BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 17th January, 2014

Present:- Councillors Vic Pritchard (Chair), Cherry Beath (Vice-Chair), Sharon Ball, Sarah Bevan, Lisa Brett, Eleanor Jackson, Anthony Clarke, Bryan Organ and Kate Simmons

64 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

65 EMERGENCY EVACUATION PROCEDURE

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

66 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Simon Allen (Cabinet Member for Wellbeing) and Dr Ian Orpen sent their apologies to the Panel.

Councillor Lisa Brett left the meeting at 12.15pm (after agenda item 12).

67 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.

Councillor Cherry Beath declared an 'other' interest as her husband is an employee of the Avon and Wiltshire Mental Health Partnership NHS Trust.

68 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was no urgent business.

The Chairman used this opportunity to inform the Panel that he received a letter from Eugene Sullivan (Chair of the Royal National Hospital for Rheumatic Diseases (RNHRD) NHS FT) with information that the RNHRD were unable to find a suitable

candidate for the post of Chief Executive Officer that met the specific skill set required for their organisation at this time. Kirsty Matthews, current Chief Executive Officer, has been offered, and agreed, to stay on a revised pattern of flexible working until suitable candidate is appointed.

The Chairman also informed the Panel that the Council had received a petition with 5,011 signatures, about the future of the RNHRD. The Political Group Leaders had debated this matter in advance of the Panel meeting and decided to forward the petition to B&NES Clinical Commissioning Group for consideration.

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

There were none.

70 MINUTES

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

71 CABINET MEMBER UPDATE (10 MINUTES)

The Chairman invited Jane Shayler (Deputy Director for Adult Care, Health and Housing Strategy and Commissioning) to give an update to the Panel (attached to these minutes) on behalf of Councillor Simon Allen.

The Panel made the following points:

The Chairman said that, in terms of the Better Care Fund, this Council was in much better position when compared to other Local Authorities because the Council was well into integration process with other NHS bodies. The Chairman asked what had been happening with the Section 256 money up until this point.

Jane Shayler explained that the Section 256 amount had varied from year to year. The Section 256 money has been confirmed as an annual amount each year. The Section 256 money had been used for a number of different services and initiatives, including schemes to address “winter pressures” and investment in re-ablement services. One of the benefits of the pooled Better Care Fund (BCF) was greater certainty as on-going funding stream. Jane Shayler added that detailed guidance for the use of the BCF in the Health and Social Care system has now been published, which would enable the development and agreement of joint plans across the Clinical Commissioning Group (CCG), NHS England and the Council. The Health and Wellbeing Board, whose members were from all of these organisations, would develop a long term vision of the integrated health and social care and formally sign off on the local BCF plan.

The Chairman noted that £552k of the Disable Facilities Grant would be a reduction in funding considering that it used to be around £600k (and the Council would make up to £1m). The Chairman asked if the Council would continue to make up that short fall.

Jane Shayler responded that for the next financial year the Council had not indicated reduction in the contribution to the Disabled Facilities Grant. The Council would continue to fund the grant directly, in addition to the central government allocation, to approximate amount of £1m.

Councillor Lisa Brett commented that the Royal United Hospital (RUH) was not invited to sit on the Health and Wellbeing Board (HWB), the arrangement she personally disagreed with it which, in her view, affected the effectiveness of discussion at the HWB. Councillor Brett asked how engaged were the RUH in the process considering that they were not represented on the HWB.

Jane Shayler responded that the HWB had had a development session in early December 2013 to discuss the BCF and also establishment of the Strategic Advisory Group (SAG) comprising main health and social care providers. The RUH are part of the SAG. The CCG and the Council had been considering engaging with all key stakeholders on the use of the BCF. Jane Shayler said that she would update the Panel on how the RUH would be engaged in the use of the BCF after the HWB meeting on 29th January 2014.

The Chairman thanked Jane Shayler who provided an update on behalf of Councillor Simon Allen.

