BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 21st March, 2014

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

79 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

80 EMERGENCY EVACUATION PROCEDURE

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

81 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Lisa Brett sent her apologies for this meeting.

82 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.

Councillor Simon Allen declared an 'other' interest as an employee of the Avon and Wiltshire Mental Health Partnership NHS Trust.

83 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

There were none.

85 MINUTES

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

The Chairman informed the Panel that the Wellbeing Board of the Local Government Association challenged a reduction in the Disable facilities Grant and the original sum had been reinstated. The Chairman suggested that the Panel should send a letter to the relevant Cabinet Member (Councillor Simon Allen), asking him to establish the exact position of the Disable Facilities Grant now.

The Panel agreed with the Chairman's suggestion.

The Chairman also drew Panel's attention to debate on the Draft Advice and Information Strategy at the last meeting of the Panel. The Chairman expressed concern that the original proposed saving target, of £225k, against Advice and Information Services suggested there would be job loses, particularly within the Citizen Advice Bureau (CAB). The Chairman suggested that the Panel write to the CAB asking them to establish their position now.

The Panel agreed with the Chairman's suggestion.

86 CABINET MEMBER UPDATE (10 MINUTES)

The Chairman invited Councillor Simon Allen (Cabinet Member for Wellbeing) to give an update to the Panel (attached as appendix to these minutes).

The Panel made the following points:

The Chairman asked what 'spot providers' were (within Domiciliary Care part of the update).

Councillor Allen responded that most of the domiciliary care has been provided through Domiciliary Care Strategic Partners, who worked under agreed contract. Spot providers could be used in circumstances where an individual, with personal budget, chose to have their domiciliary care serviced by another provider.

The Chairman commented that the Care Quality Commission (CQC) concerns, submitted in their inspection report, did not seem to be significant, yet the statistic as such was not complimentary and this might portray wrong picture to the public.

Jane Shayler (Deputy Director for Adult Care, Health and Housing Strategy and Commissioning) responded that the CQC had a whole set of standards that were marked in the same way. Some were administrative, like record keeping, and some were more closely related to quality and safety of care that an individual had received before the inspection took place. Mark of 72% was quite good pass mark and in line with national average. Jane Shayler suggested that it might be helpful for the Panel to invite the CQC for one of their future meetings and receive a briefing on those standards.

The Panel agreed with that suggestion from Jane Shayler.

The Chairman thanked Councillor Simon Allen for an update.

It was **RESOLVED** to invite the Care Quality Commission to present a briefing on standards of quality and safety.

87 CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

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

Dr Orpen updated the Panel with current key issues within BANES CCG (attached as appendix to these minutes).

The Panel made the following points:

Councillor Organ suggested that future reports and updates should be written in plain English.

Dr Orpen took on board comment from Councillor Organ.

The Chairman asked about whole 5 Pear Strategic Plan process and also on public response to the Plan.

Dr Orpen responded that the 5 Year Strategic Plan have had a detailed two-year Operational Plan, a Financial Plan and a Better Care Fund Plan (previously known as the Integration Transformation Fund). The first full draft of the Plan would be signed off by the Health and Wellbeing Board on the 26th March 2014 and the CCG's Governing Body and Council of Members on the 27th March 2014. The final 5 Year Strategic Plan would have to be submitted to NHS England in June.

Dr Orpen also said that the CCG presented an overview of the 5 Year Strategic Plan at a public meeting on Thursday 13th March, which had been attended by members of the public and representatives of voluntary sector groups. Further public engagement events would take place throughout April 2014.

Councillor Jackson asked how many patients had requested that GPs do not share their records.

Dr Orpen offered to provide that information at the next meeting of the Panel.

Councillor Bevan asked why the CCG had awarded the contract for vasectomy services to B&NES Emergency Medical Services (BEMS) when vasectomy was not part of emergency services.

Dr Orpen responded that the name change for the BEMS would be helpful, as it could create some confusion. Their main purpose were as GP providers in the area. The contract was worth £40,000 and the service had been previously provided by Sirona Care and Health. Dr Orpen confirmed that vasectomy had not been seen as an emergency service.

Councillor Jackson asked why there was a change in provider for vasectomy services.

Dr Orpen responded that, although he did not have details about the change of provider, it wasn't about the price.

The Chairman thanked Dr Orpen for an update.

88 HEALTHWATCH UPDATE (10 MINUTES)

The Chairman invited Pat Foster and Ann Harding (Healthwatch representatives) to introduce the report, as printed in the agenda.

Councillor Bevan asked for clarification on communication figures, in particular if 70% of engagement with the public had been through social media, as suggested in the report.

Pat Foster responded that the Healthwatch has been asked, through their contract with the Council, to provide 70% of engagement with the public via social media. The majority of engagement with the public had been via website, Facebook and Twitter. Pat Foster added that people still called and/or emailed the Healthwatch with their questions and concerns. The public also used leaflets to correspond with the Healthwatch.

Councillor Bevan commented that people in receipt of the higher proportion of health services would not be within the demographic which use social media. Councillor Bevan asked Healthwatch representatives how they felt on being given directive for having 70% of engagement through social media that could exclude the very people that were likely to be using most of the services, most of the time.

Pat Foster responded that the Healthwatch would try to reach out to everyone across B&NES. If people wanted to get in touch with the Healthwatch, they would have done that, no matter what way of engagement that was.

The Chairman agreed with comments and concerns from Councillor Bevan in terms of communication with the public.

The Chairman also said that Healthwatch was meant to be a development of the Local Involvement Network (LINk). The LINk, at the time of their existence, seemed to be involved with a population that was more elderly whilst Healthwatch has a wider remit to also involve younger people. The Chairman felt there had been an overemphasis on the involvement of younger people, because of the 70% of engagement through social media.

