet their housing needs will not qualify to join Homesearch. A combined income, savings, investments or capital of £60,000 or more is considered sufficient to buy a

home or pay market rent in the district. A number of exceptions apply including for applicants requiring supported housing (including sheltered accommodation).

(4) People who own a property will not qualify to join Homesearch. Exceptions apply for people in financial difficulty, such as their home is being repossessed or they are in significant and long standing mortgage arrears and those who need supported housing, (including sheltered housing) because of their age, disability or medical condition.

(5) Giving priority to applicants who are social housing tenants within Bath and North East Somerset and would like to move because their home is too large for their needs.

(6) In accordance with Government guidance giving current and ex-service personnel some additional priority on the scheme. This is to be achieved by "backdating" eligible applications by 6 months.

(7) Allowing the under-occupation of properties in rural villages where there is a shortage of properties of a particular size.

(8) There are also a range of smaller technical changes including: how MAPPA[2] applicants are processed; allowing eligible vulnerable residents to apply together as a single household; changing the age that children require their own rooms.; reducing the number of Groups from 4 to 3; incorporating Curo's transfer list into Homesearch.

4.9 At the time of writing the draft Homesearch policy has been forwarded to a specialist legal housing advisor to ensure that it is legally compliant. As such, and depending upon advice received, it may require further minor amendment.

4.10 It should also be noted that a data cleanse of the database has been delayed to coincide with any changes in Policy. In addition an IT upgrade now allows for periodic application renewal so in future an on-going data cleanse will take place.

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 The Equalities impact of the proposed changes have been considered during the development of the policy. In addition, specific equalities consultation has been undertaken with equalities group representatives A formal Equalities Impact Assessment has also been completed. Comments from the Equalities Team are currently being sought.

7 CONSULTATION

7.1 Cabinet Member; Overview & Scrutiny Panel; Other B&NES Services; Service Users; Local Residents; Stakeholders/Partners.

[2] Multi Agency Public Protection Arrangement – national protocol for dealing with dangerous offenders.

7.2 Preliminary consultation has been undertaken at meetings with Cabinet Member, and RP stakeholders to inform the evaluation of options being considered. In summary, registered providers generally support changes that are more effective at targeting affordable housing at people who need it most. However, it is important to them that the allocations scheme is broad enough to ensure that affordable housing products (including low cost home ownership) are applied for. They also want the scheme to support sustainable, mixed communities and are generally opposed to applying additional preference criteria if it disadvantages equalities groups.

7.3 Preliminary consultation has also been undertaken with equalities group representatives who share the concern above about equality of access to affordable housing if additional preference criteria are applied. They were supportive of restricting access to those with a need to live in the district and limited financial resources provided that home owners living in unsuitable housing and without means to move home are able to apply.

7.4 Consultation was also undertaken with service users using the Council's e-Consult system and telephone conversations. In summary the majority of respondents supported the proposals, particularly those around restricting access to local residents or those with a need to live here; restricting access to those who are able to afford access to the private sector and giving priority to those downsizing.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Human Rights; 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	Graham Sabourn, Associate Director (Housing) 01225 477949
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council

Homesearch

Bath and North East Somerset Council's Housing Allocation Scheme

September 2012

Address: Housing Services, Bath and North East Somerset Council, PO Box 3343, Bath, BA1 2ZH
Phone: 01225 396118
Fax: 01225 477839
Email: Homesearch@Bathnes.gov.uk
Minicom: 01225 477815
Website: www.Homesearchbathnes.org.uk
This document can be made available in a range of languages, large print and Braille.

Tenancy Fraud.

Tenancy Fraud is unlawful and in some cases is also a criminal offence. In partnership with local registered housing providers, we are committed to identifying and dealing with Tenancy Fraud. Fraud may include giving false information or withholding information to obtain housing as well as sub-letting of properties.

If you have information about social housing within Bath and North East Somerset that you believe is unlawfully occupied please let us know by contacting us below, or your own Social landlord.

By phone: 01225 396118 or by email: Homesearch@Bathnes.gov.uk or writing to us at

Housing Services, Bath and North East Somerset Council,

PO Box 3343, Bath, BA1 2ZH.

CONTENTS

INTRODUCTION TO HOMESEARCH

Homesearch is the name of Bath and North East Somerset Council's (B&NES) Housing Allocation Scheme. It allocates social housing within the district and determines priorities for those registered with the scheme. It is based upon the principles of Choice Based Lettings (CBL). CBL allows the scheme to offer people a choice about where they would like to live and gives priority to those people with the most housing need.

Those who wish to be considered for social housing will be required to apply to join the scheme. Once registered, applicants can be considered for properties advertised through Homesearch. Applicants can decide whether they wish to formally express an interest in available properties (a process which is referred to as 'bidding'). After the bidding process has closed, a shortlist of applicants is provided to the Registered Provider.

Homesearch is part of the B&NES Housing Services, which offers a range of housing options and services to the public, such as access to private rented housing, shared ownership, mutual exchanges, extra care and transfers for existing social tenants.

To apply for shared ownership, please contact 01225 477818
To apply for supported housing, please visit
www.housingsupportgatewaybathnes.org.uk
To apply for private renting, mutual exchanges or transfers for existing social tenants, please visit www.Homesearchbathnes.org.uk

All teams within Housing Services can be contacted by telephone through the Council's switchboard on 01225 477000.

Homesearch aims

Homesearch aims to:

- Provide a simple, clear and fair allocation scheme
- Promote greater choice and provide information on housing options
- Provide support for those in greatest housing need, including people who are experiencing homelessness
- Create mixed and sustainable communities
- Make the best use of the housing stock
- Promote greater mobility for existing social tenants
- Ensure the scheme complies with legislation.

The Homesearch Partnership

Homesearch is a partnership between B&NES and Registered Providers (also known as Registered Social Landlords or Housing Associations), who offer social housing tenancies in the area. In 1999, B&NES transferred its housing stock to Somer Community Housing Trust now known as Curo Places, and as a result no longer owns or manages any social housing properties. Homesearch allows applicants to access social housing offered by the Providers named below. There is one Provider, Flower and Hayes, which is currently unregistered with the Tenants Service Authority.

Anchor Housing Association

Curo Places

English Churches Housing Group Ltd

Sanctuary Housing Association

English Rural Housing Association

Places For People

German Lutheran Housing Association

Western Challenge Housing Association

Hastoe Housing

Sovereign Housing Association

Knightstone Housing Association

The Guinness Trust

Methodist Homes Housing Association Ltd

United Housing Association

Flower and Hayes Development Ltd

Statement on choice

Homesearch is committed to Choice Based Lettings. CBL allows applicants to have a degree of choice on the property they wish to be housed in. There are however, occasions when it is not advisable or practicable to offer a choice of housing to a particular applicant or category of applicants. The conditions can include:

- Applicants who are owed a homeless duty under section 193 and 195 of the Housing Act 1996, Part 7
- Applicants who require a large property, where simply no housing stock of that size becomes available
- Allocations which would result in the poor use of housing stock. For example, a property could be statutorily overcrowded or under occupied
- Applicants who are sexual or violent offenders where the need to manage the risk which they pose to other individuals or the community in general.

These conditions do not necessarily mean that applicants will be excluded from having choice through the scheme. It may in some cases be sufficient to: restrict the properties they can apply for; impose a time limit for bidding; reject their bid or only allow a professional, such as a Probation Officer to bid on an applicant's behalf.

Fairness

In order to allocate properties fairly, Homesearch have engaged fully with the wider community in the development of this allocation scheme. It will continue to provide regular, accurate and generalised information about how social housing is being allocated. This information will be published on the Homesearch website www.homesearchbathnes.org.uk and made available for inspection in Council offices.

Tenancy types

- Introductory Tenancies
- Lifetime Tenancies (Secure & Assured)
- Fixed Term Tenancies (known as flexible tenancies)

Introductory (Starter Tenancies) are granted for a trial period, usually a year. Introductory tenancies give similar rights as an assured shorthold tenancy, which affords the tenant less protection against eviction. At the end of the trial period, if a tenant has adhered to the terms of their tenancy agreement their trial period will end.

Lifetime tenancies remain available to a tenant for as long as the terms of the tenancy agreement are upheld. These are offered on an Assured Tenancy basis.

Flexible tenancies are offered for a fixed period of time, the tenancy ends on the last day of that period or term. Registered Providers will decide their own typical length to offer a tenancy but the recommendation from the Council's Tenancy Strategy is a minimum of 5 years.

Rent Levels

Social housing will be let at either a Social rent, or an Affordable rent. Social Rent is based on a rent formula set by the Government and is usually less than a market or affordable rent. Affordable rent will be set at up to 80% of the local market rent.

APPLYING TO HOMESEARCH

Eligibility and qualification criteria

Every application to join Homesearch will be considered. Homesearch will establish whether the applicant is eligible and qualifies to join the scheme. It will comply with the eligibility criteria set out in the Housing Act 1996, Part 6 section 160ZA.

Eligibility criteria

There are some applicants who will not be eligible to join Homesearch. They include:

- People from abroad who are subject to immigration control under the Asylum and Immigration Act 1996
- People who are not habitually resident in the Common Travel Area.
- People whose only right to reside in the UK is derived from their status as a jobseeker.
- People whose only right to reside in the UK is an initial right to reside for a period not exceeding three months.
- People whose only right to reside in the Common Travel Area is a right equivalent to one of the rights mentioned above.

The eligibility criterion does not apply to applicants who are already secure or introductory tenant of a housing authority or an assured tenant of a Registered Provider.

Qualification criteria
There are some applicants who will not qualify to join Homesearch. They include:

- People who are guilty of unacceptable behaviour serious enough to make them unsuitable as a prospective tenant
- People who have assets or income above the financial resource limit
- People who own their own home and have no housing need
- People who do not have a local connection to Bath and North East Somerset
- People who are serving a prison sentence of longer than 6 months.