72 CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

The Chairman invited Jane Shayler to give an update to the Panel (attached to these minutes) on behalf of Dr Ian Orpen.

The Panel made the following points:

Jane Shayler confirmed that the CCG had received the Mineral Hospital petition (mentioned by the Chairman under 'Urgent Business' agenda item) and that they were considering an appropriate response to it. Jane Shayler also said that the CCG would send a copy of the response to the Panel.

Councillor Brett expressed her serious concerns about the quality of commissioning that the CCG was undertaking. Councillor Brett said that there were huge problems with the NHS 111 services, problems with non-emergency patient transport services (NEPTS) and Northern Doctors Urgent Care were chosen over local partnership, which, in Councillor Brett's view, might be a setback. Councillor Brett also expressed her concerns that the CCG did not have management capacity, or expertise, in commissioning of services.

The Chairman said, for the record, that a comment from Councillor Brett was an individual comment and not the view of the Panel. The Chairman also said that a comment on how effective the Northern Doctors would be was built on assumption and not on hard evidence.

Councillor Eleanor Jackson said that her concern within the re-commissioning process was about the lack of monetary value on local information and local knowledge.

Jane Shayler acknowledged comments made by Councillors Brett and Jackson and commented that the CCG would probably want to make a formal response to these remarks. In relation to Councillor Jackson's comment on local knowledge, Jane Shayler confirmed that the new out-of-hours service provided by Northern Doctors, known locally as Bath and North East Somerset Doctors Urgent Care, would be provided by GPs already working in this area and, therefore, having local knowledge.

Members of the Panel debated the issues and problems around the non-emergency patient transport services (NEPTS) and expressed their concerns on the poor service delivery.

Ed Potter (Arriva Transport Solutions LTD – ATSL) addressed the Panel by offering a sincere apology on behalf of the ATSL. The ATSL had written letters of apology to all patients, in particular to a group of dialysis patients, who were affected with the poor service. This was a very complex operation and the ATSL was the sole provider of service, compared to up until the 1st December 2013 when there were up to 30 different providers. The transfer from the 30 providers to ATSL was complex and challenging and did not happen as seamlessly as ATSL or, indeed, the outgoing providers would have wished.

The Chairman felt that the Panel should receive a full report/review on this matter at the next meeting of the Panel (March 2014).

It was **RESOLVED** to receive a Non-Emergency Patient Transport Services report/review at March 2014 meeting of the Panel.

73 HEALTHWATCH UPDATE (10 MINUTES)

The Chairman invited Pat Foster and Marilyn Freeman (Healthwatch B&NES) to take the Panel through the update, as printed in the agenda.

Councillor Sarah Bevan noted that the Healthwatch expressed some concerns about mental health provision and asked if the Healthwatch had had the opportunity to communicate with LIFT Psychology services in B&NES.

Pat Foster replied that the Healthwatch haven't had any feedback from B&NES area yet though they received feedback from other areas in regards of the self-assessment.

Jane Shayler explained that she understood the issue in respect of mental health provision was about capacity, and not with the quality, within the very specific mental health liaison service based at the RUH.

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

74 CARE BILL (20 MINUTES)

The Chairman invited Jane Shayler to introduce the report.

The Panel made the following points:

The Chairman asked about pressures that Sirona Care & Health would face in regards of care and support assessments arising from the Care Bill; particularly in light of the additional savings target in the Council's Medium Service & Resource Plan 2013-14 to 2015/16 against the Sirona contract. The Chairman also asked about a Deferred Payment Scheme.

Jane Shayler confirmed that there was, indeed, an additional savings target against Sirona's contract for the next financial year. Part of the modelling of financial implications would be on what additional funding would be needed to undertake statutory care and support assessments. The Council would be required to make an assessment of individual's needs, including the needs of informal carer (those who are not paid to care). So, the Council would have to calculate what additional funding they would need to consider to ensure its statutory responsibilities to undertake an assessment of need.

