Bath & North East Somerset Council

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Date: 12 November 2013
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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Cherry Beath
Councillor Sharon Ball
Councillor Sarah Bevan
Councillor Lisa Brett
Councillor Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 22nd November, 2013

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 22nd November, 2013** at **10.00 am** in the **Kaposvar Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

   Appendices to reports are available for inspection as follows:-

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

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

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

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

6. **Emergency Evacuation Procedure**

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

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

Wellbeing Policy Development and Scrutiny Panel - Friday, 22nd November, 2013

at 10.00 am in the Kaposvar Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

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

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting. Members are asked to indicate:

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is **a disclosable pecuniary interest** *or* an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

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

   At the time of publication no notifications had been received.

7. MINUTES (Pages 7 - 20)

8. CABINET MEMBER UPDATE (10 MINUTES)

The Cabinet Member will update the Panel on any relevant issues. Panel Members may ask questions.

9. CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

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

10. HEALTHWATCH UPDATE (10 MINUTES) (Pages 21 - 26)

The Panel will receive an update from Pat Foster on the Healthwatch Bath & North East Somerset.

11. MEDIUM TERM SERVICE & RESOURCE PLANNING - 2013/14-2015/16 (30 MINUTES) (Pages 27 - 44)

The Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) Update is presented for consideration by the Panel:

(1) To ensure all members of the Panel are aware of the context for Service Action Planning
(2) To enable comment on the strategic choices inherent in the medium term plan
(3) To enable issues to be referred to the relevant Portfolio holder at an early stage in the service planning and budget process.

The Panel is asked to:

(1) Comment on the update to the medium term plan for Adult Social Care & Housing
(2) Identify any issues requiring further consideration and highlighting as part of the budget process for 2014/15
(3) Identify any issues arising from the draft plan it wishes to refer to the relevant portfolio holder for further consideration.

12. ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS FT - ORGANISATIONAL UPDATE (20 MINUTES) (Pages 45 - 48)

This paper is an organisational update from the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) to the B&NES Wellbeing Policy and Development Scrutiny Panel.

13. UPDATE REPORT ON THE RE-PROVISION OF NEURO-REHABILITATION PREVIOUSLY PROVIDED AT THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES (RNHRD) (30 MINUTES) (Pages 49 - 66)

Purpose of the report is to update Bath and North East Somerset (B&NES) Wellbeing Policy Development and Scrutiny Panel on the provision of specialised Category A (Level 1 and 2a) Neurological Rehabilitation (neuro-rehabilitation and non-specialised neuro-rehabilitation services) following the Royal National Hospital for Rheumatic Diseases (RNHRD's) decision to cease providing specialised neuro-rehabilitation at the end of March 2013.

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

• Patients needing this service have continued to be treated at the level of service that is most clinically appropriate for their needs;
• Service provision has increased as a result of the re-provision and is subject to further expansion and no patients from B&NES have had to be referred out of area;
• There have been no issues regarding access, quality or safety at any of the re-provided services;
• Very few (< 5) people from the B&NES area currently accessing any of these inpatient services;
• New rules requiring providers of neuro-rehabilitation to register with UKROC now provide independent quality assurance over and above NHS commissioning arrangements;
• Sirona Care & Health has now established service arrangements for the provision of non-specialised services;
• The CCG will extend the initial contract for non-specialised services with Sirona Care & Health to 31st March 2016.

12 NOON (APPROXIMATE) - 10 MINUTE BREAK

14. DRAFT HOMELESSNESS STRATEGY 2014-2018 (20 MINUTES) (Pages 67 - 104)

Adopting the Draft Homelessness Strategy has been identified as a 'Key Decision' because of community impact and is scheduled for the Council Cabinet meeting on 4 December 2013.

The Wellbeing Policy Development & Scrutiny Panel are asked to agree that the revised approach contained in the Draft Homelessness Strategy 2014-2018 which not only continues a successful provision of early interventions to prevent homelessness but also focuses on achieving a nationally accredited Gold Standard and targeting ten new local priorities:

1) Complies with agreed Council policies and plans.
2) Will have a positive impact on vulnerable people and reduce inequalities.

15. ALCOHOL HARM REDUCTION SCRUTINY INQUIRY DAY (30 MINUTES) (Pages

105 - 152)

The Wellbeing Policy Development & Scrutiny Panel are asked to:-

1) Consider and make any further comments on the findings of the final Alcohol Harm Reduction Scrutiny Inquiry Day report; and to

2) Consider the recommendations response table which will be received by the Cabinet Member for Wellbeing, Simon Allen; Cabinet Member for Sustainable Development, Ben Stevens; Cabinet Member for Neighbourhoods, David Dixon and the Cabinet Member for Early Years, Children & Youth, Dine Romero as detailed in the report.

16. WORKPLAN (Pages 153 - 156)

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, 20th September, 2013

Present:- Councillors Vic Pritchard (Chair), Sharon Ball, Sarah Bevan, Lisa Brett, Eleanor Jackson, Anthony Clarke, Bryan Organ and Michael Evans (substitute for Kate Simmons)

32 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

The Chairman used this opportunity to congratulate Councillor Katie Hall, previous Vice-Chair of the Panel, on the appointment as the Chair of LGA Community Wellbeing Board.

33 EMERGENCY EVACUATION PROCEDURE

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

34 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillors Cherry Beath and Kate Simmons had sent their apologies to the Panel. Councillor Michael Evans was substitute for Councillor Simmons.

Councillor Eleanor Jackson arrived at 10.55am (during the debate on Safeguarding Adults Annual Report 2012/13).

35 DECLARATIONS OF INTEREST

Councillor Eleanor Jackson declared an ‘other’ interest as a Council representative on Sirona Care and Health Community Interest Company.

Councillor Vic Pritchard declared an ‘other’ interest as a Council representative on Sirona Care and Health Community Interest Company.

36 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

There were none.

38 MINUTES

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

The Chairman used this opportunity to highlight the couple of things from the last meeting. The Chairman expressed his disappointment with the current Administration for not acknowledging the recommendation from this Panel to reconsider their decision to close some public toilets (Minute 21, page 9). The Chairman said that although the Panel had responses from the range of other bodies and organisations (i.e. Sirona, Mineral Hospital, RUH, CCG, Secretary of State, NHS England, etc.), the Panel had no response from the current Administration.

The Chairman also highlighted the reference to the Health and Social Care Integration Pioneers application in the minutes (Minute 23, Page 9). The application was made by Sirona together with the Council and the application was not successful.

Jane Shayler commented that the application was submitted jointly by the Clinical Commissioning Group and the Council and the outcome was that the application was not successful. Jane Shayler also said that there was not a great deal of feedback on why the application was not successful though it could be that it was not considered sufficiently radical on top of the arrangements that are already in place. Locally we have quite significant levels of integration. Jane Shayler also commented that we should not be disappointed with this outcome – it is just a reflection on where we are already.

The Chairman said his understanding was that Sirona would like to pursue intentions of the pioneering project even if they were not successful.

Jane Shayler commented that it is the case that Sirona, and other partners, have said that they will be committed to take out principles of the project proposals. If that is the case then there is a need for a process of prioritising of proposals that will be relevant for the area.

39 UPDATE ON NHS 111 SERVICE (30 MINUTES)

The Chair invited Tracey Cox and Dr Elizabeth Hersch (Clinical Commissioning Group representatives) to introduce the report.

The Chairman asked how we are comparing nationally in terms of the progress so far and in terms of the target date deadline (for the full service commencement).

Tracey Cox replied that there is a mixed picture nationally, for example some parts of the country still don't have NHS 111 services at all. Bath and North East Somerset

are doing very well in comparison with other authorities. Full service commencement is expected to start in couple of weeks' time. Once full service commencement is in place the CCG will then start to publicise locally.

Dr Hersch added that the NHS 111 is not delivered the same in other parts of country. For example, for some areas it is simply only call handling, in some areas it is more integrated to Ambulance Service and in some to Out Of Hours service.

The Chairman said it is national concept and anybody coming to this area, or moving out of the area, and requires the NHS 111 service, would probably expect to get the same service elsewhere.

Councillor Lisa Brett asked about contingency arrangements, if they are on-going, and for how long they are anticipated.

Tracey Cox replied that contingency arrangements will run for 6 months. B&NES CCG Board and Wiltshire CCG Board made the decision that contingency arrangements should be in place for 6 months.

Councillor Lisa Brett suggested that the Panel could have an update on post-contingency arrangements in 7-8 months' time. The Panel agreed with this suggestion.

Councillor Tony Clarke asked if the other authorities in South West are on the level that this authority is in terms of the NHS 111 provision.

Tracey Cox replied that there is a little bit of mixed picture due to campaigns being run locally by local CCGs.

Councillor Clarke asked which other authorities the Harmoni are working for in South West, to get some idea about the spread of activity.

Tracey Cox replied that, from her quick recollection, the following CCGs covered by Harmoni are: B&NES, Wiltshire, Swindon, Gloucestershire, North Somerset, South Gloucestershire and Bristol.

It was **RESOLVED** to:

1) Note the report; and
2) Receive further update to consider contingency arrangements and position that Harmoni are in delivering NHS 111for March 2014 meeting.

40 SAFEGUARDING ADULTS ANNUAL REPORT 2012/13 (15 MINUTES)

The Chairman invited Lesley Hutchinson (Head of Safeguarding Adults, Assurance and Personalisation) to introduce the report.

The Chairman informed the meeting that the Health and Wellbeing Board called for executive summary of the report. The Chairman felt that the executive summary was not necessary considering that the report had a foreword from Robin Cowen,

the Chair of the Local Safeguarding Adults Board (LSAB) which identified important points in the report.

Councillor Lisa Brett asked if service users are having the opportunity now to voice their concerns.

Lesley Hutchinson replied that there is a debate nationally what the best way of engaging and involving service users is. For a number of years different models were tested and the model used at the moment is having much better response from service users which detects their concerns early in the process. It is the area which the LSAB is looking to improve even more. The Local Government Association invited Local Authorities to take a part in the pilot (starting on 30th September) and we agreed to take part in the pilot and identified the organisations to help us look at the different areas and make changes in service delivery where needed.

Councillor Brett commented that domestic abuse towards elderly is also the area where we should communicate more with our residents considering that it is difficult for any elderly person to admit domestic abuse by their own family.

The Chairman said that, according to the study on page 38 (bullet 3.18), it is not all about having a lot of cash to rectify situation. It can be done with relatively small amount of money if managed properly.

Jane Shayler commented that it could be that the process of serious case review can cost quite a lot of money in some areas though outcomes from that serious case review don't always reflect money spent. Jane Shayler reassured the Panel that in this area a lot of the serious case review process was undertaken by staff employed by the Council, CCG or partner organisation. The cost was covered from the existing resources. We would not normally expect that the cost for a serious case review would be the £15,000 referred to in the national study.

Lesley Hutchinson added that our serious case review protocol is quite clear what the criteria are. Part of the learning done nationally is that we don't always have to undertake serious case review and gather all resources to that degree and extent.

The Chairman asked if the investigation training, designed by Sirona Care and Health in partnership with the Police, is complete.

Lesley Hutchinson confirmed that it is complete and training has been done with the South Glos Police.

The Chairman asked about the whistleblowing and asked if the policy is in place.

Lesley Hutchinson confirmed that both the Council and the CCG have policy on whistleblowing in place. The policy had not been used in relation to safeguarding to Lesley's knowledge.

Councillor Brett asked how it is communicated to other authorities if staff has concerns about care facility.

Lesley Hutchinson replied that the Care Quality Commission, or herself, might get whistle-blower's comments. Then the allegations would be looked into in accordance with the procedure and any other Locally Authority that had placed people in the care home would be made aware of the allegations. In terms of self-funded people – the team or person investigating the allegations would contact any family or relatives. This is all set out in a clear procedure.

The Chairman commented that the LSAB should benefit on focusing on the following areas in the report:

- Page 54 Outcomes 4a and 4b
- Page 66, bullet 6.48 – we should not equate with national picture but be better
- Page 67, bullet 6.54 – direction of travel from last year looks good but it could be better and not to become complacent

Councillor Brett added that she would like to see criminal prosecutions up from 1%.

It was **RESOLVED** to note and accept the Annual report and Business Plan.

41 REPORT FROM THE STRATEGIC TRANSITIONS BOARD (15 MINUTES)

The Chairman invited Mike MacCallam (Joint Commissioning Manager for Learning Disabilities) to introduce the report.

The Chairman commented that under operational procedures, as describe in the report on page 135, it is much better approach of not having dedicated transitions team or specific transitions social workers; instead case management can be accepted by any qualified social worker within the disability teams. It is far less intimidating because people get special bond with social workers.

Mike MacCallam replied that the aim is to develop the expertise in the team. There are dedicated workers in the team but there are people who primarily take transitions lead. Few years ago there was a try to have dedicated workers and that didn't work well. The cases are now brought to the team earlier.

Councillor Lisa Brett asked if there are any challenges engaging mainstream secondary schools.

Mike MacCallam replied that the reviews are focused on year by year approach. At the moment the discussion with teachers and schools is a difficult one as they cannot be asked to know the range of housing options etc. Some of the information in the report has been slightly superseded by the Statement of Educational Need (SEN) reform agenda. The Council appointed Charlie Moat to be the lead officer in this field. The statement in process and transition review will be replaced by single education health and care plan.

Councillor Michael Evans asked about the pathways.

Mike MacCallam responded that the education aspect of the education health and care plan is for supporting people into employment. Locally there are number of schemes to work with and support young people.

Jane Shayler added her thanks to Mike MacCallam for his leadership of the core group and the group itself for driving the significant improvements made in transitions planning and outcomes for children and young people going through the transition into adulthood.

The Chairman welcomed the comment from Jane Shayler.

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

42 URGENT CARE UPDATE (30 MINUTES)

The Chairman invited Dr Ian Orpen and Corinne Edwards (B&NES CCG) to introduce the report.

Dr Orpen and Corinne Edwards took the Panel through the report. Corinne Edwards added that planning application for the Urgent Care Centre at the RUH had been approved.

Councillor Lisa Brett asked about the timeframe for implementation of all of the schemes mentioned in the report.

Corinne Edwards responded that winter pressure proposals will run from November 2013 until March 2014 and that all proposals had been looked in terms of the deliverability.

Councillor Brett suggested that the Panel should receive a feedback/review from the CCG on how successful the implementation has been. The Panel agreed with the suggestion from Councillor Brett.

The Chairman commented that many people don't know if, when seeking an appointment with the GP, their case is urgent. The Chairman asked if there is any way of educating the public where the line between urgency and non-urgency, might be.

Corinne Edwards responded that one of the actions plans is to educate reception staff at GPs. It is crucial how to direct and signpost people to appropriate services.

Dr Orpen added that David Carson talked to GPs and GP forums about primary care and urgent care. GPs found these sessions quite stimulating because it made them think in a different way. Dr Orpen also said that one of the problems that primary case is facing at the moment is the workload on every day basis, which has significantly increased and because of that GPs did not have to think about alternative for the primary and urgent care.

Councillor Eleanor Jackson said that she was fascinated with the paragraph in the report describing the presentation delivered by David Carson and asked if it is possible to get more details about that presentation, what was said.

The Chairman suggested that the Panel would welcome David Carson's report/presentation to be sent to Members of the Panel for them to digest the ideas suggested to GPs and GP forums.

Corinne Edwards took on board this request from the Chairman.

Councillor Brett asked how many GPs were present for this presentation/s.

Dr Orpen responded that all practices were present with 60 (out of just over 110) GPs present. Some of the GP practices asked for more presentations from David Carson.

Councillor Brett asked what other resources are available to GPs from the CCG.

Dr Orpen reminded the Panel that the CCG do not commission primary care though they are expected to improve quality of primary care. There is a desire to make improvements; there are tools to support GPs though their time (to see patients etc.) is not supported.

Councillor Jackson asked if GPs considered the impact that all these new housing developments will have on primary care.

Dr Orpen said that the CCG do not commission primary care though the GPs had raised those issues in some areas (like Peasedown St John). Expansion of capacity of primary care is a real issue though there are financial challenges for provision of new services.

The Chairman added that the Health and Wellbeing Board will be working closely with the Council and partner organisations on the provision of the Placemaking Plan.

It was **RESOLVED** to:

1) Note the report;
2) Receive a further update on the Urgent Care provision which should include also an update on all the relevant Primary and Urgent Care schemes; and
3) Receive a document named 'Primary Care Foundation' from the CCG which will be distributed via email to Panel Members.

43 DRAFT B&NES TOBACCO CONTROL STRATEGY 2013 - 2018 (15 MINUTES)

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

The Chairman also welcomed Bruce Laurence (Director of Public Health).

The Chairman commented that information presented on page 161 should specify that the statistics presented on that page are national statistics and not for the area.

Councillor Lisa Brett asked if the Council has an approach about e-cigarette advertising.

Cathy McMahon said that the Council has no policy about advertising e-cigarettes. The Council has smoking policy which guides the staff about the use of e-cigarettes. The Public Health Team and Tobacco Action Network discussed approach to e-cigarettes with regional colleagues and they will not be promoted as they are non-regulated (as a medicine) unlicensed product. Not a part of stop smoking initiative.

Councillor Brett added that the Council should ensure that e-cigarettes don't get advertised on bus shelters and any other public displays.

Jane Shayler added that the Council has just started enabling advertising on its website with some very clear boundaries and certain products and services are explicitly excluded from advertising. Jane Shayler said that she is not sure that exclusion does cover e-cigarettes though.

Councillor Tony Clarke commented that problem with e-cigarettes is that they perpetuate the image of smoking and the main problem is the issue of children seeing this product (e-cigarettes) being used in their surroundings.

The Chairman agreed with the views from Councillors Brett and Clarke by saying that this could also be used by tobacco companies using to persuade people to try this.

The Chairman suggested that the Panel should make a recommendation that the Council don't engage with any advertising of e-cigarettes in any guise. The Panel agreed with this recommendation and requested from Public Health officers to communicate Panel's wishes to the Council.

Councillor Sarah Bevan said that those e-cigarettes might work for her (as a smoker) or other smokers as it fulfils some of the triggers that make people think they need to smoke and dismissing the advertising, especially by those who don't know how it feels to be addicted, is a bit drastic.

The Chairman said that the idea is for the Panel to make a recommendation to the Council not to engage in advertising of these products. If people choose e-cigarettes as a way of terminating smoking habits then it is their choice but it doesn't need to be advertised as it could be recommended quietly by somebody. The Chairman also said that the Council should not participate in promoting these products for general release. Effectively, it could encourage children to try these products.

Cathy McMahon said that the advertising of tobacco products is what the Public Health team is worried about, especially in how that looks to children. The Public Health team is also aware that some e-cigarettes are flavoured that makes them taste like strawberry or lemon or similar which makes people try them. So far there was no evidence that children are using these products in a way into smoking as yet (survey done by charity). But children copy adults and that is an issue.

Councillor Michael Evans commented that these products contain nicotine so in terms of the health view they are helping continuation of addiction.

Cathy McMahon agreed with Councillor Evans though added that these are lot less harmful than real cigarettes.

Bruce Laurence said that e-cigarettes can help some people to stop smoking. There is a discussion on the approach to e-cigarettes. Bruce Laurence welcomed that the Council signed the declaration at the last full Council to combat smoking.

Councillor Bevan commented that she can see that the debate is on protecting children on trying those e-cigarettes which could lead them becoming addictive to nicotine. Although, those people who are smokers, and tried everything to stop smoking, should not be ignored and these products can help them.

Councillor Clarke asked if the Public Health team thought of writing to Bath Chronicle about the picture on the 'best smoking area outside the pub' competition. Councillor Clarke added that he was appalled by Bath Chronicle actions.

Cathy McMahon took that comment and board by saying it is a good suggestion.

Councillor Eleanor Jackson commented that it is deeply depressing that there are zones in the RUH that are smoking areas, where patients are wheeled in their wheelchairs to have a cigarette. Councillor Jackson added that the report didn't mention that some people regular smokers, some smoke because they are under stress and some because they received some bad news and see smoking as escape so the report should mention these issues.

Councillor Jackson also added that people who want to stop smoking cannot get appointments in GP surgeries as walk-in so there should be faster response to people who want to give up.

Councillor Jackson said that the report did not mention traveling community and/or boat dwellers under smoking and ethnicity part of the strategy and asked the officers to include traveling community and boat dwellers in the strategy.

Councillor Jackson said that she would want to see two additional recommendations in Panel's resolution –

a. The Panel support the amendment to the motion (passed at the Full Council meeting on 12th September 2013) about writing to local MPs requesting them to ask the Government to reinstate its proposed legislation requiring cigarettes to be marketed only in standard packages and without images provided by the tobacco companies; and
b. The Panel ask Pension Committee to agree to divest in the tobacco industry.

Councillor Evans said that the Panel might be interfering in the business of Pensions Committee as it is outside the remit of this Panel.

Councillor Brett commented that legally Pensions Committee is not in the position to exclude any trading business from the investment.

The Chairman said that if this Panel feels strongly in not supporting the investment in tobacco industry then the Panel can make their feelings known to the Pensions Committee.

It was **RESOLVED** to:

1. Support the draft B&NES Tobacco Control Strategy;
2. Agree that the Strategy is refreshed in 2016 to update priorities and recommendations to ensure relevance to emerging local, regional and national issues;
3. Request that the Council do not engage with promotion and/or advertising of e-cigarettes on their website, public displays, media and similar;
4. Support the amendment to the motion (passed at the Full Council meeting on 12th September 2013) about writing to local MPs requesting them to ask the Government to reinstate its proposed legislation requiring cigarettes to be marketed only in standard packages and without images provided by the tobacco companies; and
5. Ask the Pensions Committee to agree to divest in the tobacco industry.

44 UPDATE ON DEMENTIA (15 MINUTES)

The Chairman invited Corinne Edwards (Senior Commissioning Manager for Unplanned Care and Long Term Conditions – CCG B&NES) to introduce the report.

The Chairman said that diagnosis rates in B&NES are below the South West average and the CCG set a target of 53.5%. The Chairman asked what happened to those people that were undiagnosed.

Corinne Edwards responded that this is quite a contentious area. There is a lot of work going around on how dementia is recorded in primary care. There is a belief that recording of dementia can be underrepresented. It is rather complex process due to different codes used and the way diagnosis is made. It is quite an ambitious target set by the CCG.

The Chairman asked how the CCG set the target of 53.5%.

Corinne Edwards responded that information comes from the primary care, GPs, registers who made formal diagnosis of dementia. The NHS England set the national target of 66% to achieve by 2015.

The Chairman said that the last administration had an intention to turn our community resource centres into accommodating those suffering from dementia. The Chairman asked what the situation is now in terms of the community resource centres use.

Corinne Edwards responded that it is not her place to answer that question though it is fair to say that the number of people with dementia who live in the community resource centres has increased.

Jane Shayler added that buildings are designed to meet the needs of people with dementia. The role of community based services is to increasingly meet the needs of elderly people. Sarah Shatwell is in discussion with the number of providers on

how we can best shape and influence the market to respond to increase in dementia referrals.

It was **RESOLVED** to note the report and to receive a further update on within one year.

45 SUPPORT TO AMBULANCE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (10 MINUTES)

The Chairman invited Jo Morrison (Democratic Services Manager) to introduce the item.

Councillor Tony Clarke said that Bristol City Council voted to support Ambulance Joint Health O&S Committee (JHOSC). Bristol City Council will be doing day to day management of the Committee. North Somerset Council withdrew because of financial issues. The advice received from the Monitoring Officer was that there would be no issues in meeting the financial, resource and constitutional issues raised by the Panel at the last meeting

Councillor Clarke recommended to the Panel to support Joint Ambulance Health O&S Committee.

It was **RESOLVED** to:

1) Note the advice received from the Monitoring Officer that there were no issues in meeting the financial, resource and constitutional issues raised by the Panel at the last meeting; and
2) Support the continuation of an Ambulance JHOSC for the former Great Western Ambulance area based on the current model of officer support.

46 SPECIALIST MENTAL HEALTH SERVICES UPDATE (20 MINUTES)

The Chairman invited Andrea Morland (Mental Health and Substance Misuse Commissioning B&NES Health, Social Care and Housing Partnership).

The Chairman asked if the service would be re-designed should there not be the need to identify savings (as on page 220 of the report).

Andrea Morland replied that re-design of services came about because they were not orientated towards a recovery focused empowered client choice model. There were a lot of dependent services where lot service users did not realise their potential; for example moving from quite residential model of services into having people in tendencies with support around them, to get people involved into community activities. The impetus for re-design has been to make services more dynamic and more focused on client's choice and their strengths. In the past our model was wrong and we didn't have right value for money.

The Chairman asked about Review the possibility of encouraging a village agent type of approach to delivering this support for the rest of the life of the Sirona contract.

Andrea Morland replied that she is quite excited about this approach. Everyone who has eligible social care need (which they will be able to get that through personal budgets) will be able to get floating support. At the moment, when services were transferred to Sirona, there is re-ablement service which people are able to access to 6-8 week support to prevent admission to hospital. The team did not know what the need will be as nobody ever done that before so the part of service kept on delivering floating support. The report says that the team could talk to Sirona on how to do that. A lot of people with mental health problems are still quite isolated and there was a need to build up communities of support across B&NES. So, if someone thinks that their neighbour is having some problems then they can go to the right person in the village, village agent, and report that.

Councillor Sarah Bevan said that someone from one of the AWP services, Paul Marshall from LIFT psychology, spoke to Councillor Bevan and she agreed to promote their services through the Council. In the report LIFT psychology was not mentioned in 'Primary Care Talking Therapy service update' part of the report and asked why not. Councillor Bevan said it would be useful if it had been mentioned as it would be helpful for people to understand what this part of the report is about.

Andrea Morland replied that LIFT psychology was not mentioned in the cover report though it was in the appendix 5 attached to the report, presentation given to the CCG. Andrea Morland also said that she was trying to keep the report brief and present the information which was presented somewhere else.

Councillor Bevan commented that Talking Therapy services are not only GP based services, like the case is with the LIFT psychology.

Andrea Morland agreed with Councillor Bevan adding that it is hugely flexible model. Majority of the work is through self-referral.

Councillor Bevan asked when it would be good time to invite the LIFT service to address the Panel on how it is going, what is the take up, etc.

Andrea Morland said that it would give 6 months for the service to run before they are ready to address the Panel.

Councillor Lisa Brett asked if Talking Therapy is all about cognitive behaviour.

Andrea Morland said that the national guidance said that Talking Therapies are not only Cognitive Behavioral Therapy (CBT) and it is not what is in the specification. It is on delivering the range of therapies, etc.

It was **RESOLVED** to:

1) Note -
    a. Progress in implementing more service user led, recovery focused community support services and suggested next steps.
    b. The implementation of the new Primary Care Talking Therapy service.
    c. The new locality management structure in AWP.

2) Invite Andrea Morland and the AWP to talk about the whole Pathway which will include services like LIFT Psychology for one of the future meetings (after May 2014).

47 PANEL WORKPLAN

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

- NHS 111 update (including contingency arrangements) – March 2014
- Update on Dementia (late 2014)
- AWP Pathway (not before May 2014)
- Briefing on Adult Social Care Reform (working title) – January 2014
- Further update on the Urgent Care provision which should include also an update on all the relevant Primary and Urgent Care schemes -

The Panel welcomed that a report on Care Home Performance will be presented at each meeting of the Panel. The Panel requested to receive reports on Home Care also on regular basis. Jane Shayler confirmed that performance on care homes and home care could be included in the same report.