Homesearch will accept applicants over the age of 16. Applicants aged 16 and 17 will need a guarantor.

Guarantors

A guarantor will be liable for the tenancy, such as rent payments in the event of a tenant defaulting.

A Registered Provider will consider whether the proposed guarantor is a suitable person. In considering suitability a Registered Provider may consider the guarantor's

ability to meet rent payments and understanding and acceptance of the terms of the tenancy agreement.

The decision will be made by the Registered Provider.

Local connection to Bath and North East Somerset

Homesearch aims to help people who have a need to live in Bath and North East Somerset. This is in order to ensure that wherever possible, social housing goes to local people. If an applicant does not have a need to live in Bath and North East Somerset they will not qualify for Homesearch.

Homesearch will consider the applicants individual circumstances when deciding if a person has a local connection to Bath and North East Somerset. It will also comply with the statutory guidance. Homesearch will ensure that those in the Armed Forces will not be disadvantage when Homesearch applies this criteria.

A local connection to Bath and North East Somerset is defined as:

- Person who is currently resident in the district. The residency will need to be permanent and of their own choice, or
- Person who has lived in the district for 6 out of the last 12 months or 3 out of the last 5 years
- Person who is in permanent paid employment in the district, or
- Person with close family (normally parents, adult children or adult brothers and sisters) who have lived in the district for 5 years or more, or
- Person who has a connection with the district through special circumstances, such as they need to receive specialist medical or support services within the district which cannot be provided elsewhere, or
- Person who was provided with accommodation in the district under section 95 of the Immigration and Asylum Act 1999
- Person accepted by Bath and North East Somerset as owed a duty under s 195 (2) or 193 (2) of the Housing Act 1996, Part 7, and are not subject to a referral to another local housing authority under s 198.

Members of the Armed Forces and the Reserve Forces
The Government are proposing to issue allocation regulations in regard to members of the Armed and Reserve Forces. The aim is to prevent local authorities from disqualifying a person on the grounds that they do not have a connection with a housing authority. Homesearch will comply with any regulation in this regards as it becomes available, in the meantime the following criteria will apply:

A local connection to Bath and North East Somerset does not apply to the following:

- Members of the Armed Forces and former Service personnel, where the application is made within five years of discharge
- Bereaved spouses and civil partners of members of the Armed Forces leaving Service Family Accommodation following the death of their spouse or partner

- Serving or former members of the Reserve Forces who need to move to this area because of a serious injury, medical condition or disability sustained as a result of their service.

Financial resource limit

Applicants with sufficient financial resources available to meet their housing needs will not qualify to join Homesearch. Homesearch will take into account any income, savings and investments when calculating the financial resources available. Capital money raised as a result of a previous disposal of assets such as property will be considered when calculating the financial resources available. This can include disposals for nil (for example, transfer of ownership) or below market rate value. Homesearch considers a combined income, savings, investments or capital of £60,000 or more is sufficient to buy a home or pay market rent in the district.

The following exceptions apply:

- Applicants in receipt of an income based benefit
- Existing social tenants with the right to transfer may be excluded from the financial resource limit subject to the Transfer Agreement between Homesearch and the Registered Provider.
- Lump sum payments received by a member of the Armed Forces (including former Service personnel) as compensation for an injury or disability sustained on active services
- People who need supported housing, (including sheltered housing) because of their age, disability or medical condition.

Property ownership

People who own a property will not qualify to join Homesearch.

The following exceptions apply:

- People in financial difficulty, such as their home is being repossessed or they are in significant and long standing mortgage arrears, subject to the financial resource limit
- People who need supported housing, (including sheltered housing) because of their age, disability or medical condition.

Some Registered Providers will expect home owners to have their property marketed for sale.

The decision to accept applications by a home owner will be made by the Senior Housing Practitioner – Homeseach.

Applications from family members and friends

Homesearch will accept applications where household members have long term commitments to the home. This can apply where people normally reside with the applicant as a member of the family or might otherwise reasonably be expected to

reside with the applicant. This can include people who are married, in a civil partnership or cohabitating couples. People who are in a same sex relationship and brothers and sisters who wish to live together can also make a joint application.

Dependent children
A child can be added to an application if they are:

- Substantially dependent on the applicant, including financially dependent, and
- Normally lives with the applicant as a member of the family, or could reasonably be expected to live with the applicant as a member of the family, and
- There is or will be a degree of permanence or regularity in that residency, a temporary arrangement will be insufficient.

Due to the high demand for properties, additional bedrooms cannot be given to applicants with children who do not normally live with them as their main residence. In general, unless an applicant has 50% or more of the custody of the child then they will be ineligible for an additional bedroom.

Decisions to provide an additional bedroom will be made on a case-by-case basis by the Senior Housing Practitioner (SHP). The SHP will consider which parent or guardian the child is dependent on in terms of their primary day-to-day care and normal residence.

Homesearch may request evidence that the child lives or intends to live with the applicant. This can include (but is not limited to) a signed statement of fact, a child benefit letter, a court order or confirmation of the child's address from the child's GP, nursery or school. Where a child is returning to the family from the care of social services, confirmation will be sought from the Council's Children Services Department.

Sharing a home to provide mutual support
Friends and extended family members will not normally be included on the application. In exceptional circumstances, Homesearch may agree to include a friend or extended family member on a single person's application subject to the following conditions:

- The applicant and friend (or extended family member) would provide mutual support to create a sustainable tenancy
- The applicant and friend (or extended family member) has a significant medical condition.

This could apply when an applicant has learning difficulties or a mental health issue. Homesearch may request evidence that members of the household currently live or intend to live with the applicant. This can include (but is not limited to) a signed statement of fact, adequate evidence of residence or confirmation from social services.

The decision will be made by the Senior Housing Practitioner – Homesearch. The Senior Housing Practitioner may seek advice from the Wellbeing and Hardship Panel. See page 28.

Ineligible family members

Homesearch will not grant a joint application if any one of the applicants is a person from abroad who is ineligible. However, Homesearch can grant a tenancy to the applicant who is eligible as long as they do not fail the qualification criteria. Consideration will be given to the family members when determining the size of accommodation which is to be allocated.

The decision will be made by the Senior Housing Practitioner – Homesearch who will have regard to the Human Rights Act 1998.

Reduced priority

There may be circumstances when it is appropriate to reduce the Group which an applicant would otherwise fall within. This is may be as a result of an applicant's behaviour or that they are not yet ready to live independently.

An applicant will have an effective date of the date they were given reduced priority.

An applicant may also be moved into a lower Group. For example, an applicant in Group A can be downgraded to Group B.

For an applicant in a reasonable preference category, the intention of reduced priority is not to eliminate priority altogether.

Applicant's behaviour
An applicant's conduct may not be severe enough to fail the qualification criteria or cancel their application but reducing their priority could be appropriate. Behaviour that could result in reduced priority includes (but is not limited to):

Reason for reduced priority	The period application will have reduced priority
People who are guilty of unacceptable behaviour	Decided on a case by case basis. Normally 12 months unless there are exceptional reasons.
People in rent arrears	Reduced priority until the rent arrears are clear or an agreed repayment plan has been satisfactorily maintained. This is usually 6 regular payments being made and will continue to be made.
People whose application needs further investigation as there is reasonable suspicion that the application is fraudulent.	Reduced priority until the outcome of the investigation. 24 months reduced priority if evidence of fraudulent activity.
People who have refused two reasonable property offers.	Reduced priority for 12 months

Following the period of reduced priority, an application will be reassesed and the effective date will be reinstated.

The decision will be made by the Senior Housing Practitioner – Homesearch.

Applicants not ready to move
An applicant who is not considered able to live independently or who does not wish to move until a future date will be given reduced priority.

When an applicant is ready to move their Group and effective date will be reinstated.

Fresh applications

Homesearch will consider an application afresh, where it has been decided that the applicant did not qualify in the past. An applicant will need to evidence how their circumstances have changed.

Eligibility and qualification considerations

The Senior Housing Practitioner will ensure in making these decisions that there will be no adverse implications for the good use of the housing stock (and for the ability to continue to provide for housing need.)

The final decision on whether to grant a tenancy will however rest with the Registered Provider at the time of nomination.

There are legal and financial implications to a joint tenancy which includes liability and succession rights. These can be discussed with the Homesearch Team or the Registered Provider at the time of nomination.

THE GROUP STRUCTURE

The Grouping structure sets out how the Homesearch allocation scheme will be framed. It will prioritise social housing to those in greatest housing need. There are three Groups, A, B, and C. Applicants who qualify for Group A hold the greatest priority. Priority decreases from Group B to C. The Group Structure Chart is on page 23 onwards.

The Grouping structure will take into account legal requirements and the Council's local strategic priorities.

By law, Homesearch are required to give 'reasonable preference' to certain categories of people as outlined in Part 6 of the Housing Act 1996. They are:

- People who are 'homeless' within the meaning of the Housing Act 1996, Part 7
- People who are owed a particularly statutory duty by any local housing authority under certain provisions of the homeless legislation or who are occupying accommodation secured by any housing authority under s.192(3)
- People occupying insanitary or overcrowded housing or otherwise living in unsatisfactory housing conditions
- People who need to move on medical, welfare, or disability grounds, and,
- People who need to move to a particular locality within Bath and North East Somerset, where failure to meet that need would cause hardship to themselves or to others.

Examples of circumstances which may result in an applicant being placed in all Groups are provided below.

Group A –
This Group is for applicants who need to be housed urgently. For example, there is a serious risk to health, safety, wellbeing or a specific statutory requirement.

Group B –
This Group is for people who have a high or medium level housing need.

Group C –
This Group includes people who have a low housing need or simple wish to move.

Applicants should tell Homesearch about any change in their circumstances which would affect their application. Homesearch will routinely review applications in Groups A and B to ensure their priority remains valid. Frequency of reviews will depend on the needs of the service.