Jane Shayler also responded about the Deferred Payment Scheme. The Council had recently agreed a local Deferred Payment Scheme (DPS) that complies with the national guidance for the DPS. The way the DPS would be working: if somebody was placed in the residential care home to meet their eligible personal care needs, and if they own property, then they could elect to set any costs/contribution towards the cost of care against the property they own. The DPS would enable individuals not to sell their family homes, for example, to finance the cost of care, and instead any such financial contribution could come from individual's estate after they have died. There would be a cap on the level of contribution. That would mean that the Council would be funding the cost of the residential care for that individual. The Council would be able to recoup that money after that individual had died and contribution recovered from the estate after the adequate process.

Jane Shayler also commented that there might be a few inconsistencies in the paper. A reason for that is partly because of the complexity of the paper and also because Local Authorities, other organisations and Central Government started to do their own analysis, which is why there was a level of inconstancy between various assessments of the financial impacts and implementations of implementing the Care Bill once it becomes law.

Councillor Jackson commented that some people were concerned that they would have to sell their homes to fund residential care. Councillor Jackson also said that the Bill did not take into account what would happen if an individual was in residential care and their partner stays at home.

It was **RESOLVED** to:

1) Note the key proposals in the Care Bill and early analysis of the implications for Bath and North East Somerset Council and other key partners with great concern because of the financial implication of this policy;

2) Receive a further update prior to enactment of the Bill or if any substantive changes are made to the Bill as it proceeds through the House of Commons; and

3) Write to local Members of the Parliament (Rt Hon Don Foster MP and Hon Jacob Rees-Mogg MP) expressing Panel's concerns on the financial implications of the policy.

75 DRAFT ADVICE & INFORMATION STRATEGY 2014-17 (40 MINUTES)

The Chairman invited Jane Shayler and Ann Robins (Planning and Partnership/Supporting People Manager) to introduce the report.

Jane Shayler commented that she was aware that the Panel had received a copy of a correspondence between the Citizen Advice Bureau (CAB) B&NES and the Leader of B&NES Council. Jane Shayler said that she was not in position to make a reference on this paper but her understanding was that the CAB B&NES would meet with Councillor Paul Crossley and Councillor Simon Allen on Monday 20th January in order to discuss next steps.

Jane Shayler also said that it was likely, subject to the Full Council Budget meeting in February, that the savings target against Advice and Information Services, funded from the Supporting People and Communities, would be reduced from £225k to a target saving of £118k.

The Panel made the following points:

The Chairman said that the report provoked a series of questions. In his view, one of the major failings was that it failed to match the demand with the available resources. The Chairman also said that, in his view, officers had been asked to make a strategy in a very constrained timescale. The Council had been operating for years without the strategy and now officers were given only ten days to formulate the strategy before going out for consultation. The Chairman felt that the timescale for the strategy was not realistic.

Councillor Brett welcomed the strategy and said that she wished the Council had had the strategy years ago and that the Panel should have had the strategy on the agenda some time ago before the proposed budget savings were published.

Councillor Organ said that he supported the work of the CAB B&NES. The general public look on the CAB as an independent adviser. Councillor Organ welcomed that the CAB B&NES would meet with Councillor Paul Crossley and Councillor Simon Allen on Monday 20th January in order to discuss next steps.

The Vice Chair reminded the Panel that they were asked to look at the draft strategy and not on the issue of the CAB B&NES. The Vice Chair congratulated the officers on the report and welcomed an initiative from the Council to have the strategy.

Councillor Tony Clarke also congratulated the officers on the report. Councillor Clarke felt that the officers had had enough time to put the strategy together. Councillor Clarke felt that there was a reliance on internet, which not necessarily could be valuable or safe, and also that there were a lot of people who wanted to complain, or get an advice, but would not want to do that via Council.

The Vice Chair commented that the Panel should not be seeking to influence the discussion between the CAB B&NES and Councillors Crossley and Allen on Monday 20th January.