The Panel expressed their wishes to have informal meeting with Bruce Laurence, Director of Public Health, and receive a presentation on the direction of travel for the next few years. The Democratic Services Officer will communicate this message with Bruce Laurence and look for the best date to set up informal meeting.

The meeting ended at 1.15 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER	**Policy Development & Scrutiny Panel** **Committee**	
MEETING/ DECISION DATE:	**22nd November 2013**	
TITLE:	**Healthwatch Bath and North East Somerset update**	
WARD:	All	
AN OPEN PUBLIC ITEM LIKELY TO BE TAKEN IN EXEMPT SESSION		
List of attachments to this report: Please list all the appendices here, clearly indicating any which are exempt and the reasons for exemption		

1 THE ISSUE

1.1 Update report from Healthwatch Bath and North East Somerset

2 RECOMMENDATION

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

5 THE REPORT

healthwatch Bath and North East Somerset

Report to the Wellbeing Policy Development and Scrutiny Panel 22 November 2013

1. **Setting Up Healthwatch – the implementation stage**
   Since April 2013 and the start of the contract Healthwatch Bath and North East has revamped current staff contracts and advertised and employed new staff. New staff will support the recruitment of volunteers, provide the new function of information and signposting for the public and the research and evaluation officer who will map the issues coming from the public.

2. **Patient and Public Involvement**
   Healthwatch has a dedicated phone line, email address and website for the public to use, plus face book and twitter accounts. Healthwatch e bulletins have been produced monthly along with 'In Contact' the quarterly newsletter. Marketing and communication has designed a range of leaflets, postcards, posters and pull up banners to assist with awareness with the general public. So far leaflets have been put in venues across the area including libraries, health centres, One Stop Shop Centres. A large part of our work will be to explain to people what Healthwatch is and how volunteers can get involved. Healthwatch Bath and North East Somerset has been listening to people who use services and building relationships with those who commission services so that we can reflect, what local people say is most needed.

3. **Information and signposting**
   Healthwatch Bath and North East Somerset has been signposting local people with information on how to access health and social care services through Well Aware and we have been building the information Well Aware holds on services in Bath and North East Somerset. An animation on the website helps people navigate the system. Well Aware was already commissioned in Bath and North East Somerset and the Care Forum has bought this as added value to the Healthwatch contract. Well Aware has information about groups and organisations offering health and social care services and activities to the public and professionals. Well Aware has special information on learning difficulties, low vision resources, mental health and employment and men's health and wellbeing issues. As the project co-ordinator meet new groups in the community these are added to the database. Well Aware can be accessed online but also though a freephone number for those who cannot access the web and can be talked through their needs.

4. **Volunteers in Healthwatch**
   The first cohort of volunteers have been inducted, given Healthwatch information, safeguarding and enter and view training and we are actively engaging a second cohort of volunteers. Volunteer champions will bring issues and concerns to Healthwatch and if volunteers have more time to give they can become a representative for Healthwatch on NHS trust boards and Bath and North East Somerset Council meetings, providing two way communication. Healthwatch staff, have attended meetings and have met with groups to raise awareness of Healthwatch and the need to establish a volunteer base to support the work of Healthwatch. The governance and terms of reference for the Healthwatch Advisory group have been drawn up and shared at the first Advisory group meeting in June where participants were taken through the new health and social care climate and given information on NHS England, the CCG, the JSNA and the Health and Wellbeing Strategy. At the second meeting in August of the Healthwatch Advisory group the draft Community Engagement Strategy was discussed. The third meeting is planned for 14th November 2013. We have been discussing with

commissioners how we can involve volunteers in service planning and redesign to maintain focus on what is important and to ensure local people get the services they need.

5. Engaging with Communities

Healthwatch Bath and North East Somerset has a particular responsibility for championing the needs of those who are seldom heard and we have been reflecting this in the production of the draft Community Engagement Strategy and the action plan. Healthwatch has engaged with:

- Good contact has been made with Bath One Stop Shop and the organisations that use the venue to ensure the public can be signposted through Wellaware and can access information about Healthwatch
- Met with Mike McCallum to discuss how Healthwatch Bathnes can reach people with Learning Difficulties to hear their concerns
- Met with the West of England Gypsy and Traveller Health Partnership
- Ensured that information on Healthwatch Bathnes was available at the Bath City Farm World Mental Health event
- Worked in partnership with the CCG PPI events across the area to ensure a Healthwatch presence
- Met with West England Rural Network to link with village agents in rural areas

Healthwatch Bath and North East Somerset will work with priority neighbourhoods and we have a new Project Co-ordinator Jan Perry, in post who has begun visiting and discussing ways of engaging these communities.

6. Engaging with children and young people

Healthwatch Bath and North East Somerset has been contacting groups who work with children and young people to raise awareness of the important of young people being having their say and being heard.

- Bath Mums – through twitter
- Bath Area Play Project to discuss how we can work together to hear the issues and concerns of children and young people
- Meeting with Mary Kearney Knowles on Nov 18 to discuss how safeguarding advocates who meet with children in care could feedback the issues and concerns 'looked after' children have with their health and social care

Healthwatch Bath and North East Somerset have been working with a young care leaver who will be producing a Healthwatch leaflet and poster for young people. A page on the website will be dedicated to Healthwatch hearing from young people and we are planning an event for young people in the new year to hear their issues and concerns.

7. Healthwatch launch

Healthwatch Bath and North East Somerset held a launch for stakeholders and volunteers on 23 September. Claire Pimm, Healthwatch England Head of Communications, spoke on the development of Healthwatch England and participants were given an update of what has been achieved so far. The launch was well attended and the press releases ensured some press coverage that enabled the public to hear more about Healthwatch.

8. Network of networks

Healthwatch Bath and North East Somerset has been developing a network of networks with meetings held before the Health and Wellbeing Board meetings and the opportunity to feed views from these meetings to the board. The network also give the opportunity to ensure service users and the third sector can learn from each other. We are working with our commissioners to establish this without duplication and ensure we capture the information from particular groups of service users and focus their views to make the most impact. As the network grows we will hear more local issues that can be raised with commissioners and nationally through Healthwatch England and the regulator CQC.

9. Advocacy

The Care Forum held an event on 25th September for all advocate organisations to hear more about the work of Healthwatch and how important it is to be aligned to Healthwatch. Healthwatch Bath and North East Somerset work closely with SEAP (Support, Empower, Advocate and Promote) Complaints Advocacy team and we have signposted 4 people to them for support in making their complaint. The Care Forum communication team have produced two presentations to explain NHS concerns and complaints process and another to explain the Adult Social Care concerns and complaints process; these are on the Healthwatch website. Information is regularly tweeted, monthly e bulletins have been produced and a quarterly newsletter sent to everyone.

10. Healthwatch and the Health and Wellbeing Board

Healthwatch has a statutory place on the Health and Wellbeing Board, The Care Forum General Manager – Hea;thwatch Pat Foster has been attending the Health and Wellbeing Board on behalf of Healthwatch Bath and North East Somerset. This has ensured continuity until the volunteer is found to represent Healthwatch and provide the two way flow of communication, it has been important to get the right volunteer who has been recruited, inducted and trained to enable them to bring the evidence from Healthwatch, we are pleased to say that we have just selected Diana Hall Hall to be the volunteer rep.

11. Building Relationships with Stakeholders

Relationships have been built with new commissioners in the NHS England Local Area team around primary care and specialist services, the Clinical Commissioning Group around secondary care, community care and mental health services and with Public Health now that it has moved into the Local Authority. Healthwatch Bath and North East Somerset has attended the Clinical Commissioning Quality group and discussed how to develop a common understanding and how to develop a conduit for sharing information with commissioners to enable Healthwatch to develop an informed view of the commissioning issues and trends. Healthwatch has renewed the relationships built with Patient and Public Engagement Managers at NHS Trusts and the new manager for the Care Quality Commission, we are also building a relationship with the regulators and have a meeting planned with the CQC compliance officer to share ways of working. Healthwatch has also been busy contacting Patient Participation Groups and visiting when asked to given information about Healthwatch. Worked with the West of England Academic Health Science Network and attended their event to discuss patient and public involvement so as not to duplicate resources.

12. Healthwatch England

Staff attended the launch of Healthwatch England in June, following this we registered Healthwatch on the Healthwatch England communication and information hubs. Healthwatch Bath and North East Somerset has been working closely with Healthwatch England to ensure that we can share information through the Healthwatch hub. A new member of staff, Kate Strong joined us in August as the Research and Information Officer and it will be her role to take the information from the public stories and identify patterns of concern. Kate has met with Jon Poole to discuss the health inequalities identified within the JSNA. These patterns will form the basis of the work programme for Healthwatch. Healthwatch have worked with Healthwatch England's advisory group on complaints and the complaints video made by Healthwatch England is on the Healthwatch website. The Care Forum has agreed to pilot the draft Healthwatch England Outcomes and Impact Development tool to develop an effective operational approach to governance, finance, relationships and operations.

Pat Foster
General Manager - Healthwatch

6 RATIONALE

7 OTHER OPTIONS CONSIDERED

8 CONSULTATION

9 RISK MANAGEMENT

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

Contact person	**Pat Foster – General Manager** **The Care Forum** **Tel: 0117 9589344** **Email: patfoster@thecareforum.org.uk**
Background papers	*List here any background papers not included with this report because they are already in the public domain, and where/how they are available for inspection.*
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development & Scrutiny Panel	
MEETING DATE:	22 November 2013	**AGENDA ITEM NUMBER**
TITLE:	Medium Term Service & Resource Planning – 2013/14-2015/16	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: ANNEX 1 – Adult Social Care & Housing Medium Term Service & Resources Plan 2013/14-2015/16 Update with Appendices 1 - 3		

THE ISSUE

The Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) Update is presented for consideration by the Panel:

(1) To ensure all members of the Panel are aware of the context for Service Action Planning

(2) To enable comment on the strategic choices inherent in the medium term plan

(3) To enable issues to be referred to the relevant Portfolio holder at an early stage in the service planning and budget process

RECOMMENDATION

The Panel is asked to:

(1) Comment on the update to the medium term plan for Adult Social Care & Housing

(2) Identify any issues requiring further consideration and highlighting as part of the budget process for 2014/15

(3) Identify any issues arising from the draft plan it wishes to refer to the relevant portfolio holder for further consideration

FINANCIAL IMPLICATIONS

This report sets the framework for the service planning and budget processes relevant to this Panel for years 2 and 3 of the 3-years plan agreed by Council in February 2013. The financial implications are set out in the enclosed annexes.

The overall financial background for the Council is set out in Appendix 1.

THE REPORT

This report forms part of the service and resource planning process. As set out in the enclosed medium term plan (Annex 1), the next steps include:

(1) Panel comments considered by Portfolio Holders

(2) PDS Resources meeting in January to take overview of comments from Panels and progress on budget setting plus equalities issues.

(3) February Cabinet budget recommendations to Council

(4) February Council approval of budget and Council Tax setting.

The draft Medium Term Service & Resource Plan for Adult Social Care & Housing is attached as Annex 1, and includes its own appendices.

The Panel needs to consider the implications of this medium term plan and make recommendations to the relevant portfolio holder(s) and Cabinet. Where the panel wishes to either increase expenditure or reduce savings targets alternatives should be proposed.

The Panel should concentrate only on the parts of the plan relevant to its own remit as the PDS Resources meeting in January will be taking an overview.

RISK MANAGEMENT

A risk assessment will be completed as part of the final budget papers and inform the Council's reserves strategy. The main risks relate in the next financial year to:

(1) The robustness of the savings estimates.

(2) The potential for some service levels to deteriorate as a result of the savings, some savings are from service reductions but most savings are directed at efficiencies.

(3) The implications for staff arising from savings albeit that the costs of severance will be budgeted for corporately and unions are being consulted together with the affected staff.

(4) The need to maintain a planned and phased approach to savings at a time when pressures are starting to require substantial and immediate cuts.

(5) Equalities impacts of the savings.

EQUALITIES

1.2 Service Action plans will be developed for management purposes and will be subject to Equalities Impact Assessments as they are completed.

1.3 Equalities issues will be considered in more detail as the budget is prepared. The PDS Resources meeting in January will take an overview of progress.

CONSULTATION

1.4 The corporate implications of this report have been considered by Strategic Management Team (SMT) including the *Section 151 Finance Officer; Chief Executive & Monitoring Officer*

1.5 Further consultation has taken place as part of developing the revised Corporate Plan. Budget fairs took place during the week commencing 4th November and feedback from these has helped inform updates to the plan.

ISSUES TO CONSIDER IN REACHING THE DECISION

1.6 All the following issues are relevant to service and resource planning: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Legal Considerations*

ADVICE SOUGHT

1.7 The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Finance Director) have had the opportunity to input to this report.

Contact person	*Jane Shayler, Tel: 01225 396120*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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MEDIUM TERM SERVICE & RESOURCE PLAN UPDATE

PEOPLE & COMMUNITIES (Adult Social Care & Housing)

2013-14 until 2015-16

Introduction

This is the second year of the period covered by the 2013-14 to 2015-16 medium term plans. The plans were reflected in the 2013/14 budget approved by Council in February 2013. The original plans can be found on the Council's web site with the agenda papers for the November 2012 PDS panels.

This 2014-15 update is a summary of key changes affecting the plan and does not restate the information contained in the original plan. This update provides important background information to the 2014-15 budget process, which will culminate in a report to the February 2014 meeting of Council. The February budget report will incorporate assumptions made as part of the three-year planning process, summarise planned variations to the anticipated budget for 2014/15, seek approval for those variations and set both the budget and the consequent level of Council Tax for that year.

This document contains the following updates:

- Strategic Context – financial, legal, service and policy headlines
- Structural Changes – summary of the new management arrangements
- Progress Achieved – how the delivery of the 3 year plan is progressing
- Variations to the plan – proposed changes concentrating on 2014-15
- Risks & Opportunities –key risks to delivery of the plan but also opportunities
- Equalities – summary of approach

Strategic Context

The Corporate Plan and refreshed Council Vision remains the main policy context. These documents can be found at http://www.bathnes.gov.uk/services/your-council-and-democracy/vision-and-values

The financial challenge was summarised last year. This equated to a 40% reduction in the Council's government grant funding over the period 2011/2012 to 2014/2015. At this time the challenging outlook for local government funding as set out in the Autumn Statement in December 2012 looked to continue well into the future and over the period of the Medium Term Service and Resource Plan from 2013/2014 to 2015/2016 we estimated at least £30M of savings would be required.

Since then there have been a series of Government announcements that have increased the challenge. The key announcements and effects are as follows:

- The Budget Statement delivered by the Chancellor on 20 March 2013 provided for an additional 1% cut in council funding assessments for 2014/2015. This actually equates to a further 2% reduction in grant (from 16% to 18%).

- The Spending Review 13 announced by the Chancellor on 26 June 2013 covers the 2014/2015 and 2015/2016 financial years and together with subsequent consultation documents, sets at least a 13.5% reduction in council funding assessments for 2015/2016. This actually equates to a 27% reduction in grant.

Other key funding changes set out in the Spending Review 13 include:-

- A requirement to pass 35% of New Homes Bonus funding to LEP's from 2015/2016 to support Single Local Growth Funds.
- A reduction of 20% in the Education Support Grant in 2015/2016.
- The confirmation of a Council Tax Freeze Grant for both 2014/2015 and 2015/2016 equivalent to 1% of council tax for councils who freeze their council tax in these years.

These changes, together with the existing savings to be identified, mean further savings of at least £7m for the Council need to be identified over the next two years. This assumes the savings in the existing approved medium term plans are delivered in full.

For 2014/15 the focus will be on the variations that are needed to the approved medium term plan to deliver a balanced Budget proposal for the Council in February 2014. The Variations section of this update (below) provides further details of the projected Budget Gap for 2014/2015 together with the specific proposals being considered to address this.

The Cabinet's aim remains to achieve the medium term plan with minimal alterations, but at the same time to reflect public feedback together with local and national policy changes. The Council has a good level of reserves and can use these to smooth the effects of policy changes and additional financial challenges. The indication from Treasury figures is that an equally tough set of financial targets will need to be repeated in the next 3 year plan which starts in 2016, and of course at that time the difficulty in meeting the challenge will have increased as efficiency opportunities will be less.

In the case of the Adult Social Care & Housing the key policy context changes are:

- The Department of Health (DH) is consulting on how to implement major reforms to adult social care. The consultation on the Care & Support Bill covers:
  - How to manage the large increase in demand from people who pay for their own care and support; and
  - Major changes to social care practices and systems, including assessment and charging.

  The proposed reforms have significant implications for the Council and also, for some key partners. The direct impact will be on care assessment and financial systems but there will be knock-on effects including on market management, information and integration.

- In the June 2013 spending round covering 2015/16 a national £3.8 billion "Integration Transformation Fund" (ITF) was announced. Initial analysis suggests that of this £9.8m, a maximum of £1.2m will be new investment into the local health and social care system. This fund, established by the Department of Health, is to be held by local authorities and will include funding previously transferred by local NHS commissioners to the Council under Section 256 Agreements. In order to access the ITF, each locality will be required to develop a local plan by March 2014. Plans for the use of the pooled monies will need to be developed jointly by Clinical Commissioning Group and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

- New Council Procurement strategy with a "Think Local" theme to encourage local procurement and support for local businesses.

- Publication of the Council's new Health & Wellbeing Strategy and also the new Joint Strategic needs Assessment that supports it.

Progress Achieved

Delivery of the 2013/14 savings plans for adult social care and housing are in line with proposals set out in the MTSRP 2013/14-15/16 presented to Wellbeing PDS in November 2012 and agreed by Council in February 2013.

The remaining two years of the medium term plan are attached at Appendix 1 and this has been updated to include a commentary on progress towards delivery of the approved savings and additional income streams.

With the exception of the specific variations identified below, full delivery of the medium term plan is anticipated and any further changes considered by the Council would require the identification of further additional savings to balance the Budget.

Variations to the Plan

The variations to the medium term plan approved by the Council in Feb 2013 have arisen for 2014/2015 for a number of reasons including:-

- The implications of the 2013 Budget Statement and Spending Review
- Unidentified savings in the approved medium term plan
- Areas where savings or additional income are now unlikely to be delivered
- Revenue impact of additional capital schemes

In order to present proposals for a balanced budget in 2014/2015, the Cabinet have examined a range of options to generate the additional savings or income, required to address the arising Budget gap. Where possible the Cabinet has sought to avoid further frontline service reductions and focus on efficiency, innovation, demand changes and trend analysis to meet this challenge.

Full details of the variations are set out at Appendix 2

Capital Programme

There are no proposed variations to the capital programme for incorporation into this service and resource plan.

Risks & Opportunities

The adult social care purchasing budget and key partner organisations, including Sirona Care & Health and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) continue to experience resource pressures arising from demographic change – in particular, the complexity and acuity of people being supported to live in community settings. Whilst, to some extent, the allocation of Section 256 funding against pressures in adult social care has helped mitigate these pressures, this remains a risk.

Proposals in the Care & Support Bill represent the most significant reform of adult social care in decades. It is difficult, at this stage, to accurately estimate the financial implications of these reforms. London Councils have estimated that the national cost of implementing the reforms over a four year period are in the region of £6 billion, as opposed to the government estimate of £1 billion a year.

In London, it is estimated that there will be a 37 per cent increase in people qualifying for local authority support for residential care by 2019/20 and the impact on the South West as a region is likely to be considerably higher as people will reach the contribution cap more quickly, reflecting the cost of residential care in the South West.

London Councils have estimated the total increase in cost pressures from 2016/17 to 2019/20 as £1.3b of which a minimum of £877m is a direct result of implementation. These costs include an estimate of £421m for inflation and demographics (based on Institute of Public Care demographic data and inflation forecasts from the Office of Budget Responsibility). The estimated costs for the South West are of similar magnitude.

Costs pressures are likely to be seen in the adult social care commissioning budgets, with increases in the costs of purchasing care to meet eligible needs for service users and carers and, also, the requirement to ensure that self-funders are able to access advice and information. There are implications for the resourcing of the Council's finance support function, with pressures associated with increased numbers of financial assessments, the requirement to establish individual "care accounts" and to provide an annual statement to individuals which confirms their progress towards the cap on their personal contribution.

Sirona Care & Health as the primary provider of care and support assessments will face similar pressures associated with the staffing needed to undertake an increased number of needs assessments, including carers' assessments. The Council will be responsible for commissioning/funding the staffing required to undertake this increased number of needs assessments in fulfilment of its statutory responsibilities. The mental health social work service (managed by AWP and employed by the Council) will experience similar pressures on staffing capacity though on a smaller scale, reflecting the smaller numbers of service users and carers with mental health needs.

The development of plans for use of the pooled Integration Transformation Fund, which will be in place from April 2015, presents the Council and partner organisations an opportunity to further develop integrated commissioning and service delivery to the benefit of people and the communities in which they live.

Equalities

Equalities impacts of key changes are considered as service plans are set and as part of any key management change. The main equalities impacts for People & Communities were assessed when the 3 year plan was set.

MEDIUM TERM SERVICE & RESOURCE PLAN – SAVING DETAILS (2014/15 & 2015/16 ONLY)

ADULT SOCIAL CARE

2014-15 Saving £000	2015-16 Saving £000	How saving to be achieved	Previously Reported Impact to Service Delivery	Strategic Director's Update on Saving Proposal for November 2013 PDS Panel
293	296	Decrease in Sirona contractual values as agreed.	Already accommodated in service planning and contractual arrangements.	This saving is already incorporated in the contract with Sirona.
575	575	In partnership with Sirona Care & Health further efficiency savings from the contract with 'Sirona' Care & Health. This would be in addition to the £9.0m savings already built into the five year contract between Sirona, the Council and the Primary Care Trust. A recently published Audit Commission report "*Reducing the cost of assessments and reviews"* based on 2010/11 benchmarking information, which pre-dates the establishment of Sirona, suggests that efficiencies from social care processes could be achieved in the medium term. Target is based on bringing B&NES costs closer to the national benchmark. Delivery of the saving would need to be supported by: i) improved access to signposting, provision of advice and information (including to self-funders); ii) policy and process redesign, including increases in self-assessment; and iii) pathway redesign, culture change and skill-mix review.	Any service impacts would need to be assessed in light of the detailed savings plans, to be developed and agreed during 2013/14. The Audit Commission report suggests that savings can be made without adversely impacting on quality. If implemented in the right way, this change could impact positively on service users as a) some service users would self-assess or be signposted to services with no requirement for an assessment; and b) people who 'self-fund' their care services would be able to access advice (particularly financial advice) and, also a 'brokerage' service that would enable them to choose the provider of their service in light of up to date, accurate information on value for money, quality etc.	Negotiations in respect of plans for the delivery of this saving are on-going with Sirona and are closely linked to the redesign of the adult social care pathway, which, in turn is linked to the development of community cluster teams and alignment to GP practice clusters. The design and implementation of the first two phases of the adult social care pathway redesign [i) access, advice, information and signposting; and ii) integrated reablement services] is progressing well with positive engagement from Sirona and other partners, including the Domiciliary Care Strategic Partners who, along with Sirona, will play a key role in broadening and increasing access to integrated reablement services. The third phase of the redesign, Community Care Assessment and Support Planning for those with enduring and complex needs, is less well progressed but will flow from implementation of the first two phases.

2014-15 Saving £000	2015-16 Saving £000	How saving to be achieved	Previously Reported Impact to Service Delivery	Strategic Director's Update on Saving Proposal for November 2013 PDS Panel
60		The Fairer Contributions policy, which is based on national guidance and determines individuals' personal contribution to the costs of their community based personal care services. The policy requires that individuals are left with basic minimum income thresholds, which are nationally prescribed. Further protection is provided by a nationally prescribed 25% "buffer", which in B&NES is set above the required minimum at 30%. A very small amount of additional income could be generated by reducing this buffer back down to the statutory 25%.	Impact on the income of service users subject to the Fairer Contributions Policy, though these service users would continue to receive the income protection prescribed through national guidance. Some impact on commissioning and finance capacity to implement change.	This amendment to the policy has now been implemented, as agreed.
375	455	A planned reduction of spend on purchasing the provision of personal care and support for older people, including those with dementia, adults with mental health needs, adults with learning difficulties and disabled adults, including those with sensory impairment. Primarily achieved by reducing admissions to residential care, particularly for older people, including those with dementia, by improving access to preventative and early intervention and also, by ensuring that signposting, access to universal services and advice to	Some service users and their families/carers view admission to residential or nursing care as the "safe" (low-risk) option. Our staff will work to ensure that any concerns about community-based alternatives are addressed effectively. In order to reduce such concerns and mitigate any risks, it would be critical to ensure strong, effective preventative and early intervention services, pathway redesign, and improved signposting and access (including to self- funders) to financial advice. Further investment of Section 256 funding as well as a strategic shift in the investment of a proportion of	An expansion of access to early intervention and preventative services, in particular integrated reablement and rehabilitation services funding through agreed use of Section 256 funding is being progressed as are other preventative services such as the

		all, including self-funders, is effective. This saving aligns with investment plans to develop preventative services.	Supporting People & Communities Funding would be appropriate in supporting the further development of this approach, which is in line with current national and local health and social care strategies. Proposal will increase pressures on Commissioning Team and will require culture change programme for practitioners.	
2014-15 Saving £000	**2015-16 Saving £000**	**How saving to be achieved**	**Previously Reported Impact to Service Delivery**	**Strategic Director's Update on Saving Proposal for November 2013 PDS Panel**
689		Over the coming years, the Council will focus the money it has available on care for the most vulnerable adults to support their independence. As a result of this focus, there will be a reduction in the level of services which are not directly discharging defined statutory duties under Community Care legislation. Detailed proposals for 2014/15 will be worked up during 2013/14 and the estimated savings by "sector" set out below should, therefore, be treated with caution. Detailed proposals to be worked up during 2013/14 will enable consideration of: a) alignment with the Council's priorities; b) service performance, utilisation and value for money; c) engagement with providers, including views on how they might help deliver savings by for example	Proposals represent a shift in the focus of Supporting People & Communities (SP&C) funding away from lower level support and towards delivery of more mainstream adult social care objectives. There will be an impact on the people who currently use these specific services, such as older people, people who need support to enter or re-enter the workplace, people who need support to avoid/prevent homelessness, people who are socially excluded because of multiple/complex vulnerabilities such as mental ill health, disability, poverty, poor educational achievement & poor housing. There will be an impact on a range of services which community organisations, as well as independent sector organisations, provide on our behalf. However, as we continue to target our	Over the last 18 months and by a range of means, the SP&C team has communicated to all providers the likely implications of the Council's Medium Term Service & Resource Plan 2013/14-15/16 and the requirement to make significant savings from the SP&C budget. Since February 2013, the team has undertaken theme-based sector reviews with the intention of finding the required savings through a strategic approach rather than a top-slicing exercise. Using data on performance, utilisation and demand, feedback from providers and stakeholders (including service users) and intelligence on duplication of provision, the reviews aimed to inform the development of commissioning plans for 2014/15 onwards. Following carefully consideration of outcomes of this work, including with the Cabinet Member for Wellbeing it was agreed that in order to mitigate the overall impact of these savings on delivery of services targeted at more vulnerable people, it would be necessary to increase the saving to be achieved by reducing investment in generalist and

		working together more effectively to avoid duplication; d) the overall picture including how targeted investment is made to mitigate the impact of delivering the savings and, indeed, help deliver the savings; and e) work with other partners including the CCG to join up commissioning intentions and take a whole-system view including along care pathways. It is proposed that £500k be reinvested in order to mitigate the impact of proposals and enable the development of targeted services to realise savings from a) assessment/care management; & b) further reductions in admissions to residential care. Estimated savings, by discontinuing or reducing services by "sector", taking account of the application of £500k reinvestment/ mitigation are as follows: • Older people support, including 'sheltered' housing, estimated saving £449k - • Mental Health support, estimated saving £77k • Learning Difficulties support £20k • Physical & Sensory Impairment support £11k • Young People estimated saving £61k • Ex-offenders/substance misuse estimated saving £42k • Generic (not age/client group	services towards more vulnerable people, there will still be an important part for the independent/ community sector to play in respect of delivering some of the £500k reinvestment in targeted advice/information; preventative services; and "pump-priming" third-sector organisations to recruit and support volunteers. Managing the de-commissioning of services represents a significant challenge to commissioning capacity. Officers will continue to examine this area of spend and the various contracts in place to seek to bring forward settings into 2013-14 if possible.	universally available advice and information. The target saving from the generalist advice and information service provision was, therefore, increased to £225,000. Council officers communicated this revised savings target to CAB B&NES and discussed the likely implications both for the service and on the CAB as an organisation in detail in meetings and, also in correspondence. CAB B&NES was given the opportunity to respond directly to the proposals to the multi-agency Commissioning Body, which met in September 2013 in order to review the recommendations arising from the sector reviews and associated savings proposals in order to inform the decision- making process. The Commissioning Body agreed the recommendation that the advice and information be re-commissioned in accordance with the recommendations arising from the review and proposed new model for advice delivery with an annual contract value of £182,000 delivering the required saving of £225,000. Other reductions were agreed at the same meeting by members of the multi-agency Commissioning Body in the context of the overall saving of £689k to be achieved from the SP&C budget in 2014/15. The Commissioning Body, which comprises commissioning managers from Probation Services, Health, Housing and Adult Social Care, agreed these reductions in the context of the overall reduction in the SP&C commissioning budget of £689k in 2014/15 and the need to mitigate the impact of these savings on targeted services to the most vulnerable people. For illustrative purposes only, services that

		specific) estimated saving £160k. • Advice & information estimated saving £118k. Total saving £841k.		continue to be funded from the SP&C budget at an equivalent level to the saving from advice and information services include: • Floating support services for people with a learning disability and/or physical disability or sensory impairment; • Supported accommodation for people with mental health needs; • A tenure neutral older people's independent living service; • Floating support and supported housing for people with a learning disability; • Care and repair services for older people and those with a disability; • Day services for older people, including those with dementia.
2014-15 Saving £000	**2015-16 Saving £000**	**How saving to be achieved**	**Impact to Service Delivery**	**Strategic Director's Update on Saving Proposal for November 2013 PDS Panel**
500		Through more cost-effective home care contractual arrangements.	No direct impact on service delivery is anticipated from these changes to the contracting arrangements for home care.	The change to contracting arrangements has already been made, the only risk to delivery of this saving, is therefore, the continued pressure on adult social care commissioning budgets arising from demographic change despite provision in the 2013/14-15/16 MTSRP, including agreed use of Section 256 funding.
280		Reduce provision for inflation allowance in adult social care purchasing budgets from 1.75% to 1.25% with contingency of £280k held in reserves.	No direct impact on service delivery is anticipated as the Council has a statutory obligation to meet assessed and eligible care needs and is not proposing to make changes to adult social care eligibility criteria.	Commissioning managers will make best endeavours in negotiations with all providers to hold overall growth arising from inflationary uplifts to maximum 1.25%. However, the ability to meet the Council's statutory obligations within the budgetary provision is dependent on market forces, hence the contingency provision.
2,772	1,326	**ADULT SOCIAL CARE TOTAL SAVING**		