A chart of the group structure

A summary of the Grouping Structure is set out below. The Group an applicant will be placed in depends on their current circumstances. The assessment criteria are explained in more detail from page 29 onwards.

Group A
An applicant: Is statutory homeless Is under occupying social housing by two or more bedrooms Is statutorily overcrowded Has urgent medical priority Has urgent welfare or hardship priority Lives in dangerous housing Is a social housing tenants needing sheltered accommodation
Group B
An applicant: Has high medical priority Has high welfare or hardship priority Is under occupying social housing by one bedroom Is overcrowded (2 or more bedrooms short) Needs to move on from supported accommodation Has discretionary housing priority Has a reasonable preference as a homeless person Has prevention of homelessness priority
Group C

An applicant: Does not qualify for Groups A or B Wants to move

ASSESSMENT OF APPLICATIONS

Homesearch will assess all applications and will inform the applicant of their:

- Effective date
- Bedroom entitlement
- Group.

Homesearch will tell applicants how to register their interest in advertised properties. Information about how long they are likely to wait before being successful will be available. If an application does not meet the eligibility and qualification criteria Homesearch will provide the reasons for this. If an applicant is given reduced priority, Homesearch will also provide reasons.

Homesearch may ask applicants to provide further information to complete the assessment. This information should be provided as soon as possible as any delay may result in a longer wait for an assessment. In addition Homesearch may make necessary inquiries in order to assess the application adequately. For example, an applicant's doctor or social worker, the UK Border Agency or Immigration Enquiry Bureau may be contacted. Homesearch will ensure that the applicants consent is obtained prior to third party contact.

An application will not be made active until the assessment is complete. Information which may be requested from an applicant includes (but is not limited to):

- Identification, such as a birth certificate or photographic ID
- Passport or information from the Home Office
- Financial information
- Medical information
- Social information

An officer from the team may need to visit an applicant at home in order to complete an assessment.

Effective date

Homesearch takes into account how long an applicant has been waiting for housing when calculating their housing priority. This is known as the effective date. The effective date is when Homesearch receives a complete application. Once registered, if the applicant moves to a higher Group the effective date will change to the date they changed Groups. This is so that people in the higher Groups have an effective date that is relevant to their situation and grouping at that time. If an applicant moves down a Group the original effective date will be used.

The following are examples of when an effective date will change
If an application was originally received on the 10th January 2008 this would be the effective date. If, however, the applicant moved to Group B from Group C on the

21st June 2010, their effective date would become the 21st June 2010.
If the same applicant's situation changes once more, and they went from Group B to Group C their effective date would revert to the 10th January 2008.

Additional priority for housing can be awarded by granting additional waiting time to an applicant. Please see Discretionary Housing Preference on page X.

Bedroom entitlement

This table shows the size of property a household will be considered for:

Household circumstances	Studio	1 bed	2 bed	3 bed	4 bed	5 or more bed
Single applicant	✓	✓				
Couple		✓				
Two people not in a relationship			✓			
Parent/couple with 1 child or pregnant			✓			
Parent/couple with 1 child under 10 and pregnant			✓			
Parent/ couple with 2 children (eldest under 10 years)			✓			
Parent/couple with 2 children same sex (eldest 10 years or over)			✓	✓		
Parent/couple with 2 children of different sex (eldest 10 year or over)				✓		
Parent/couple with 2 children and pregnant with 3rd child				✓		
Parent/couple with 3 or more children				✓	✓	
Household circumstance are at the discretion of the Senior Housing Practitioner – Homesearch						✓

Additional bedrooms

If an applicant requires an additional bedroom for medical reasons, confirmation will be required from a suitable professional, such as a GP or Occupational Therapist.

An additional bedroom can be agreed in exceptional circumstances, such as where failure to meet this need will significantly affect the health or wellbeing of the applicant.

The following are examples of cases that could qualify for an extra bedroom:
If an applicant has been assessed by social services as needing 24 hour care.

If an applicant requires large and essential medical equipment which cannot be stored elsewhere in the property.
If an applicant will be adopting or fostering a child

The decision will be made by the Senior Housing Practitioner - Homesearch. In making a decision, the Senior Housing Practitioner will consider

- The risk that the extra bedroom will not be used, leading to a property being under occupied
- The wider benefits which would be realised by an applicant or child
- An applicant's ability to afford a larger property.

Assessment of support or care needs

When assessing applications and allocating accommodation to people with support and care needs, Homesearch will liaise with statutory and voluntary agencies as necessary. These can include (but are not limited to) social services, the Supporting People Team and Registered Providers.

An applicant's housing and support needs will be assessed before allocating appropriate accommodation. This is to ensure that the property meets their needs and is delivered at the right time for the tenancy to be successful and sustainable. Consideration can be given to the applicant's individual circumstance; their views and preferences and any educational, employment opportunities or needs.

Support and care needs can include (but are not limited to) the following factors:

- Age
- Drug or alcohol abuse
- Rough sleeping
- Physical disability
- Mental illness
- Learning difficulties.

Support Plan

A Support Plan is person centred and aims to identify areas where an applicant needs support with their life. It will put in place strategies to provide that support.

Support needs can have an impact on the lives of the community. In the interests of everyone details of the support which will be made available to an applicant will be sought.

Statutory and voluntary agencies who are working with an applicant are able to provide a support plan.

An applicant who does not have a support plan or their support plan is not adequate will be given reduced priority.

Applicants aged 16 or 17

A homeless young person or a lone parent of this age is likely to benefit from a period in supported accommodation before moving on to a tenancy of their own.

Homesearch will ensure that an appropriate support plan is in place before the applicant is considered for a tenancy. If the applicant is not ready for independent accommodation they will be given reduced priority.

Any applicant under the age of 18 will require a guarantor (please see eligibility and qualification criteria).

Separated families

A separated family is a household who is forced to live in separate properties.

All properties occupied by the family can be considered when assessing the application. Subject to the following factors:

- Members of the households must meet the eligibility and qualification criteria
- Members of the households intend to live together as a single family unit
- Members of the households are not currently able to live together as a single family unit
- There is a good reason why the family must currently live in separate properties.

People who fail the eligibility and qualification criteria or do not intend to live as a single family unit will not be considered as part of the application.

In severe cases, a separated family can be considered by the Welfare and Hardship Panel.

ASSESSMENT OF HOUSING NEED

As previously mentioned, Homesearch would like to support people who are in the greatest housing need. This is achieved by awarding priority to those in the greatest need. This section will lay out how priority is awarded and reflected in the Grouping structure.

Applicants who need to move on medical or disability

If an applicant or a member of their household has a medical condition or disability which is affected by their current housing, they can ask to be considered for medical priority. A Medical Assessment form will need to be completed. If an applicant requires help to complete this form, a member of staff at Council Connect offices can be asked to assist.

Homesearch can award priority for housing if a member of the household needs to move home on grounds of a medical condition or disability. Medical priority will only be given in cases where a move to alternative accommodation would significantly improve or alleviate the problems the applicant is experiencing.

Homesearch may seek advice from a medical professional as this may help give an understanding of an applicant's medical condition or disability. Homesearch may also contact the applicant's doctor or other professionals working with them, who may have direct knowledge of their condition. Homesearch will take into account any relevant medical advice and use this information to help decide whether to award the applicant priority.

In determining whether to give an application medical priority the following factors will be relevant, (but are not limited to):

- An applicant's diagnosis, prognosis and the severity of their medical condition
- The type of medication or support an applicant is receiving
- If an applicant's housing affects their ability to carry out normal activities of daily living
- If an applicant's housing significantly affects their quality of life
- An applicant's current position on Homesearch and whether the applicant has been bidding for properties
- An applicant's ability to access alternative accommodation in the private sector
- An applicant's ability to use transport, including public transport.
- An applicant's ability to stay in their current accommodation with the installation of appropriate aids or adaptations
- An applicant's ability to remedy their housing difficulties such as disrepair, neighbourhood dispute and housing advice, (through other avenues).

An application with an agreed medical priority can qualify for Groups A or B. This reflects either an urgent or high need.

Group A medical priority is when:

An applicant's health is so severely affected by their accommodation that it is likely to become life threatening. An applicant's accommodation is directly contributing to the deterioration of their health and there is no method of improving their accommodation or their medical condition whilst in the accommodation. An applicant is unable to move about within their accommodation and use any facilities and requires a property which is suitable for their use.

Group B medical priority is when:
An applicant's accommodation has a significant negative affect on their health and activities of daily living and there is no method of improving their accommodation or their medical condition whilst in the accommodation.

The following is an example of a case that could qualify for urgent priority:
If an applicant is both housebound and cannot assess any facilities within their home, including their kitchen, bathroom, toilet or lounge, and a move to alternative accommodation will alleviate these problems.
The following is an example of a case that could qualify for high priority:
If an applicant is living in a 3rd floor flat (no lift) and has significant medical problems which affects their mobility, and a move to alternative accommodation will alleviate these problems.

The decision will be made by a Homesearch Advisor.

Applicants who need to move on welfare or hardship grounds

If an applicant or a member of their household is experiencing problems relating to welfare or hardship issues as a result of their current housing circumstances, they can ask to be considered for welfare and hardship priority. Circumstances can include issues relating to social problems such as racial or domestic violence, harassment, financial difficulties, care and support needs. It can also include a person who needs to move to the district in order to give or receive care, or to access specialised medical treatment.

A Homesearch Advisor will compile a report. The report will provide information about the applicant's circumstances and the problems with their current housing. A report can also be produced by a professional working with the applicant in a social care, housing or support environment.

Welfare and hardship priority will only be given in cases where a move to alternative accommodation would significantly improve or alleviate the problems the applicant is experiencing.

Homesearch may contact the applicant's doctor or other professionals working with them, who may have direct knowledge of their housing problems. Homesearch will take into account any relevant advice and use this information to help decide whether to award the applicant priority.

An applicant with an agreed welfare and hardship priority can qualify for Groups A or B. This reflects either an urgent or high need.