The Chairman added this was not what the Panel wanted to hear, or read about.

The Panel wanted more proactive reports that could demonstrate the effectiveness of the Healthwatch. The Panel also did not want to read inventory of events that

took place and which events, or meetings, representatives from Healthwatch had attended.

The Chairman commented that the LINk reports, for example from care home inspections, had been comprehensive and the Panel knew everything and anything they needed to know about that inspection - whether it was good, or bad or to note.

Pat Foster responded that the Healthwatch would present reports once the community engagement work is completed. These reports would be about the work with the carers, partnership with village agents in Chew Valley and all these reports/updates would be included in the main report.

The Chairman said that the current report from Healthwatch only presents cold statistics of operations and the Panel would prefer to see a story to reflect on the merits of the Healthwatch operation.

Pat Foster suggested that future reports from the Healthwatch could be around specific themes. The Chairman welcomed that suggestion.

Councillor Beath agreed with the comments from the Chairman and Councillor Bevan. Councillor Beath said that 70% of engagement through social media would not give evidence that Healthwatch were getting through to the groups they had been set up to reach. Councillor Beath suggested that the report should also include which groups Healthwatch reached.

Councillor Jackson agreed with the Chairman and Councillors Beath and Bevan. Councillor Jackson expressed her concerns on overemphasis on social media, especially if sensitive issues would be discussed in public (i.e. personal drug problems, issues with pharmacies, etc).

Councillor Simmons commented that it would be impossible to find out, or recognise, how many people, within the 70% who engaged via social media, were actual service users. Councillor Simmons also said that Twitter and Facebook, although quite useful tools, should not be seen as main source of contact with service users.

Councillor Jackson asked about the work with Diversity Trust to reach LGBT community.

Pat Foster responded once the partnership work with the Diversity Trust develops Healthwatch would then set a forum to involve people in the discussion, to hear what they have to say about services.

Councillor Bevan asked if, given the discussion held today on the social media engagement and the Panel's view on that matter; it would be worth questioning the appropriate team in the Council responsible for establishing remit of operation by pointing out this flaw in the process.

The Chairman commented that the Healthwatch would have to discuss this with the relevant team in the Council and present concerns raised by the Panel.

It was **RESOLVED** to note the update and for Healthwatch representatives to take on board comments made by the Panel.

89 NHS 111 UPDATE (20 MINUTES)

The Chairman invited Dr Ian Orpen to go through the report.

The Panel made the following points:

The Chairman invited South Western Ambulance Service (SWAS) NHS Foundation Trust representative, Francis Gillen (Executive Director of Information Management & Technology) to comment.

Francis Gillen said that the biggest pressure on ambulance service was on Saturday and Sunday mornings. Francis Gillen also said that the SWAS, as an emergency transport service, would have different criteria from non-emergency transport service, in terms of response.

Dr Orpen agreed with Francis Gillen on pressures during weekends.

Councillor Bevan asked if working conditions for clinical staff were unrealistic and the expectations from the staff were quite high.

Dr Open responded that this would be the provider's responsibility, on how they treat and train their staff. The CCG had discussions with the provider on how they could support them on this issue.

Members of the Panel felt that the NHS 111 had improved in the last few months. Councillor Jackson added that organisations in Radstock as well acknowledged an improvement in the NHS 111 services.

It was **RESOLVED** to note the latest performance of the NHS 111 service, to acknowledge that the NHS 111 service has improved and also to receive a further update in 6 months' time.

90 NON-EMERGENCY PATIENT SERVICES FROM ARRIVA TRANSPORT SOLUTIONS LTD (30 MINUTES)

The Chairman invited Corinne Edwards (B&NES CCG) to give a presentation to the Panel.

Corinne Edwards highlighted the following points in her presentation called 'Non-Emergency Patient Transport Services' (attached as appendix to these minutes):

- Why did we tender PTS?
- Our service model
- Our procurement process
- Service launch
- Four months on
- Our governance arrangements

- Improvements made since service launch

The Panel made the following points:

Councillor Jackson thanked Corinne Edwards for a quite comprehensive presentation, which was very helpful in understanding in more detail how commissioner and providers understood this issue. Councillor Jackson read out comments from one of patients, who complemented the new service launch though some dialysis patients were not allowed to phone for their return journey until 1.15pm.

Corinne Edwards took those comments on board.

Councillor Jackson also asked if there was an intention to have a dialogue with patients to improve services even further.

Corinne Edwards responded that the first patient experience would be undertaken in the first quarter of 2014/15.

Councillor Beath said that she was glad to see improvements since the last meeting of the Panel. The report did not have any figures for the Panel to analyse so Councillor Beath asked for a further report/update in six months' time

Councillor Simmons expressed some concerns regarding staffing issues, in particular if the same number of staff were taking more work. Councillor Simmons was also concerned about training of the new staff members.

Corrine Edwards and Arriva Transport Solutions representatives assured the Panel that staffing arrangements had been resolved.

Councillor Bevan asked why the tender was data inaccurate, making it difficult for the provider to plan for a far greater provision than expected.

Corrine Edwards responded that there were 30 providers across the area with different contracts in place. The key providers were giving the right information though other, smaller, providers were submitting limited information. Now, with one accountable provider, there is an expectation for a more efficient system.

The Chairman concluded the debate by saying that the Non-Emergency Patient Services had to go through this exercise. The Chairman was pleased that some issues had improved though some others, such as booking times, were still unsatisfactory.

It was **RESOLVED** to note the report and presentation and to receive a further update in 6 months' time.

91 THE RUH PRESENTATION ON THE LATEST CARE QUALITY COMMISSION INSPECTION (20 MINUTES)

The Chairman invited James Scott (The Royal United Hospital in Bath Chief Executive) to give a presentation to the Panel on the latest Care Quality Commission inspection.