It was **RESOLVED** to note the content of the draft Advice and Information Strategy. The Panel were conscious that there was a need for a considerable amount of work done to make this Strategy a working document, in particular with matching appropriately the demand of available resources.

The Panel **CONFIRMED** that they received a confidential document from the Citizen Advice Bureau B&NES, letter sent to the Leader of the Council, and **RESOLVED** not to respond to, or comment on, for the benefit of the discussion between the Citizen Advice Bureau B&NES and Councillors Crossley and Allen on Monday 20th January.

76 SUBSTANCE MISUSE SERVICES (30 MINUTES)

The Chairman invited Carol Stanaway (Substance Misuse Commissioning Manager), Jo Green (AWP Specialist Drug & Alcohol Services – SDAS), Rosie Phillips (Developing Health and Independence - DHI) and Alex Newman (DHI) to give a presentation to the Panel.

The following points were highlighted in the presentation:

- Pictures of different offices within Substance Misuse Services across B&NES
- An update on Re-configured Services
- Graph on the DHI Growth in Alcohol Clients Receiving Treatment
- Increasing Drug and Alcohol clients 2013
- Integrated Working
- Housing Support
- Service User and Family Consultation Day - August 2013 at St Mary the Virgin Church

A full copy of the presentation is available on the Minute Book in Democratic Services.

The Panel made the following points:

Members of the Panel asked questions about treatments for ketamine users to which officers responded accordingly.

The Panel asked how people gain access to new drugs.

Carol Stanaway and Rosie Phillips explained that internet was primarily responsible as a source. There were also shops selling new drugs. The reason why these drugs were available was that they were classified as legal drugs at that moment of time.

Members of the Panel welcomed the on-going work with village agents, street pastors and the support provided to certain community pockets (such as Chew Valley, Foxhill, etc.).

It was **RESOLVED** to note:

1) Services in place to support substance misusers to overcome their dependence following re-commissioning and service redesign; and to support their families.

2) Progress being made to support ketamine misusers;

3) Progress being made to support alcohol misusers in B&NES.

It was also **RESOLVED** to congratulate Substance Misuse Services in Bath & North East Somerset, and the partners, on their work.

77 THE ROYAL UNITED HOSPITAL BATH UPDATE (20 MINUTES)

The Chairman invited James Scott (Chief Executive RUH) to give a verbal update to the Panel.

James Scott briefed the Panel on the latest CQC inspection to the RUH.

The CQC had been visiting acute hospitals first and soon they would be visiting mental health trusts. The CQC had identified 18 pilots sites (hospitals) – six of those were low risk trusts, six were higher risk trusts and the last six were in the middle (RUH Bath included). The CQC would produce a quality summit report once all inspections are completed. The inspection at the RUH happened from 4-6 December 2013 with around forty of inspectors on site. Five or six academics were amongst those forty inspectors, doing a research into the process itself, as a pilot exercise.

At previous inspections there were two or three inspectors on site with generic skills/experience. This time, the RUH were inspected by a group of generic inspectors (up to six of them), clinicians with different expertise and from different parts NHS organisations and patient representatives (experts by experience).

The inspection lasted for two and a half days. The RUH also had an unannounced inspection on Sunday afternoon where inspectors spent six hours checking on all the wards and departments in the RUH.

James Scott also said that he received a report on Wednesday (15th January) which was shared with the RUH management to look at factual accuracies in the report. A quality summit, set up by the CQC, would happen on 4th February. This would not

be a public meeting though two stakeholders would be invited for that meeting – representatives from the Council and also from the Healthwatch. The RUH would also invite representatives from Wilshire considering that the RUH catchment area extends to that region. The idea behind the quality summit was to look at the CQC report and to consider what actions were required as per the CQC's recommendations.

The CQC checked the following about care services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

The CQC looked at seven services in the RUH:

- A&E
- Medicine (cardiology, diabetes, older people's care
- Surgery
- Intensive Care
- Children Services
- End of Life Care
- Outpatients

The report would become public sometime after 4th February 2014.