Group A welfare and hardship priority is when:
An applicant's safety is seriously affected by their social circumstances and moving home is vital and the only way to resolve the problem.

Group B welfare and hardship priority is when:
An applicant independence and quality of life is seriously affected by their social circumstances and moving home is vital and the only way to resolve the problem.

The decision to award priority will be made by the Senior Housing Practitioner – Homesearch in partnership with the Welfare and Hardship Panel.

Welfare and Hardship Panel

The Welfare and Hardship Panel is a group of people who work for Adult Health, Social Care and Housing and Sirona Care and Health. The panel can also include people from internal and external agencies, such as the NHS and Registered Providers. An up to date list of panel members is available from the Senior Housing Practitioner - Homesearch. The panel aim to meet monthly.

The Welfare and Hardship Panel will take into account the report, any relevant advice provided and use this information to help them decide whether to recommends the welfare and hardship priority.

In determining whether to give an applicant welfare and hardship priority the following factors will be relevant (but are not limited to):

- The severity of an applicant's circumstances and prospects of the situation improving
- In the case of harassment and violence the scale of the problem, including the number of incidents, the frequency and nature of those incidents
- An applicant's ability to manage their social circumstances and medical or supports needs
- The effect an applicant's housing has on their quality of life
- An applicant's ability to stay in their current accommodation with the provision of other services, such as a referral to the Environmental Health Department, Police or legal advice
- An applicant's behaviour or that of a member of their household which may be considered to affect their suitability for social housing
- The welfare of the children in the household or children looked after by the local authority who will be living with the applicant
- An applicant's current position on Homesearch and if their circumstances have been given the correct priority

- If an applicant has been bidding for properties
- An applicant's ability to access alternative accommodation in the private sector
- An applicant's financial circumstances, including the need to move because of employment, education or training opportunities
- An applicant's ability to use transport, including public transport.

The following is an example of a case that could qualify for urgent priority:
If an applicant is prevented from adopting or fostering a child because their housing circumstances are unsafe for the child. And the child is in the care of Bath and North East Somerset Council. If an applicant needs urgent housing to escape serious anti-social behaviour and violence.
The following is an example of a case that could qualify for high priority:
If an applicant is in financial difficulties through no fault of their own and their home is at imminent risk of repossession. Financial difficulties are such that an applicant is able to provide only the basic provisions, such as food, shelter and heating.

Applicants needing to move on from supported accommodation for welfare reasons

Applicants who are leaving care
An applicant can be awarded priority if they are in the care of B&NES Council - Children Services and they are ready to live independently.

An applicant who is a 'former relevant child' as defined by the Children (Leaving Care) Act 2000 and needs to move from foster accommodation can be given priority in Group B. This could also include an applicant living in a children's home but does not apply to any other housing tenure unless there are exceptional circumstances.

The following criteria will apply:

- An applicant is ready and prepared to move to independent settled accommodation
- An applicant has the life skills to manage a tenancy
- An applicant has a support package and appropriate Pathways Plan
- An applicant is not or has not previously been a tenant of a Registered Provider as a result of being granted this priority.

In exceptional circumstances priority may be given to:

- A 'former relevant child' who is owed a duty by another Council
- A 'former relevant child' (up to the age of 24) who has completed higher education funded by B&NES Council.

Applicants living in a supported housing project

Supported accommodation provides a home for people who need support; this includes people who have drugs and alcohol problems, mental health or learning difficulties. An applicant living in supported housing can be awarded priority if their housing provider is part of the Council's Assisted Move on Scheme (AMOS).

An applicant living in supported accommodation which is part of the AMOS scheme can be given Group B. There are a limited number of spaces on the AMOS scheme which means that not all applicants in supported accommodation can be awarded priority. Each Supported Housing Provider is able to nominate a given number of residents to the scheme. A list of organisations participating in AMOS is available from the Senior Housing Practitioner – Homeseach. The AMOS scheme will be reviewed on a regular basis.

The following criteria will apply:

- An applicant has been resident in the housing project for a minimum of six months
- An applicant wishes to build a stable life and is ready and prepared to move to independent settled accommodation
- An applicant has the life skills to manage a tenancy, such as paying rent
- An applicant has an appropriate support package.
- An applicant has a clear rent account.

The Senior Housing Practitioner - Homesearch may agree under exceptional circumstances that an applicant in rent arrears can qualify under this scheme if a repayment plan is in place. Exceptional circumstances can include rent arrears accrued through no fault of the applicant.

Applicants living in dangerous (insanitary or unsatisfactory) housing conditions

An applicant can qualify for priority if it can be shown that they need to move because their home is insanitary or in an unsatisfactory condition. This is determined by the Council's Housing Standards and Improvement Team including using the Housing Health and Safety Rating system (HHSRS). For an applicant to qualify for priority, the following factors will be relevant:

- The property is assessed to have a category 1 hazard or equivalent for 'non bricks and mortar' accommodation (this excludes category 1 hazard for overcrowding)
  and
- The Housing Standard and Improvement Team are satisfied that the problem cannot be resolved within a reasonable period. A reasonable period is normally 6 months
  or
- By continuing to live in the accommodation it will pose a considerable risk to the applicant's or a member of their household's health and safety. Homesearch will

have regard to whether there is an imminent risk as set out in the Housing Act 2004.

An applicant who lives in dangerous housing conditions can qualify for Group A.

Applicants living in social housing and need to move to a smaller property

If an applicant is a tenant of social rented accommodation within Bath and North East Somerset and would like to move because their home is too large for their needs, they can be given Group A or B. To quality, the applicant's landlord will need to be a member of the Homesearch Partnership. The Senior Housing Practitioner - Homesearch will agree with the applicant's landlord whether their existing property is to be let through Homesearch. This can be a condition of the Group A or B priority. The following criteria will apply:

Group A priority is when:
An applicant is under occupying their property by two or more bedrooms.

Group B priority is when:
An applicant is under occupying their property by one bedroom.

The size of the property the applicant will be considered for is set out in the table on page X. Where there is good reason an applicant may be considered for a larger property than would normally be the case. For example, an applicant is a single person who is the tenant of a four bedroom property.

There are circumstances when an applicant is given reduced priority, for example, an applicant has minor rent arrears. These are set out on page (number). If there is a good management reason, such as their existing home is in high demand, an applicant will not be given reduced priority.

Properties which are classified as 'hard to let' may not qualify for this priority.

The decision will be made by the Senior Housing Practitioner - Homesearch.

In addition, an applicant who is a tenant of social rented accommodation within Bath and North East Somerset and would like to move because their home is unaffordable can be considered by the Welfare and Hardship panel.

Applicants needing to transfer to sheltered accommodation

If an applicant is a tenant of a general needs social rented property within Bath and North East Somerset and would like to move because they need support provided by sheltered housing they can be awarded Group A.

To qualify, the applicant's landlord will need to be a member of the Homesearch Partnership. The Senior Housing Practitioner will agree with the applicant's landlord whether their existing property is to be re-let through Homesearch.

An applicant will not be given this priority if they bid or intend to bid for general needs properties. Any bid made will be withdrawn by Homesearch.

Applicants living in an overcrowded property

If an applicant's property is deemed to be overcrowded by Homesearch, they may qualify for a Group A or B priority. This will be determined by Homesearch in partnership with the Housing Standards and Improvement Team. The following criteria will apply:

Group A overcrowding priority is when:
An applicant is statutorily overcrowded as defined by the Housing Act 1985, Part 10.

Group B overcrowding priority is when:
An applicant is two or more bedrooms short in relation to bedroom entitlement as set on page X.

Additional reception rooms, such as a dining room or study can be used as a bedroom when calculating overcrowding.

Applicants who are homeless or threatened with homelessness

Homesearch will work in partnership with the Housing Options and Homelessness Team in order to assess whether an applicant is entitled to homelessness priority. Homesearch will comply with the Housing Act 1996 Part 7 (as amended).

An application with an agreed homelessness priority can qualify for Groups A or B.

The following criteria will apply:

Group A	Section 193 (2) and Section 65 (2)
Homeless duty accepted by Bath and North East Somerset. An applicant is: eligible for assistance, homeless, has a priority need, is not homeless intentionally and has a local connection to B&NES.	

Group B	Duties as set out in sections 190 (2), 193 (2), 195 (2) or 192 (3) of the Housing Act 1996 and sections 65

	(2), 68 (2) of the Housing Act 1985. Sections 175 – 177,
An applicant who is assessed as homeless. An applicant who is homeless, has a priority need and intentionally homeless. An applicant who is threatened with homelessness, has a priority need and not threatened with homelessness intentionally. An applicant has been provided with accommodation through legal power. An applicant is homeless, not in priority need and did not become homeless intentionally. An applicant is owed a duty by another housing authority, including section 193 (2).	

Homesearch may request an up to date homelessness decision, this is referred to as a section 184 decision.

A homeless applicant will not be given priority if they would only qualify by taking into account a 'restricted person'. A restricted person is defined by s 184 (7) of the Housing Act 1996.

Reviewing homeless preference
Homesearch together with Housing Options will review an applicant's circumstance after 3 months. If the homeless duty or situation is no longer current and appropriate the priority will be removed. For example, an applicant has been offered private rented accommodation to end the main homelessness duty under section 193 (2).

Applicants who require homeless prevention advice

An applicant can be awarded this priority if they are:

- Considered to be at risk of homelessness, and
- Have a priority need for accommodation under the Housing Act 1996 Part 7, and
- Homelessness can be prevented by this priority, and
- Advice is being provided by the Housing Options and Homelessness Team.

Circumstance which will effect whether an applicant will be given this priority includes (but is not limited to):

- If an applicant is at risk of homelessness as a result of a deliberate act or omission

The decision will be made by a Housing Advisor, in conjunction with the Senior Housing Practitioner – Housing Options and Homelessness.