James Scott highlighted the following points in the CQC presentation about the inspection of the RUH Bath (attached as appendix to these minutes):

- Our new approach
- CQC New approach: Site visits
- Key Findings by service
- Areas of Good Practice
- Areas for improvement: Should

The Panel congratulated James Scott and the staff of the RUH Bath on a good result and good outcome of the CQC inspection.

The Chairman enquired on the current status of the Foundation Trust (FT) application.

James Scott responded that the outcome of the CQC inspection, as quality regulator, certainly would give a boost for the FT application. The Monitor (economic regulator) would have to give at least 'good' rating before the RUH could move forward with the FT application.

It was **RESOLVED** to note the presentation and to congratulate everyone at the RUH Bath on excellent results from the CQC's latest inspection.

92 PUBLIC HEALTH "DIRECTION OF TRAVEL" (20 MINUTES)

The Chairman invited Bruce Laurence (Director of Public Health to give a presentation to the Panel.

Bruce Laurence highlighted the following points in his presentation named 'The direction of travel – Public Health' (attached as appendix to these minutes):

- What is Public Health
- Obesity System map
- Public Health in 3.5 nutshells
- Public health policy: Why would we do what we do?
- Leading causes of death in perspective
- Risks leading to death in perspective
- Causes of avoidable death
- Illness: "Years Lived with Disability"
- The common long term conditions
- Burden of disease from 20 leading risk factors
- Needs assessment and issues informing commissioning intentions
- Emerging priorities for commissioning and strategy in 2014/15
- New strategy, pathways, services or programmes expected to be in place in 2014/15

Members of the Panel welcomed the presentation from Bruce Laurence.

Members of the Panel recognised the value of the Joint Strategic Needs Assessment, which identified the needs of the people in B&NES.

The Panel commented that suicide had been placed quite high on the list of leading causes of death and asked what more could be done to help people.

Bruce Laurence commented that talking therapies were designed to help people on how to deal with distressing and difficult thoughts, feelings and behaviours, though it was not Public Health who commissioned that service. Jane Shayler commented that Andrea Morland would present a report at one of the future meetings of the Panel, which would include information about talking therapies.

It was **RESOLVED** to note the presentation from Bruce Laurence.

93 ALCOHOL HARM REDUCTION SCRUTINY INQUIRY DAY - CABINET MEMBERS' RESPONSES (20 MINUTES)

The Chairman invited Emma Bagley (Policy Development and Scrutiny Project Officer) to introduce the report.

The Panel made the following comments:

Recommendation 9.1 – Although this recommendation didn't naturally fall within the remit of the Wellbeing PDS Panel, Members flagged how "appropriate licensing enforcement" may not fall under the PCC, as this is a duty of the Council with onward linkages to environmental health. The Panel asked for the relevant Cabinet Member to take this on board and to re-consider the response in view of this perceived anomaly.

Recommendation 2A – Whilst the Panel were mindful that a business case was to be raised, there was no date given to when the action would be deferred. The Panel asked the relevant Cabinet Member to agree a date.

Recommendation 3.1 - The Panel would like to understand more about the alcohol liaison service at the RUH.

It was **RESOLVED** to note the report and for the relevant officers to communicate Panel's comments to relevant Cabinet Members.

94 PANEL WORKPLAN

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

- Non-Emergency Patient Services update for September 2014
- Care Quality Commission briefing on standards of quality and safety – date to be confirmed
- NHS 111 update for September 2014

The meeting ended at 2.00 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 –March 2014

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1. PUBLIC ISSUES

Supporting People and Communities 'Market Place' Day

More than 30 providers commissioned by the SP & C team came together for a 'Market Place' event on 5th February 2014 in the elegant surroundings of the Banqueting room at the Guildhall, Bath. SP & C commissions a wide range of services aimed at maximising independence, preventing needs from escalating and promoting community resilience. The aim of the day was to inform colleagues working across the health and social care sector in B&NES about all the services and groups available to support the local community. Many visitors commented that they had found out about useful services that they had not known about previously.

Workers and service users set up stalls with lots of leaflets and photos about the wide range of activities they provide throughout Bath and North-East Somerset. Those attending included elected members and colleagues from a wide range of local services/partners, including the Connecting Families Service, RUH, AWP, St John's Hospital and Sirona Care and Support.

There were lots of sampling opportunities, including the chance to try out the latest technology for people with hearing loss and gadgets designed to keep people safe at home. Visitors could listen to music CDs and admire wooden cabinets and other furniture produced by service users and some of the social enterprises that Supporting People and Communities fund.

Many Providers are keen to hold a similar event aimed at service users and their families and carers and SP & C are working to help facilitate this in the summer.

Learning Disabilities Partnership Conference 2014

Approximately 220 people recently attended the Bath and North East Somerset annual Learning Disabilities Partnership conference, of whom more than 100 were people with learning disabilities and more than 30 family members also attended. The theme for this year's conference was one of Partnership and how people with learning disabilities have worked with other agencies, particularly around keeping safe and being healthy. Amongst the highlights were presentations from Avon and Somerset Police about a new Safe Places scheme; Aquaterra and the Active Sports and Lifestyles team who presented information about an innovative 'Sports Buddy' scheme to support people to take exercise and use the local leisure facilities. Plus Bath University who have supported students to volunteer at the Bath Bistro, and a monthly restaurant night run by and staffed by people with learning disabilities.