The Chairman commented that the previous CQC inspection were critical about record keeping in the RUH.

James Scott responded that the CQC were critical on record keeping on the wards. The CQC didn't criticise the quality of care that patients were getting on the wards. The issue was about nursing issue – nurses were not capturing all of the interventions they were making and, as a consequence, that could create the potential for harm.

The Chairman anticipated that the outcome of the CQC inspection would be satisfactory. The Chairman asked when the RUH would proceed with the Foundation Trust (FT) status.

James Scott responded that the CQC (quality regulator) and the Monitor (economic regulator) would have to give at least 'good' rating before the RUH could move forward with the FT application.

Councillor Jackson asked if the CQC just inspected functions in the RUH or they also inspected the cleanliness and the state of the building.

James Scott responded that the CQC did not comment on designs and similar in the hospital though they did inspect cleanliness.

It was **RESOLVED** to note verbal update from James Scott and to receive a full report at the next meeting of the Panel (March 2014).

78 PANEL WORKPLAN

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

- Non-Emergency Patient Transport Services (March 2014)
- The Royal United Hospital Bath update on results of the Care Quality Inspection held on 4-6 December 2013 (March 2014)
- Dentistry – for near future
- Podiatry services – for near future
- Public Health – HIV (July 2014)
- Care Bill update (date to be confirmed)

The Panel also agreed to re-visit recommendations of the Home Care Review 2010 – date to be confirmed.

The meeting ended at 1.35 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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

Wellbeing Policy Development & Scrutiny Panel – January 2014

1. PUBLIC ISSUES

Better Care Fund 2015-16

The Better Care Fund (previously referred to as the "Integration Transformation Fund") was announced in the June 2013 spending round covering 2015/16. This national £3.8 billion 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.

The Better Care Fund encompasses a substantial level of funding to help local areas manage pressures in the health and social care system, including those associated with demographic change, and to improve long term sustainability. Nationally, the Fund is being seen as *"an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change".* The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

At a development session of the Health & Wellbeing Board in early December 2013, which included H&W Board members from the Clinical Commissioning Group (CCG), Council, NHS England Area Team and Healthwatch, some local principles for use of the Fund were agreed in draft form, in advance of the issue of the planning guidance. The principles agreed were consistent with the principles and aims set out in the national planning guidance, which was published on 20th December 2013.

Principles agreed in draft form for further discussion and development at the H&W Board meeting in January were:

- Needs to support the priorities in the Joint Health and Wellbeing Strategy as well as align with the CCG Plan, NHS England operational plan and others;
- Needs to be based on clear evidence including cost/benefit analysis of funding early-intervention and prevention services to achieve greater long-term sustainability and reduce pressure on acute/specialist services;
- Services should be encouraged through the Fund to be work in different and innovative ways, rather than simply creating new services as the fund itself is bringing together resources already committed to existing core activity;
- "Do no harm", that is, the use of the Fund should add value and not adversely impact on core budgets.

Given the extent of integrated commissioning and service delivery already in place in Bath and North East Somerset, the Health & Wellbeing Board acknowledged that local plans for use of the Fund may largely represent a formalisation of what is already in place, including through Section 256 agreements.

The 2015-16 allocations to the Fund were announced on 20th December alongside the planning guidance. For Bath and North East Somerset the 2015-16 allocations have been confirmed as follows: Total: £12.049 million comprising £11.091m from the CCG to the BCF; £406k Social Care Capital Grant; and £552k Disabled Facilities Grant. Early analysis indicates that this allocation is slightly higher than anticipated based on an estimated 3% share of the national Fund. The detail of this is being worked through to understand the extent to which the 'extra' funding identified in the allocations data, which is in the region of £800k, represents additional NHS funding to the Better Care Fund and how much is the Government contribution to the additional costs expected to be incurred by the Council as a result of the Care Bill, which is due to come into force in 2015-16.

Plans for the use of the Better Care Fund must be jointly agreed by the Council and CCG and formally signed off by the Health and Wellbeing Board for submission by 4 April 2014.