Discretionary housing preference

An applicant can be awarded Discretionary Housing Priority if Housing Services have a strategic or management need for an applicant to move. Priority can be awarded in exceptional circumstances, this includes (but is not limited to) the circumstances below.

Applicants can qualify for Groups A, B or C. This reflects their degree of urgency. Group C is the lowest group and priority is awarded by granting additional waiting time through an applicant's effective date.

Group A discretionary housing priority is when:
An applicant has been identified as requiring accommodation and is being assisted through the Multi-Agency Public Protection Arrangements (MAPPA). An applicant is being assisted through the National Witness Protection Scheme.

Group B discretionary housing preference is when:
An applicant is living in a property within Bath and North East Somerset which is owned by a Registered Provider and the property is being redeveloped. The Registered Provider must be a member of the Homesearch Partnership. An applicant is a tenant of a Registered Provider within Bath and North East Somerset and there is a management reason for them to move. The Registered Provider would normally be a member of the Homesearch Partnership. An applicant has been given a 'legitimate expectation' by B&NES that they will be nominated to a Registered Provider. Legitimate expectation is referred to in housing case law.

Discretionary waiting time:
The following categories of people will receive discretionary housing priority if they are in Groups A or B. • Members of the Armed Forces • Former serving members of the Armed Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service • Bereaved spouses and civil partners of members of the Armed Forces leaving Services Family Accommodation following the death of their spouse or partner • Serving or former members of the Reserve Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service. 6 months additional waiting time will be granted.

The decision will be made by the Housing Services Manager.

APPLYING FOR A PROPERTY 'BIDDING'

Advertising available properties

Homesearch is an open advertising scheme. Vacant properties will be advertised on the Homesearch website weekly and will include as much information as possible, such as:

- Type of property
- Number of bedrooms
- Location
- Floor level and whether the property has a lift
- Whether the property is adapted for an applicant with disabilities
- Type and length of tenancy
- Type and amount of rent or other applicable charges
- Photographs of properties, buildings or areas if available.

In some circumstances it will be appropriate to attach more restrictive lettings criteria to individual properties. For example, where there are restrictive covenants arising from planning conditions. Letting criteria will help an applicant to decide whether they are entitled and wish to 'bid' for a property. Properties will be advertised in key locations across the district, so information can be widely accessible.

Homesearch website
The Homesearch website www.homesearchbathnes.org.uk allows an applicant to view the availability of affordable housing across Bath and North East Somerset. It also provides a function to bid for CBL properties. Applicants that do not have access to a computer at home can use one at any Council Connect reception or library.

CBL property adverts
Property adverts will be available in Council Connect receptions, some Registered Providers' reception areas or from local parish councils. A list of locations is available from Homesearch.

Local newspapers
Homesearch currently advertise properties in local newspapers.

Letting criteria

Lettings criteria, in relation to individual properties, is attached to an advert where necessary. Letting criteria can be used to:

- Give effect to a Local Lettings Policy (see page 51)
- Meet targets and quotas (see appendix 3)
- Match applicants with access needs to appropriate accommodation
- Assist Registered Providers when operating alternative eligibility criteria.

The adverts will clearly set out the letting criteria which apply to each property. This can include, but not restricted to:

- Size of family
- Age of applicants' dependants
- Age of applicants
- The support needs of the applicant which will or will not be considered
- The percentage of applicants in work
- Applicants requiring adaptations
- Applicants who have a connection to a parish
- Whether pets are prohibited
- Applicants who are tenants of a partner Registered Provider
- Social housing tenants who have a clear rent account and their property has been inspected by the Registered Provider as in reasonable condition.

Homesearch and Registered Providers will comply with the Equality Act 2010 and will not directly or indirectly discriminate against an applicant or a member of their household. Registered Providers will evidence the reasons for applying the lettings criteria, such as criminal activity by the previous tenant, in order to minimise future housing management issues.

The decision to apply letting criteria will be made by the Senior Housing Practitioner - Homesearch.

Bidding for a property

An applicant can bid for advertised properties online or by phone. The time frame to bid is six days, currently midnight Wednesday to midnight Tuesday. The time frame can be shorter or longer for exceptional circumstances or as a result of bank holidays. To register a bid, applicants can apply:

Online:	www.homesearchbathnes.org.uk
By phone:	0845 270 1239
By SMS Text:	07781484692 To SMS text use this format: Homesearch Ref (space) Memorable date usually a date of birth (space) Property Ref For example: 99999 (space) 14011976 (space) 643
By visiting Council Connect:	The Guildhall, High Street, Bath, BA1 5AW The Hollies, High Street, Midsomer Norton, BA3 2DP Riverside, Temple Street, Keynsham, BS31 1LA

Assisted bidding

If an applicant is vulnerable or has specific needs, Homesearch will provide support with bidding for a property. An applicant may need support if the following circumstances apply:

- English is not a first language
- Have literacy problems
- Have learning difficulties
- Diagnosed with a mental health problem
- Diagnosed with a long-term disability
- Live a chaotic lifestyle, such as misuse of drugs or alcohol
- Is undergoing a crisis, such as a victim of domestic violence
- Are social exclusion, such as rough sleepers.

Help is available by visiting Council Connect or in some Registered Providers offices. Additionally, an applicant can nominate a helper to bid on their behalf, such as a friend, relative or support worker. The helper can also deal with the applicant's Homesearch correspondence, subject to the applicant's written permission.

Alternatively, an applicant can have a personal Homesearch Advisor to bid on their behalf. An applicant will need to make a request to the Senior Practitioner – Homesearch.

Reassessing applications and removing bids

After close of bidding, an applicant's circumstances will be reassessed. Either a Registered Provider or Homesearch will verify an applicant's circumstance to determine whether to offer a tenancy. Circumstances which will be considered include:

- The size of the applicant's household matches the property advertised
- An applicant meets the letting criteria as set out in the advert
- An applicant has the appropriate priority under the Grouping structure
- An applicant meets the eligibility or qualification criteria
- An applicant's effective date is correct
- The property is affordable.

If an applicant does not meet these requirements or has failed to keep their application up to date, a Registered Provider or Homesearch may remove their bid.

An applicant's bid can also be removed in the following situation:

- An applicant fails to co-operate with a Registered Provider
- An applicant fails to reply to telephone calls or a letter about the property
- An applicant does not make a decision on whether to accept a tenancy within a reasonable timescale
- An applicant is suspected of making a fraudulent or misleading application.

If an applicant's Group, effective date, eligibility or qualification is changed as a result of reassessing their application, Homesearch will write to explain the reasons.

Assessment of bids

Properties can be advertised to one or a combination of Groups. More properties will be allocated to people in the higher priority Groups to recognise those applicants in the greatest housing need.

As a general rule, properties which have been advertised will be offered to the applicant with the earliest effective date within the highest Group.

The following are examples of a nomination.
If applicant 1 was in Group A with an effective date of 15/01/2001and applicant 2 was in Group B with an effective date of 20/06/2000. Applicant 1 would be offered the property.

If there is more than one application with the same effective date and Group, the applicant with the earliest Homesearch reference would be offered the property.

The following are examples of when a Homesearch reference would apply.
If applicant 3 was in Group B with an effective date 20/11/2006 and Homesearch ref.123. And applicant 4 with an effective date 20/11/2006 and Homesearch ref. 415. Applicant 3 would be offered the property.

If following an assessment an applicant is unsuccessful, they will not normally be contacted, however information about lettings is available on-line at www.Homesearchbathnes.org.uk or by contacting Homesearch.

Offering a property

A Registered Provider may contact an applicant who meets the criteria in the previous sections to arrange an interview. To decide whether an applicant will be a suitable tenant in addition to the interview a Registered Provider may contact professionals involved with an applicant. This could include an applicant's current landlord or support worker. If a Registered Provider refuses to offer a property to an applicant, they must write to an applicant to explain their reasons.

Viewing a property

A Registered Provider will contact an applicant to arrange to view a property. Reasonable notice will be given to allow an applicant to view the property and to make a decision whether to accept a tenancy. An applicant does not have to sign the tenancy agreement until they have viewed the property.

The time frame for offering a property is at the discretion of a Registered Provider.

A Registered Provider may decide to arrange a group viewing whereby a number of applicants will be invited to attend the property. An applicant's chance of being successful is determined by their position on the register in relation to other applicants who have bid on a particular property. This information is available on-line at www.homesearchbathnes.org.uk, from the Registered Provider and Homesearch.

In some instances longer periods can be granted for an applicant to view or decide whether to accept a tenancy. For example, if an applicant is in hospital, needs to travel a long distance or is a vulnerable person in some form of temporary accommodation. Registered Providers will make reasonable adjustments for disabled applicants.

Applicant property refusal

If an applicant bids for a property, but after viewing decides it is not suitable, the applicant and the Registered Provider will need to contact Homesearch.

An offer is defined as when an applicant has viewed a property.

If an applicant refuses two reasonable offers of accommodation, their application may be given reduced priority for a period of 12 months.

This is in order to ensure that applicants only bid on properties they are willing to consider, thus preventing unnecessary delay which may negatively impact on other applicants.

If an applicant refuses a property, Homesearch will consider the applicant's reason for refusing. An applicant can appeal to the Senior Housing Practitioner – Homesearch within 21 days if they disagree with the decision to count a property as an offer for the purposes of reduced priority.

Registered Providers refusal of an applicant

A Registered Provider can refuse to offer a property to the first bidder in line for nomination. A Registered Provider must tell Homesearch if they wish to reject an applicant.

There may be circumstances when a Registered Provider feels that an applicant or a member of their household is considered unsuitable for a property or area. If an applicant is refused for a property it will be offered to the next person in line for nomination. A list of acceptable reasons a Registered Provider may refuse an applicant at nomination can be found in appendix 1.

If an applicant is refused for a property, the Registered Provider will write to the applicant to:

- Explain their reasons for refusing an applicant
- Inform an applicant of the properties they can be considered for
- Include information on how to appeal to a senior manager about any refusal made.