Changes to adult social care recording from 1st April for 2014/15

Key points

a) A national review by the Health & Social Care Information Centre (HSCIC) of the adult social care data collected nationally from local authorities was completed in 2012. This was known as the "Zero Based Review" (ZBR).

b) The purpose was to completely update the data collections to meet more up to date requirements which fit with the DH direction of travel regarding the transformation of social care service. (The ZBR and the new requirements pre-date the 2013 Care Bill.)

c) Much of the data published nationally will change. The data available locally and which we will want to monitor locally will also change.

d) There were some small changes for 2013/14 recording but the majority take effect in 2014/15 for reporting in 2015.

e) The main changes over the two periods include:
   i. Two statutory returns covering referrals, assessments and community and residential support (RAP and ASC-CAR) have been replaced with a return looking at the data in terms of Short And Long-Term support (known as the SALT return).
   ii. A new-format financial return will be based on the SALT return.
   iii. Small changes to the:
      - Abuse of Vulnerable Adults return – now known as the Safeguarding Adults Return (SAR) this has been in place for 2013/14 collection
      - Guardianship Return
      - Deprivation of Liberty Safeguards Return
   iv. A new equalities and classification framework has been introduced. This expands the recording about clients, carers and the care pathway.

f) To implement these changes we have been working with Council colleagues and service providers (principally Sirona Care & Health and Avon & Wiltshire Mental Health NHS Trust) to ensure that data they report to the Council meets the new formats and requirements.

g) Sirona Care and Health have informed all staff of the changes and the rationale for this through a number of roadshows; AWP have informed staff through team meetings.

h) The Council and service providers are confident that all data requirements will be fulfilled and deliverable to the HSCIC.

Social Care Pathway

Redesign is on target to be implemented on the 1st July.

Direct Payment Service

The existing Direct Payment Support Service is being re-tendered following notice given by the incumbent provider to end the current contract on the 30th September 2014. A draft specification is currently being consulting upon; there is a consultation event planned for the 18th March 2014 along with various other ways in which the public can give their views for example the new online consultation portal . The new specification includes the requirement to be mindful of social value, the requirement to demonstrate a user led organisation and the move towards the use of pre-payment cards.

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 13th March 2014 1151 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 an increase since the last report of 11 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. The performance for the Quarter 4 period will be available in the next report.

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 where no concerns were raised have been reviewed during the reporting period as part of the planned schedule of contract review activity. In addition 7 homes have been reviewed during January and February 2014 and 9 homes have received short reviews to follow up action plans from the full review process.

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 (January 2014 – End of February 2014)

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 a projected number of care hours they will deliver, then this amount is adjusted to reconcile with the actual number of care hours delivered.

During the reporting period the total number of care hours delivered by all contracted providers was between 4969 (29th of January 2014 to 550 service users) and 4821 care hours (25th of February 2014 to 537 service users). These hours are 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. On the 11th March 2014 83% of all commissioned domiciliary care (4643) was being delivered by the strategic partners with the remaining 17% being delivered by either a contracted spot provider or commissioned under a 'one off agreement'.

The 17% of hours commissioned outside of the strategic partnership contract are delivered equally through spot and one off agreement contracts.

Hours of Service Provided by Four Strategic Providers per Zone:

Zone	Number of Service Users	Number of Visits	Care Hours
Bath North	117	1173	879
Bath South	139	1620	1223
NES (Keynsham)	74	940	692
NES (Norton Radstock)	116	1481	1064
	446	**5214**	**3858**

Care Quality Commission Data

Three of the four domiciliary care strategic partners have been inspected by CQC since December 2013. Two have been found to be fully compliant with all essential standards being met. The third was judged to not be meeting the standard around supporting staff. The Inspection report states the following:

Staff we spoke with confirmed they had completed core skills training and records welooked at showed evidence of this training being completed. One care worker described the training available as "very good" and another told us "it was very worthwhile". Staff received good informal support however there was a failure to provide 1:1 supervision and yearly appraisals. We asked care workers about the support they received. All of the 10 care staff we spoke with were very positive about the informal support they received. Particularly the availability of supervisors and the response they received if they spoke to office staff. One care worker said the support was "very good" and another described it as "brilliant". A third care worker said they were "really impressed with the agency". However staff told us there was little one to one supervision available. We were told there was "no regular 1:1 supervision", "can't remember when I last had 1:1 and "have only ever had one 1:1 supervision. We looked at records for nine care staff. Of these there was evidence of 1:1 supervision for three, of the remainder there was no evidence of their having had 1:1 supervision. Staff we spoke with told us they had not received a yearly appraisal. The records we examined showed none had received an appraisal in 2013.

This was, however, judged by the Compliance Inspector to have a minor impact on people who use the services of this provider. The provider has produced an action plan to address this issue, which has been submitted to CQC and shared with Commissioners.

At the time of writing the fourth strategic domiciliary care provider had just been inspected (8th March 2014) but the report has yet to be published. It is understood that the provider was verbally informed that they had been judged to be fully compliant.

Two of the spot contract providers have also been inspected by CQC since the end of December 2013 and both have been judged as being fully compliant.

Service User & Stakeholder Feedback

Feedback about the quality of services received from the domiciliary care strategic partners and spot providers is sought by Sirona Care and Health staff when conducting service user reviews. Since the beginning of January 2014 4 concerns have been shared with Commissioners and providers following reviews undertaken.

- One concern related to staff not recording food consumed by the service user in the person's day to day records. This was reported to the agency who have addressed this concern with staff.

- One related to a late visit. This was due to staff sickness.

- Two related to care plan not being followed. These issues were discussed with the provider and addressed following review meetings.

Two concerns have been received with regards to spot contract providers. These concerns relate to timing of visits and have been addressed with the provider concerned**.**

Commissioning & Contracts Review

All strategic providers were reviewed in November and December 2013 by Commissioning and Contracts and no concerns were identified as part of this review process.

A Strategic Partnership Meeting was held on the 13th of March 2014. Providers presented feedback on their latest internal quality monitoring results and provided information on their staff recruitment and retention. All providers demonstrated a commitment to providing quality services and a willingness to address concerns.