2. CARE HOMES PERFORMANCE QUARTERLY UPDATE (OCTOBER - DECEMBER 2013)

Baseline Data

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

As at 30th December 2013 1140 individuals were recorded as being 'permanently placed' in residential/nursing care, supported living or extra care settings although this figure also includes a number of individuals who are placed out of area i.e. not with a contracted provider in the B&NES local authority area. This is a reduction since the last report of 36 people.

Care Quality Commission Data

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

In Bath and North East Somerset all homes under contract have been inspected by CQC, the performance for the October to December period is summarised in the table overleaf.

All standards met	32 homes
One standard requiring improvement	8 homes (decrease of 2 since last period)
Two standards requiring improvement	1 homes (decrease of 1 since last period)
Three standards requiring improvement	3 homes (same since last period)

When one or more essential standards are not met *and* there are serious concerns regarding the quality of care provision in a home, CQC may issue compliance notices which require providers to respond within specific timescales, after which follow up inspections take place. At the time of writing 13 homes in B&NES were under compliance action. The action was evidenced to have a minor impact to service users for 10 homes, a moderate impact to 1 homes and a mix of minor and moderate to 2 homes.

All homes with outstanding compliance issues are required to produce action plans setting out how, and in what timescales full compliance will be achieved. This information is utilised to inform the review B&NES schedule and to inform contract monitoring activity.

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

Service User & Stakeholder Feedback

Information regarding the quality of care homes is collected at each individual service user review and collated on a 'feedback database' by commissioners. The database is also used to store 'adverse incident' reports received from health colleagues. During the period October to December 2013 feedback relating to 8 care homes was received via the feedback database, these are summarised in the table below.

Nursing home	Staffing levels, record keeping and communication
Nursing home	Staff not wearing ID badge
Residential home	Staff turnover
Nursing home	Attitude of staff member
Nursing home	Staff support relating to eating/drinking
Residential home	Behaviour of staff member
Nursing home	Record keeping
Nursing home	Use of equipment

Commissioning & Contracts Review

Of the above homes 3 have been reviewed by Commissioning & Contracts Officers and the remainder are scheduled for review in the first quarter of 2014. A further 7 homes were no concerns were raised have been reviewed during the reporting period as part of the planned schedule of contract review activity.

Six of the above homes have been recently inspected by CQC and three of these were found to be fully compliant whilst two have one outstanding compliance action and one has two outstanding compliance actions.

Officers liaise closely with CQC and with health and social care colleagues to triangulate intelligence and to agree collaborative responses to all concerns identified. This information sharing process is relied on to prioritise inspection and review activity, thus making most effective use of limited capacity in the commissioning team.

Financial Monitoring

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

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

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

The Council's November 2013 revenue forecast for adult social care summarises performance against financial plan targets for 2013-14. The net end of year forecast shows a balanced budget.

3. DOMICILIARY CARE PERFORMANCE QUARTERLY UPDATE (OCTOBER - DECEMBER 2013)

Baseline data

At the time of writing there were four domiciliary care strategic partners under contract in B&NES and four spot providers, plus a small number of 'one off agreements'. The contract with strategic partners is a framework agreement under which providers are paid quarterly in advance for the projected number of hours they will deliver, then this amount is adjusted to reconcile with the actual hours delivered. During the reporting period the total hours delivered by all contracted providers ranged between 4672 (1st October 2013) and 5040 (31st December 2013) which is within projected demand limits.

The strategic partners are commissioned to accept the majority of all referrals for domiciliary care made by Sirona Care & Health as part of the statutory social care assessment and care management process. As at 31st December 2013 just over 81% of all commissioned domiciliary care was being delivered by the strategic partners with the remaining 19% being delivered by either contracted spot providers (16%) or under 'one off agreements' (3%).