HOUSING

2014-15 Saving £000	2015-16 Saving £000	How saving to be achieved	Previously Reported Impact to Service Delivery	Strategic Director's Update on Saving Proposal for November 2013 PDS Panel
39		Savings identified from the customer services workstream which looks at redesigning the customer pathway making better use of IT systems and implementing streamlined processes (including family information)	Yet to be determined. Service will transfer work to the customer service equivalent to this reduction	These savings are associated with the transformation project/customer services programme and split over the period 2013/14 and 14/15. Savings were predicated on a number of assumptions around the corporate provision of IT systems and other services. So far the delivery of these systems is falling short of expectations. As such the required saving is unlikely to be made through "efficiency" measures. Plans for delivery of an equivalent saving, through service reductions, are being worked on.
51		£25k saving from ceasing the voluntary Accreditation Scheme for private rented accommodation. £26k saving from a reduction in staffing capacity in Housing Services.	We are changing our approach to ensuring quality standards in HMOs – this is currently being consulted on. The Accreditation Scheme provides landlords & tenants with reassurance that a property meets minimum standards. Proposed additional HMO licensing areas cover a significant proportion of the accreditation properties. – as a result, the voluntary scheme will be stopped. Reduction in staffing capacity is likely to result in increased waiting times for some housing services.	It is anticipated that the delivery of this saving in 2014/15 will be in accordance with plans.

2014-15 Saving £000	2015-16 Saving £000	How saving to be achieved	Impact to Service Delivery	Strategic Director's Update on Saving Proposal for November 2013 PDS Panel
50		As a consequence opportunities for further financial savings without impacting on service delivery are highly limited. Proposals to achieve this additional saving in 2014/15 are a combination of: • Reduce empty property recovery work and stop domestic energy efficiency work relying purely on government initiatives. • Reduce Disabled Facilities Grant/Housing Grant budget.	Increased waiting times and/or reduced access to financial assistance for essential repairs to elderly, low-income & otherwise vulnerable residents' homes. LA benchmarking puts the current service provision in top quartile for service efficiency and cost effectiveness and it is highly unlikely that the saving can be achieved through further efficiencies.	Detailed plan for achievement currently being worked on.
140		**HOUSING TOTAL SAVINGS**		

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PROPOSED VARIATIONS TO 2014/2015 BUDGET				
	Sub Total	**2014/15**	***2015/16***	***2YR***
	£M's	**£M's**	***£M's***	***TOTAL £M's***
Opening Budget Gap - based on Financial Planning Model		**1.80**	***5.00***	***6.80***
Medium Term Plan Variations				
- Trading Opprtunities		0.50	*0.25*	*0.75*
- Community Assets / Asset Consolidation		0.50		*0.50*
- Adjustments to MTSRP Growth		*-0.45*	*-0.15*	
- Additional Capital Proposals (Revenue Costs)		1.00	*0.40*	*1.40*
Total Estimated Budget Gap		***3.35***	***5.50***	***9.45***

Further Savings Proposals for 2014/2015		
Corporate		
Ongoing additional debt interest savings arising from debt restructuring in 2013/2014	1.00	
Increase in the assumed Council Tax Collection Rate from 98.25% to 98.75%	0.40	
Reductions in External Audit Fees following changes to Audit Commission and new contracting arrangements	0.05	
Reduction in cost of historic unfunded pensions relating to previous Avon Council	0.03	
Miscellaneous - review of other retained corporate budgets	0.05	
		1.53
Place		
Waste Related Budgets - reducing tonnages of waste (including landfill)	0.25	
Heritage - additional increased income target	0.25	
Transport - demand for concessionary fares	0.07	
Park & Ride - increased income	0.07	
		0.64
People & Communities		
Adult Social Care - more efficient home care contract arrngements.	0.50	
		0.50
Resources		
Housing Benefits - technical subsidy adjustment	0.20	
Procurement and Efficiency savings	0.20	
Property Budgets and Improvement & Performance - Efficiency Savings linked to review of Regeneration and Skills*	0.15	
		0.55
TOTAL SAVINGS IDENTIFIED		**3.22**
REMAINING BUDGET GAP / (SURPLUS)		**0.14**

5.50	**5.64**

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Royal National Hospital for Rheumatic Diseases
NHS Foundation Trust

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Meeting:	**Bath and North East Somerset Council** **Wellbeing Policy and Development Scrutiny Panel**
Date:	22nd November 2013
Title:	**Royal National Hospital for Rheumatic Diseases NHS FT – Organisational Update**
Purpose:	For information

1. Introduction

This paper is an organisational update from the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust (RNHRD) to the B&NES Wellbeing Policy and Development Scrutiny Panel.

2. Update on Quality – Care Quality Commission (CQC) Intelligent Monitoring Report October 2013

The CQC has developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals. Each of these indicators has been assigned a risk level – 'no evidence of risk', 'risk', or 'elevated risk'.

The CQC's analysis of the key indicators for the RNHRD identified one area of elevated risk and two other risk areas, these risks and actions to address them are outlined below:

- The elevated area of risk related to staff turnover, which was unusually high due to the closure of the Trust's neuro rehabilitation service in March 2013.
  Action to address: No direct action required. The Trust will ensure that up to date Electronic Staff Record data on turnover is provided to reflect the significant subsequent decrease in turnover and to ensure that the CQC have the most current information.

- The risks identified related to:

  - Consistency of reporting to National Reporting and Learning Service (NRLS), the risk identified did not relate to the number of incidents reported, but the time taken to sign them off.
    Action to address: The Trust will ensure that it reports to NRLS monthly and that line managers review all incidents within 2 weeks as specified in the incident and risk reporting policy.

  - Monitor Governance red rating, this is a known risk relating to the Trust's financial position.
    Action to address: Strategic Plan submitted to Monitor.

Overall, the RNHRD is in band 3 (out of 6, 1 being low performing, 6 high performing), and has an overall risk score of 4 out of a possible maximum risk score of 84.
The full CQC report can be accessed at the following link:
http://www.cqc.org.uk/sites/default/files/media/reports/RBB_101_WV.pdf

3. Finance and Activity Update

3.1 Financial Position

The Trust has published its 2012/13 Annual Report and Accounts and these illustrate the financial challenges that the Trust has faced during this period and outlines that these challenges are set to continue throughout 2013/14. Access to this document is available via the following link http://www.rnhrd.nhs.uk/about-us/trust-documents

The Trust finished the year with an underlying operational deficit of £2.6m. At the start of the new financial year the forecast deficit was £3.7m for 2013/14. Improvements in activity levels alongside savings in pay and non-pay have enabled the Trust to improve the forecast outturn position for the year to a deficit of £2.7m as reported to the Board in October 2013.

Whilst this forecast represents a real improvement against plan, there is still a significant underlying deficit. The RNHRD will work on the delivery of its strategic plan to resolve this position.

3.2 Endoscopy Referrals

Over the last 3 years referrals to the Trust's endoscopy services have been declining to the extent that there has been over a 50% reduction during this period. In response to this trend and in line with commissioning intentions the Trust has reduced its planned activity forecast for endoscopy in 2013/14. These factors, combined with the risk that referrals will stay at a similar level or decline further and the requirement to make a significant investment in equipment in 2014, will require close monitoring and Board discussion to ensure the service continues to provide value for money.

The unit continues to report high levels of patient satisfaction; short waiting times and good patient safety record.

3.3 Rheumatology follow-up activity:

The Trust has made significant progress in reducing the problem of delayed rheumatology follow-up appointments, however, due to a number of factors the situation has worsened over the last 6 months, factors contributing to this include:

- an increase of 4.5% in rheumatology referrals this year
- planned and unplanned reductions in medical capacity

Actions in place to address this problem include:

- tighter management and control of cancelled clinics and additional clinic capacity created
- two Locum Consultants in post
- demand management plans being developed by CCG

The delay in follow up appointments represents limited risk for deterioration of the patient as patients who may be at risk of rapid or sudden clinical change are flagged and clinically managed accordingly.

3.4 Increased Activity for Pain Services

The Trust has seen a higher level of referral to the Pain Management and Complex Regional Pain Syndrome services in 2013/14 and as a result the waiting times for assessment and for treatment on these programmes has increased. In response the Trust has created additional clinical capacity by appointing additional therapists and increasing its bed and clinic capacity until the end of the year. The services will be reviewing referral trends to inform the planning process for 2014/15.

4. Future of Our Services

4.1 Strategic Plan Update

The RNHRD continues to face significant and long-standing financial challenges and to work on a strategic solution to resolve the underlying issues. Following presentations made to the panel on this issue in March 2012, February 2013 and a submission of a report and update to the panel at its May 2013 meeting, a further description on the future of our services is outlined below.

In April 2013 and under the new FT provider licence regime the healthcare regulator Monitor wrote to the RNHRD specifying enforcement undertakings on its provider licence. The principle actions of which were to; by the end of June 2013 submit a strategic intent for resolving the financial issues followed by the submission of a realistic and deliverable strategic plan by the end of September 2013.

In developing its strategic plan to ensure a managed and organised solution that is in the best interests of patients, protects the continuity of existing services, whilst addressing its financial issues, the RNHRD Trust Board has outlined a plan through which the RNHRD could join with the Royal United Hospital, Bath, and which takes into account the current unavoidable uncertainty around timescales.

High quality patient care remains our priority. The Board of the RNHRD has noted the content of the recent RUH Care Quality Commission (CQC) report, based on the CQC inspection of the RUH in June 2013, and of the RUH's plans to address the issues raised. The RNHRD Trust Board will now focus on the outcome of the RUH's December CQC inspection, which will provide an up-to-date picture and allow the RNHRD Board to make an informed decision on the future of the Trust's services.

In determining its strategic direction achieving maximum patient benefit for the current and future patients of the services the RNHRD offer has always been a priority for the RNHRD Board. The RNHRD has sustained an excellent patient quality and safety record despite its significant financial challenges and uncertain future, safeguarding these aspects remains a priority within the strategic plan.

The respective Boards of both organisations will continue to work closely to identify the next steps to ensure the future of the services.

4.2 Current position and next steps

The RNHRD, in line with its enforcement undertakings outlined above, has submitted a strategic plan to Monitor within the timescales agreed. The Trust is currently awaiting feedback on next steps.

4.3 'Refresh' project:

'Refresh' is a project to reconfigure and refurbish the main Trust's outpatient department. The outpatient area is used by each of the hospital departments and supports around 40,000 appointments each year. It is situated at the main entrance of the hospital and is the primary access for all patients, visitors and public attending the RNHRD.

The present appearance of the outpatient's area does not reflect the excellent quality of care provided by the hospital's clinical services. The 'Refresh' project will:

- **Enhance** confidentiality, privacy and dignity
- **Improve** access for patients
- **Provide** child-friendly appearance and facilities
- **Improve** signage to facilitate movement
- **Enable** more efficient delivery of the clinical model
- **Maximise** and increase capacity
- **Deliver** an environment responsive to changing requirements of healthcare and activity
- **Embrace** technological advances

The Refresh programme has been developed with the support of patients, staff, governors and clinicians. Work is due to start during December 2013 and funding for this project has been raised through the RNRHD charitable fund.

5. Changes to the RNHRD Board

Recent months have seen a number of changes to the Trust Board:

Eugene Sullivan has taken on the position of Chair of the RNHRD and the Council of Governors. Eugene has over 40 years' experience as a public sector auditor and accountant including as the CEO of the Audit Commission. He takes up the role following the completion of Peter Franklyn's three year term of office.

Mike Attenborough-Cox has been appointed as Non-Executive Director and Finance and Activity Committee Chair. Mike is a qualified accountant and internal auditor with extensive experience of working in and with the public sector. Mike takes up this position following the completion of Stephen Cole's three year term of office.

Finally, Kirsty Matthews, will be standing down as Chief Executive of the RNHRD with effect from 31st December 2013. The Trust has started the process of finding a successor and will update the panel further in due course.

Kirsty Matthews
RNHRD, NHS FT
12/11/2013

NHS
Bath and North East Somerset
Clinical Commissioning Group

NHS
England

B&NES WBPD&SP update report on the re-provision of neuro-rehabilitation since April 2013

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England - Bristol, North Somerset, Somerset and South Gloucestershire Area Team

Update Report on the Re-provision of Neuro-Rehabilitation previously provided at the Royal National Hospital for Rheumatic Diseases (RNHRD)

Wellbeing Policy Development & Scrutiny Panel Briefing: For Information & Comment

First published: September 2013

Updated: November 2013

Prepared by Lou Farbus (NHS England, Bristol, North Somerset, Somerset, South Gloucestershire Area Team) and Tracey Cox (B&NES CCG)

1 Purpose of the Report

1.1 To update Bath and North East Somerset (B&NES) Wellbeing Policy Development and Scrutiny Panel on the provision of specialised Category A (Level 1 and 2a) Neurological Rehabilitation (neuro-rehabilitation and non-specialised neuro-rehabilitation services) following the Royal National Hospital for Rheumatic Diseases (RNHRD's) decision to cease providing specialised neuro-rehabilitation at the end of March 2013.

2 Decisions / Actions Requested

2.1 The B&NES Wellbeing Policy Development and Scrutiny Panel is asked to note:

- patients needing this service have continued to be treated at the level of service that is most clinically appropriate for their needs;
- service provision has increased as a result of the re-provision and is subject to further expansion and no patients from B&NES have had to be referred out of area;
- there have been no issues regarding access, quality or safety at any of the re-provided services;
- very few (< 5) people from the B&NES area currently accessing any of these inpatient services;
- new rules requiring providers of neuro-rehabilitation to register with UKROC now provide independent quality assurance over and above NHS commissioning arrangements;
- Sirona Care & Health has now established service arrangements for the provision of non-specialised services;
- The CCG will extend the initial contract for non-specialised services with Sirona Care & Health to 31st March 2016.

3 Background

3.1 On 22nd March 2013 members of the (then) South West Specialised Commissioning Team (SWSCT) reported to the B&NES Wellbeing Policy Development and Scrutiny Panel the planned arrangements for re-providing Neurological Rehabilitation (neuro-rehabilitation) once services at the Royal National Hospital for Rheumatic Diseases (RNHRD) were no longer available from 1st April 2013.

3.2 As the smallest Foundation Trust in the country the Royal National Hospital for Rheumatic Diseases (RNHRD) in Bath took the difficult decision to cease providing specialised neuro-rehabilitation after 31st March 2013 in an attempt to address the

Trust's serious financial challenges.

3.3 At the time the neuro-rehabilitation service at the RNHRD was providing care for patients requiring either specialised or non–specialised (less complex) care. The RNHRD decided to stop providing this service because of a steady decline in patient numbers over the last few years, with patients from outside the area particularly, being treated closer to where they live. There have also been new pathways for some of the non–specialised patients, which reflect appropriate developments in the way care is delivered, that had also led to a reduction in non-specialised referrals.

3.4 Specialised rehabilitation is the total active care of patients with a disabling neurological condition, and support for their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led/supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation.

3.5 Services are identified on the basis of complexity of their caseload. Generally, the severity of the condition is broken down into different categories as follows:

- Four categories of rehabilitation need (categories A to D)
- Three different levels of service provision (1 to 3)

3.6 Following brain injury or other disabling conditions:

- The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist rehabilitation services (Level 3).
- Some patients with more complex needs (category B) may require referral to local specialist rehabilitation services (Level 2b).
- A small number of patients with highly complex needs (category A) usually caused through stroke or trauma of some kind will require the support of tertiary 'specialised' services (Level 1/2a).

3.7 'Tertiary specialist' rehabilitation services (Level 1/2a) are high cost/low volume services which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1 to 3 million through collaborative (specialised) commissioning arrangements.

3.8 Levels 2b-d are not specialised services and are therefore currently commissioned by Clinical Commissioning Groups (CCGs). Hence, an update on these levels of care can best be provided by B&NES CCG (please see Part 2).

3.9 Category A (Level 1 and 2a) services are specialised and are the only levels of neuro-rehabilitation that are currently commissioned by NHS England specialised

commissioning teams. Part 1 of this report has been completed by the relevant NHS England area team and only refers to Category A (Level 1 and 2a) care.

4 Part 1- Specialised Service Re-provision

4.1 Since the RNHRD announced its final decision at the end of December 2012 the then South West Specialised Commissioning Team (SWSCT) worked with a variety of stakeholders to determine what Level 1 and 2a (specialised) care would be needed in service re-provision.

4.2 Looking at annual usage (approximately 50 patients from the South West per year, approximately 10 of whom would come from the B&NES area) and lengths of stay, the SWSCT identified that it would require 8-9 beds per annum as follows:

- 6-7 Level 1 beds
- 1-2 Level 2a beds

4.3 Originally the plan was to divide this activity across the following providers for Level 1 care:

- an additional 2 beds to be provided at Frenchay's Brain Injury Rehabilitation Centre (BIRC) with an additional 3 beds coming available following some building alterations by the end of June 2013 (from a 24 bedded unit).
- 2 additional beds at Oxford Centre for Enablement (OCE), from April with the potential to increase to 3 if required (from a 26 bedded unit). Both of these services also to provide follow up outpatient care to any patients admitted.

4.4 It was anticipated that Level 2a care would be provided by the range of providers below that is nearest to the patient's home. However, although each provides a quality service, under the specific criteria needed for registration with UKROC the Dean Neurological Centre in Gloucestershire (see a full description of the service at: http://www.neurologicalservices.co.uk/our-centres/the-dean-neurological-centre.aspx) and Taunton Neuro-Rehabilitation Service (see description at: http://www.tsft.nhs.uk/OurServices/Neurology/Introduction/tabid/1745/Default.aspx) are not currently registered as specialised providers. Taunton Neuro-Rehabilitation Service is registered as a Level 2b provider and The Dean delivers specialist 24 hour nursing and therapy services for people with complex long term neurological conditions and brain or spinal injuries who require ongoing support and assistance to maximise functional ability that do not fall within the Level 1a or 2b criteria.

- The Plym Rehabilitation Centre (Plymouth)
- Glenside unit (Salisbury)
- The Dean Neurological Centre (Winfield, Gloucestershire)
- Swindon Brain Injury Rehabilitation Trust (opening May 2013)

- Rehabilitation unit, Poole General Hospital
- Taunton Neuro-Rehabilitation Service

In August 2013 these centres were asked to provide:

- The number of beds for level 1 care
- The number of beds for level 2a care
- The support provided for patients' families (is there anywhere for families to stay; psychosocial support for families; support for families to facilitate patients' return to home; anything else)
- Whether providers have recently increased the number of beds available or have plans to do so.
- Whether each provider had a waiting list and the average waiting time from referral.
- Results of the most recent Friends and Family Test and any other measures of patient satisfaction and any complaints that had been received since April 2013.

4.5 The following table provides an overview of each service since April 2013 based on the above responses. As expected, the service at BIRC in Bristol has expanded, with a further 3 beds due to become available in December 2013. A new facility able to take 10 Level 2a patients out of a total 20 bedded unit also opened in Swindon a month later than anticipated in June, with 17 beds still vacant in early September. This has significantly increased available provision in the region to ensure patients are able to move without problems down the levels of care from Level 1 with a view to returning home as soon as it is appropriate.

4.6 The only provider to have received referrals for people from the B&NES locality is the Brain Injury Rehabilitation Centre (BIRC) in Bristol. However, only limited information can be provided to scrutiny colleagues because the number of patients since April 2013 is less than 5. What can be reported is that no patients from B&NES were waiting to access the service, with 3 vacant beds week commencing 21 October 2013.

4.7 In addition, BIRC has been implementing the new NHS national measure of patient experience for acute trusts, the Friends and Family Test, since April 2013. This was last collated and reported at the beginning of October 2013 – the findings were as follows:

- 34 questionnaires handed out and 31questionnaires returned
- 30 responded they were 'Likely' or 'Extremely Likely' to recommend BIRC (96%)
- 1 person said they were 'Neither Likely nor Unlikely' to recommend BIRC (4%)

4.8 There have been no complaints from Level 1 or 2a patients at any of the providers. Therefore, we are reassured that there is sufficient capacity to provide safe specialised

neuro-rehabilitation services to meet current and future need in response to the RNHRD's decision to cease providing the service at the end of March 2013.

	Level 1 beds	Level 2a beds	Family Support	Service Expansion	Waiting lists	Current BaNES patients
BIRC (Frenchay, Bristol)	26		Family accommodation at Frenchay & NBT. Access to the Staff Restaurant and WRVS shop. Psychological support, psychotherapy sessions and a relatives group once a month. Inter-disciplinary therapy (IDT) and nursing team conduct home visits prior to discharge. Keyworker and IDT have regular family meetings, during patients' stay & families are invited to goal planning, review & discharge planning meetings. Community Liaison Co-ordinator has regular contact and discharge planning meetings with families and relevant agencies. Families signposted to relevant support charities and agencies – e.g. Headway. Headway will visit the families on the unit and provide the Headway 'Relative Support Group'.	Increased from 24 to 26 beds on 1st April 2013. Awaiting planning permission for 3 more by December 2013.	Referral to assessment = 1 week; referral to admission = 3 weeks	<5
Glenside (Salisbury)	40		Pathway manager provides welfare and benefits advice and provides family support and signposting throughout patients' stay and discharge. There are also links with legal firms and Headway provide visiting clinics on site.	No plans	No waiting list. Average referral to assessment – 4 days.	No patients from B&NES
BIRT (Swindon)	0	10	Psychosocial family therapy; mental health social worker to provide benefits and other support advice; family room on site with a private garden; 2 independent living flats; discount for families to stay at nearby Holiday Inn and plans to review the provision of family accommodation on site.	Unit just opened in May so no plans.	17 vacancies, no Level 1/2a patients have been referred since opening	No patients from B&NES
Plym (Plymouth)	0	15	Support psychological support to all family, including siblings. No family accomodation on site as yet (plans	Would consider delivering Level 1a care with investment.	Above 90% vacancy.	No patients from B&NES

			depend on whether they upgrade to Level 1a). B&Bs and Premier Inn are nearby. Café onsite run by RVS. They also provide the community services so work with families to ensure discharge plan runs smoothly. Free parking on site.			
Oxford Centre for Enablement (OCE)	26		Database of local B&Bs etc, and there are some beds for families on the nearby John Ratcliffe site. Sometimes relatives stay in the Independent Living flat with the patient over a weekend for example, to spend private time together, or to prepare for discharge. Relatives often see the family psychologist who has this particular interest. Support for getting patients home is provided according to individual needs. Home visits by staff take place pre discharge.	There are no current plans to increase the number Level 1/2a beds	There is a short waiting list, which varies according to the intensity level of each individual referral, e.g. if a patient has a tracheostomy. Average waiting time is about 1-4 weeks from referral.	No patients from B&NES
Dorset Brain Injury Service, Poole Hospital Dorset	0	5	A well developed keyworker system which is highly appreciated by families. Close links with Headway Dorset. Neuropsychology support for struggling families. A practice of weekend leave. No accommodation for families but most families, live within the county.	Could increase to seven	Referral to admission 2 - 3 weeks	No patients from B&NES

5 Decisions / Actions Requested

5.1 The B&NES Wellbeing Policy Development & Scrutiny Panel is asked to note:

- patients needing this service have continued to be treated at the level of service that is most clinically appropriate for their needs;
- service provision has increased as a result of the re-provision and is subject to further expansion and no patients from B&NES have had to be referred out of area;
- there have been no issues regarding access, quality or safety at any of the re-provided services;
- very few (< 5) people from the B&NES area currently accessing any of these inpatient services;
- new rules requiring providers of neuro-rehabilitation to register with UKROC now provide independent quality assurance over and above NHS commissioning arrangements.

Part 2

6. Non-Specialised Services Re-Provision

Sirona Out-Patient Neuro-Rehabilitation Service

6.1 Following the closure of the RNHRD's neuro-rehabilitation service at the end of March 2013, BaNES and Somerset CCGs commissioned Sirona Care & Health to provide a replacement service for BaNES and Mendip patients who needed on-going care and management. This was on the basis that Sirona already provided a community based neuro-rehabilitation and stroke service.