Properties will not normally be kept available during an appeal period.

If an applicant's appeal is successful the Registered Provider and Homesearch will work in partnership to directly offer the applicant the next suitable property. In selecting the next suitable property, Homesearch will consider the size and general area of the property the applicant was originally refused for. If an applicant refuses the property no further offer will be made. However, an applicant can continue to participate in the

bidding system during and after this process, subject to normal Homesearch Allocation Scheme rules.

SPECIFIC PROPERTY LETTING CRITERIA

Some properties allocated through CBL will have special conditions imposed. The conditions are set out in the letting criteria (page 33) and will be displayed in the property advert. Some properties which are subject to special condition are detailed below.

Properties reserved for existing social housing tenants – 'Transfers'

Homesearch do not have nomination rights to all social housing in Bath and North East Somerset. Registered Providers are required to meet the housing needs of their tenants and may reserve some of their properties to offer to tenants in housing need. The process of a Registered Provider nominating an existing tenant is referred to as a 'transfer'. Transfers do not fall with Part 6 of the Housing Act unless a tenant requests a transfer and they have a reasonable preference under the Housing Act. Allocating some properties to transfer tenants will ensure Homesearch and the Registered Provider can make the best use of housing stock.

A Registered Provider may decide to advertise transfer properties through Homesearch. In this instance Homesearch will assess the housing need of their tenants. Transfer properties will be subject to lettings criteria and advertised as either available to transfer tenants of a Registered Provider only or preference will be given to transfer tenants of a Registered Provider. Transfer tenants will be considered before other applicants.

High demand rural properties should be considered for general advertising through Homesearch, with rural connection criteria applying rather than being used for a transfer property. This will be agreed between the Registered Provider and Homesearch.

Transfer agreement between B&NES and a Registered Provider
Registered Providers who advertise their transfer properties through Homesearch are set out in Appendix 3. If a Registered Provider decides to allocate their transfer property via Homesearch this will be subject to a transfer agreement. A copy of a transfer agreement can be obtained from the Senior Housing Practitioner – Homesearch.

The transfer agreement may include a decision on:

- An applicant's effective date
- Percentage of properties which will be designated for transfer tenants
- The properties to be put forward for transfer in terms of location and size
- Any housing management issues which the tenant must comply with before being considered for nomination, such as repairing their property and clearing rent arrears.

Adapted and accessible properties

Some properties are adapted for people with disabilities, such as, wheelchair accessible, have a low level kitchen or a walk in shower. Properties with significant adaptations may be matched to applicants who require these facilities.

Disabled applicants can also bid for property adverts where the property has not been adapted for their need. Homesearch will work in partnership with other services, such as Occupational Therapy when allocating the property. Homesearch and the Registered Provider will consider whether it is reasonable and practical to adapt the property for an applicant's needs. In some circumstance adapting the property will not be possible. Disabled applicants will be considered on the same basis as other applicants who have submitted a bid for the property.

Sheltered or older person properties

Sheltered properties are for older or disabled applicants who have support needs and wish to live independently. Properties are typically one bedroom bungalows or flats. Tenants live independently with support provided by a Sheltered Housing Officer. The Sheltered Housing Officer visits the tenant regularly and can help with many tasks, such as helping to complete paperwork. Properties are usually within a housing development with a number of other sheltered properties.

Sheltered properties can be subject to letting criteria. An applicant may need to be of a certain age to qualify. This is typically 50+, 55+ or 60+ but will vary depending on the Registered Provider.

Applicants in receipt of middle or high rate care or mobility component of the benefit Disability Living Allowance (DLA) may also qualify, subject to the criteria of the Registered Provider.

Under occupation of a property

Under-occupying is when a property is allocated to a person who does not meet the bedroom eligible criteria. This criterion is set out in appendix 2.

Circumstances when a property could be under-occupied include:
A property is subject to the rural connection provision.
A property is on a rural exception site.
A property is hard to let.

The decision to allow under occupation of a property will be made by the Housing Services Manager, Senior Housing Practitioner – Homesearch and the Registered Provider.

Local lettings policy

A local letting policy is an agreement between the local authority and a Registered Provider. It decides how properties will be allocated in certain defined geographical areas. A local letting plan may include further letting criteria than stated on page 42. This is in order to meet specific local issues within an area.

The Registered Provider will consult interested parties and evidence the need for the local letting plan. Examples of the circumstances when a local letting plan can be agreed are:

- To deal with concentrations of deprivation or create a more mixed community
- To ensure new housing developments are mixed and sustainable
- To deal with anti-social behaviour.

A local lettings policy will include the following:

- Neighbourhood profile
- Purpose of the plan
- Objectives
- Timescale
- Review date.

A local letting policy will be agreed between the Housing Services Manager and the Registered Provider. Local letting policies are time limited; and will be monitored and reviewed regularly to ensure they are effective. When a local letting plan is no longer effective it will be revised or revoked in agreement with the Registered Provider and the Housing Services Manager.

A copy of a particular local letting plan can be obtained from Homesearch.

Rural connection

In rural communities where there is a population of less than 3000, people with a connection to the parish will be given priority when a property becomes vacant. To have a priority an applicant will need to meet the rural connection criteria.

Applicants must meet one or more of the following criteria to have a rural connection:

- Live in the parish and have done so for at least the last year
- Work in the parish in permanent paid employment
- Have close relatives in the parish with which there is on-going positive contact. Relatives are a mother, father, adult brother or sister, or adult child over 18 who currently live in the parish and have done so for at least the last year
- Have lived in the parish for 3 out of the last 5 years

Homesearch will allocate properties in rural communities in the following priority order:

1st priority	Applicants who have a rural connection
2nd priority	Applicants who meet the bedroom need
3rd priority	The highest Group
4th priority	The earliest effective date

The following is an example of a rural connection nomination for a 3 bedroom property
If Applicant 1 had a rural connection to the parish and needed a 3 bed property and Applicant 2 had a rural connection to the parish and needed a 2 bed property. Applicant

1 would be offered the property regardless of Group and effective date.

Under occupation of rural properties

To help local residents and recognise the shortage of properties in rural communities, Homesearch will consider under-occupation of a rural property by up to 1 bedroom. The decision to allow under occupation of a property will be made by the Senior Housing Practitioner – Homesearch in agreement with the Registered Provider.

The following is an example of a nomination for a 3 bedroom property which can be under-occupied.
If Applicant 3 had a rural connection to the parish and needed a 2 bedroom need and there were no applicants with a rural connection and 3 bed need they would be offered the property.
If Applicant 4 had a rural connection to the parish and a 1 bedroom need they would not be offered the property.

No bids from applicants with a rural connection

If there is no demand from applicants with a rural connection to the parish, Homesearch will consider applicants who have a connection to a surrounding parish.

Rural exception sites

Some new build affordable housing has been developed on land outside of the parish development boundary, where normally housing is not allowed to be developed. This is known as a rural exception site and this housing is primarily for people with a connection to the parish.

First priority will be applicants that meet one or more of the following local connection criteria which is taken from the Rural Exception Site Legal Agreement:

The Rural Exception Site Legal Agreement says:

4.2 The Developer covenants with the Council at all times not to occupy or allow or cause to be occupied any Affordable Housing Unit other than by anyone in need of Affordable Housing and who in priority order (with the greatest priority being given to the occupant described in 4.2.1:-

4.2.1 Has immediately prior to occupation of the Affordable Housing Unit been resident in the Parish for five years or

4.2.2 Has a strong local connection with the Parish based upon any one or more of the following criteria (with the greatest priority being given to the occupant described in (i):

(i) prior to the time of commencement of occupation of the Affordable Housing Unit has lived in the Parish for three years
(ii) has family associates in the Parish who are currently resident and have lived continuously within the parish for at least five years, or
(iii) has been permanently employed in the Parish for a minimum of one year.
(iv) prior to the time of commencement of occupation of the Affordable

Housing Unit has lived in the Parish

4.2.3 Has immediately prior to occupation of the Affordable Housing Unit been resident in the adjoining parishes for a period of five years or

4.2.4 Has a strong local connection with a parish in paragraph 4.2.3 above based upon the factors set out in paragraph 4.2.2.

As with rural connections, in certain circumstances, applicants may be able to under-occupy in areas where there is a shortage of a particular bedroom need.

ALLOCATIONS OUTSIDE PART 6 OF THE HOUSING ACT 1996

Most social housing will be allocated in accordance with Part 6 of the Housing Act 1996. This section lists circumstances when Part 6 and hence some sections of this document do not apply. This can include the Group Structure, Assessment of Housing Need, and Applying for Property 'Bidding'. Each section explains in more detail the process and if these section apply.

Part 6 does not apply to the allocation of the following properties:

Private rented properties

Private rented properties are advertised on Homesearch. A private landlord can advertise a private rented property subject to fulfilling the following property criteria:

- In a reasonable condition
- Has satisfactory management arrangements
- Is an affordable rent

Selection of an applicant is based on the landlords own criteria. If an applicant is successful for a private rented property they will be offered an Assured Shorthold Tenancy (AST). AST's have more limited tenancy rights in comparison to a tenancy offered by a Registered Provider.

In exceptional circumstances, Homesearch may decide not to advertise a property or to exclude advertising all properties of a private landlord for a specified period of time. Circumstances when this could apply include (but not limited to):

- A failure to comply with the Equality Act 2011
- A breach of the tenant's legal rights

Mutual exchange properties

Mutual exchange properties within Bath and North East Somerset are currently advertised on Homesearch. A mutual exchange occurs when an existing social housing tenant decides to 'exchange' their property with another social housing tenant.

A tenant can select another tenant to exchange their home with, based on their own criteria. Logically, this will be whether they would like to live in the other tenant's home. Whether an applicant is successful in exchanging their home will be decided between the tenants and their Registered Providers. Terms and condition which apply to mutual exchanges are available by contacting Registered Providers.