One strategic partner was de-commissioned from the 1st April 2013 due to on-going performance and relationship issues. The table below shows the number of care hours commissioned in B&NES at equivalent points during 2012-13 and 2013-14. The fall in

hours during the first two quarters of 2013 relates to the exit of this provider and the corresponding transfer of service users to other support services.

The transfer process highlighted the fact that a significant proportion of service users who had been receiving a care service no longer required it, and could be appropriately transferred to alternative forms of support such as the Curo Independent Living Service. These findings provided further support for the re-modelling of our adult social care pathway to focus greater attention on short term, rehabilitative interventions.

	April	June	August	October	December
2012	5016	4922	5006	4627	4796
2013	4489	4451	4661	4658	4874
Net change	-527	-471	-345	+31	+78

Care Quality Commission Data

In Bath and North East Somerset all four domiciliary care strategic partners have been inspected by CQC and have been found to be fully compliant with all essential standards. All four spot providers have been inspected and two of these have been found to require improvements against two standards.

When one or more essential standards are not met *and* there are serious concerns regarding the quality of care provision, CQC may issue compliance notices which require providers to respond within specific timescales, after which follow up inspections take place. At the time of writing only one provider in B&NES was under compliance action and had been due to be re-inspected by CQC during December 2013 however at the time of writing the findings of this inspection were not known.

Service User & Stakeholder Feedback

Information regarding the quality of domiciliary care provision is collected at each individual service user review and collated on a 'feedback database' by commissioners. The database is also used to store 'adverse incident' reports received from health colleagues. During the period October to December 2013 feedback relating to two strategic partners and one 'one off provider' was received via the feedback database, this is summarised below.

Strategic partner 1	Continuity of carers, record keeping and communication
Strategic partner 2	Continuity of carers
One off provider	Attitude of staff member

Commissioning & Contracts Review

Of the above providers both strategic partners have been reviewed during the reporting period as have the two other strategic partners where no concerns have been raised as part of the planned schedule of review activity.

The 'one off' provider has not been reviewed during the reporting period however this provider delivers less than 1% of all commissioned hours in B&NES which must be balanced against the capacity of officers to devote the necessary time.

Officers liaise closely with CQC and with health and social care colleagues to triangulate intelligence and to agree collaborative responses to all concerns identified. This information sharing process is relied on to prioritise inspection and review activity, thus making most effective use of limited capacity in the commissioning team. A follow up inspection of the above 'one off' provider is planned by CQC for the 14th February 2014 as discussed at the most recent CQC liaison meeting on 7th December 2014.

Financial Monitoring

The strategic partnership contract sets out the basis on which providers are paid and the reconciliation process as well as the indices on which inflationary uplifts are calculated. The exit of one provider from the partnership arrangement has resulted in significant savings to the Council which it is proposed will contribute towards the medium term resource and service plan for 2014-15.

A number of these indices on which inflationary uplifts are calculated have however changed and it is no-longer possible to use all of the ones set out in the contract. For the previous three financial years providers have been willing to negotiate an acceptable uplift and have in this way contributed to Council efficiencies. This is the planned approach for 2014-15 rate setting.

The Council's November 2013 revenue forecast for adult social care summarises performance against financial plan targets for 2013-14. The net end of year forecast shows a balanced budget.

Bath and North East Somerset
Clinical Commissioning Group

BaNES CCG Update - Well-being Policy Development & Scrutiny Panel - 17th January 2014

Update on Winter Pressures

The RUH achieved the 4-hour A&E target (95% of patients being admitted, discharged or transferred) in Quarter 3, securing a performance level of 96.9%. This was one of the best scores compared to a number of hospitals in the local area. So far this year the winter period has been comparatively mild and the health and social care community has benefited from the impact of the £4.4m Winter pressures provided by NHS England to health communities that had previously been identified as at high risk of not achieving the 4-hour target. A daily urgent care dashboard has been put in place and amongst the health and social care community there is a greater sense of partnership and collaboration between providers. The Winter Plan is being supported by a public awareness campaign to advise people to make the right choice for their health needs - *Choose Well This Winter.* A range of leaflets, posters and media coverage will help spread the message about making the right choice and not using the RUH's Emergency Department as the default place for treatment.