6.2 63 patients were transferred by the RNHRD to Sirona:

- 35 for consultant follow-up & spasticity management;
- 24 for physiotherapy;
- 1 for orthotics and;
- 3 for psychology.

6.3 In addition, 10 new patient referrals for people who had been referred to the RNHRD service but not accepted due to the imminent closure of the service were also received.

6.4 All patients who needed on-going review were written to, informing them that their care was transferring to Sirona. New patients were also sent information about the new service. At the same time each patient's GP was also informed of the transfer of care. All practices were informed of the closure of the RNHRD service and that any new referrals for out-patient neuro-rehabilitation should be made to Sirona.

6.5 Sirona ensured that the following out-patient neuro-rehabilitation services were re-provided:

- Consultant clinics
- Spasticity management clinic
- Physiotherapy (including Functional Electrical Stimulation)
- Psychology
- Counseling
- Orthotics
- Occupational therapy

6.6 All the transferred patients that needed the out-patient physiotherapy service had been seen by the end of July. Similarly those patients who were transferred needing on-going psychology input had been reviewed by Sirona's neuro-psychologist.

6.7 Dr Angus Graham, Rehabilitation Medicine Consultant, from the Brain Injury Rehabilitation Centre based at Frenchay Hospital, began providing the consultant clinics at the end of July.

6.8 Since the beginning of April, Sirona has received 35 new referrals to the service.

6.2 Activity Levels

Specialist Neuro Outpatient Service Report May - Oct 2013

Referrals Received

Result of Referral	May-13	Jun-13	Jul-13	**Aug-13**	**Sep-13**	**Oct-13**	**Grand Total**
ACCEPTED INTO SERVICE	73	3	2	5	4	11	98
Grand Total	73	3	2	**5**	**4**	**11**	**98**

Number of Appointments Attended

	May-13	Jun-13	Jul-13	**Aug-13**	**Sep-13**	**Oct-13**	**Grand Total**
Consultant		0	4	8	3	7	22
Occupational Therapy		0	0	0	0	0	0
Orthotics		0	0	2	0	4	6
Physiotherapy		2	11	9	9	8	39
Psychology		2	1	2	4	10	19
Grand Total		4	16	**21**	**16**	**29**	**86**

Number of Contacts

	May-13	Jun-13	Jul-13	**Aug-13**	**Sep-13**	**Oct-13**	**Grand Total**
Cons - Botox		0	2	3	1	0	6
Cons - Follow Up		0	2	6	3	7	18
Cons- Medication Review		0	1	5	3	4	13
Cons- Spasticity Mngmnt		0	1	3	3	0	7
Consultant Total		*0*	*6*	***17***	***10***	***11***	***44***
Physio - Assessment		2	10	9	9	6	36
Physio - FES		0	0	6	7	5	18
Physio - Treatment		0	1	4	6	8	19
Physio Total		*2*	*11*	***19***	***22***	***19***	***73***
Psych - Assessment		1	0	0	1	6	8
Psych - Treatment		1	1	1	2	2	7
Cognitive Assessment		0	0	1	1	2	4
Psych Total		*2*	*1*	***2***	***4***	***10***	***19***
Orthotics - Assessment		0	0	2	0	4	6
Orthotics - Follow-Up		0	0	2	0	2	4
Orthotics Total		*0*	*0*	***4***	***0***	***6***	***10***
DNA		0	1	0	0	0	1
Grand Total		4	19	**42**	**36**	**46**	**147**

7. Contractual Arrangements

7.1 The CCG initially commissioned Sirona Care & Health for a 12 month period. The CCG has since made a decision to extend the contract to 31st March 2016.

Appendix A – Glossary

BIRC	The Brain Injury Rehabilitation Centre in Bristol provides comprehensive assessment, rehabilitation, therapy and community integration programme for people with physical and cognitive impairment and people with challenging behaviour following brain injury. We also provide SMART (Sensory Modality Assessment and Rehabilitation Technique) assessment for people who are in a minimally conscious state. More information about them can be found at: http://huntercombe.com/centre/frenchay-brain-injury-rehabilitation-centre/
BIRT	The Brain Injury Rehabilitation Trust in Swindon is a continuing rehabilitation centre that provides residential rehabilitation for adults with an acquired brain injury showing behavioural and/or cognitive deficits which in turn means lead to complex care needs. Service users may also have pre-existing or concurrent mental health problems in addition to their brain injury and may also be subject to detention under the Mental Health Act. More information about them can be found at: http://www.thedtgroup.org/brain-injury/news/new-service-in-swindon.aspx
CCG	Clinical commissioning groups are groups of GPs that will, from April 2013, be responsible for designing and commissioning local NON-SPECIALISED health services in England. They will do this by commissioning or buying health and care services including: • Elective hospital care • Rehabilitation care • Urgent and emergency care • Most community health services • Mental health and learning disability services
Commissioning	Term used to describe the overall process of planning, funding, procuring (purchasing), and monitoring of healthcare services.
Glenside	Glenside Neuro-rehabilitation Hospital provides a complete range of inpatient medical care and rehabilitation services to adults who

	are living with severe physical, cognitive or behavioural impairments, resulting from long-term neurological conditions including acquired or traumatic brain injury. More information about them can be found at: http://www.glensidecare.com/
Inpatient	Inpatient care is the care of patients whose condition requires admission to a hospital.
Local Area Team	Ten of the NHS commissioning board's 27 local area teams will commission specialised services for their whole region.
Neuropsychology	Neuropsychology is the application of neuropsychological knowledge to the assessment, management, and rehabilitation of people who have suffered illness or injury (particularly to the brain). • A Consultant Clinical Psychologist provides an outpatient service one day per week to cover child, adolescent and adult outpatients. • Referrals are from the Consultant in Rehabilitation Medicine, GPs and Solicitors. Typical referral requests relate to assessment and intervention for level of cognitive, emotional or behavioural disorders with people with neurological conditions.
NHS Commissioning Board (NHS CB)	The NHS CB will, from April 2013, be responsible for designing and commissioning specialised health services in England through local area teams. Specialised services involve complex treatments or packages of care, often for relatively rare conditions. The services may involve the use of very specialised technology and equipment or drugs delivered by a specialist expert workforce. Some, but not all, specialised services are high cost. To be most safe and cost effective specialised services need to be planned and commissioned using populations of at least 1 million, which is larger than most Primary Care Trusts/CCGs, with many of the rarer conditions needing much larger planning populations than this. Consequently, specialised services are not provided in every hospital and tend to be found only in larger ones, which perhaps provide a range of specialised services.
OCE	The Oxford Centre for Enablement (OCE) provides specialist neurological rehabilitation services for patients with long-term conditions. More information about them can be found at: http://www.noc.nhs.uk/oce/

Out of Area	Outside of the South West of England
Outpatient	Outpatient care describes medical care or treatment that does not require an overnight stay in a hospital or medical facility. There are several strands to the outpatient service for Neuro-rehabilitation: • General medical clinic • Spasticity clinic (Consultant led) • Physiotherapy (including FES) • Neuropsychology • Counselling • Splinting • Hydrotherapy
Plym(outh) Neuro Rehab Unit	The Plym Neuro Rehab Unit is a 15 bedded inpatient neurological rehabilitation unit for adults aged 16 years and over who have suffered an acquired brain injury, spinal cord injury and other neurological conditions. More information about them can be found at: http://www.plymouthcommunityhealthcare.co.uk/services/plym-neurological-rehab-unit
Poole Hospital NHS Foundation Trust	Neurological rehabilitation provides a service for both in-patients and out-patients. 1. For inpatients, an assessment and rehabilitation service is based on the acute medical wards including the acute stroke unit; 2. For outpatients, an on-going rehabilitation service it offered to patients within the Poole area who have physiotherapy needs. More information about them can be found at: http://www.poole.nhs.uk/our_services/therapy_services.asp
Rehabilitation	Rehabilitation is the process of assessment, treatment and management by which the individual (and their family/carers) are supported to achieve their maximum potential for physical, cognitive, social and psychosocial function, participation in society and quality of living. Patient goals for rehabilitation vary according to the recovery trajectory and stage of their condition. Specialist rehabilitation is the total active care of patients with a disabling condition, and their families, by a multi-professional team who have undergone recognised specialist training in

	rehabilitation, led/supported by a consultant trained and accredited in rehabilitation medicine (RM) or neuropsychiatry in the case of cognitive / behavioural rehabilitation. Services are identified on the basis of complexity of their caseload. Generally, the severity of the condition is broken down into different categories as follows: • Four categories of rehabilitation need (categories A to D) • Three different levels of service provision • Following brain injury or other disabling conditions: • The majority of patients have category C or D needs and will progress satisfactorily down the care pathway with the help of their local non-specialist rehabilitation services (Level 3). • Some patients with more complex needs (category B) may require referral to local specialist rehabilitation services (Level 2b). • A small number of patients with highly complex needs (category A) will require the support of tertiary 'specialised' services (Level 1/2a). 'Tertiary specialist' rehabilitation services (Level 1) are high cost/low volume services which provide for patients with highly complex rehabilitation needs following illness or injury, that are beyond the scope of their local general and specialist services. These are normally provided in co-ordinated service networks planned over a regional population of 1 to 3 million through collaborative (specialised) commissioning arrangements. Level 2b-d are not specialised services and are therefore currently commissioned by CCGs. Level 1 and 2a services are specialised and are commissioned by specialised commissioning groups.
Service Specification	Service specifications are drawn up by a commissioner before organisations are invited to put in applications to provide the service. They describe the service that the commissioner wants provided. They often set the standards required and may include things like staffing arrangements, skills, levels of activity, referral criteria, inpatient care and follow-up.

Social care	The range of services that support the most vulnerable people in society to carry on in their daily lives.
Specialised Brain Injury Counselling	Specialised Brain Injury Counselling is psychological adjustment work for people who have had a brain injury and also for couples where one partner has a brain injury. It is very specialist and will only be funded where the work is over and beyond that which could be provided by a GP counsellor, or locally by the psychologist in the community team.
The Dean Neurological Centre, Gloucestershire	The Dean delivers specialist 24 hour nursing and therapy services for people with: • Complex long term neurological conditions • Brain or spinal injuries who require ongoing support and assistance to maximise functional ability More information about them can be found at: http://www.ramsayhealth.co.uk/pdf/The_Dean_Booklet_Web_Version.pdf

Bath & North East Somerset Council		
MEETING	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING DATE:	**22 November 2013**	
TITLE:	**Draft Homelessness Strategy 2014-2018**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: **Appendix 1 Draft Homelessness Strategy 2014-2018v4** **Appendix 2 Homelessness Strategy Equality Impact Assessment**		

1 THE ISSUE

1.1 Adopting the Draft Homelessness Strategy (attached at Appendix 1), has been identified as a 'Key Decision' because of community impact and is scheduled for the Council Cabinet meeting on 4 December 2013.

2 RECOMMENDATION

That the Wellbeing Policy Development & Scrutiny Panel agrees that the revised approach contained in the Draft Homelessness Strategy 2014-2018 which not only continues a successful provision of early interventions to prevent homelessness but also focuses on achieving a nationally accredited Gold Standard and targeting ten new local priorities:

2.1 Complies with agreed Council policies and plans.

2.2 Will have a positive impact on vulnerable people and reduce inequalities.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 There are no direct financial implications arising from the approval and publication of the Bath and North East Somerset Homelessness Strategy 2014-2018. However, it should be noted that the effective prevention of homelessness has a significant and positive direct financial impact on the Council. This is due to the reduction in the costs associated with preventing homelessness, investigating and assessing statutory homelessness applications and the very significant costs associated with the provision of temporary accommodation.

3.2 The priorities of the Strategy should also form a key consideration in the commissioning and allocation of health, social care and wellbeing resources.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The Homelessness Act 2002 imposes a duty on local housing authorities to carry out a homelessness review and to formulate and publish a homelessness strategy every 5 years. The current Homelessness Strategy is due to expire on 25 February 2014.

4.2 In accordance with the Homelessness Act, a homelessness strategy must include specific actions to prevent homelessness and ensure that sufficient accommodation and support is available for people who are or may become homeless and support to prevent them becoming homeless again.

4.3 The actions set out in the strategy include those that the authority expects to be taken by public authorities (eg police and health services) and which are offered by voluntary and community organisations whose activities are capable of contributing to the achievement of these aims.

4.4 The draft Homelessness Strategy proposes a number of enhancements to homelessness prevention and support for the homeless in the light of current evidence and best practice. It follows extensive public and stakeholder engagement, analysis of the impacts of welfare reform on vulnerable people, a current homelessness review and an Equalities Impact Assessment (attached at Appendix 2).

5 THE REPORT

5.1 The Draft Homelessness Strategy is the proposed joint high level strategic plan for all services working with or coming in to contact with vulnerable people, troubled families and young people. It is supported by the Health and Wellbeing Board who have agreed to champion the homelessness agenda in Bath and North East Somerset.

5.2 The Draft Homelessness Strategy builds on the successes of previous homelessness strategies. The number of households in temporary accommodation was halved in 2010 and the rate of homeless households in temporary accommodation is less in Bath and North East Somerset than in other West of England Authorities and nationally. 60% of homelessness enquires are resolved with advice provision demonstrating the effectiveness of our current homelessness prevention strategies.

5.3 However, since the current homelessness strategy was adopted (2009) two new pieces of legislation have been introduced that could have a significant negative impact on households at risk of homelessness. The Welfare Reform Act 2012 gives people on benefit increased personal responsibility for money management. The Localism Act 2011 provides that social housing is made available to people with greatest housing need and allowed the Council to have greater control of who is admitted onto the social housing waiting list (Homesearch). The Localism Act also allowed social landlords to provide flexible tenancies for social housing and required the Council to publish a Tenancy Strategy providing guidance on how these flexibilities should be implemented in Bath and North East Somerset.

5.4 The Joint Strategic Needs Assessment identifies associated risks of the impacts of welfare reform on vulnerable people that include worsening health outcomes, particularly mental ill health, domestic abuse, family breakdown, fuel poverty, debt and homelessness. An Equalities Impact Assessment carried out for the draft Homelessness Strategy demonstrates that it has the potential to mitigate these risks and improve the health and wellbeing of vulnerable residents. In particular it is likely to have a positive impact on equalities groups such as women, disabled people, young people and older single homeless people, socio-economically disadvantaged and rural communities. See Equalities Impact Assessment as Appendix 2

5.5 The Welfare Reform Act and Localism Act are being implemented locally through changes to income benefits, changes to flexible tenancies in social housing and changes to the allocation of social housing. The Draft Homelessness Strategy takes account of these changes and potential risks for vulnerable people and the Delivery Plan is framed around ten local priorities to mitigate negative impacts and prevent homelessness more effectively in the current context:

Priority 1	Identify people most at risk of domestic violence and prevent homelessness
Priority 2	Improve housing advice and support for people living in rural areas
Priority 3	Target mortgage rescue advice and assistance at low income households
Priority 4	Target welfare advice at low income households living in social housing
Priority 5	Prevent evictions of social housing tenants in the first year of new tenancies
Priority 6	Review the distribution and tenant profile of family sized social housing
Priority 7	Protect housing standards and conditions in low cost private rented housing
Priority 8	Develop access to shared rented housing for single people aged under 35
Priority 9	Provide suitable temporary accommodation and stop using Bed & Breakfast
Priority 10	Review rough sleeper services and adapt to meet changes in diversity

5.6 The Delivery Plan also measures the Council's performance against ten improvement challenges devised to help local authorities deliver more efficient and cost effective homelessness prevention and implement the government report 'Making every contact count: A joint approach to preventing homelessness' published in 2012. Rising to the challenge will mean that local provision for homelessness will be peer reviewed and could be acknowledged nationally by achieving the Gold Standard. The ten challenges are:

1. To adopt a corporate commitment to prevent homelessness which has buy in across all local authority services
2. To actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs

3. To offer a Housing Options prevention service to all clients including written advice
4. To adopt a No Second Night Out model or an effective local alternative
5. To have housing pathways agreed or in development with each key partner and client group that include appropriate accommodation and support
6. To develop a suitable private rented sector offer for all client groups, including advice and support to both client and landlord
7. To actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme
8. To have a homelessness strategy which sets out a proactive approach to preventing homelessness, reviewed annually to be responsive to emerging needs
9. To not place any young person aged 16 or 17 in Bed and Breakfast accommodation
10. To not place any families in Bed and Breakfast accommodation unless in an emergency and for no longer than 6 weeks

5.7 Throughout the process of developing the revised Draft Homelessness Strategy a programme of broad consultation has been in place see section 8 below.

6 RATIONALE

6.1 The Council has a statutory responsibility to produce and publish a Homelessness Strategy based on a homelessness review every five years.

6.2 The draft Homelessness Strategy takes account of national guidance, local priorities arising from a homelessness review and consultation responses received over the course of several months as the strategy developed.

6.3 A corporate commitment to preventing homelessness is fundamental to achieving the main objectives of the Homelessness Strategy and the intention is for this to be endorsed by Cabinet decision.

7 OTHER OPTIONS CONSIDERED

7.1 It is a statutory duty to produce and publish a Homelessness Strategy based on a homelessness review every five years, and as such, no other options were considered.

8 CONSULTATION

8.1 A programme of extensive consultation has been implemented throughout the development of the Draft Homelessness Strategy. It commenced with initial planning meetings with a wide range of organisations that form the local Homelessness Partnership in early 2013. A Welfare Reform conference was subsequently facilitated by Housing Services and the Homelessness Partnership in March 2013. The conference enabled key stakeholders to consider local challenges and contribute to forming a draft Homelessness Strategy.

8.2 The Wellbeing Policy Development and Scrutiny Panel has received two reports relating to the Draft Homelessness Strategy this year. At the meeting on 22 March it received the report ‘Homelessness and the Use of Temporary

Accommodation' and on 5 July 'Rough Sleepers'. It resolved to receive draft Homelessness Strategy at one of the future Panel meetings.

8.3 The draft Homelessness Strategy was approved by the Homelessness Partnership and presented to the Health and Wellbeing Board in September 2013. A formal open public consultation on the draft Homelessness Strategy was endorsed by the Board and launched on 28 September running until 6 November 2013. The consultation together with the draft strategy and evidence base was posted on the council website and summarised as follows:

'We review our Homelessness Strategy every five years. We would like you to tell us if you think we've got the new draft strategy right or what you think we need to do to improve it. We started the review with a Welfare Reform Conference in March and we've also reviewed national guidance and local data. This draft strategy continues to focus on ways of preventing homelessness. It places even greater emphasis on practical and joined up responses from the many excellent services and agencies that provide help and support for the homeless and it includes the government's ten Gold Standard Challenges. If you know someone who has been homeless or you have been homeless yourself or if you represent an organisation that provides services for people who've been homeless or can contribute to preventing homelessness we would like to hear from you.'

8.4 Everyone who attended the welfare reform event, homelessness service providers, key local authority service managers and all councillors on the exchange were invited to contribute to the consultation. Comments from the Board and other respondents led to amendments and improvements in the strategy, for example a greater emphasis on the health impacts of homelessness.

8.5 A strategic core group of the Homelessness Partnership met on 7 November to review the amended strategy and their comments have been taken into account in the final version of the strategy that will be presented to Cabinet.

9 RISK MANAGEMENT

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

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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

NHS
Bath and North East Somerset Clinical Commissioning Group

Draft

Homelessness Strategy

2014-2018

V4

Preventing homelessness and making every contact count

1 HOMELESSNESS STRATEGY

1.1 EXECUTIVE SUMMARY

House prices and private rents in Bath and North East Somerset have stayed high despite a national trend for a housing market slowdown. It is an area of high demand for social housing and contains some of the least affordable areas of the country for housing. The local area covers around 20kms of countryside from west to east and is serviced from the city of Bath and the principal towns of Keynsham and Midsomer Norton and Radstock.

The overall stock of social housing has remained broadly the same for the last 10 years and is now around 14% of all housing. It has been estimated that 3,400 new affordable homes are needed between now and 2031 in Bath and North East Somerset to meet the needs of people who can't afford market housing. Our housing delivery programme expects to achieve significant new provision within the next five years; however we cannot rely solely on the delivery and distribution of new housing to resolve the needs of all homeless people.

Demand for private rented accommodation, particularly amongst single people who are homeless or at risk of becoming homeless, greatly outstrips supply. Reforms mean that single people aged 35 or younger will only be entitled to shared accommodation rates of housing benefit so we are anticipating an increased demand for shared housing. Although levels of homelessness have not changed substantially since 2008 when the previous strategy was published there are considerable new challenges for the Council in tackling homelessness.

Areas of south west Bath where the predominant tenure is social housing, rank amongst the most deprived 20% of the country. Domestic abuse is a common cause of homelessness and accounts for the greatest cost to the health care services, making up 22% of the total cost (£3.7 million). Rates of domestic abuse are strongly correlated with socio-economic inequality in Bath and North East Somerset.

National evidence[1] suggests that 8 in 10 single homeless people have one or more physical health condition and 7 in 10 single homeless people have one or more mental health condition. Some of the causes of poor health are more prevalent in the single homeless population: for example, 77% of single homeless people smoke compared to 21% of the general population. As a result of their complex needs, single homeless people disproportionately use acute local health services at a cost four times more than the general population.

In developing this Strategy we consulted with the public, our partners and local stakeholders many of whom have been actively involved in our local Homelessness Partnership, to listen to their views and

[1] 'Improving The Health Of The Poorest, Fastest': Including Single Homeless People In Your JSNA

concerns and we identified local issues from evidence based information. This has helped us to put together a delivery plan to support the Homelessness Strategy and respond to local needs.

There have been a significant number of achievements since the last Homelessness Strategy. However, with continuing demands and challenging circumstances, much more remains to be done and we are planning ahead and will work in partnership with others who can help deliver solutions. We have prioritised the government's 'Gold Standard' for homelessness prevention and aim to achieve it within the next five years, building on our past success and responding to the impacts of changing housing markets and social and welfare reform.

Our major challenges include:

- Demand for affordable housing currently significantly outstrips supply
- High housing costs both for rent or purchase
- Increased pressures on household incomes
- Meeting the needs of all residents across the whole geographical area
- Meeting the needs of households with complex needs
- Increasing problems in accessing private rented accommodation
- Developing solutions to future funding constraints
- Improving communications, knowledge and managing expectations

During the next five years we plan to strengthen our corporate commitment to prevent homelessness through the influence and scrutiny of the Health and Wellbeing Board. We will work with extended partnerships to tackle the underlying causes of homelessness such as low income and worklessness which affect the most disadvantaged people in our communities. We plan to build on our successful approach to homelessness prevention, improve pathways into settled accommodation and make a big difference to the health and wellbeing of homeless people.

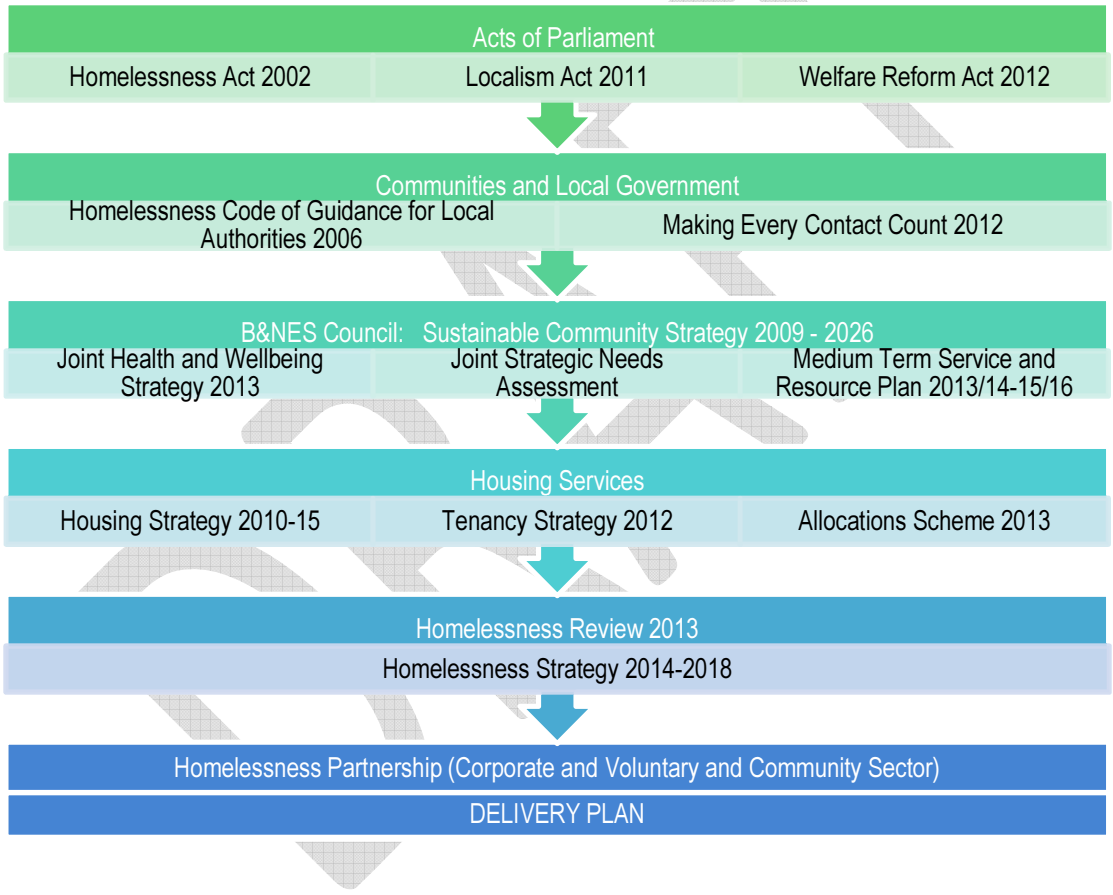
Cabinet Member for Wellbeing

[Date]

2 SHARED AIMS AND OBJECTIVES

2.1 NATIONAL AND LOCAL CONTEXT

This Homelessness Strategy responds and relates to the Acts of Parliament and statutory guidance that set out the government's intentions for protecting homeless people, preventing homelessness and managing welfare benefits and support. The following diagram shows the main national and local strategies and plans taken into account by this Homelessness Strategy leading to a Delivery Plan that is implemented and monitored by the Homelessness Partnership:



Since the **Homelessness Act 2002** the Council must have a Homelessness Strategy in place that sets out how it plans to prevent homelessness and make sure that there is sufficient accommodation and support for homeless people or anyone who is at risk of becoming homeless. The Council also has a range of duties to people who are homeless, and this includes advice and assistance and the provision of temporary accommodation. The main housing duty is to accommodate those who are unintentionally homeless and in priority need.

The Homelessness Code of Guidance explains how the Act should be implemented. In practice it is a guide that tells the Council how to review the effectiveness of its homelessness provisions and produce a new strategy every five years. It states the requirement that all organisations, within all sectors, whose work can help to prevent homelessness and/or meet the needs of homeless people in their district must be involved in the development of the strategy.

Making Every Contact Count 2012 is the government's most recent report on preventing homelessness. It expresses how the government expects all local services to work together locally to make every contact with a vulnerable person count and to target funding and resources on early intervention initiatives for groups most at risk of homelessness. It contains five cross cutting themes and introduces an accreditation for council homelessness services called the Gold Standard.

Vision statement:

> 'There is no place for homelessness in the 21st Century. The key to delivering that vision is prevention - agencies working together to support those at risk of homelessness.'