As well as Homesearch there are national schemes available to advertise a property for mutual exchange such as, Homeswappers Direct and House Exchange. The websites are:

www.homeswapper.co.uk
www.houseexchange.org.uk

Shared ownership properties

Shared ownership properties are not advertised on Homesearch. An applicant who is interested in purchasing a property through shared ownership should contact Housing Services on 01225 477818.

Supported housing 'Gateway'

Supported housing is available to people with housing support needs. This includes people with:

- A mental illness or disability
- A drug or alcohol problem or
- Fleeing domestic violence

These properties offer housing and support to help people who struggle to live independently. To apply for supported housing, view available properties and the eligibility criteria please visit:

www.housingsupportgatewaybathnes.org.uk.

Properties allocated for transfer tenants

As already mentioned some allocations to existing social tenants (known as a transfer) do not fall with Part 6 of the Housing Act. For Part 6 to apply to an allocation special conditions must be met. These are:

- The allocation involves a transfer
- The transfer is made at the tenant's request, and
- The housing authority is satisfied that the tenant has reasonable preference for an allocation.

Additionally, transfers initiated by a Registered Provider for management purposes do not fall within Part 6.

In practice, this means that a transfer applicant in Group C would not fall within Part 6.

Direct property offers 'Offering a property directly to an applicant'

A direct offer happens when Homesearch selects a suitable property on behalf of an applicant. A direct offer will provide an applicant with limited or in some circumstances no choice over the property they will be allocated. As a result direct offers are rarely used. Circumstances when an applicant may be directly offered a property are:

- An adapted property is required for an applicant in Group A
- Compliance with a legal requirements, such as a judicial instructions

- A property is required for an applicant to discharge B&NES housing duty under section 193 (2)
- A large property is required for a homeless family who are owed a housing duty by B&NES under section 193 (2) or 195 (2) of Part 7 of the Housing Act 1996. A failure to directly offer a property to the family will result in a significant financial burden for B&NES or severe hardship for the family.
- An applicant is assisted through the MAPPA scheme
- An applicant is assisted through the National Witness Protection Scheme

Before directly offering a property, the housing need of an applicant will be assessed to ensure the property would be suitable. The wishes and feelings of an applicant will be relevant but not decisive in concluding whether the offer is suitable.

The decision will be made by the Senior Housing Practitioners. In making a decision the Senior Housing Practitioner will have regard to the Equality Act 2010 and the view of the Registered Provider.

Hard to let properties

A property can be classified as hard to let if it has been advertised by Homesearch and the Registered Provider has been unable to offer the property to an applicant.

The Senior Housing Practitioner - Homesearch in partnership with the Registered Provider may decide to offer a property to an applicant on the basis of 'first-come, first-served'.

HOMESEARCH ADMINISTRATION

An applicants' circumstance will change during the life of their Homesearch application. This can include an applicant moving home, a member of their family leaving home or a new addition to the family. Changes like these will affect an application. An applicant must update their Homesearch application if their circumstances change as this could affect:

- Their eligibility or qualification
- Their Group
- Their bedroom entitlement

Group reassessment

An applicant placed in Group A or B will have their application reassessed regularly. Our aim is to reassess an application every 6 months. Reassessing will ensure an applicant remains in high or urgent housing need. Applicants in Groups A and B will be expected to bid for properties. An applicant who fails to bid or is unreasonable in restricting the properties they are willing to consider could have their Group changed.

Applicants in Group C will not be reassessed routinely, unless Homesearch identifies a fault in how their circumstances have been assessed.

The decision will be made by the Senior Practitioner – Homesearch.

Homeless duty reassessment

Introduction Paragraph needed

An applicant with a homeless preference in Group A because B&NES have a duty under the Housing Act Part 7 has three months to bid for a property. Three months reflects the amount of time it is likely to take for a property to become available and gives an applicant an opportunity to express choice about the property they would like.

An applicant who has bid for properties unsuccessfully can be assisted through a direct property offer or a private rented sector offer.

Direct property offer - Applicant owed a homelessness duty in Group A
An applicant who has not been allocated a property by the end of the third month can be assisted through a direct property offer. A direct property offer will prevent a homeless applicant waiting an unreasonably long time for a social housing tenancy. Additionally a direct property offer will prevent an applicant staying a long time in temporary accommodation which can be costly, oversubscribed and not an ideal home for an applicant.

If an applicant is offered and refuses a direct property offer their homeless duty may be discharged. Discharging homeless duty is likely to result in an applicant being placed in a lower Group. This is because their Group A homeless preference will be removed.

Before making a direct property offer, the Senior Housing Practitioner – Housing Options and Homelessness will review an applicant's circumstance. Circumstances to be reviewed include:

- Any properties that have become available within this time frame and are considered suitable for an applicant
- If an applicant was informed and understood the time frame to bid for a property
- If an applicant was capable of using Homesearch and if advice and assistance was provided.

If an applicant has a good reason why they did not participate or has failed to be offered a tenancy an extension to the three month time frame can be agreed by the Senior Housing Practitioner – Housing Options and Homelessness. Good reasons can include (but are not limited to):

- An applicant needs a specific property which is in short supply
- An applicant has learning difficulties and was unable to participate in bidding.

Private rented sector offer - Applicant owed a homelessness duty in Group A or B
An applicant may be assisted through a private rented sector offer. If an applicant is housed in private rented accommodation or the Council discharge their homeless duty Homesearch will update an applicant's application to reflect the change.

The decision will be made by the Senior Housing Practitioner – Housing Options and Homelessness.

Periodic review

Homesearch recognises the need to check periodically whether there are any changes in the circumstances of an applicant. A periodic review also gives Homesearch the chance of discussing other housing options with an applicant. This is especially relevant if an applicant is unlikely to be allocated a property through Homesearch. This will normally be every twelve months.

An applicant who fails to respond to the review will have their application cancelled.

Cancelling an application

There are circumstances when it is appropriate to cancel an application. If an application is cancelled an applicant's effective date will no longer be valid. An application can be cancelled for the following reasons:

- An applicant asks to cancel their application
- An applicant has been housed through Homesearch
- A sole applicant has died

- Homesearch correspondence has been returned because it could not be delivered.
- An application is deemed by Homesearch to be fraudulent
- An applicant no longer meets the Homesearch eligibility or qualification criteria
- An applicant has not responded to the periodic review.

Cancellation letter
In some circumstances it is appropriate to write to an applicant to explain why their application has been cancelled. Examples of circumstances which may result in a cancellation letter are:

- An applicant does not responded to Homesearch correspondence
- An applicant does not bid for a property within four years
- An application is deemed by Homesearch to be fraudulent
- An applicant no longer meets the Homesearch eligibility or qualification criteria
- An applicant has not responded to the periodic review

An applicant who responds to the letter within 30 days will not have their application cancelled but any change in circumstances including a new contact address should be provided.

An applicant has a right to request a review if their application is cancelled (see table).

Decisions which can be subject to review

There will be circumstances when an applicant is unhappy with the way their Homesearch application has been dealt with. An unhappy applicant can ask Homesearch to conduct a review of a decision made on their application. This is referred to as an applicant appealing a decision. Decision which are subject to review fall into two categories, these are:

- The facts of an applicant's case which are likely to be, or have been, taken into account in considering whether to allocate accommodation, and
- Whether the applicant is eligible or qualifies to join Homeseach.

Homesearch aims to have a review process which is fair and transparent. The review procedure is:

- An applicant should write to Homesearch giving their reasons for their appeal and enclose any documents supporting their claim
- An applicant can appoint a representative, such as a solicitor to act on their behalf
- An applicant will be told the timescale to request a review of a decision. Only in exceptional circumstances will Homesearch extend the timescale for an applicant to appeal.
- The review will be carried out by an officer senior to the original decision maker
- The review will have regard to the housing allocation scheme, legal requirements and all other relevant information
- An applicant can make verbal representation in support of their appeal

- A review will be completed with 56 days unless an extension to the review period is agreed.
- An applicant who has difficulties understanding the implications of a decision will be seen by Homesearch face to face. Where this is not feasible, arrangements will be made for the reasons to be explained face to face with the applicant by another person or professional involved with the applicant
- An applicant will be informed of the outcome and reasons for the review decision in writing. Any decision will be based on the relevant facts of an applicant's case.
- If a contact address is not available, the decision will be made available for collection by an applicant at a Council Office for a period of 30 days
- An applicant who is unhappy with the outcome of a review may wish to seek a judicial review or contact the Housing Ombudsman.

The table shows the decisions which can be reviewed:

Types of review	**Timescale for an applicant to appeal** (calendar days)	**Responsible officer**
Whether the applicant is eligible or qualifies to join Homeseach		
If an applicant meets the eligibility and qualification criteria	Within 21 days of being notified of the decision	Senior Housing Practitioner – Homesearch
The facts of an applicant's case which are likely to be, or have been, taken into account in considering whether to allocate accommodation		
An applicant's effective date	Within 21 days of being notified of the decision	Senior Housing Practitioner – Homesearch
Type of property an applicant will be considered for	Within 21 days of being notified of the decision	Senior Housing Practitioner – Homesearch
If an application is cancelled	Within 21 days of their application being cancelled.	Senior Housing Practitioner – Homesearch
If an applicant is given reduced priority	Within 21 days of being notified of the decision	Senior Housing Practitioner – Homesearch
The extent of the applicant's household to be considered for housing	Within 21 days of being	Senior Housing Practitioner – Homesearch

	notified of the decision	
If an applicant is entitled to a reasonable or additional preference based on the facts of their case	Within 21 days of being notified of the decision	Senior Housing Practitioner – Homesearch or Housing Options & Homelessness

Fraudulent applications

The Council and our partners undertake random sampling of Homesearch applications to ensure the information supplied is correct.

It is a criminal offence, when making a Homesearch application, or when giving us further information to:

- knowingly or recklessly to make a statement which is false in a material particular or
- knowingly withhold information which we reasonably require an applicant to give.