Mobilisation of the Urgent Care Services

Since the tender award for the the Bath Urgent Care Centre at the RUH, BaNES GP Out of Hours and Care of the Homeless Services, Northern Doctors Urgent Care have moved into their administrative offices at Kelston House. Locally they will also be called Bath and North East Somerset Doctors Urgent Care (BDUC) to reflect the local service provision. A mobilisation group has been established between BDUC and BaNES, Somerset and Wiltshire CCGs which is meeting fortnightly to ensure the successful launch of the services. During March these meetings will move to weekly. BDUC have also established regular meetings with the RUH to agree the clinical and operational model for the new urgent care centre. The building work for the centre started during the first week of December and has a completion date of 17th March 2014, allowing ten-days to commission the new building.

Non-Emergency Patient Transport Services

The non-emergency patient transport service (NEPTS) contract for the CCGs of BaNES, Gloucestershire, Swindon and Wiltshire was awarded to specialist transport provider, Arriva Transport Solutions Ltd (ATSL) in summer 2013, and went live on 1st December 2013. Go-live was preceded by six months of planning and mobilisation work between the four the CCGs and ATSL to transfer over staff from incumbent providers, recruit and train new staff, procure and equip ambulances, establish ambulance base stations and a control centre, establish online booking systems and processes for transferring existing journeys as well as engage with numerous acute trusts and other NHS providers across the region to provide information about changes in booking processes etc.

The aim of bringing in a single new provider of NHS-funded patient transport across the area is to provide a better quality and reliability of service for patients who are eligible for

NHS-funded transport. However, it is clear that the early days of the service did not achieve this for some patients. In part this was due to the problems involved in transferring from the multitude of piecemeal pre-existing arrangements that were in place across the four CCG areas; and in part to the inevitable challenge of moving to a single new transport provider using a new booking process. This is a particular challenge where hospitals, such as the Royal United Hospital, see and treat patients who come from a range of different geographical areas, some of which have different transport arrangements.

The CCG is confident that once the new service fully beds in, which it is already starting to, patients will experience an improved service. To ensure this happens, a senior manager from the CCG and representatives from the other three CCGs are holding weekly mobilisation and performance review meetings with ATSL. These are used to highlight any issues and collectively work with ATSL and the hospitals to resolve them. During December ATSL and the Royal United Hospital together reviewed the early weeks of the new service, identified the issues, and agreed a comprehensive action plan to address the issues. Both organisations are working through January to put those actions into place.

NHS Planning Guidance for 2014/15 -

On the 19th December 2013, NHS England issued the planning guidance for the coming year. *Everyone Counts: Planning for Patients 2014/15 to 2018/19* sets out how NHS England's overarching vision "high quality care for all, now and for future generations" will be delivered.

The guidance sets out a requirement for all CCGs to produce a 5-year Strategic Plan, a detailed two-year Operational Plan, a Financial Plan and a Better Care Fund Plan (previously known as the Integration Transformation Fund).

The development of the detailed plans will involve engagement and participation with CCG staff, patients and members of the public, providers and health and social care colleagues. The Plan will need to set out how the Clinical Commissioning Group will deliver its commissioning intentions and strategic plan whilst meeting a set of challenging financial targets and at the same time maintaining or improving the quality of care. The national timetable for delivery of the detailed plans is very challenging. The final set of plans will be signed off by the CCG's Council of Members and Governing Body and the Health and Wellbeing Boards at the end of March.

Lay Member – Patient and Public involvement

The Clinical Commissioning Group held interviews on the 8th January 2014 for the vacant Lay Member's post on the CCG Board. The role has specific responsibility for patient and public participation - an area the Clinical Commissioning Group has started to develop but where the CCG need's to fully realise and strengthen its approach. Subject to successful references, the new Lay Member will join the CCG in a few weeks.

Ends.