During the last twelve months providers have introduced computer monitoring systems which allow for planning travel time between scheduled visits and continue to encourage staff to ring into their offices when they are running late so that contact can be made with the service users.

Commissioning and Contract Officers liaise closely with CQC and with health and social care colleagues to triangulate intelligence and to agree collaborative responses to any 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

The strategic partnership contract sets out the basis where providers are paid along with the reconciliation process. Bath & North East Somerset is one of only four Local Authorities who pay over the UKHCA's recommended minimum hourly rate for care. The four strategic providers have been willing to negotiate inflationary uplifts with the Local Authority on an annual basis.)

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NHS
Bath and North East Somerset
Clinical Commissioning Group

BaNES CCG Update
Well-being Policy Development & Scrutiny Panel - 21st March 2014

Update on 5 year plan preparation

All CCGs are required 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 first full draft of the plans will be signed off by the Health and Wellbeing Board on the 26th March 2014 and the CCG's Governing Body and Council of Members on the 27th March 2014.The final 5 Year Strategic plan has to be submitted to NHS England in June.

The CCG has held a series of workshops with our key stakeholders during February and March to identify and agree on our key priorities for the next five years. The six priorities we have agreed are:

1. Safe Compassionate are for Frail Older People
2. Prevention and self-care
3. Diabetes care
4. Musculoskeletal services
5. Interoperability of Patient record systems
6. Urgent Care

We presented an overview of our 5 year plan at a public meeting on Thursday 13th March which was attended by members of the public and representatives of voluntary sector groups. Further public engagement events will take place throughout April.

New Lay Member Appointed

We are delighted to have appointed Suzannah Power as our new lay member for public and patient involvement. Suzannah was Patient Representative on the British Heart Foundation Council from 2007–2013 and has represented the public viewpoint on several NICE guidelines, including Patient Experience in Adult NHS Services. Suzannah will Chair the CCG's new public and patient involvement group: Your Health, Your Voice.

Your Health Your Voice

The CCG has held four events during March to recruit volunteers for our new public and patient participation group: Your Health, Your Voice. Events have been held in Bath, Midsomer Norton and Keynsham and at different times of day to try to give as many people as possible the opportunity to attend. We are now making active contact with those community groups who cannot or may not want to attend public meetings to seek their views on representation on Your Health Your Voice.
Patients and members of the public are being offered two different ways to get more involved in the CCG.

Core members will form a committee of 10 to 15 people who will meet every two months to review the current work of the CCG and ensure that patient voice is at the heart of the CCG's decision making. The intention is for the committee to be representative of the BaNES population and contain a mix of ages and backgrounds from across BaNES.

Associate members will not be required to commit to regular meetings but will be able to provide feedback to the CCG on a regular basis through e-mail, post and phone. We expect our network of associate members to continually expand as we encourage more people to get more involved in the planning of their local health services.

Urgent care update

We remain on track for the opening of the new Urgent Care Centre at the RUH and the mobilisation of the new Out of Hours and Homeless Service on Tuesday 1 April.

The CCG is facilitating weekly mobilisation meetings with the new provider, Bath and North East Somerset Doctors Urgent Care (BDUC), and other key partners including local GPs and the RUH. Dr Alan Whitmore has been appointed as the Local Clinical Director for BDUC and they are also in the process of inducting local GPs and nurse practitioners who will provide the out of hours service from their new base at the RUH.

A communications plan is being followed to raise awareness that services are moving from the Riverside to the new UCC on 1 April. This includes letters to key stakeholders, posters at the existing GP led HealthCentre and leaflets and posters in a range of key health and public locations, including the majority of businesses in Bath as well as public sector organisations.

Vascular stakeholder event

On the 6th March 2013 a range of stakeholders came together to discuss the proposed changes to vascular services in this area. Vascular Services are a specialised service area and are commissioned by NHS England.

The main topics covered at the event, which brought together specialist commissioners, members of the public, GPs and hospital clinicians, included:

- Giving information about the proposed service changes to local vascular services to meet the new national service specification requirements
- Providing an opportunity for current patients and carers that have vascular surgery to tell us what was good about current services and what could be improvedso this can inform future service changes.
- An opportunity for people to share ideas that will be sent to the national clinical reference group that developed the service specification and is responsible for setting the strategic direction and performance monitoring of vascular developments nationally.
- An opportunity for participants to express an interest in getting more involved in the work of NHS England and their local CCG so they can be added to the region's PPE database.

All the feedback obtained is currently being put together and will be published in due course.

Friends and Family Test in GP Practices

The CCG has been awarded funding to trial the use of electronic tablets in nine surgeries to collect patient feedback. The questions are based on the NHS Friends and Family Test which will be mandatory for all GP practices from December this year. The feedback will be used to help measure the quality of patient experience and identify ways to improve this further.

The new technology is also being used to measure the quality of care across the whole care pathway for heart failure patients. The Heartfelt Project is collecting feedback from heart failure patients at a range of touch points including their GP practice, the RUH and Sirona Heart Failure Nurse Specialists.

Vasectomy Contract

The CCG has awarded the contract for vasectomy services to BaNES Emergency Medical Services (BEMS). The contract is worth £40,000 and the service was previously provided by Sirona Care and Health.

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NHS Bath and North East Somerset Clinical Commissioning Group

Non-Emergency Patient Transport Services

Date: 21/03/2014 Corinne Edwards

Healthier, Stronger, Together

Why did we tender PTS?