Cross cutting themes:

- Agencies working together to target those at risk of homelessness
- Identifying and tackling the underlying causes of homelessness as part of housing needs assessments by referral to appropriate support
- Local authorities coordinating access to services for vulnerable people; multi agency action, case work, agencies responding flexibly
- Increasing access to the private sector; supporting people to remain in private sector tenancies
- A focus on youth homelessness.

Gold Standard:

1. To adopt a corporate commitment to prevent homelessness which has buy in across all local authority services
2. To actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs
3. To offer a Housing Options prevention service to all clients including written advice
4. To adopt a No Second Night Out model or an effective local alternative
5. To have housing pathways agreed or in development with each key partner and client group that include appropriate accommodation and support
6. To develop a suitable private rented sector offer for all client groups, including advice and support to both client and landlord
7. To actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme
8. To have a homelessness strategy which sets out a proactive approach to preventing homelessness, reviewed annually to be responsive to emerging needs
9. To not place any young person aged 16 or 17 in Bed and Breakfast accommodation

10. To not place any families in Bed and Breakfast accommodation unless in an emergency and for no longer than 6 weeks

The Homelessness Partnership is a group of agencies that contribute to the development and delivery of Bath and North East Somerset Council's Homelessness Strategy. Membership includes the Council's Housing Services, registered providers, commissioned homelessness and advice service providers, police and voluntary and community sector agencies. The Partnership holds networking events, champions homelessness initiatives and monitors the Delivery Plan.

The Joint Strategic Needs Assessment is the Council's live research and evidence base for local facts and intelligence for the area and includes data from the 2013 review of homelessness. It helps elected members and council officers understand and identify local priorities and to target services and understand how decisions impact on different communities in different ways. It establishes evidence that the prevention of homelessness through a raft of early interventions will reduce the risks of a wide range of negative health outcomes that are commonly experienced by homeless people and families.

2.2 LOCALISM

The Localism Act 2011 includes measures for ensuring that social housing is made available to people with greatest housing need by enabling flexible tenancies for social housing and changes to securing accommodation for homeless people. It meant that local authorities had to consider increasing mobility within the social housing sector by introducing these new flexibilities within their local context and formulate a Tenancy Strategy as a framework for registered providers of social housing in the area.

The B&NES Tenancy Strategy 2012 was developed from an evidence base that demonstrated the high demand for social housing in this area and how supply could be improved by encouraging the new flexibilities. The framework explains why and under which circumstances private sector tenancies may be used to accommodate homeless households and social sector tenancies will be allocated for fixed term rather than as a home for life. As a result, most local social housing for non-retirement age households is now let on one year introductory or starter tenancy followed by a minimum five year fixed term tenancy. Landlords will be able to review the tenant's housing need at the end of a fixed term period and decide whether or not to continue the tenancy depending on the circumstances of the tenant and housing demand at that time.

The B&NES Allocation Scheme 2013 is the way that social housing is allocated within the area. The Scheme was reviewed in the light of recent government guidance and now restricts access to local social housing to means tested households that pass a residency test about their local connection with Bath and North East Somerset area. Housing applicants, including current social housing tenants wanting to move house, must actively search and bid for properties. The scheme gives priority to applicants depending on their housing needs and medical and welfare requirements. Priority is given to

homeless households, those leaving the armed forces and social housing tenants who need to downsize.

2.3 HEALTH AND WELFARE

The Welfare Reform Act 2012 is the governments' legislative framework for the biggest change to the welfare system for over 60 years. The intention of the Act is to give people on benefit increased personal responsibility for money management and improved incentives to work. Changes include Universal Credit which is a new single payment for people who are looking for work or on a low income and changes to rates of Housing Benefit such as a shared accommodation rates for single people aged 34 and under and cuts for working age social housing tenants with spare bedrooms.

The Health and Wellbeing Strategy 2013 provides the big picture about current and future health and wellbeing needs of the Bath and North East Somerset. The **Health and Wellbeing Board** connects work with schools, local commissioners, including the Police and Clinical Commissioning Group and local delivery partners. Its objective is to narrow the health and inequalities gap between different geographical areas, communities, social and economic groups in the local population by improving the lives of those worst affected and champion the priority themes:

- Helping people to stay healthy
- Improving the quality of people's lives
- Creating fairer life chances

The Medium Term Service and Resource Plan (MTSRP) 2013/14-15/16 includes savings from the Supporting People and Communities budget, which incorporates work on homelessness. In the short term the Council's reserves and commercial sources of income, together with its long term financial plans and efficiencies, put it in a relatively strong position. There are also key demographic changes, with a projected 40% increase in the older population by 2026 creating a significant additional financial pressure and an increase of the entire population of 12% by the same date.

In this context, the Council is faced with meeting increasing levels of need with shrinking resources and this does mean the focus of the money available will be on the most vulnerable groups of people to support their independence and wellbeing and delaying or eliminating the need for more acute, higher cost services. Services commissioned from community and independent sector organisations will reflect this principle, with higher access thresholds being applied. Since planning to meet the requirements of the MTRSP, Central Government has published its Spending Review for 2015/16, the full implications of which are yet to be fully assessed by the Council.

Supporting People and Communities (SP&C) have been implementing theme-based sector reviews with the intention of finding the required savings through a strategic approach rather than a top-slicing exercise, minimising wherever possible the impact on service users since February 2013. Commissioned services were looked at within the following groupings:

- Advice, Information & Advocacy

- Housing related support
- Community Services
- Day Services

Using data on performance, utilisation and demand, feedback from providers and stakeholders (including service users) and intelligence on duplication of provision, the reviews aim to inform the development of commissioning plans for 2014/15 onwards. SP&C will continue to focus on prevention and early intervention as the cost benefit of this approach has been clearly evidenced (ref 'The Cost Benefit of Housing Related Support in Bath and North East Somerset. Sitra 2011). Services commissioned will provide quality and choice, they will work in partnership, be person centred, outcome focused, accessible, and promote independence. They will, necessarily, be targeted at the most vulnerable groups of people.

2.4 CONSULTATION

Consultation has been extensive and includes strategy development meetings with the wide range of organisations that form the local Homelessness Partnership, a consultation event held in March 2013 that enabled key stakeholders to consider local challenges and contribute to forming local priorities and an open public consultation on these priorities.

Homelessness Partnership

At the consultation event the key stakeholders asked for practical solutions, better communications and access to information, financial inclusion and joined up messages:

Practical: build practical responses to support people to manage with less money; and work sub-regionally to support needs of single homeless people. Practical responses should include shared housing for single people, access to private rented housing and lodgings.

Communicating Together: work 'smarter' and avoid duplication so that everyone understands the current offer/help available from all relevant council services and partner agencies and our front-line staff have access to information / know who and how to refer customers onto services.

Financial Inclusion: make best use of all the available resources, for example by expanding "drop in's" using the Forwards Work Clubs, which aim to help people with mental health challenges, learning disabilities and higher functioning autism to find and stay in work. Expansion could enable a Job Centre Plus adviser and service users such as care leavers and people with disabilities to attend.

Joined up: Join up to share consistent messages and resources and a more strategic approach linking up all stakeholders. Create positive messages about getting into work and promote a shift of mind-set among people affected and those supporting them. Investment in job readiness/ promote employment as an option, overcome self-imposed barriers, create self-belief.

Health and Wellbeing Board

The draft Homelessness Strategy was presented to the H&W Board on 18 October 2013. Members expressed concern about the effect of homelessness on young people , ex armed forces and people in rural areas and requested that the strategy take account of the particular needs of these groups. The Board also requested that the mental and physical ill health of homeless people should be emphasised in the strategy.

Open Public Consultation

Outcomes of open public and H&WBoard H&WPDSPanel (to be completed)

I do not agree with preventing the evictions of social housing tenants by reviewing pre-eviction protocols and ensuring adequate support in the first year of new tenancies if the tenant is guilty of Anti-Social Behaviour or is a threat to other tenants.

I think you should prioritise the needs of local people leaving military service, have practical help for older people to downsize, prioritise young people's problems ... and have a policy to help troubled families get rehoused locally whenever possible.

There appear to be a growing number of beggars on the streets of Bath - some clearly have addiction/mental Health issues. Is anything being done to support them?

..

Speaking as a councillor in a rural ward, i would say we need more rural outreach the strategy should take into account the needs of people in rural areas, considering how difficult for them is to access services in Bath.

We need council and third sector resources to hold families with teenagers together, and more help with substance abuse as alcohol and ketamine cause many young people to become temporarily homeless.

Through regular monitoring of changes in the diversity of service users, identify gaps in service provision and work to adapt to any changing needs.

There are not enough services to provide care for homelessness for working people **Look at what empty properties and land you have to provide cheap housing for homeless. put benefits and homes and help for local potential and homeless people 1st. Working people that are made homeless should have priority.**

there are specific health services funded by the CCG for homeless people

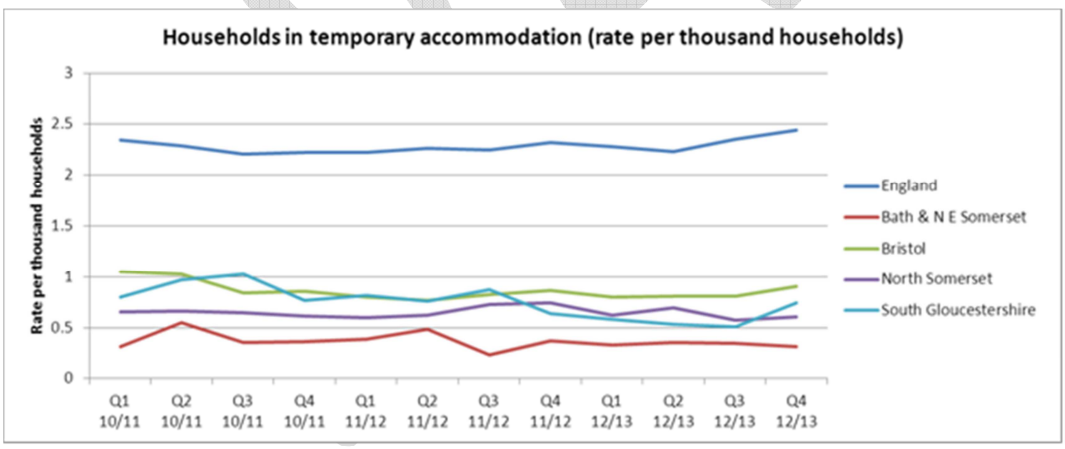
3 HOMELESSNESS REVIEW

3.1 MAKING A DIFFERENCE 2008-2013

The Homelessness Strategy 2008-2013 set out strategic priorities to improve information and understand need better, for partnerships to prevent homelessness more efficiently and to broaden the range of housing options for homeless people. During the five years that the strategy was implemented there were some significant changes and achievements in the way homelessness services responded to the needs of service users:

Improving information. Housing and Mental Health Commissioners pooled resources to fund a specialist mental health worker to provide housing advice. The Housing Support Gateway was commissioned by Supporting People to improve partnership work amongst the provider organisations that help people who need support or risk becoming homeless. Julian House created a reporting line and website so that local residents can ask them to make contact with and provide support for rough sleepers throughout the district.

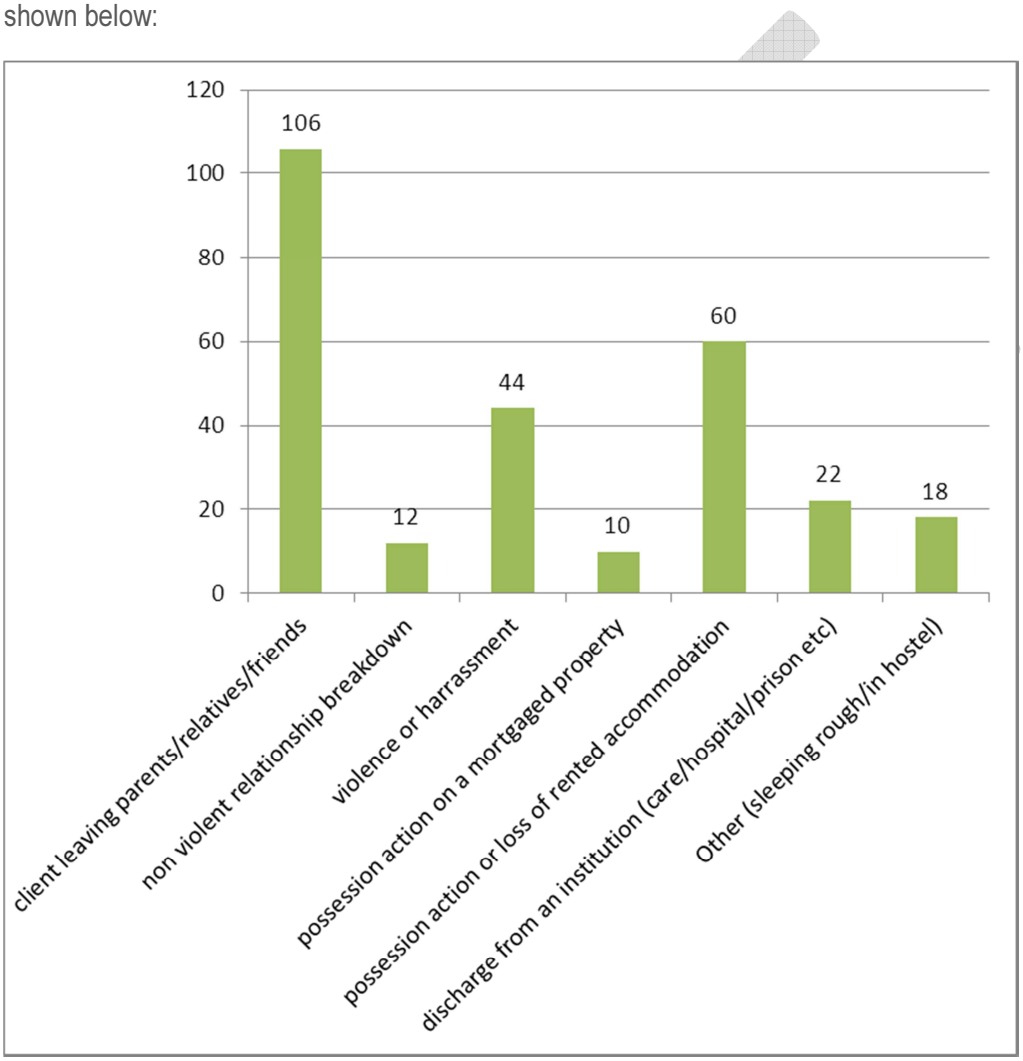
Preventing homelessness. The number of homeless applications from 2007 to 2011 decreased by 52% and more than half (60%) of homelessness enquires to the Council were resolved by housing advice that prevented homelessness. The rate of homeless households in temporary accommodation was halved in 2010 and is currently lower in Bath and North East Somerset than in other West of England Authorities and nationally:



Housing options. Since 2008 our private rented sector access scheme, Homefinder, and the Supported Lodgings Scheme prevented around 300 families, young people and care leavers from being homeless. A new Family Mediation service was commissioned to support families and young people to find safe and practical housing options and plan pathways to independence. The innovative Supported Lodgings Scheme means that young people and care leavers can live in a supportive home until they are ready to move on into other housing options.

3.2 LOOKING AHEAD TO 2014-2018

Homelessness and homelessness services and support were reviewed in 2013 and fed into the Council's Joint Strategic Needs Assessment (JSNA) which is a 'live' document on the Council's website. In the three years from 2010 - 2013, 272 families and single people were homeless and entitled to a 'main housing duty' which means that the Council had to make sure that they were provided with settled housing. These households became homeless for a variety of reasons, the main three are leaving the home of parents/relatives or friends, loss of a rented accommodation and violence or harassment as shown below:



Main reasons for Homelessness April 2010 – April 2013

Only homeless people with a 'priority need' are entitled to the 'main housing duty'. The three main reasons for having priority need amongst those entitled to the main housing duty were having dependent children or being pregnant, having a mental or physical disability and being a young person aged 16 or 17 or a care leaver.

The Joint Strategic Needs Assessment also includes an impact assessment of welfare reform JSNA Welfare Reform. It indicates that the number of people affected could include around11000 Council Tax Support recipients and 770 under occupying Housing Benefit recipients. Associated risks for this group include worsening health outcomes, particularly mental ill health, domestic abuse, family breakdown, fuel poverty, debt and homelessness. Ten local priorities have been identified for the next five years of Homelessness Strategy emerging from the review and JSNA:

PRIORITY 1 IDENTIFY PEOPLE MOST AT RISK OF DOMESTIC VIOLENCE AND PREVENT HOMELESSNESS

Domestic violence is the third most common reason for women with children becoming homeless. **Southside** is a charity that works with children and families with multiple and complex difficulties in Bath and North East Somerset, to help them get the care and support they need. 90% of victims of domestic violence reported to Southside are social housing tenants and reported incidence of domestic violence is increasing. (From July 2009 to June 2012 the number of referrals to Southside have increased by 41%). JSNA Domestic Abuse

PRIORITY 2 IMPROVE HOUSING ADVICE AND SUPPORT FOR PEOPLE LIVING IN RURAL AREAS

Around 14% of Bath and North East Somerset residents live in dispersed rural areas or villages. The cost and difficulties of accessing centralised services is a particular problem for older people, families with young children and young people. Between 8-18% of low income households live in areas outside of the market towns and Bath city and it is likely that these populations will experience similar risks to those living in larger, more deprived communities. JSNA Rural Areas

PRIORITY 3 TARGET MORTGAGE RESCUE ADVICE AND ASSISTANCE AT LOW INCOME HOUSEHOLDS

32.1% of the resident population own their homes with mortgages or shared ownership. We are seeing gradual increases in rates of mortgage repossession locally and risks are greatest for owner occupiers with lower incomes and with less employment security. Typically, these mortgagors will have less or no capital resources and will risk becoming homeless without good advice and assistance that helps them to keep their home. JSNA House Prices and Tenure

PRIORITY 4 TARGET WELFARE ADVICE AT LOW INCOME HOUSEHOLDS LIVING IN SOCIAL HOUSING

Bath and North East Somerset is a popular place to live and most people who live here enjoy a good standard of living. Within the area, however, are distinct geographical locations where high densities of social housing correspond with multiple deprivations ranking amongst the worst 20% in the country. Two in every three social housing tenants are in receipt of either full or part Housing Benefit for housing costs. Under welfare reforms, Housing Benefit payments will be rolled into a single Universal Credit payment for recipients to manage. JSNA Socio-Economic Inequality

PRIORITY 5 PREVENT EVICTIONS OF SOCIAL HOUSING TENANTS IN THE FIRST YEAR OF NEW TENANCIES

44 households have been evicted from Curo tenancies in the previous 3 years (April 2010-March 2013). All evictions have been on grounds of rent arrears. Last year, the rate of evictions from Curo tenancies doubled (22). Social housing is let intensively to those with greatest housing needs. New working age tenants have less security of tenure as the pattern is for them to have an initial one year starter tenancy followed by a fixed term tenancy reviewed at the end of 5 years. There are signs that the impact of these changes could increase the number of failing social housing tenancies and 'revolving door' homelessness. JSNA Homelessness

PRIORITY 6 REVIEW THE DISTRIBUTION AND TENANT PROFILE OF FAMILY SIZED SOCIAL HOUSING

The resident population in B&NES is getting older and, since 2001 the greatest increases in the ageing population are within the very old (23% increase in age 85+). The age profile of social housing tenants is significantly older than nationally (50% of social rented sector tenants are retirement age compared to 31% nationally). However the demand for social housing is greatest from working age population (90% of households on the Housing Register). The supply of family sized social rented housing is not meeting demand (61% of average annual lettings are 2+ bed homes). We must have a good understanding of how to meet the housing aspirations of older social housing residents so that they can live safely, well and with independence and to free up family sized social housing. JSNA Aging Population

PRIORITY 7 PROTECT HOUSING STANDARDS AND CONDITIONS IN LOW COST PRIVATE RENTED HOUSING

There has been no significant expansion in the provision of social housing locally and the number of private rented sector tenancies has been increasing and is now 18% of all housing in the area. 9.5% of private residential buildings in Bath & North East Somerset are Houses in Multiple Occupation. The

allocation of social housing is targeted at those with greatest statutory housing need, including people to whom there is a 'main housing duty'. We can expect that the demand for lower cost private rented housing might increase amongst those with non-statutory housing needs and that people with lower incomes will be seeking lower cost housing in lower cost areas where landlords are willing to let to Housing Benefit recipients. 34% of private sector tenants are considered to be vulnerable households in 'non decent homes'. JSNA House Conditions

PRIORITY 8 DEVELOP ACCESS TO SHARED RENTED HOUSING FOR SINGLE PEOPLE AGED UNDER 35

Young people are at particular risk of homelessness and 50% of homelessness applications in Bath and North East Somerset are from people aged under 25. Young people are newly independent and relatively inexperienced at managing household expenses or finding and keeping a roof over their heads. Changes to Housing Benefit mean that most young people (except those who have lived in supported accommodation) will only be entitled to shared housing rates until the age of 35. Failure to find and keep shared housing may increase the number of homeless young people. JSNA Children and Young People

PRIORITY 9 PROVIDE SUITABLE TEMPORARY ACCOMMODATION AND STOP USING BED & BREAKFAST

The combination of early and effective homelessness prevention services and provision of a range of good quality suitable temporary accommodation means that we have only placed 16 households, of which 4 are young people in B&B each year since 2010 (annual average 2010 -2013) Although we try to avoid the use of B&B it can sometimes be used for people with complex needs or homelessness applications and 13 households (2 families, 3 young people and 8 singles aged 25+) have spent longer than 6 weeks in B&B. We accept that lliving in B&B is not a good option for families with children, young people or those with a mental or physical disability. JSNA Homelessness

PRIORITY 10 REVIEW ROUGH SLEEPER SERVICES AND ADAPT TO MEET CHANGES IN DIVERSITY

Demand for the Nightshelter and associated services for rough sleepers are high. The total number of people using B&NES Nightshelter is increasing every year and doubled from 2011/12 (75) to 2012/13 (146). Only a small proportion of service users are women however the number of women using the service trebled from 2011/12 (9) to 2012/13 (27). Around 60 % of service users are aged 36 or older. More than half of new service users come from other areas and the percentage of out of area service users is increasing every year. JSNA Homelessness

4 DELIVERY PLAN – 2014 2018

The Delivery Plan is focused on making an impact on the ten local priorities and working towards achieving the Gold Standard administered by the National Practitioner Support Service. The ten improvement areas set out in the Gold Standard are:

Adopt a Corporate commitment to prevent homelessness which has buy in across all local authority services
Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs
Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme
Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually to be responsive to emerging needs
Offer a Housing Options prevention service to all clients including written advice
Have Housing pathways agreed or in development with each key partner and client group that include appropriate accommodation and support
Develop a suitable private rented sector offer for all client groups, including advice and support to both client and landlord
Not place any young person aged 16 or 17 or families in Bed and Breakfast (unless in an emergency and for no longer than 6 weeks)
Adopt a No Second Night Out model or an effective local alternative

PRIORITY	Who will do it	Outcome
Priority 1 Identify people most at risk of domestic violence and prevent homelessness	Health and Wellbeing Board Homelessness Partnership	Victims of domestic violence have access to advice and homelessness interventions.
Priority 2 Improve housing advice and support for people living in rural areas	Economic and Community Development Policy Development and Scrutiny Panel Homelessness Partnership JCP/ VCS Training and Education Providers Registered Social Landlords	Low income and workless have access to good quality education, volunteering and employment opportunities and needs are included in corporate Economic Strategy. People with mental or physical difficulty get positive message about getting into work.
Priority 3 Target mortgage rescue advice and assistance at low income households	Supporting People and Communities	Low income mortgagors have access to advice and interventions.
Priority 4 Target welfare advice at low income households living in social housing	Supporting People and Communities Homelessness Partnership Housing Services	Low income social housing tenants have access to advice and interventions. Single people as well as families in need are given a comprehensive prevention service, steps to improve the service through Peer-led Practitioner Prevention Partnership developed by the National Homelessness Advice Service.
Priority 5 Prevent evictions of social housing tenants in the first year of new tenancies	Registered Providers (Curo) Housing Services	New social housing tenants have access to first year tenancy advice and interventions. Pre-eviction protocols reviewed. Homesearch applicants have access to Enhanced Housing Options Services
Priority 6 Review the distribution and tenant profile of family sized social housing	Supporting People and Communities Registered Providers (Curo) Housing Services Homelessness Partnership	Family sized and retirement social housing mapped and gapped. Accommodation needs of locally targeted offenders met by having clear processes in

	lead agencies for delivering local initiatives and accommodation pathways in relation to young people, ex-offenders and people with drug, alcohol mental health needs	place (using the published Integrated Offender Management key principles to set out the advantages of a wide partnership involvement). Accommodation needs of homeless people met by improving hospital admission and discharge (Improving Hospital Admissions and Discharge for People who are Homeless 2012, a joint report from Homeless Link and St Mungos. Commissioned by the Department of Health)
Priority 7 Protect housing standards and conditions in low cost private rented housing **Priority 8 Develop access to shared rented housing for single people aged under 35**	Housing Services Supporting People and Communities Private rented sector landlords and lettings agencies	Young people aged under 35 have access to good quality shared housing.
Priority 9 Provide suitable temporary accommodation and stop using Bed & Breakfast	Supporting People and Communities Mediation Service Supported Lodgings Service and Providers Registered Providers	Prevent blocking of supported accommodation and advice services by improving pathways and options for people with high needs or assessed risk
Priority 10 Review rough sleeper services and adapt to meet changes in diversity	Local Authority and VCS Senior Managers managing services that come into contact with homeless Homelessness Partnership	Rough sleepers are sign posted to services by street cleaners/waste collectors. Diversity (particularly of women and older homeless) and out of area needs mapped and gapped.

This document about the Homelessness Strategy 2014-2018 can be made available in a range of languages, large print, Braille, on tape, electronic and accessible formats from:

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	Homelessness Strategy 2014-2018
Name of directorate and service	Adult Social Care, Health and Housing Housing Services
Name and role of officers completing the EIA	Mike Chedzoy: Housing Options and Homelessness Manager Sue Wordsworth: Planning and Partnership Manager Amanda Taylor: Homelessness Review and Policy Officer
Date of assessment	

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

1.	Identify the aims of the policy or service and how it is implemented.	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	The Homelessness Strategy prevents homelessness and protects vulnerable homeless people by • mainstreaming homelessness prevention across council and key partnership services • tackling local priorities • performance targets leading to the government's Gold Standard for Homelessness Prevention. Homelessness prevention services are delivered by the council's Housing Options and Homelessness Team and many other service providers and third sector organisations who are members of the Homelessness Partnership.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	Homelessness Prevention Services have been in place since the Homelessness Act 2002 made it a national requirement that all housing authorities to have a homelessness strategy based on a 5 yearly review of all forms of homelessness in their district. The 5 yearly review was carried out in 2013. Ten local homelessness prevention priorities were identified: Priority 1 Identify those most at risk of domestic violence and enable early interventions to prevent homelessness Priority 2 Improve housing advice, information and support for people living in rural areas Priority 3 Target mortgage rescue advice and assistance at low income households. Priority 4 Target welfare and money management advice at low income households living in social housing.