An applicant who deliberately provides false or misleading information may be given reduced priority or their Homeseach application could be cancelled. Furthermore, giving fraudulent information may lead to a summary conviction and a fine not exceeding level 5 on the standard scale and eviction from any housing accommodation offered.

If there is reasonable suspicion of fraudulent activity, Homesearch will investigate the applicant's circumstances, this can include (but is not limited to):

- Obtaining further documents to confirm identity, such as passport, birth certificate and driving licence
- Obtaining further documents to confirm residency, such as, utility bills, bank statements and tenancy agreement.
- Obtaining further documents to clarify a child's residency, such as court order, letter from government agencies, schools and doctors.
- Visiting an applicant's home announced or unannounced.

Homesearch may contact other professionals working with an applicant, this includes (but is not limited to):

- A employer
- A school, college or university
- A medical professional
- Another government department.

A decision to prosecute an applicant will be made by Homeseach in partnership with the Council's Legal Services Department.

Fraudulent Employees

The Council and partners will monitor the Homesearch Allocation Scheme to detect any fraud committed by employees of any organisation involved in the administration of the scheme.

Employees found to be fraudulently benefitting from the scheme for themselves or on behalf of others will be dealt with through the organisation's disciplinary proceedings.

Deliberately worsening circumstances

If an applicant has deliberately worsened their circumstances in order to qualify for reasonable or additional priority, their application will be assessed on their housing need before the change in circumstances.

Circumstances could include (but are not limited to):

- An applicant sells a property that is affordable and suitable for the applicant's needs
- An applicant moves from a secure property to an insecure or overcrowded property
- An applicant increases the number of people in their household for no good reason.

Homesearch will also consider whether an applicant has made a fraudulent application.

IMPORTANT INFORMATION

Equalities

On 5 April 2011 the public sector equality duty (the equality duty) came into force in England, Scotland and Wales. This duty replaces the existing race, disability and gender equality duties.

Housing Services and Partnership Registered Providers will comply with the new duties by committing to ensure that every application to Homesearch is assessed equitably and in a lawful and non-discriminatory manner.

Through this Allocations Scheme, Housing Services seeks to

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who don't.
- Foster good relations between people who share a protected characteristic and those who don't.

Regular monitoring of Homesearch, including applications and nominations to Registered Providers will be undertaken and the evaluation of this fed into Homesearch service development.

Monitoring

Homesearch will monitor the Homesearch Allocation Scheme to ensure:

- The aims set out on page 10 are being achieved
- Overall reasonable preference for allocations is given to applicants in the reasonable preference categories
- All legal requirement have been met
- The quotas set out in appendix 3 are being achieved.

Homesearch will comply with any monitoring requirements set out in the Code of Guidance.

Legal considerations

Homesearch has been informed by the Housing Act 1996 (as amended by the Homelessness Act 2002 and Localism Act 2011), the Allocation of Housing and Homelessness (Eligibility) (England) Regulation 2006 (SI 2006 No. 1294). Homesearch has also been informed by the statutory guidance: Allocation for Accommodation: Guidance for Local Housing Authorities in England. June 2012.

Homesearch will also keep up to date with any developments in the law in this area.

Homesearch also has regard to the following Acts:

- Environmental Protection Act 1990, Part 3
- Housing Act 1985, Part 10
- Housing Act 2004, Part 1
- Equality Act 2010
- Data Protection Act 1998
- Asylum and Immigration Act 1996
- Welfare Reform Act 2012
- Human Rights Act 1998

Homesearch also has regard to the Council's Housing, Homelessness and Tenancy Strategies.

Information sharing

Homesearch will process personal data which we hold about applicants consistently with the Data Protection Act 1998.

Information contained in the Homesearch application may be shared with other agencies including registered providers, private landlords, local authorities, the Home Office, Immigration and Nationality Directorate and other government departments and agencies.

Letting outcomes
Homeseach will publish information on letting outcomes, including the effective date and Group the property was allocated to. Letting outcomes provides valuable information to help other applicants understand how long they are likely to wait for a property. Where providing information might put the successful applicant at risk of violence or intimidation by other individuals or a member of the public, Homesearch may not publish the letting outcome.

An applicant's personal information will not be published.

Anonymous applications
Homesearch may restrict access to the personal details of an applicant from employees of Homesearch or Registered Providers. An applicant's personal details will be anonymous and a false name and address will be used.

Circumstances which may require an anonymous application are:

- An applicant is being assisted through the Multi-Agency Public Protection Arrangements (MAPPA)
- An applicant is being assisted through the National Witness Protection Scheme.

Security procedure
Homesearch recognises the importance of data protection and will ensure that confidential information is not discussed with third parties. An applicant who wishes to discuss their Homesearch application will be asked to comply with the following procedure.

- Confirm their name, address and date of birth and
- Confirm their mother's maiden name, first school or password.

Complaints, comments and compliments

Homesearch aims to provide the best possible service but sometimes things can and do go wrong. We are committed to putting these situations right and preventing them from happening again.

An unhappy applicant may speak to the Senior Housing Practitioner – Homesearch who will try and resolve their concerns. Alternatively or if the applicant is not satisfied with the response, the Council's complaints procedure is available on line at www.bathnes.gov.uk.

An applicant who would like to make a comment or compliment can also speak to the Senior Housing Practitioner – Homesearch or visit www.bathnes.gov.uk.

Registered Providers complaints procedures

Registered Providers complaints procedures are published on the Homesearch website www.Homesearchbathnes.org.uk or available from the Senior Housing Practitioner – Homesearch.

Health and safety

Bath & North East Somerset Council believes that violence, aggression, threatening or abusive behaviour or harassment towards its employees is unacceptable and that no employee should be required to accept it as a part of their job.

Homesearch will comply with the Council's policies and procedures in this regard. Remedial action could include (but not limited to) an applicant's name being added to a database as a potentially aggressive person, advising an applicant that they cannot attend Council offices or only dealing with an applicant by telephone or in a structured interview.

Homesearch may also consider if an applicant's behaviour has resulted in them failing the qualification criteria.

Information about an applicant who presents health and safety concerns can be shared with other agencies in the interest of the safety of the applicant, the public and members of staff.

People who present a risk of harm

To protect the communities, information will be sought from agencies such as the Police and Probation Service where an applicant is considered to pose a serious risk of harm to the public. Circumstances include people convicted of sexual and violent offences.

Gathering information from agencies will form part of the assessment process, as such an application will not be made active until the assessment is completed.

APPENDIX 1

Acceptable reasons for a Registered Provider to refuse to offer a property to an applicant

Registered Providers may refuse to accept an applicant nominated by Homesearch. This can occur when an applicant has been nominated for a property.

The circumstances when this could apply are:

- An applicant has a history of anti-social behaviour and housing the applicant is likely to have a significant affect on neighbouring tenants
- An applicants has support needs and does not have a support plan in place
- An applicant is unsuitable for the property because of a recent tenancy management issue in the property
- An applicant has unmanaged rent arrears relating to a current or former tenancy
- An applicant was previously evicted for breach of tenancy conditions in the last 2 years
- An applicant has displayed threatening, violent or otherwise unreasonable behaviour, such as towards a member of staff or neighbouring tenant in the last 12 months
- An applicant is a tenant of the Registered Provider and has rent arrears or management issues with the tenancy
- An applicant has bid for another property and accepted that property
- An application appears to be false or misleading and further investigation is required
- An applicant is unable to afford the rent for the property
- An applicant has been found guilty of tenancy or benefit fraud relevant to their suitability to be a tenant.

All applicants will be considered individually. A registered provider will comply with the Equality Act 2010 and evidence their reason for refusing an applicant for a property.

A registered provider's decision to refuse an applicant for a property should be made in partnership with the Senior Housing Practitioner – Homesearch.

APPENDIX 2

Quotas and targets

Homesearch recognises the importance of giving priority for social housing to those in the greatest housing need, this does not mean that every property which is advertised will be allocated in this way.

The Senior Housing Practitioner - Homesearch will set broad targets on an annual basis which will be monitored throughout the year. These targets will reflect the aims of the Homesearch Allocation Scheme. These targets are subject to change in agreement with the Housing Services Manager.

The Senior Housing Practitioner - Homesearch will ensure that people who do not have a reasonable preference do not dominate the scheme or undermine the Council's ability to ensure that reasonable preference is given to those prescribed by law in the reasonable preference categories.

Quotas for groups
This table shows the percentage of properties which will be allocated to each Group.

Group	Proportion of Available Properties
A	**50%**
B	**30%**
C	**20%**

Quota for transfer applications
This table shows the percentage of properties which will be allocated to transfer tenants.

Register Provider	Proportion of Properties
Curo Places	25%

INDEX

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Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **21st September 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 11.09.12.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
21st Sep 12						
	Cabinet Member update					
	NHS/CCG update					
	Urgent Care		Dr Ian Orpen (tbc)			
	LINk update					
	JSNA – Dementia		Jon Poole			
	Winterbourne View Findings update		Jane Shayler			
	Care Quality Commission update		Karen Taylor from CQC			
	Personal Budgets Policy Report		Sarah Shatwell			
	Specialist Mental Health Services update		Andrea Morland			
	Alcohol Harm Reduction Scrutiny Inquiry Day – Terms of reference		Lauren Rushen			
	Homesearch Policy		Graham Sabourn			
16th Nov 12						
	Medium Term Service and Resource Plans		tbc			
18th Jan 13						

Last updated 11.09.12.

	JSNA – Social Inequalities					
	Strategic Transition Board update					
	Energy Efficiency report				The Panel on suggestion from Cabinet member	
	The Mineral Hospital update (tbc)					
	Alcohol Harm Reduction SID - recommendations		L Rushen			
22nd Mar 13						
	JSNA – topic ?					
Future items						
	Talking Therapies update		Andrea Morland			