- Provision split over at least 30 different providers
- Limited clinical or financial governance processes in place
- Almost impossible to measure service performance; understand activity; monitor standards and; understand costs
- Increasing charges from PTS providers without clear rationale for uplift
- Ad-hoc requests not under contract
- Increasing demand due to demographic changes & shift of services into the community

NHS Bath and North East Somerset Clinical Commissioning Group

Our service model

- A single point of contact
- Assessment of eligibility criteria
- Operates 24/7, 365 days
- Sign posting for non-eligible patients
- On-line booking system
- Min 10% of activity to be sub-contracted to support capacity & develop the market
- Continued use of volunteer car drivers

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Our procurement process

- Single joint process agreed in May 2012
- Included competitive dialogue to help develop service spec, discuss service issues & provider experiences
- Four contracts to be awarded to a single accountable provider
- 18 months of stakeholder engagement inc acute providers and patient representatives

NHS Bath and North East Somerset Clinical Commissioning Group

Service launch

- Arriva service went live on 1st Dec 2013
- Preceded by six months of planning and mobilisation work
- Initial weeks characterised by:
  - Extremely high call volumes
  - Incomplete or inaccurate booking information inherited
  - Journey volume that exceeded expected level
  - Variation to expected journey mix
  - Movement of out of area patients
- Impact on acute hospitals & renal dialysis units

NHS Bath and North East Somerset Clinical Commissioning Group

Four months on

- BaNES total journeys above expected (bid) level
- Average mileage below expected
- Patient mobility significantly different
- Performance improving, but two KPIs below target (cause of complaints)
- Performance for renal dialysis patients better than the full patient cohort

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Our governance arrangements

- Frequent & regular mobilisation and post go-live meetings plus conf calls
- Routine contract performance monitoring & quality review meetings start this month
- Weekly and monthly activity & performance data
- Specific weekly acute Trust level dashboards
- KPI penalty regime starts 1st April 2014
- Quality incentive uplift earnable against five KPIs

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Improvements made since service launch

- Average & maximum calls waits have reduced
- Increasing trend of on-line bookings
- Increase in front-line staffing
- Re-profiling of vehicle shift patterns
- Renal hotline and renal champion
- Move to dedicated drivers for dialysis patients
- Built-in buffer time in schedules for dialysis journeys
- Acute Trust action plans
- Patient experience manager appointed
- Local complaints administrator to be appointed

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Thank you
Any questions?

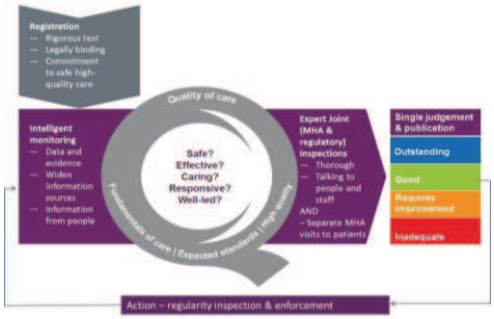
Healthier, Stronger, Together

Royal United Hospital Bath NHS

RUH BANES Wellbeing Policy Development & Scrutiny Panel

Healthcare you can Trust

Our new approach



2

CQC New approach: Site visits

- **Eight Core service areas** : A&E, Medicine, Surgery, Critical Care, *(Maternity & Family Planning),* Children's Care, End of Life Care, Outpatients.
- Announced and unannounced
- Large teams – chair, team leader(s), doctors, nurses, AHPs, managers, experts by experience, CQC inspectors, analysts, planners
- Presentation by CEO
- Visits to clinical areas
- Staff focus groups (junior/senior doctors and nurses etc.)
- Patient and public listening event(s)
- Interviews with senior managers

3

Key Findings by service

Accident & Emergency

- Safe and effective. Good clinical outcomes – and improving. Patients with mental health needs could be waiting a long time for assessment but efforts were being made to improve this. Staff caring and A&E was well led by a strong and cohesive team. Service changes had improved response to demand for services. Staff felt better able to cope with pressures.

Medical Care (including older people's care)

- Safe and effective. Good clinical outcomes. Better record keeping and **warning notice lifted**. Staff were caring but staffing levels had an impact on patient care particularly at busy times and on busy wards (eg MAU). Good dementia care on wards – and developing. Patient discharge was well supported but some delays to the discharge of patients with complex needs. – and improving.

Surgery

- Safe and effective . Good safety checks and cleanliness and infection control . Some areas could have been better maintained (eg PACU). Equipment was usually available when needed, although some checks were not done as required. Staff were caring and services were responding to patient needs. Staffing levels sometimes delayed patient surgery and delayed patient transfers between theatre, recovery and ward areas. Some concerns, at busy times and in busy areas (eg SSSU). Care was improving care for people with dementia and learning disabilities . Most teams worked well together

4

Key Findings by service

Intensive / Critical Care

- Safe and effective. Staffing levels in the critical care unit needed to improve to reduce the pressures on staff. Clinical outcomes good - improving. Staff showed outstanding consideration and compassion. Staff morale was improving and there was effective team working, although training and professional development needed to improve. There was an unacceptably high level of delayed discharges because of capacity problems elsewhere in the hospital, and this added to the pressures on the unit. The trust was taking action to managed risks but national delays to recruiting staff had not been effectively communicated . Staff told us risks were now being managed effectively

Children's Care

- Children received safe and effective care. Staffing met needs of children in centre. Staffing in the neonatal unit needed to improve to meet intensive care standards, and the supervision of children in A&E needed to improve. Service was caring and responsive eg parents praised the neonatal unit and commented on how it created a feeling of calm and wellbeing. Staff engaged well with the children and treated them with dignity and respect. Staff told us they felt supported and took pride in their work, although in some areas they needed further specialist training. Risks needed to be better monitored to demonstrate that these were being managed effectively.

5

Key Findings by service

End of Life Care

- Safe and effective. Service was integrated with GPs and community services, which supported effective discharge arrangements and care at home. Most patients and their families were positive about the care and support they received, and said they were treated with dignity and respect from reception staff through to consultants. Staff had appropriate training and supported patients to be fully involved in their care and decision making. The service was well-led and staff were dedicated to improving standards of end of life care across the hospital.