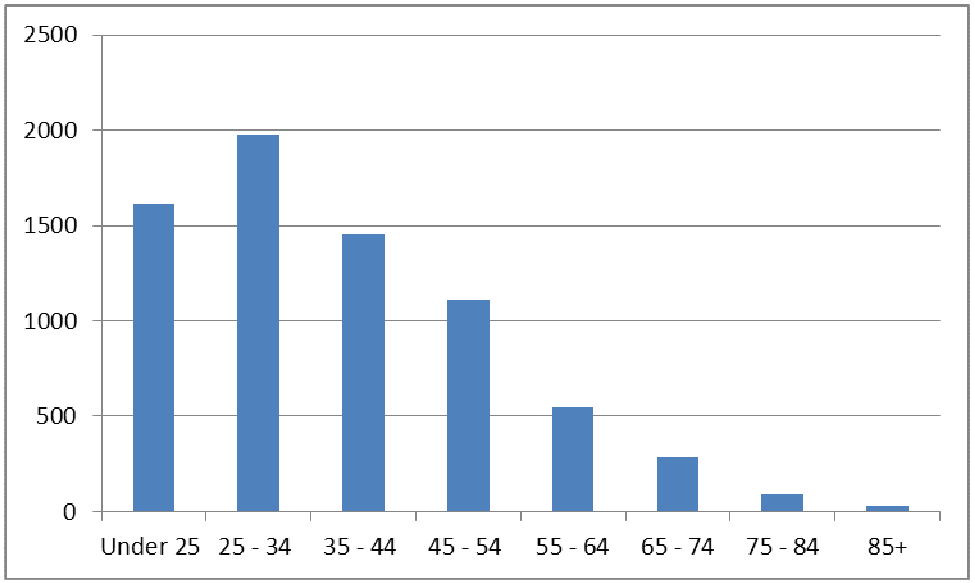
		Priority 5 Prevent evictions of social housing tenants by reviewing pre-eviction protocols and ensuring adequate support in the first year of new tenancies. Priority 6 Review the housing aspirations of older social housing residents to enable safe and independent living and potential for freeing up family sized social housing. Priority 7 Protect housing standards and conditions in low cost private rented housing. Priority 8 Develop private sector access schemes to facilitate shared rented housing for single people aged under 35. Priority 9 Provide suitable temporary accommodation and stop using Bed & Breakfast except in emergencies and then for less than 6 weeks. Priority 10 Review the housing needs of women and older rough sleepers, rough sleepers with no local connection and people with complex needs and improve their accommodation pathways and options.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	The Homelessness Strategy links to: Sustainable Community Strategy 2009-26 Joint Health and Wellbeing Strategy 2013 Housing and Wellbeing Strategy 2010-15 Tenancy Strategy 2012 Allocations Scheme 2013 This Homelessness Strategy will directly contribute to the Health and Wellbeing Board's priority themes: • Helping people to stay healthy • Improving the quality of people's lives • Creating fairer life chances

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	Homelessness prevention services are delivered by several provider organisations whose equalities profile is not known. The equalities profile of B&NES housing services is broadly similar to the equalities profile of B&NES population. (With the exception of gender likely to be caused by higher rates of part time women housing officers).
2.2	What equalities training have staff received?	Housing officers must attend corporate Equalities Training or be trained in Equalities at appropriate level. Equalities training must be updated every 3 years.
2.3	What is the equalities profile of service users?	Equalities profile main applicant seeking homelessness prevention advice (Council Services) October 2007-October 2013 Sex: 55% Female 45% Male Disablity: 18% Disability Age:



Ethnicity:

Prefer not to say/unavailable	175
Asian - Pakistani	3
Asian - Bangladeshi	35
Asian - Indian	20
Asian - Other	46
Black - African	61
Black - Caribbean	65
Black - Other	51
Chinese	10
Dual Heritage - Asian	16

		Dual Heritage - Black African: 22 Dual Heritage - Black Caribbean: 61 Dual Heritage - Chinese: 2 Dual Heritage - Other: 32 Dual Heritage - White: 15 Eastern European: 38 Gypsy/Irish Traveller: 8 Other: 48 South East Asian: 12 White - British: 6104 White - Irish: 39 White - Other: 273
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	**Young People:** Leaving the home of parents, friends or relatives is the **main reason for homelessness** locally. The resident population has increased by 4% since 2001 and a significant proportion is young adults aged 15-24, many of them students (17% compared to 13% nationally). **Older People:** The age profile of social housing tenants is significantly **older than nationally** (50% of social rented sector tenants are retirement age compared to 31% nationally). However the demand for social housing is greatest from working age population (90% of households on the Housing Register). **Social housing tenants:** Within the area, however, are distinct geographical locations where there are high densities of social housing and greatest likelihood of **multiple deprivations**. Two in every three social housing tenants are in receipt of either full or part **Housing Benefit** for housing costs. The **age profile** of social housing tenants is significantly **older** than nationally (50% of social rented sector tenants are retirement age compared to 31% nationally). **Women:** Only a small proportion of nightshelter service users are women however the number of women using the service trebled from 2011/12 (9) to 2012/13 (27). **Domestic violence …is the third most common reason for becoming statutorily homeless** amongst people who have a

		priority need for housing. **Rough Sleepers**: Demand for the nightshelter and associated services for rough sleepers are high. The total **number of service users is increasing every year** and doubled from 2011/12 (75) to 2012/13 (146). Rough sleepers characteristically have mental and/or physical ill health. Around 60 % of nightshelter service users are aged 36 or older.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	A programme of extensive consultation has been implemented throughout the development of the Draft Homelessness Strategy. It commenced with initial planning meetings with a wide range of organisations that form the local Homelessness Partnership in early 2013. A Welfare Reform conference was subsequently facilitated by Housing Services and the Homelessness Partnership in March 2013. The conference enabled key stakeholders to consider local challenges and contribute to forming a draft Homelessness Strategy. The draft Homelessness Strategy was approved by the Homelessness Partnership and presented to the Health and Wellbeing Board in September 2013. A formal open public consultation on the draft Homelessness Strategy was endorsed by the Board and launched on 28 September running until 6 November 2013. The consultation together with the draft strategy and evidence base was posted on the council website. Everyone who attended the welfare reform event, homelessness service providers, key local authority service managers all councillors on the exchange and all parish councillors were invited to contribute to the consultation. Comments from the Board and other respondents led to amendments and improvements in the strategy, for example a greater emphasis on the health impacts of homelessness. A strategic core group of the Homelessness Partnership met on 7 November to review the amended strategy and their comments have been taken into account in the final version of the strategy that is presented to Cabinet.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	None planned
3. Assessment of impact: 'Equality analysis'		

	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups		
		What steps have been or could be taken to address the negative/adverse impacts	**Examples of actual or potential negative or adverse impact**
3.1	**Gender** – identify the impact/potential impact of the policy on women and men.	Priority 10 Review the housing needs of women … rough sleepers, … Priority 1 Identify those most at risk of domestic violence and enable early interventions to prevent homelessness	Potential adverse impact if nightshelter services are not tailored to meet women's specific needs. Potential adverse impact if domestic violence preventative services are not in place.
3.2	**Pregnancy and maternity**		No adverse impact
3.3	**Transgender –** – identify the impact/potential impact of the policy on transgender people		No adverse impact
3.4	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration both physical and mental impairments)	Priority 10 Review the housing needs of …rough sleepers with …complex needs and improve their accommodation pathways and options. Review pathways into employment for people with mental or physical disability	Potential adverse impact if rough sleepers fail to access health and employment services.
3.5	**Age** – identify the impact/potential impact of the policy on different age groups	Priority 8 Develop private sector access schemes to facilitate shared rented housing for single people aged under 35. Prevent youth homelessness by producing an evidence-based document which sets out	Potential adverse impact on Housing Benefit claimants aged 34 and under (entitled to shared accommodation rates). Potential adverse impact on older social housing tenants if housing needs are unmet.

		effective local approaches Priority 6 Review the housing aspirations of older social housing residents to enable safe and independent living … Priority 10 Review the housing needs of … older rough sleepers…and improve their accommodation pathways and options.	Potential adverse impact on older rough sleepers if housing and other needs are unmet.
3.6	**Race** – identify the impact/potential impact on different black and minority ethnic groups		No adverse impact
3.6	**Sexual orientation -** identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people		No adverse impact
3.7	**Marriage and civil partnership –** does the policy/strategy treat married and civil partnered people equally?		No adverse impact
3.8	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion.		No adverse impact
3.9	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood, employment status can influence life chances	Priority 3 Target mortgage rescue advice and assistance at low income households. Priority 4 Target welfare and money management advice at low income households living in social housing. Priority 5 Prevent evictions of social housing tenants by reviewing pre-eviction protocols and ensuring adequate support in the first year of	Potential adverse impact on low income, unemployed households if a)homelessness prevention services are inaccessible. b)standards in low cost private rented housing are driven down Potential adverse impact on new social housing tenants if introductory tenancies fail.

		new tenancies. Priority 7 Protect housing standards and conditions in low cost private rented housing.	
3.10	**Rural communities** – identify the impact / potential impact on people living in rural communities	Priority 2 Improve housing advice, information and support for people living in rural areas	Potential adverse impact on rural communities because access to advice and homelessness prevention services is more difficult.

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

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

	Issues identified	Actions required	Progress milestones	Officer responsible	By when
1	All the issues identified in this Equalties Impact Assessment are included in the Homelessness Strategy Action Plan	The Homelessness Strategy Delivery Plan will be implemented in 2014 enabling agencies to work together to address the local priorities and issues.	Annual progress review	Housing Options and Homelessness Manager	December 2014

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

Signed off by: (Divisional Director or nominated senior officer)
Date:

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Bath & North East Somerset Council		
MEETING:	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING DATE:	**22nd November 2013**	
TITLE:	**Alcohol Harm Reduction Scrutiny Inquiry Day**	
WARD:	**All**	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 Report: A review into alcohol harm reduction in B&NES Appendix 2 Recommendations Response table Appendix 3 Equalities Impact Assessment		

1 THE ISSUE

1.1 In March 2012, the Government launched its Alcohol Strategy that included new powers for local authorities from April 2012. Licensing and health bodies became responsible authorities under the Licensing Act 2003. They are now notified of applications or reviews; and can instigate a review of a licence. From Oct 2012, local authorities' also have powers to introduce Early Morning Restriction Orders (to restrict alcohol sales if a problem) and the Late Night Levy (from businesses to cover the cost of policing and local authority action).

1.2 In April 2012, the cabinet adopted the refreshed B&NES Alcohol Harm Reduction Strategy. The key themes were: health & treatment, community safety, crime and disorder, children and young people as well as partnership working. A steering group was tasked with responsibility for implementation.

1.3 The purpose of the scrutiny inquiry day was to provide the opportunity to formulate policy approaches with relevant experts and stakeholders on the B&NES Alcohol Harm Reduction Strategy, with a view to refreshing its desired outcomes; and the new powers being introduced through the Government's Alcohol Strategy.

1.4 Cllr Brett, Vice Chair of the Planning, Transport & Environment (PTE) Panel led a steering group with councillors representing four PDS panels: Early Years, children & Youth (EYCY), Planning, Transport & Environment (PTE), Economic & Community Development (ECD) and Wellbeing.

1.5 The Wellbeing PDS Panel may be aware that the Health and Wellbeing Board have identified alcohol as a key priority within the Joint Health and Wellbeing Strategy (full sign off expected in November 2013).

2 RECOMMENDATION

At the Wellbeing Policy Development & Scrutiny Panel on the 22nd November 2013, the Panel are asked to:-

2.1 Consider and make any further comments on the findings of the final Alcohol Harm Reduction Scrutiny Inquiry Day report; and to

2.2 Consider the recommendations response table which will be received by the Cabinet Member for Wellbeing, Simon Allen; Cabinet Member for Sustainable Development, Ben Stevens; Cabinet Member for Neighbourhoods, David Dixon and the Cabinet Member for Early Years, Children & Youth, Dine Romero as detailed in Appendix 2 to this report.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The review was completed within the resources available to the four Policy Development and Scrutiny Panels involved in this joint scrutiny work; namely Early Years, children & Youth (EYCY), Planning, Transport & Environment (PTE), Economic & Community Development (ECD) and Wellbeing.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Equalities issues were considered by the Panel as part of their work in formulating the scope of this proposed investigation and further equalities work was undertaken during the course of consultation. Appendix 3 provides the full Equalities Impact Assessment for this work

4.2 The Council has a statutory duty to promote the health & wellbeing of the inhabitants of its area and reduce inequalities amongst its population. This PDS scrutiny work seeks to present evidence of how alcohol harm impacts local communities. The work also seeks to identify those initiatives that would help reduce alcohol harm.

4.3 Under the Crime & Disorder Act 1998, the Council has to have regard to the need to reduce crime and disorder in exercising any of its functions. In seeking to reduce the impact of alcohol harm, the Council will be meeting this obligation.

5 THE REPORT

5.1 The full report for this review is attached at Appendix 1.

6 RATIONALE

6.1 Appendix 2 provides the Recommendations Response Table for this work

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

8.1 Ward Councillors; Cabinet Member; Parish Councils; Town Councils; Policy Development and Scrutiny Panels; Staff; Other B&NES Services; Local Residents; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer

8.2 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.

9 RISK MANAGEMENT

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

Contact person	Emma Bagley/ Liz Richardson ext: 6410 / 6053
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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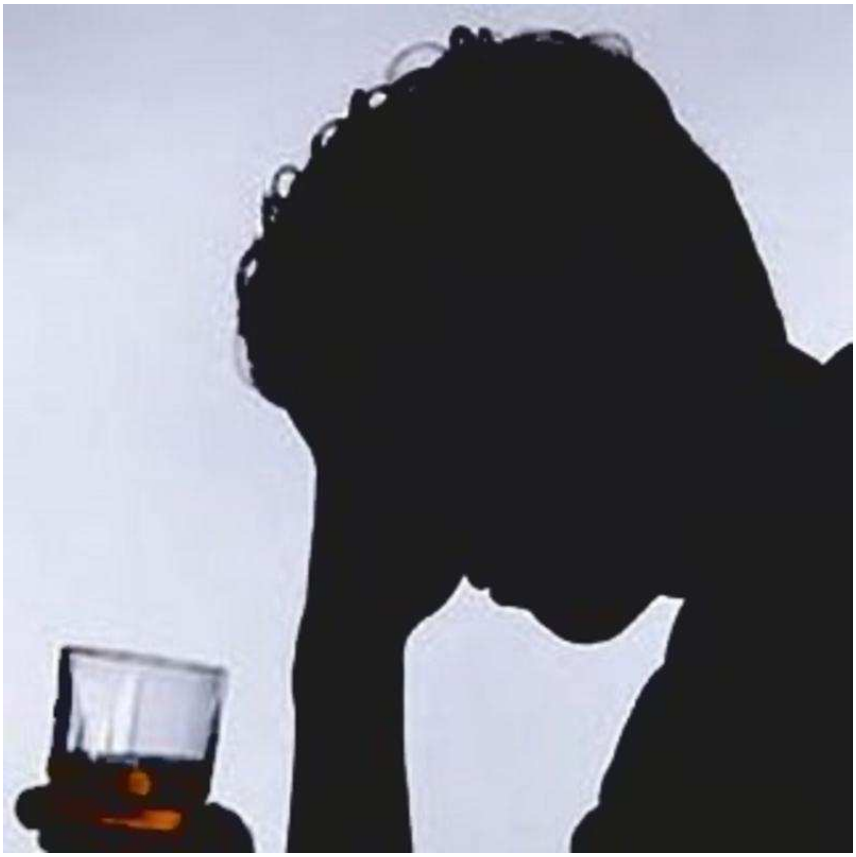
Bath & North East Somerset Council

A review into alcohol harm reduction in B&NES



Steering Group Members
Cllr Lisa Brett, Cllr Vic Pritchard, Cllr Robin Moss, Cllr Liz Hardman and Cllr Marie Longstaff

Project Officers
Emma Bagley, Donna Vercoe, Liz Richardson, Sue Dicks, Cathy McMahon, Kate Murphy and Andrew Jones

E-mail: scrutiny@bathnes.gov.uk
Tel: 01225 396053

Foreword

Bath & North East Somerset (B&NES) is a great place to live, work and visit. Our Council is committed to encouraging thriving communities and enabling residents to enjoy fulfilling lives. We recognize that feeling healthy and safe is an import aspect of this.

While most people in B&NES enjoy moderate alcohol consumption, for a minority of others excessive consumption can present a risk to their health, to their families and to the wide community. By seeking to tackle the challenge of irresponsible drinking, we hope to ensure people enjoy better health, better relationships and suffer less fear of crime and anti-social behavior.

We know that tackling alcohol harm cannot happen in isolation and as resources contract, targeted work to tackle concerns needs to be a priority not just for the Council but also in our communities, with our strategic partners and the voluntary sector.

This project has allowed councillors and stakeholders the opportunity to examine a range of data, evidence and best practice around the three main themes of health / wellbeing, community safety and licensing / environment. By considering this information we:

- Listened to what is happening
- Learnt about what can be done to make things better
- Made policy proposals that will make a difference

We would like to particularly thank the Community Alcohol Partnership and Midsomer Norton Town Council for sharing their experiences, and allowing their voices to be included in our work.

We would like to thank all of the participants who took the time to attend our Scrutiny Inquiry Day (SID). We would also like to extend our thanks to the service officers who have supported us through this investigation.

- Cathy McMahon – Development and Commissioning Manager, Public Health
- Andrew Jones – Environmental Monitoring and Licensing Manager
- Sue Dicks – Community Safety Manager, Strategy and Performance
- Kate Murphy – Drugs and PSHE Advisor
- Emma Bagley – Policy Development and Scrutiny Project Officer
- Liz Richardson – Policy Development and Scrutiny Project Lead Officer
- Donna Vercoe – Policy Development and Scrutiny Project Lead Officer

We fully support the recommendations within this report and hope that progress can be made soon to reduce alcohol harm.

Councillor Lisa Brett
Lead Councillor, Alcohol Harm Reduction SID Steering Group
Vice Chair, Planning Transport and Environment
Policy Development & Scrutiny Panel

Contents

What is Policy Development & Scrutiny?

Overview and Scrutiny is the name given in legislation to the system of checks and balances implemented by all other councillors as they monitor the activity of the Cabinet and assist them in developing and reviewing policy. In Bath & North East Somerset Council, this is known as Policy Development and Scrutiny. Policy Development and Scrutiny is intended to review the work of the Cabinet and to enhance the performance of services. It is also designed to provide a forum through which policy review and policy development can be extensively examined before consideration and decision by the Cabinet and/or Full Council.

There are six Policy Development and Scrutiny Panels which meet approximately six to seven times a year and oversee a specific area of work, generally matching the Cabinet portfolios. These panels are:

- Early Years, Children and Youth
- Economic and Community Development
- Housing and Major Projects
- Planning, Transport and Environment
- Resources
- Wellbeing

Executive Summary

The alcohol harm reduction review is a joint panel task. The relevant Policy Development and Scrutiny Panel (PDS) panels are: Planning, Transport and Environment (PTE); Early Years, Children and Youth (EYCY); Economic & Community Development (ECD) and Wellbeing PDS Panels. The lead councillor for this review was Cllr Lisa Brett.

Following a data audit, a Scrutiny Inquiry Day was held. 68 councillors, officers, stakeholders and residents attended the day. Delegates heard evidence and information from officers and stakeholders about what work is currently being done to prevent, address and reduce the impact of the misuse of alcohol. Delegates sought to deliberate over policy initiatives on both the new powers being introduced through the government's alcohol strategy and the locally-targeted B&NES alcohol harm reduction strategy. Statements from residents and various organisations augmented the experience. A facilitated workshop was dedicated to identifying potential recommendations for changes in local policy.

Following this review, ten recommendations are proposed within the following themes:

- More education programmes that encourage a voluntary shift in attitude to alcohol
- Improved and more frequent alcohol screening mechanisms
- Targeted interventions that deal with adverse effects of alcohol
- Greater emphasis on prevention of alcohol harm through national and local policy
- A local licensing policy that considers a broader range of issues and impacts
- More accessible training that emphasises issues and effects of alcohol harm
- Improved engagement at local level though more positive and proactive information sharing and publicity
- Communities that are safer from alcohol harm
- Communities that are safer from outcomes of alcohol harm

Recommendations

More education programmes that encourage a voluntary shift in attitude to alcohol

1 To continue working in partnership with commissioned and statutory service providers to deliver a long-term education programme for professionals, parents and young people on the causes and effects of alcohol harm. In particular, develop targeted education programmes for specific vulnerable groups, including:

a. younger children by encouraging schools to start introducing topics sensitively from primary school age;

b. young people by encouraging schools to facilitate further work through Personal Social Health Education. To help facilitate this work it will be important to have a better knowledge of the causes of self-harm through alcohol use. To commission a piece of work that extends current knowledge and builds on previous SHEU evidence. This work to report back to the Wellbeing / EYCY PDS Panel;

c. older 'working age' population by supporting current initiatives of public protection; and

d. parents by public health working together with schools. (EYCY / Wellbeing)

Improved and more frequent alcohol screening mechanisms

2 Develop and implement a quick screening method within front line services (including primary care such as pharmacies and waiting rooms - although potential scope for acute settings too). Build on the existing AUDIT tool by exploring a potential 'app', scratch cards, themed bar mats or self-assessment pro-forma. (Wellbeing)

Targeted interventions that deal with adverse effects of alcohol

3.1 Build on in-situ interventions and street treatments in order to tackle isolated instances of inebriation in the night time economy. Support the ACPO initiative of 'drunk-tanks', and express an interest in hosting a pilot service in B&NES. (Wellbeing)

3.2 To provide 'wet house' supported accommodation for patients requiring longer term health and social care rehabilitation or interventions. This recommendation to be implemented where there is the demand and an evidence base for this (Wellbeing)

4 Encourage improved workplace health by developing a simple toolkit that local employers can use in the workplace. This initiative seeks to raise awareness about alcohol use in employees. (Wellbeing)

Greater emphasis on prevention of alcohol harm through national policy

5 Health to be embedded as an alcohol licensing objective. The government to be lobbied about incorporating this into licensing legislation via the LGA. (PTE)

A local licensing policy that considers a broader range of issues and impacts

6 Refresh the B&NES licensing policy to acknowledge prevention of alcohol harm with such inclusions as:

a. A vision of what B&NES' night time economy will look like (including an overview of cultural expectations). This high-level vision to be supplemented by district level aspirations (such as Bath, Keynsham, Midsomer Norton, Radstock etc.);

b. Early Morning Restriction Orders in areas based on resident demand;

c. Appraisal of Cumulative Impact (CI) zones;

d. Consideration of 'dry streets' where a community wishes to exclude licensed alcohol traders completely;

e. The option of including a condition in a license around minimum unit pricing, high strength alcohol restrictions and/or irresponsible promotions where the evidence suggests this would be appropriate; and to

f. Incorporate health into licensing policy at a local level. (PTE/ ECD)

More accessible training that emphasises issues and effects of alcohol harm

7.1 Establish and deliver a local Best Bar None training scheme for trade staff. (PTE)

7.2 B&NES to express an interest in applying a business rate rebate to those premises successfully participating in the Best Bar None scheme. (PTE)

Improved engagement at local level though more positive and proactive information sharing and publicity

8 Improve the information available to residents about making complaints and contributing to licensing reviews.

Refresh existing information about licensing contacts and processes in the B&NES Connect magazine and on the B&NES website.

Consider a 24hr answerphone line to gather evidence from residents about licensing concerns. Promote a direct telephone line within licenced premises if a customer wants to raise a concern or report issues. (PTE)

Communities that are safer from alcohol harm

9.1 Build on existing work to prevent anti -social behaviour. Contain early issues through strong and clear enforcement presence in B&NES. Continue existing measures such as street marshals and police presence in ‘hot spots’; as well as appropriate licensing enforcement action. Encourage greater information sharing between the police and council (e.g.101 and street marshal data) to guide enforcement. (PTE/ECD)

9.2 Extend existing initiatives, or foster new approaches in encouraging collective working between all alcohol traders (both on and off-trade). Encourage communication between businesses to allow them to work together optimally and, take a firm approach on sale of alcohol to people inebriated (legislation places licensees responsible for selling alcohol in this manner).. (PTE/ECD)

Communities that are safer from outcomes of alcohol harm

10.1 Encourage more integrated community safety work by rolling out further Community Alcohol Partnerships (CAPs) where underage drinking is a problem and residents want a CAP. (ECD)

10.2 Tackle alcohol-fuelled domestic violence and abuse by exploring ways of introducing a CAP style model of integrated working across B&NES.

To develop existing work by the council as part of the public service transformation network. Funding could potentially be earmarked through the community budget that covers this area of work. (ECD)

Introduction

In March 2012 the government launched its alcohol strategy that included new powers for local authorities from April 2012. Licensing and health bodies become responsible authorities under the Licensing Act 2003. As a result, they are now notified of applications / review and can instigate a review of a licence. From Oct 2012, local authorities' also have powers to introduce Early Morning Restriction Orders (EMROs) (to restrict alcohol sales if a problem) and the Late Night Levy (LNL) (from businesses to cover cost of policing and local authority action).

During April 2012 the cabinet adopted and set key priorities of the refreshed B&NES alcohol harm reduction strategy. The key themes were: health & treatment, community safety, crime and disorder, children and young people, partnership working. A steering group would be responsible for implementation. In May 2012, the Wellbeing PDS Panel received a briefing on B&NES alcohol harm reduction strategy. Later in 2012, initial terms of reference for a SID set out to review and refresh the B&NES alcohol harm reduction strategy, and to consider how the new powers from the government's alcohol strategy would impact. The work would also aim to feed into a government consultation which included topics such as minimum pricing.

Then in Oct 2012, new powers of licensing become available to local authorities. The Government also held a consultation on alcohol harm that closed in February 2013. Following from these events, the existing steering group decided during May 2013 that the need to address alcohol harm reduction remained, but the work needs input from different panels. A new steering group was assigned and carried this project forward.

In tandem, the Health and Wellbeing Board also identified alcohol as a key priority within the joint health and wellbeing strategy. This is due for sign off in November 2013.

Purpose and Objectives

The purpose of the scrutiny inquiry day was 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.

The key objectives of the SID were:

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. For example, the use of other new powers including extended EMROs for businesses in B&NES;

2. To examine existing evidence in order to identify the harm caused by alcohol in B&NES. 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.

Methodology

Phase One: Data review

A data review was made at the start of this work. The aim of this task was to identify relevant data and to meet any gaps in kowledge ahead of the SID. For example to ensure that the necessary data was available to support decision making and allow best practice to be heard. Sourced data was used during the presentations for the SID, and a sample of this is included under findings and in the associated Appendices.

Phase Two: SID

A SID was held on 10th October 2013 for delegates to hear evidence and information from officers and stakeholders about what work is currently going on to prevent, address and reduce the impact of the misuse of alcohol. Delegates deliberated over policy initiatives on both the new powers being introduced through the government's alcohol strategy and the locally-targeted B&NES alcohol harm reduction strategy. Part of the day was also dedicated to identifying potential recommendations for changes in local policy.

A range of stakeholders were invited to attend the SID. These included various B&NES councillors and officers, health and housing service providers, healthwatch, emergency services, business and trade representatives, schools and colleges, universities, resident associations and town / parish councils. To ensure we reached the right audience, two press releases were issued; one aimed toward the trade, and the other towards residents. A twitter feed was used to connect with social media users who may not read routine print publishing.

68 councillors, officers, stakeholders and residents attended the day. Delegates represented the following organisations:

- Avon and Somerset Police
- AWP NHS Trust
- B&NES Council Officers and Councillors
- Banwell House Pub Company Ltd
- Bath Spa University
- BRA
- Combe Hay Parish Council
- Community Alcohol Partnership
- Developing Health and Independence
- Federation of Bath Residents' Associations
- Faith Forum
- Julian House

- Keynsham Town Council
- Midsomer Norton Town Council
- PERA
- Project 28
- Public Health England
- Pub Watch
- Residents
- Royal United Hospital
- Sirona Care and Health
- Southside
- South Western Ambulance Service
- University of Bath

The SID received a mixture of presentations during the first half of the day that raised many questions, and set the points for discussion at the workshop sessions later. The presentations included:

- ***A key note address*** on the purpose and background to the SID by Cllr Brett and Bruce Laurence (Director public health).
- ***Health / wellbeing*** (Wellbeing PDS panel with input from the EYCY PDS panel): Cathy McMahon (Public Health), Kate Murphy (Drugs and PSHE advisor), Jodie Smith (Health improvement), Carol Stanaway (Substance misuse commissioner) contributed to a presentation around health and wellbeing factors.
- ***Community safety*** (ECD PDS panel): Sue Dicks (Community safety manager), Russell Sharland (Partnership officer, Community Alcohol Partnership) and Councillor Dunford (Midsomer Norton Town Council) provided a useful overview of community safety factors.
- ***Licensing / environment*** (PTE PDS panel): Andrew Jones (Licensing manager), Kirsty Morgan (Licensing officer) and Alan Bartlett (Principal licensing officer) gave an overview of licensing / environment factors for consideration.

Following each presentation, delegates had the opportunity to ask questions about topics of interest. This provided every possible opportunity for everyone's views and thoughts to be shared with the rest of the group.

Statements were also invited for those who wished to submit them.

Findings

This section of the report will give an overview of the SID presentations, and draw out particular findings from each.

<u>Key note address</u>

Cllr Brett welcomed delegates and outlined the purpose of the SID. She said the aim of the event was to agree strategic priorities for alcohol harm reduction, identify best practice, build on lessons learnt and to identify deliverable and cost effective solutions.

Bruce Laurence gave a view of why alcohol is a public health issue and some historical context. He spoke of the risks and benefits of alcohol use. Bruce presented a range of statistics

describing the impacts that alcohol has locally and nationally. He reported drinking patterns in B&NES that show an estimated 5100 people are dependent on alcohol, 5500 are at high risk and 29,300 are at increasing risk of harm from alcohol misuse. Graphs of annual mortality due to liver disease, consumption of alcohol and B&NES alcohol related hospital admissions are given in Appendix 3 (see Graphs 1-4). Bruce suggested a number of ways to reduce harm such as advertising controls and education. To close, he flagged the challenges that include the perceived imbalance between the notional £3m industry advertising budget in B&NES versus the £50K spent on health promotion.

Health and wellbeing (Wellbeing and EYCY PDS Panels)

The presentation opened with an estimate of the financial costs of alcohol to health and wellbeing. The government alcohol strategy 2012 reports annual estimated costs of alcohol to the NHS (from Department Of Health) as £2.7 billion (2006/07 figures). In B&NES, up to £10.0 million is spent yearly on health care and treatment for alcohol-use disorders. Graph 5, Appendix 3 gives further detail on financial costs to NHS.

The speakers touched on the impact of alcohol harm on young people. In B&NES there is a higher than national average rate of alcohol specific hospital admissions in under 18 year olds. Alcohol specific admissions and attendances are defined as those wholly caused by alcohol. They include mental and behaviour disorders due to alcohol and toxic effects of alcohol. More females than males are reported to be admitted in B&NES, and ethanol poisoning is twice as common in females as in males. Approximately 45% of admissions are to children under 16. A quiz based on the results of the SHEU Survey 2013 provided an insight to drinking experiences of young people:

Table 1: Extract of SHEU survey 2013

School Year (approx. age)	% of year who had an alcoholic drink in the last week
8 (12/13yrs)	13
10 (15yrs)	33

The speaker gave examples of what was being done in B&NES. Whilst approaches such as early intervention and training were already used, there was an appreciation that more work could be done with parents and carers; and also to focus on approaches to tackle girls' drinking.

Media perceptions often focus the effects of alcohol harm on young people. The speaker said most drinking however occurs in the home, with 25% drinking over recommended limits. These people are consuming 75% of all alcohol consumed. A challenging factor is that alcohol use is under estimated and un-detected. There are complex reasons for alcohol misuse: social isolation, bereavement, divorce, illness, unemployment and financial stress. High risk groups are often people in their 30's, 40's and 50's. As the same amount of alcohol can have a more detrimental effect on an older person than on a young person, the reality is that as this generation gets older, the impact on health services could be high.

Part of the presentation focused on alcohol use in older people and the impacts on physical and mental health. In B&NES, an estimated 16% of the working age population have a common mental illness. An estimated £32m is spent on mental health. These figures are in line with national levels, although are slightly higher than comparator areas. People who start drinking at a young age are more at risk of mental impairment because the brain is still developing until the

age of 18 or 19. Interestingly, data showed that over 65's experienced higher rates of admission for mental and behaviour disorders due to alcohol in a 2004 South West survey. A quiz on understanding alcohol units was given to delegates before introducing those interventions and tools currently in use.

Brief advice interventions were described by the speaker. Higher-risk and increasing-risk drinkers were reported to be twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no intervention. Positively, brief advice can reduce weekly drinking by between 13% and 34%. For every 8 people who receive simple alcohol advice, 1 will reduce their drinking to within lower risk levels. In health care terms this is a highly cost effective intervention.

The presentation noted how over 400 frontline health professionals were trained to provide local action in 2012/13. This figure includes GPs, GP registrars, pharmacists, health visitors, social workers, mental health workers and Royal United Hospital medical staff. An estimated £1 spent on treatment was said to save £5 in health and crime costs. A reported 424 adults are in structured treatment (7% up Q1). Graph 4, Appendix 3 shows an increase in alcohol related hospital admissions between 02/3-11/12. In B&NES, the single point of entry, joint treatment and recovery services, RUH, project 28, criminal justice work and support for family and friends were all cited as good local practice. Reported challenges include getting people into treatment earlier, meeting the balance of capacity versus demand as well as meeting the need for rural services.

During the question and answer session one delegate talked of the stresses young people face and the impact this has on them. The speaker recapped on the SHEU data, and explained that young girls' top reported worry is exams, followed by body image, bullying and family issues.

Community Safety (ECD PDS Panel)

The SID heard a range of evidence around the social impacts of alcohol on communities including crime, domestic violence and abuse.

One area of interest to the SID was the impact alcohol has on crime. Data of crimes linked to the night time economy was reported for the period 2008 – 2013 (see Graph 6, Appendix 3). Whilst these figures show a 14% reduction in the number of crimes linked to the night time economy between 2011 and 2012, the decrease was said to be likely caused by a range of factors.

The speaker also touched on the impact of alcohol harm by domestic abuse. Statistics given showed that of 299 referrals to Southside Independent Domestic Violence Advice service between April 2012 to March 2013, 114 referrals were identified as having an issue with substance misuse. Of interest were figures from the B&NES probation team that show a high proportion of supervised offenders who perpetrated domestic abuse between April – December 2012, whose risk is linked to alcohol (61%) (see Graph 7, Appendix 3). Information on referrals was also given from the New Way Service (a social services project working with couples to address issues of domestic violence and abuse). Whilst not a major factor, alcohol was a known factor in 26% of referrals to the service between Jan 2010-Dec 2012 (see Graph 8, Appendix 3).

The presentation gave estimates of the costs of alcohol abuse, alcohol specific crime and community safety to organisations such as the Police and B&NES. For the police and criminal

justice system alcohol specific crime costs were reported to fall into 3 areas: those incurred in anticipation, as a consequence and in response. An estimated £21.3m is spent yearly as a result of crime related to alcohol use disorders in B&NES. £20,000 per year is spent on taxi marshals by B&NES Council. Considerable costs can be associated with an emergency service river rescue: with costs over 6 months in 2009 exceeding £66,000. British Transport Police report costs associated with alcohol misuse too. In 2013, one drunken man fooling around on a rail track resulted in 54 train cancellations and costs of £56,000.

Next a speaker from the Community Alcohol Partnership (CAP) discussed best practice in tackling under-age drinking. CAP schemes draw together education, diversionary activities, enforcement and communication. An interesting 62% of CAP's focus is on friends, parents and the home. In making progress, the CAP may involve wide ranging stakeholders including street pastors, schools, alcohol retailers, licensing and the police. Aligned with this working are Challenge 25 schemes, the Drink aware website, and the Alcohol Education Trust. The presentation reported how positive steps seen through other CAP schemes. St Neots CAP (2007) has seen a 42% decrease in anti-social behaviour. Mid Devon CAP (2010) has seen 170 licensees & staff trained and an anti-fake ID scheme created.

The SID heard evidence from a Midsomer Norton town councillor about their CAP scheme launched in 2012. Following public consultations and a night audit, a range of measures were implemented including street marshals and a Designated Public Place Order ('DPPO'). A DPPO can be used by the local authority where alcohol disorder or nuisance has been experienced. In simple terms, such an order can make it an offence to consume alcohol when required not to do so, or an officer can also ask an individual to surrender alcohol. Police figures from Midsomer Norton report a 21% decrease in reported violence and 81% decrease in reported criminal damage. A quote from the presentation, concerning Midsomer Norton CAP said "We have our town back… for a better, lasting future for all".

During the question and answer session interest was expressed in using the CAP model in several areas of B&NES. The speaker said the model will work where there is the priority. The CAP speaker said the model was a framework where not one size fits all. The workings of a scheme could be tailored to cap resident needs.

Licensing / Environment (PTE PDS Panel)

This presentation gave an overview of the Licensing Act 2003 and the council's role as a licensing authority. Data was given to provide a snapshot of what is happening in B&NES. For example, figures exploring the number of licenses and applications. Whereas the number of licensed premises grew from 686 to 732 in the period 2009 to 2013 (including for example on and off trade as well as club certificates), new applications made in 2012 numbered only 40, with 35 being granted. Currently, only 192 of these licensed premises are pubs or bars.

Of concern was the level of perceived complaints. The licensing team have only received 63 complaints however between 2010 and 2013 concerning premises serving alcohol. Of these complaints, 56% related to noise of music or people, 8% to perceived crime or disorder, 6% underage sales, 5% irresponsible drinks promotions and 5% due to breach of opening hours. In responding to licensing and environmental concerns, the council's licensing enforcement, trading standards and neighbourhood services incur costs. For example, investigation of complaints costs £30K p.a, proactive enforcement costs £20K p.a., a review by a committee costs £2K+ per hearing and trading standards costs £500 per under age sales team event.

The SID learnt about the B&NES Licensing Enforcement Group that draws together officers from the police, fire, environmental health, child protection and licensing. The partners meet monthly to consider intelligence and consider risks of premises so that a stepped enforcement approach can be used. In 2012, 10 planned enforcement evenings and 80 premises were visited.

The SID heard of a number of best practice examples, of which B&NES has adopted a number (such as the purple flag, pub watch and the Midsomer Norton CAP).

Table 2: Best practice examples in licensing

Initiative	Details
Challenge 21 & Challenge 25	If you look under 21/25 then you will be challenged.
Proof of Age Standards Scheme (PASS)	Accredited card to overcome fake IDs
Purple Flag	An objective assessment of key elements of the area at night
Community Alcohol Partnerships (CAP)	Tackles the problem of underage drinking
Community engagement	Good Practice Guide produced by licensed trade
Security by design	Guidance on designing an environment that minimises opportunities for crime
Dispersal policy	Good practice guide outlining useful pointers when considering a dispersal policy.

Future options were discussed such as the LNLs and EMROs. The speakers explored what can and can't be done for legal reasons. Delegates also heard about a locally implemented minimum pricing scheme in Newcastle, Best Bar None scheme piloted in Manchester and a ban of super-strength drinks in parts of Wakefield. Initial recommendations were put forward for delegate consideration.

During the question and answer session comments included: recognition that the four licensing objectives did not include public health; the licensing policy consultation in 2014; interest in an EMRO in the George Street area; community impact areas; street marshals; conditions of minimum pricing and high strength; and mention of work with older people.

Workshops

The workshop exercises asked focused questions to generate ideas about future policy initiatives that B&NES council and its partners could adopt:

"Question 1: Given the range of agencies involved in alcohol harm reduction strategies, which task(s) should the Council and local agencies prioritise in order to bring about the greatest improvement(s) in B&NES?" (rate 1,2 and 3)"

“Question 2: What alcohol harm reduction strategy does the group perceive to have the highest return on investment?”

“Question 3: What new practices would the group most like to see introduced?”

Many issues and ideas were debated during the workshops, some of which have been incorporated into the final recommendations. Below is a summary of the main themes that delegates said they would like to see acted upon:

- Broader and more focused education
- Change in policy locally and nationally to be able to be stronger on those who breach law / agreements
- Health campaigns that are more targeted
- Stronger and clearer enforcement
- Improved screening mechanisms
- Better publicity that is positive and pro-active
- Intervention methods that target certain groups and deal with issues as they happen
- Open training that improves understanding of issues and causes
- Consideration of the use of minimum pricing and restriction orders

Statements

A range of statements were submitted for consideration by delegates to the SID. A selection of quotes from the statements is given below to illustrate the type of views that were being put forward:

“It is important to distinguish between the valuable evening economy and the valueless post midnight economy.

This post midnight activity or, as some would call it, economy, is not sustainable. Whilst brewers and distillers count their profit from late night drinking, people who live in cities can only count the loss in disturbed sleep, vandalism and the inevitable cleanup”. ***B&NES Councillor***

“the disturbance is the worst to residents - elderly, families, workers, etc, who have to get up early and often feel weary after disturbed sleep due to drunk students” ***B&NES resident***

”…any punitive measure, such as a Late Night Levy, which results in reduced profits for the pub trade will result in reductions in staffing affecting both employment and staffing, and business closing” ***B&NES Councillor***

”The Coalition Government has recently introduced a new power for local authorities to adopt an Early Morning Restriction Order which would restrict the sales of alcohol between midnight and 6.00 am. The Council should consider introducing one of these orders for Bath as soon as possible…” ***B&NES resident***

“Research carried out by the ALMR in association with CGA Strategy suggests that there are over 500 licensed retail premises in bath and Northwest Somerset; three quarters in Bath itself. Between them, these outlets generate £90 million GVA to the region, support tourism, retail and other leisure businesses and over 11,200 people depend on them for jobs and livelihoods”. ***National trade association***

“…the number of irresponsible premises are very small.

The majority of licensed premises in BANES are run very well, the low number of licensing reviews shows this.

Any new policies or conditions will be tarring the good premises with the same brush as the very small minority”. ***Managing Director of a local pub company***

Conclusions

The alcohol harm reduction review gave councillors and stakeholders the opportunity to take stock of what is currently happening to tackle the impacts of alcohol on the community. 68 councillors, officers, stakeholders and residents attended the day. Presentations were given on the themed areas of health and wellbeing, community safety and licensing. The workshop element allowed people to contribute toward future policy initiatives. A series of recommendations were generated that will be put to the cabinet for consideration.

Next Steps

This report and the associated recommendations table will be submitted to the Wellbeing PDS Panel on 22nd November 2013. The relevant cabinet member will then have 8 weeks to consider and respond to these recommendations. The individual decision and rationale will then be presented back to the Wellbeing PDS Panel at its meeting in early 2014.

Appendices

Appendix 1: Terms of Reference

Appendix 2: Bibliography

Appendix 3: Selected graphs and charts

Appendix 1: Terms of Reference

Alcohol harm reduction strategy
Scrutiny inquiry day (SID)
(A joint working task by EYCY, ECD, PTE and Wellbeing Policy Development and Scrutiny Panels)

Date: 10th Oct 2013
Room: Brunswick, Guildhall, Bath

Background

- March 2012 the Government launched its Alcohol Strategy that included new powers for local authorities from April 2012. Licensing and health bodies become responsible authorities under the Licensing Act 2003. They are now notified of applications / review and can instigate a review of a licence. From Oct 2012, Local Authorities' also have powers to introduce Early Morning Restriction Orders (to restrict alcohol sales if a problem) and the late Night Levy (from businesses to cover cost of policing and Local Authority action).
- April 2012 the cabinet adopted and set key priorities of the refreshed B&NES Alcohol Harm reduction Strategy. Key themes: health & treatment, community safety, crime and disorder, children and young people, partnership working. A steering group would be responsible for implementation.
- May 2012, the Wellbeing PDS Panel received a briefing on Bath & North East Somerset Council's (B&NES) Alcohol Harm Reduction Strategy.
- Later in 2012, initial ToR of the SID set-out to review and refresh the B&NES Alcohol Harm Reduction Strategy, and to consider how the new powers from the Government's Alcohol Strategy would impact. The work would also aim to feed into a government consultation which included topics such as minimum pricing
- Oct 2012 new powers of licensing become available to local authorities
- Government holds a consultation on alcohol harm closing in Feb 2013
- Existing steering group decides during May 2013 that the need to address alcohol harm reduction remains but that the work needs input from different panels. New steering group assigned
- The Health and Wellbeing Board have also identified alcohol as a key priority within the Joint Health and Wellbeing Strategy (due to go to 10 July Cabinet and full sign off in November 2013).

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

4. 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'. For example, the use of other new powers including extended Early Morning Restriction Orders for businesses in Bath and North East Somerset

5. 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.

6. 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.

Scope

The Scrutiny Inquiry Day will 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?
- Formulation of joint recommendations about how to refresh the B&NES Alcohol Harm Reduction Strategy and the role these new powers will play in the strategy. Recommendations may also be made about how to deliver the strategy including consideration of partnership working and funding.
- This work will inform the current review of licensing policy. As such, the scope may include discussion of Early Morning Restriction Orders and late Night Levies.

Approach

This is a joint panel task led by Cllr Lisa Brett. The relevant PDS panels are: PTE, EYCY, ECD and Wellbeing.

Whilst this SID is a public meeting, members of the public must submit any statements in advance of the meeting (with 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). It is envisaged these statements will be supplied as part of the briefing pack / papers on the SID day.

Outcomes will be presented to the next public meeting of the Wellbeing Policy Development and Scrutiny Panel (potentially Nov 2013) with all the relevant PDS Panels invited to attend this meeting.

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 future 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:-

- Health and wellbeing factors (with input on children)
    - Social / financial impact
    - What is currently being done?
    - Best practice
    - Challenges
    - Recommendations from panels
- Community safety issues
    - Social impact on communities – ASB and DV
    - Financial cost to police and local authority
    - What is currently being done?
    - Best practice
    - Challenges
    - Recommendations from panels
- Licensing and environmental factors
    - Types of complaint and financial costs of these
    - What is being done?
    - Best practice
    - Challenges
    - Recommendations from panels

An afternoon workshop will take groups of stakeholders from a mix of health, community safety, residents and licensing to consider potential questions:

- Given the range of agencies involved in harm reduction strategies, which task should be the main priority for improved performance for BaNES?
- Which alcohol harm reduction strategy will have the highest return on investment?
- What practices would the group most like to see introduced?

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: Invitations sent to all members of the EYCY, PTE, ECD and Wellbeing panels
Cabinet Members: An invitation will be sent to all Cabinet members. Those with a particular interest would include Simon Allen (Wellbeing), Dine Romero (Early Years Children and Youth) and David Dixon (Neighbourhoods), David Bellotti (Resources)
Council: 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.
Other Cllrs: Chair of Licensing

Partners and Stakeholders:
Clinical Commissioning Group

Health and Wellbeing Board Members

Healthwatch

Health and Social Care Organisations: Sirona, Royal United Hospital (A&E / gastroenterology), South West 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, NHS Rep, City Centre Manager (Future Bath Plus/Bath Business Improvement District), Curo

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

University of Bath: Institute of Policy Research (Tobacco Control Group)

Timescales

The planning and preparation for the Scrutiny Inquiry Day will take a minimum of 3 months with an event in October. This would allow for a report of findings/ outcomes to be delivered to the November 2013 PDS Panel meeting and to Cabinet for December 2013.

Enquiries

For further information, contact:

Lead Cllr:	Lisa Brett	Lisa_Brett@bathnes.gov.uk
Policy Development & Scrutiny	Emma Bagley	Emma_Bagley@bathnes.gov.uk

Appendix 2:
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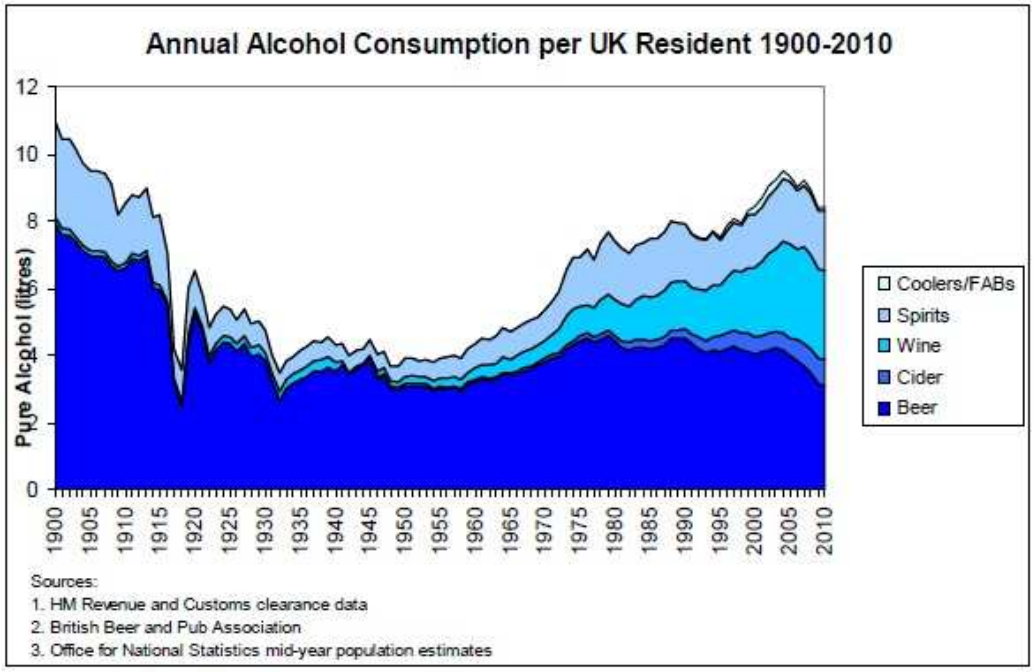
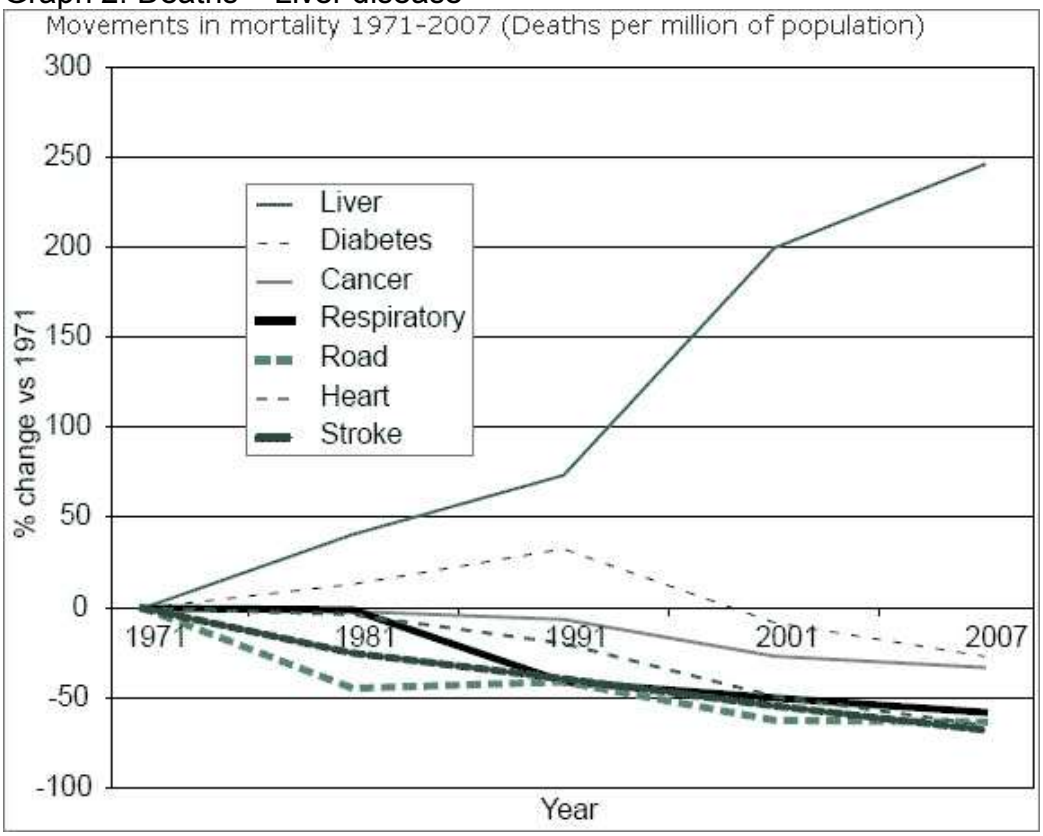
Appendix 3