Outpatients

- Safe and effective. Staff needed to improve understanding of MCA (2005). Patients waiting times were within national targets. Some patients waited longer for appointments at the pain management clinic, and some patients waited a long time for consultations when clinics were busy. Patients told us the breast care clinic was outstanding. The outpatient clinics were managed differently by departments and information on quality and safety was just beginning to be shared. The trust had commissioned work to review and further improve outpatient services.

6

Areas of Good Practice

- Good progress towards **seven-day working**, for example, in the A&E department, for patients receiving emergency medical and surgical care.
- Patient **in-hospital mortality rates** were lower than expected and there was no difference between weekday and weekend mortality.
- The trust had developed a number of **innovative services** to cope with winter pressures and a high demand for services.
- The A&E department had a rapid assessment team known as 'senior with a team' (**SWAT**). This team had improved the speed at which patients who arrived by ambulance were assessed, investigated and treated.
- Regional and national recognition for developing **Dementia Charter Marks** (with the Alzheimer's Society) for its model of dementia care at ward level.
- **Coombe Ward** had been redesigned and refurbished as a dementia-friendly ward.

7

Areas of Good Practice

- WHO surgical checklist was well embedded. Staff understood its value and importance - no **never events** in surgical theatres for 18 months.
- The emergency surgical ambulatory clinic was s designed to see patients with urgent general surgical problems - helped to avoid hospital admissions and had reduced the time inpatients waited for emergency surgery.
- Staff in the **critical care** unit showed dedication to the service and provided outstanding compassionate care.
- The **neonatal unit** created a calm environment and was designed to enhance people's feeling of wellbeing.
- End of life care was an **integrated pathway of care** with GP and community services and provided a 24-hour service based on good out-of-hours arrangements with a local hospice.
- Patients overwhelmingly told us that the **breast care clinic** provided an excellent service.
- '**See it my way**' events were held for staff - these events had patients telling stories of their experiences of care

8

Areas for improvement: Should

- The trust needs to ensure that there are effective operations systems to regularly assess and monitor quality of the services provided; to identify, assess and manage risks and to make changes in treatment and care following the analysis of incidents that resulted in, or had the potential to result in harm.

- *Staffing levels, training, impact of service changes*
- *Monitoring – trust, divisional and service levels; risk registers to demonstrate risks are being managed / mitigated; checks eg on equipment monitored.*
- *Monitoring and learning from incidents and complaints*
- *Patient needs met but monitoring and response in busy areas, staff working under pressure (eg surgical lists, critical care, neonatal unit) supervision of children in A&E*
- *Patient flow – patients on the appropriate wards - or monitoring where patients are on outlying wards (eg critical care in PACU)*

9

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Wellbeing PDS Panel

The direction of travel

Public Health

March 2014

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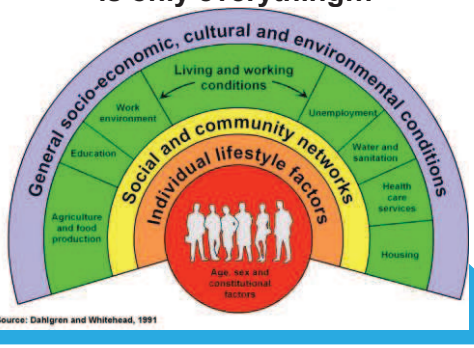
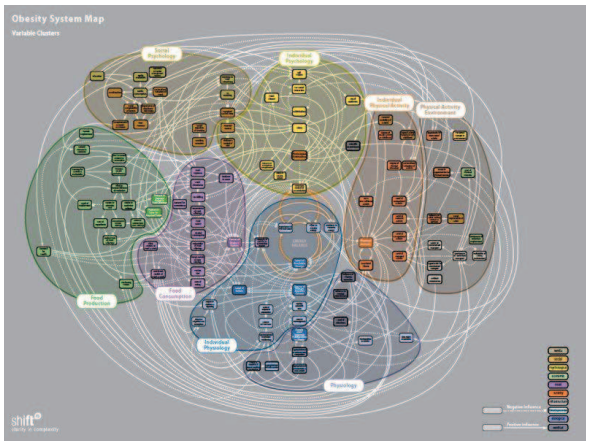
Public health: is only everything…





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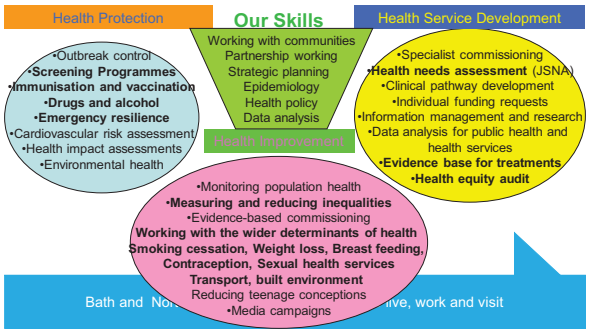
Public health in 3.5 nutshells



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Public health policy: Why would we do what we do?