Selected graphs and charts

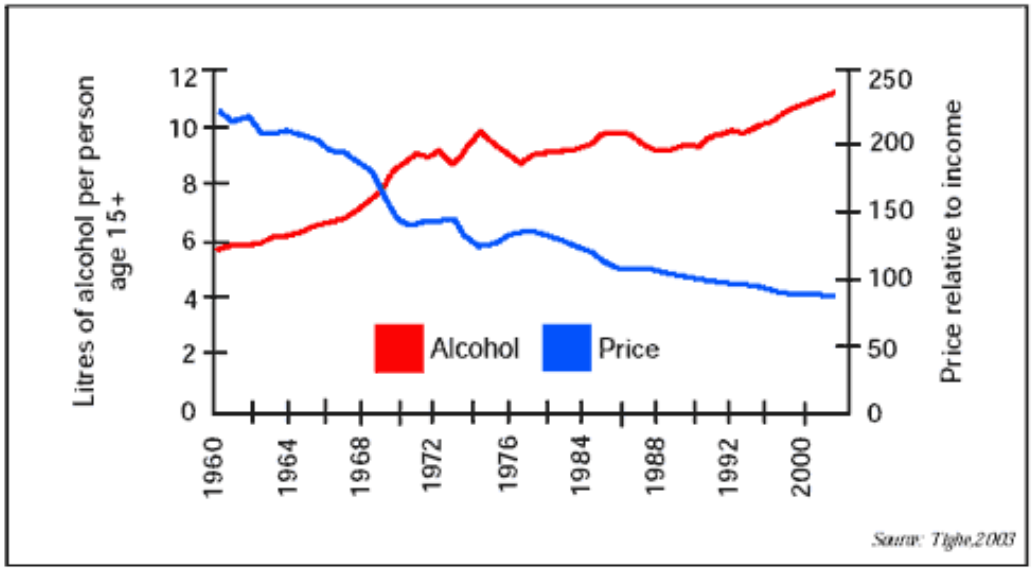
Graph 1: Alcohol consumption



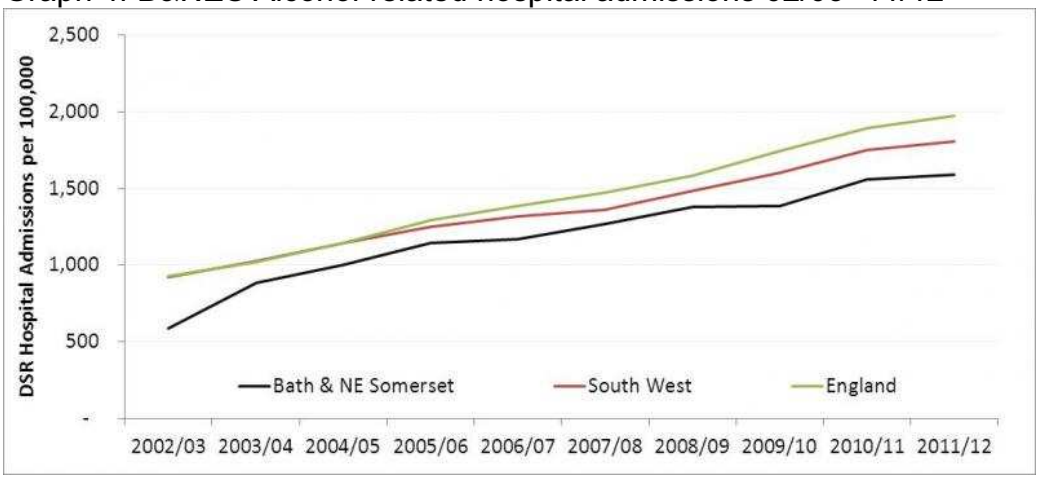
Graph 2: Deaths – Liver disease



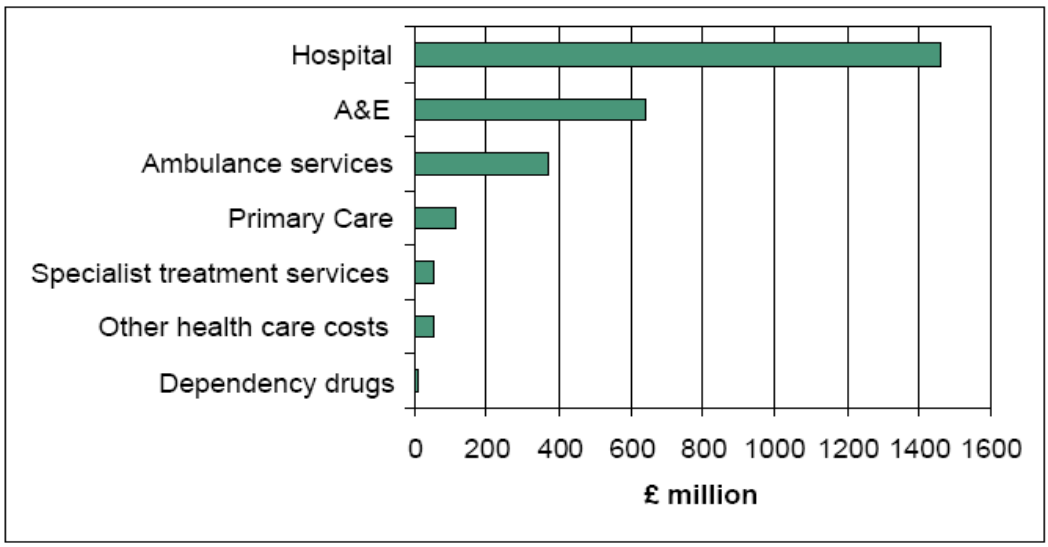
Graph 3: Consumption of alcohol in the UK (per person aged 15+) relative to its price: 1960-2002



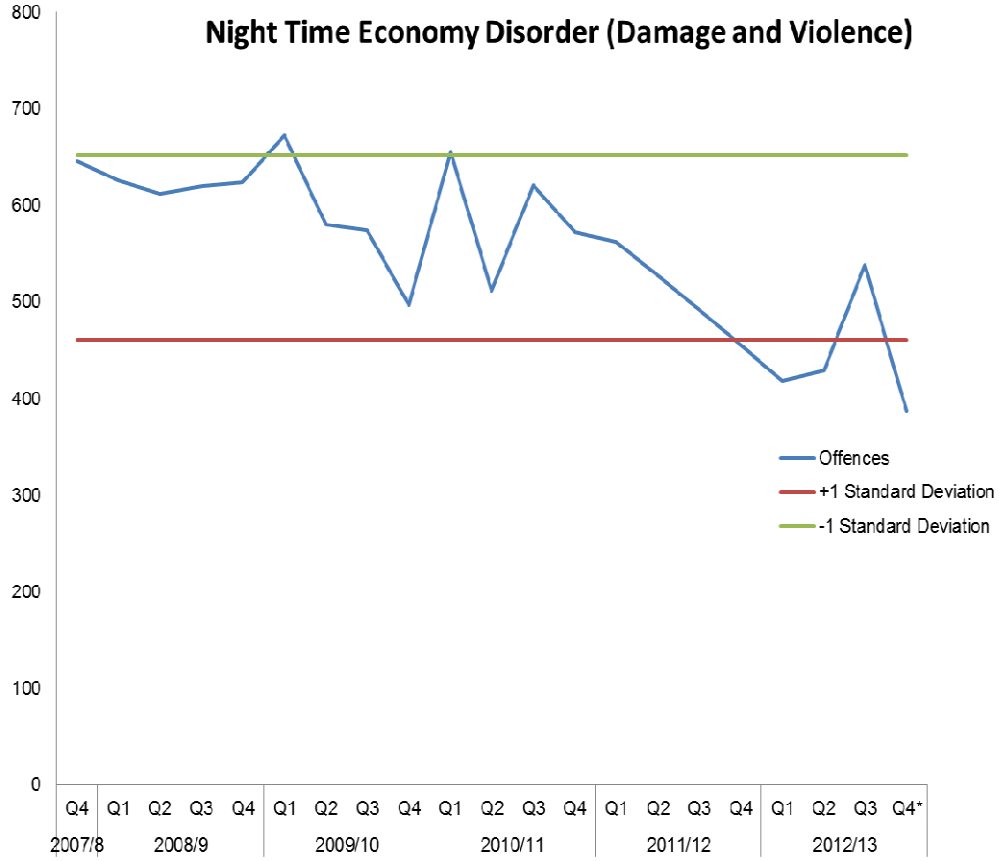
Graph 4: B&NES Alcohol-related hospital admissions 02/03 -11/12



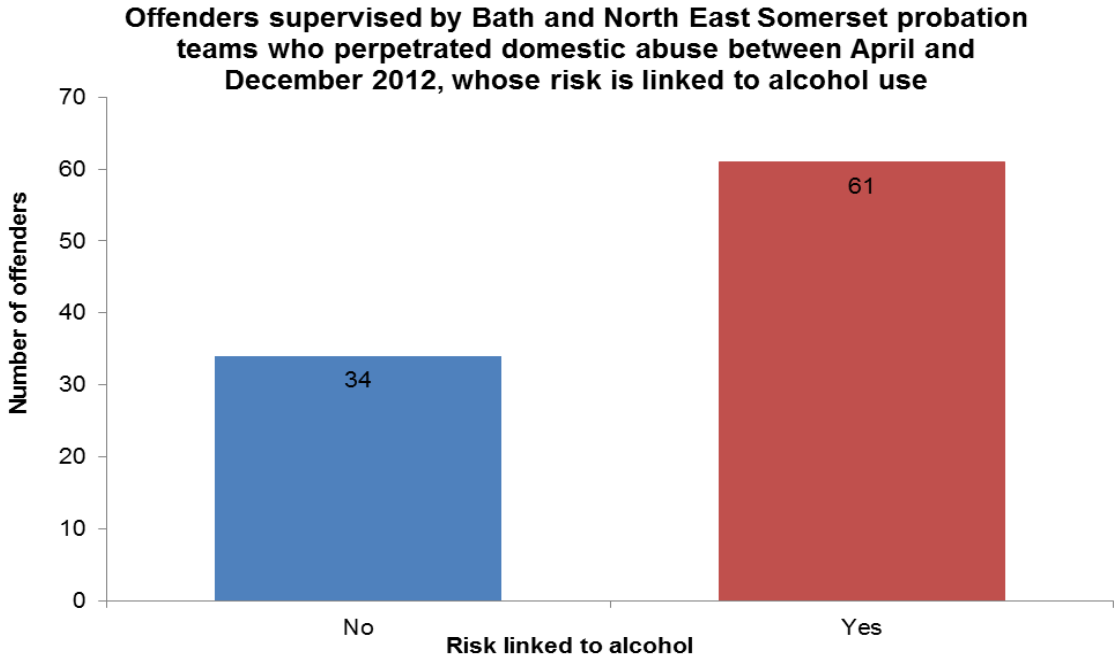
Graph 5: Financial cost to NHS



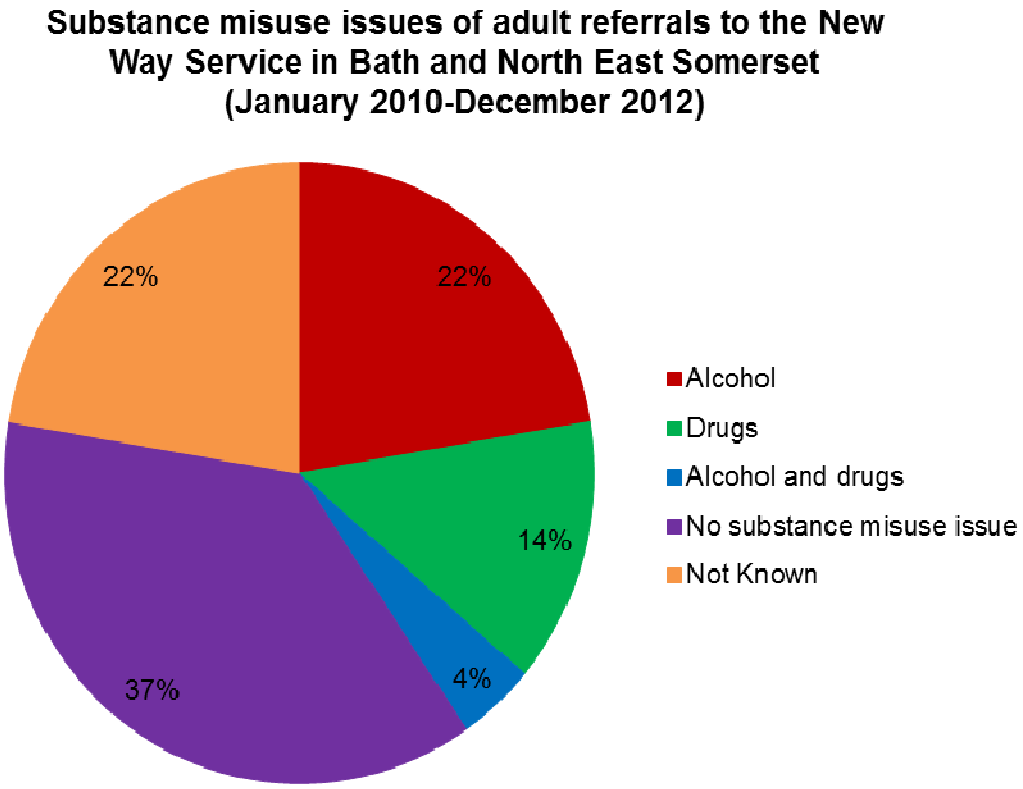
Graph 6: Crimes linked to the night time economy 2008-13



Graph 7: Alcohol related violent crime domestic violence and abuse



Graph 8: Referral information from the New Way service



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Review Title: Alcohol Harm Reduction
Policy Development & Scrutiny Panel: A joint review by ECD, EYCY, PTE and Wellbeing PDS Panels led by Cllr Brett, and reporting to Wellbeing PDS Panel
Panel Chair and Vice Chair: Cllr Pritchard and Cllr Beath
Policy Development & Scrutiny Project Officer: Emma Bagley / Liz Richardson
Supporting Service Officer: Cathy McMahon, Sue Dicks, Andrew Jones and Kate Murphy

Process for Tracking PD&S Recommendations - <u>Guidance note for Cabinet Members</u>
The enclosed table lists all the recommendations arising from the above Policy Development & Scrutiny Review. Individual recommendations are referred to the relevant named Cabinet Members (or whole Cabinet in the case of a whole Cabinet referral) as listed in the '**Cabinet Member'** column of the table. Cabinet members are requested to seek help from your relevant service Officers within your portfolio to help complete the Rationale for your response. A copy of this has also been forwarded to your appropriate Lead Officer. In order to provide the PD&S Panel with a Cabinet response on each recommendation, the named Cabinet member (or whole Cabinet) is asked to complete the last 3 columns of the table as follows:

Decision Response
The Cabinet has the following options:

- **Accept** the Panel's recommendation
- **Reject** the Panel's recommendation
- **Defer** a decision on the recommendation because a response cannot be given at this time. This could be because the recommendation needs to be considered in light of a future Cabinet decision, imminent legislation, relevant strategy development or budget considerations, etc.

Implementation Date

- For 'Accept' decision responses, give the date that the recommendation will be implemented.
- For 'Defer' decision responses, give the date that the recommendation will be reconsidered.
- For 'Reject' decisions this is not applicable so write n/a

Rationale
Use this space to explain the rationale for your decision response and implementation date. For accepted recommendations, please give details of how they will be implemented.

Alcohol harm reduction review: Recommendations

Recommendation	Cabinet Member	Decision Response	Implementation Date	Rationale
More education programmes that encourage a voluntary shift in attitude to alcohol 1 To continue working in partnership with commissioned and statutory service providers to deliver a long-term education programme for professionals, parents and young people on the causes and effects of alcohol harm. In particular, develop targeted education programmes for specific vulnerable groups, including: a. younger children by encouraging schools to start introducing topics sensitively from primary school age; b. young people by encouraging schools to facilitate further work through Personal Social Health Education. To help facilitate this work it will be important to have a better knowledge of the causes of self-harm through alcohol use. To commission a piece of work that extends current knowledge and builds on previous SHEU evidence. This work to report back to the Wellbeing / EYCY Panel; c. older 'working age' population by supporting current initiatives of public protection; and	**Cllr Allen / Cllr Romero**			

d. parents by public health working together with schools. (EYCY / Wellbeing)				
<u>Improved and more frequent alcohol screening mechanisms</u> 2 Develop and implement a quick screening method within front line services (including primary care such as pharmacies and waiting rooms - although potential scope for acute settings too). Build on the existing AUDIT tool by exploring a potential 'app', scratch cards, themed bar mats or self-assessment pro-forma. (Wellbeing)	**Cllr Allen**			
<u>Targeted interventions that deal with adverse effects of alcohol</u> 3.1 Build on in-situ interventions and street treatments in order to tackle isolated instances of inebriation in the night time economy. Support the ACPO initiative of 'drunk-tanks', and express an interest in hosting a pilot service in B&NES. (Wellbeing) 3.2 To provide 'wet house' supported accommodation for patients requiring longer term health and social care rehabilitation or interventions. This recommendation to be implemented where there is the demand and an evidence base for this (Wellbeing) 4 Encourage improved workplace health by developing a simple toolkit that local employers can use in the workplace. This initiative seeks to	**Cllr Allen**			

raise awareness about alcohol use in employees. (Wellbeing)				
Greater emphasis on prevention of alcohol harm through national policy 5 Health to be embedded as an alcohol licensing objective. The government to be lobbied about incorporating this into licensing legislation via the LGA. (PTE)	**Cllr Dixon**			
A local licensing policy that considers a broader range of issues and impacts 6 Refresh the B&NES licensing policy to acknowledge prevention of alcohol harm with such inclusions as: a. A vision of what B&NES' night time economy will look like (including an overview of cultural expectations). This high-level vision to be supplemented by district level aspirations (such as Bath, Keynsham, Midsomer Norton, Radstock etc.); b. Early Morning Restriction Orders in areas based on resident demand; c. Appraisal of Cumulative Impact (CI) zones; d. Consideration of 'dry streets' where a community wishes to exclude licensed alcohol traders completely; e. The option of including a condition in a	**Cllr Dixon**			

license around minimum unit pricing, high strength alcohol restrictions and/or irresponsible promotions where the evidence suggests this would be appropriate; and to f. Incorporate health into licensing policy at a local level. (PTE/ ECD)				
<u>More accessible training that emphasises issues and effects of alcohol harm</u> 7.1 Establish and deliver a local Best Bar None training scheme for trade staff. (PTE) 7.2 B&NES to express an interest in applying a business rate rebate to those premises successfully participating in the Best Bar None scheme. (PTE)	**Cllr Dixon** **Cllr Stevens**			
<u>Improved engagement at local level though more positive and proactive information sharing and publicity</u> 8 Improve the information available to residents about making complaints and contributing to licensing reviews. Refresh existing information about licensing contacts and processes in the B&NES Connect magazine and on the B&NES website. Consider a 24hr answerphone line to gather evidence from residents about licensing concerns. Promote a direct telephone line within licenced premises if a customer wants to raise a concern or	**Cllr Dixon**			

report issues. (PTE)				
<u>Communities that are safer from alcohol harm</u> 9.1 Build on existing work to prevent anti -social behaviour. Contain early issues through strong and clear enforcement presence in B&NES. Continue existing measures such as street marshals and police presence in 'hot spots'; as well as appropriate licensing enforcement action. Encourage greater information sharing between the police and council (e.g.101 and street marshal data) to guide enforcement. (PTE/ECD) 9.2 Extend existing initiatives, or foster new approaches in encouraging collective working between all alcohol traders (both on and off-trade). Encourage communication between businesses to allow them to work together optimally and, take a firm approach on sale of alcohol to people inebriated (legislation places licensees responsible for selling alcohol in this manner). (PTE/ECD)	**Cllr Dixon** **Cllr Dixon / Cllr Stevens**			
<u>Communities that are safer from outcomes of alcohol harm</u> 10.1 Encourage more integrated community safety work by rolling out further Community Alcohol Partnerships (CAPs) where underage drinking is a problem and residents want a CAP. (ECD) 10.2 Tackle alcohol-fuelled domestic violence and abuse by exploring ways of introducing a CAP	**Cllr Dixon**			

style model of integrated working across B&NES. To develop existing work by the council as part of the public service transformation network. Funding could potentially be earmarked through the community budget that covers this area of work. (ECD)				

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Equality Impact Assessment / Equality Analysis

Title of service or policy	Alcohol Harm Reduction Review
Name of directorate and service	Democratic Services (Policy Development & Scrutiny)
Name and role of officers completing the EIA	Emma Bagley (Policy Development & Scrutiny Project Officer)
Date of assessment	October 2013

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

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

1.	**Identify the aims of the policy or service and how it is implemented.**	
	Key questions	**Answers / Notes**
1.1	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	**Background** Alcohol harm reduction isn't a specific service but describes partnership activity drawing on various B&NES services as well as organisations such as the NHS and Avon & Somerset Police. The most recent policy was the Refreshed Alcohol Harm Reduction Strategy for Bath and North East Somerset 2012. B&NES officers work across a number of work-streams for example community safety, licensing, public health and education. **Purpose** The purpose of the scrutiny inquiry day review was 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 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 in developing a future policy direction for the use of new powers for local authorities and health bodies through the Government's 'Alcohol Strategy'. For example, the use of other new powers including extended Early Morning Restriction Orders 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
   b. Decreasing the physical and emotional harm arising in people who misuse alcohol
   c. Decreasing the crime and disorder arising in people who misuse alcohol
   d. Decreasing the impairment at work arising in people who misuse alcohol
   e. Decreasing the amount of family and community harm related to alcohol misuse
   f. Preventing children and young people and adults from misusing alcohol

Intended Outcomes

This was a joint panel task. The relevant Policy Development and Scrutiny panels were:

- Planning, Transport and Environment
- Early Years, Children and Youth
- Economic and Community Development and
- Wellbeing

The steering group set out to produce recommendations that aim to reduce alcohol harm reduction.

A report including recommendations is to be presented to a public meeting of the Wellbeing Policy Development and Scrutiny Panel on 22nd November 2013.

Responsibility for implementation

The recommendations will be made available to the relevant Cabinet Member in B&NES for them to accept, reject or defer. There may be recommendations that impact on partner organisations.

		These will be made available to the relevant partners for a response.
1.2	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?). • How much room for review is there?	The scrutiny inquiry day set out to investigate the impacts, challenges and recommendations for alcohol harm reduction across the broad topic areas of health/education, community safety and licensing/environment. The inquiry day considered the new powers being introduced through the Government's Alcohol Strategy and looked to refresh the B&NES Alcohol Harm Reduction Strategy. Whilst there is not a national requirement to undertake this work, the subject is of interest to a number of scrutiny panels. In addition, the Health and Wellbeing Board have identified alcohol as a key priority within the Joint Health and Wellbeing Strategy The focus of this work has been on initiatives where B&NES is likely to either have impact locally (through the Alcohol Harm Reduction Strategy) or influence nationally (by responding to future government consultation). The scrutiny inquiry day did not therefore focus on areas that, whilst important, the council has limited influence over such as supermarket pricing policies.
1.3	Do the aims of this policy link to or conflict with any other policies of the Council?	Joint Health & Wellbeing Strategy: http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/ working-partnership/health-and-wellbeing-board Licensing Policy: http://www.bathnes.gov.uk/services/business/licences/alcohol-and-entertainment/statement-licensing-policy Community Safety Plan: http://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/crime-prevention-and-community-safety/community-safet-0 Refreshed Alcohol Harm Reduction Strategy: http://democracy.bathnes.gov.uk/documents/s16367/ Appx%201%20Refreshed%20Alcohol%20Harm%20Reduction%20Strategy.pdf

2. Consideration of available data, research and information

Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data** (including ethnicity, gender, disability, religion/belief, sexual orientation and age)
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	The steering group for this work comprised 9 people; 6 women, 3 men. The scrutiny officers supporting this work were both women.
2.2	What equalities training have staff received?	All elected members on the steering group have attended equality briefings. All officers have attended equality updater training.
2.3	What is the equalities profile of service users?	• This EqIA covers all residents and visitors to the area. • The equalities profile of residents and visitors reflects a diverse population and is representative of all nine equalities strands. • A summary of our populations equality data from the Joint Strategic Needs Assessment 2012-15 is found here: http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/research-library

2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	Data collated for discussion during the scrutiny inquiry day spanning health, community safety and licensing / environment. Emails, phone calls and statements from stakeholders including residents.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	The steering group undertook a scrutiny inquiry day with various stakeholders. A full stakeholder analysis was made. Invitations to the event were sent to a range of statutory and voluntary sector organisations, schools / colleges, NHS, representatives of young people, older people, communities etc. Cllr Hartley worked with the faith forum to ensure representation from faith groups. A press release and twitter social media was included to engage with wider residents and community members. Phone calls were received from various interested delegates to find out more about the work such as councillors, business owners, licensees, health professionals and resident associations. Statements were submitted by those who may not be able to make the day, or who wanted to make written representations.
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	No further work is envisaged in the immediate future.

3. Assessment of impact: 'Equality analysis'

	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way.

	• Could have a negative or adverse impact for any of the equalities groups		
		Examples of what the service has done to promote equality	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
	All people	When undertaking the stakeholder analysis, it was important to include a range of residents and community representatives. By publicising the Scrutiny inquiry day and inviting written statements it was possible to capture a wider audience to contribute to the work.	The aim of this work was to draw from a range of voices, including those who work with or are residents or families within local communities. Health watch was invited to the scrutiny inquiry day to bring the voice of service users. Southside was present at the scrutiny inquiry day to share the voice of families experiencing domestic violence. One speaker talked about young people and attainment Young people may perceive barriers to engaging with a scrutiny process. To encourage input, officers circulated an invitation to the day to PSHE leads, schools, colleges and universities. In addition a twitter strategy was included to capture on-line views via social media. To ensure the work included views of those with different religious/faith groups Cllr Nathan Hartley worked to ensure the participation of the faith forum. To bring a good balance of city / urban views, both city based councillors as well as parish councillors were invited to attend the day. One speaker on community safety issues spoke of experiences in a non-city district of B&NES. The views of business/ employment and residents were heard. Scrutiny inquiry day delegates and statements drew from both the licensing trade as well as from residents.

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

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

Issues identified	Actions required	Progress milestones	Officer responsible	By when
None envisaged				

5. Sign off and publishing

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

Signed off by: Vernon Hitchman TBC

Date: October 2013

Bath & North East Somerset Council

WELLBEING PDS FORWARD PLAN

This Forward Plan lists all the items coming to the Panel over the next few months.

Inevitably, some of the published information may change; Government guidance recognises that the plan is a best assessment, at the time of publication, of anticipated decision making. The online Forward Plan is updated regularly and can be seen on the Council's website at:

http://democracy.bathnes.gov.uk/mgPlansHome.aspx?bcr=1

The Forward Plan demonstrates the Council's commitment to openness and participation in decision making. It assists the Panel in planning their input to policy formulation and development, and in reviewing the work of the Cabinet.

Should you wish to make representations, please contact the report author or Jack Latkovic, Democratic Services (01225 394452). A formal agenda will be issued 5 clear working days before the meeting.

Agenda papers can be inspected on the Council's website and at the Guildhall (Bath), Hollies (Midsomer Norton), Riverside (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

Wellbeing PDS Forward Plan

Bath & North East Somerset Council
Anticipated business at future Panel meetings

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 22ND NOVEMBER 2013				
22 Nov 2013	**Wellbeing PDS**	**Medium Term Plan and 2014/15 Budget Update**	Jane Shayler Tel: 01225 396120	Ashley Ayre
22 Nov 2013	**Wellbeing PDS**	**Neuro-rehab services update**	Specialised Commissioning Team - Dr Lou Farbus; Clinical Commissioning Group - Tracey Cox	Jane Shayler, Ashley Ayre
22 Nov 2013	**Wellbeing PDS**	**Update on the future of the RNHRD**	The RNHRD	
18 Sep 2013 22 Nov 2013	**HWB** **Wellbeing PDS**	**Homelessness Strategy**	Sue Wordsworth Tel: 01225 396050	Ashley Ayre
22 Nov 2013	**Wellbeing PDS**	**Alcohol Harm Reduction Scrutiny Inquiry Day**	Emma Bagley	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 17TH JANUARY 2014				

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
17 Jan 2014	**Wellbeing PDS**	**Briefing on Adult Social Care Reform (working title)**	Jane Shayler Tel: 01225 396120	Ashley Ayre
17 Jan 2014	**Wellbeing PDS**	**Public Health England**		
17 Jan 2014	**Wellbeing PDS**	**Briefing paper on reconfiguration of vascular services**	Tracey Cox	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 21ST MARCH 2014				
21 Mar 2014	**Wellbeing PDS**	**NHS 111 update (including contingency arrangements)**		
21 Mar 2014	**Wellbeing PDS**	**Further update on the Urgent Care provision which should include also an update on all the relevant Primary and Urgent Care schemes**		
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 16TH MAY 2014				
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 25TH JULY 2014				
25 Jul 2014	**Wellbeing PDS**	**AWP Pathway**	Andrea Morland	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 19TH SEPTEMBER 2014				

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
19 Sep 2014	**Wellbeing PDS**	**Update on Dementia**		
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 28TH NOVEMBER 2014				
FUTURE ITEMS				
	Wellbeing PDS	**Dentistry (requested by the Panel on 28.01.13)**		
	Wellbeing PDS	**Teenage Pregnancy**		
	Wellbeing PDS	**The RUH status update**		
	Wellbeing PDS	**NHS Healthchecks**		

The Forward Plan is administered by **DEMOCRATIC SERVICES**: Jack Latkovic 01225 394452 Democratic_Services@bathnes.gov.uk