- **Needs of the people of Bath and North East Somerset based on data, JSNA, local democratic voice**
- **Council's vision and Health and Wellbeing Strategy**
- **Finding the new opportunities in local government: working with planning, place-making, transport, leisure, children and adult services.**
- **Nationally mandated services and roles and emerging policy**
- **Existing contractual commitments and legacies**
- **Serving others in a way that promotes public health**
  - **The NHS through CCGs**
  - **Other partnerships**

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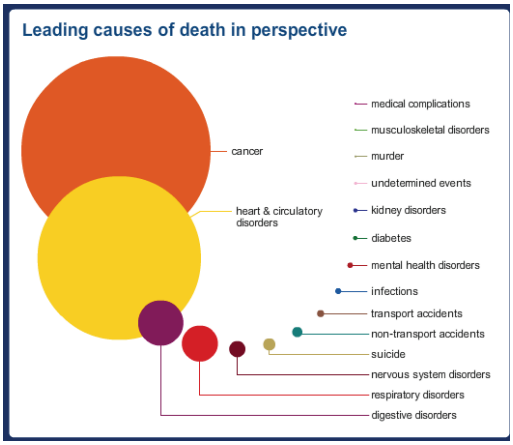
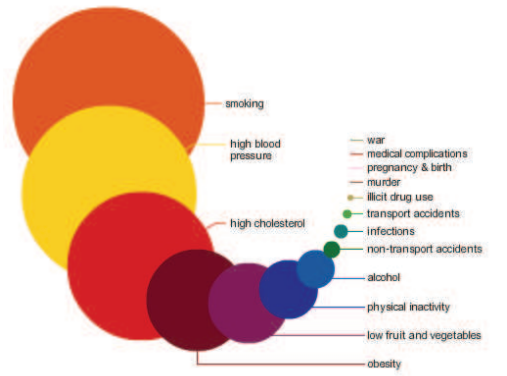


Risks leading to death in perspective



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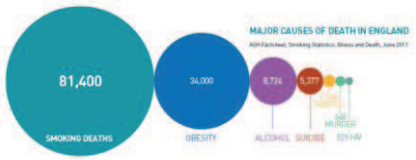
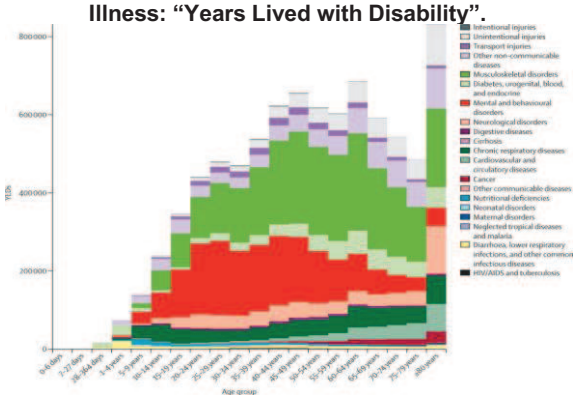
Causes of avoidable death



Illness: "Years Lived with Disability".



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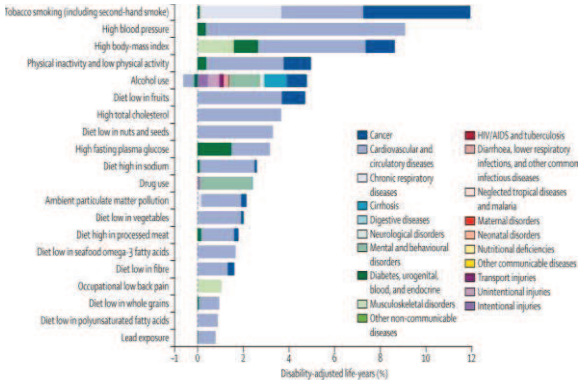
The common long term conditions

Type of Long-Term Condition	Numbers affected		% Change
	2006/07	2010/11	
Hypertension	6,706,000	7,460,000	11%
Depression	0*	4,878,000	N/A
Asthma	3,100,000	3,273,000	6%
Diabetes	1,962,000	2,456,000	25%
Coronary heart Disease	1,899,000	1,878,000	-1%
Chronic Kidney Disease	1,279,000	1,855,000	45%
Hypothyroidism	1,367,000	1,667,000	22%
Stroke or Transient Ischaemic Attacks	863,000	944,000	9%
Chronic Obstructive Pulmonary Disease	766,000	899,000	17%
Cancer	489,000	876,000	79%
Atrial Fibrillation	692,000	791,000	14%
Mental Health	380,000	438,000	15%
Heart Failure	420,000	393,000	-6%
Epilepsy	321,000	337,000	5%
Dementia	213,000	267,000	25%

Plus 8.5 million with arthritis!!

Burden of disease from 20 leading risk factors



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Needs assessment and issues informing commissioning intentions

- Local residents needs, identified through the Joint Strategic Needs Assessment (JSNA) www.bathnes.gov.uk/JSNA
- Local wellbeing priorities, set out in the Health and Wellbeing Strategy and the Annual Report of the Director of Public Health (DPH)
- Learning from local reviews during 2013/14, including an external assessment of our work on tobacco control and a council inquiry day on alcohol harm reduction.
- New evidence and policy emerging on key public health issues during 2013/14 and a review of local service provision for gaps or opportunities to improve quality
- Input from members, Healthwatch and other channels for local opinion
- Partner's needs for public health evidence analysis and advice

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Emerging priorities for commissioning and strategy in 2014/15

- Implement the priorities arising out of key local needs assessments, strategies and reviews. Support delivery of all HWS streams
- Influence wider work of B&NES council to impact on the social and economic determinants of health and health inequalities. Particularly through placemaking plans and transport and get active strategies
- Shifting investment from treatment to prevention across system
- Develop stronger locality focus inc. through Connecting communities
- Meet obligations to commission a range of public health services.
- Support our Clinical Commissioning Group partners with public health information and advice in delivering their services

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New strategy, pathways, services or programmes expected to be in place in 2014/15:

- Tobacco control strategy and action plan agreed and implementation underway
- Refresh healthy weight & physical activity strategies. Food policy focus
- Progress delivery of the public health priorities within the Health and Wellbeing Strategy (including child obesity, alcohol, mental health, healthy and sustainable places)
- New Contraception and Sexual Health service contracted by October 14
- Increase uptake of Health Checks across B&NES, with greater increase in areas of low uptake and higher risk of vascular disease
- A range of programmes to support mental wellbeing and reduce the risk of self-harm
- Support CCG plans particularly self care and healthy living workstream

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