Bath & North East Somerset Council

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Date: 13th March 2014
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To: All Members of the Wellbeing Policy Development and Scrutiny Panel

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

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 21st March, 2014

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 21st March, 2014** at **10.00 am** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

   Appendices to reports are available for inspection as follows:-

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

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

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

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

6. **Emergency Evacuation Procedure**

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

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

Wellbeing Policy Development and Scrutiny Panel - Friday, 21st March, 2014

at 10.00 am in the Council Chamber - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

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

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

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

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

   (b) The nature of their interest.

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

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

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

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

   At the time of publication no notifications had been received.

7. MINUTES (Pages 7 - 24)

8. CABINET MEMBER UPDATE (10 MINUTES)

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

9. CLINICAL COMMISSIONING GROUP UPDATE (10 MINUTES)

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

10. HEALTHWATCH UPDATE (10 MINUTES) (Pages 25 - 28)

The Panel will receive an update from the Healthwatch representative on current issues. Panel Members may ask questions.

11. NHS 111 UPDATE (20 MINUTES) (Pages 29 - 36)

This report will update the Wellbeing Policy Development & Scrutiny Panel members on the implementation of the new NHS111 Service to the Bath & North East Somerset area and to report on current performance.

Panel Members received a briefing in September 2013, at a time when an Improvement Plan was in place to improve performance following problems during the launch of NHS 111. The Briefing Paper explains progress made and how the service performance continues to improve to meet the needs of local people.

The Panel is asked to note the latest performance of the NHS 111 Service.

12. NON-EMERGENCY PATIENT SERVICES FROM ARRIVA TRANSPORT SOLUTIONS LTD (30 MINUTES) (Pages 37 - 64)

This is a full report to the Panel on the contract with Arriva Transport Solutions Ltd for non-emergency patient transport services following the request made at the Panel's meeting on 17th January 2014.

The Panel is asked to note this report and consider when it would wish to receive a further update.

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

The Panel will receive a presentation from the RUH Bath representatives on the latest Care Quality Commission (CQC) inspection.

14. PUBLIC HEALTH "DIRECTION OF TRAVEL" (20 MINUTES) (Pages 65 - 66)

The Director of Public Health, Dr Bruce Laurence, has been invited to attend the Wellbeing Policy Development and Scrutiny (PDS) Panel to discuss the “direction of travel” for public health over the next few years, now that it is embedded within the Council.

The Panel are asked to note the contents of the presentation, endorses the general approach of the DPH and his team, and comments on any areas for further consideration.

15. ALCOHOL HARM REDUCTION SCRUTINY INQUIRY DAY - CABINET MEMBERS' RESPONSES (20 MINUTES) (Pages 67 - 78)

The Wellbeing Policy Development and Scrutiny Panel on the 21st March 2014, the Panel are asked to consider the recommendations response table completed by the Cabinet Member for Wellbeing, Simon Allen; Cabinet Member for Community Resources, David Bellotti; Cabinet Member for Sustainable Development, Ben Stevens; Cabinet Member for Neighbourhoods, David Dixon and the Cabinet Member for Early Years, Children & Youth, Dine Romero as detailed in the report; and also to discuss in particular the recommendations flagged as falling within the Wellbeing PDS Panel’s remit.

16. PANEL WORKPLAN (Pages 79 - 84)

This report presents the latest workplan for the Panel.

The Committee Administrator for this meeting is Jack Latkovic who can be contacted on 01225 394452.

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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 – 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.

Bath & North East Somerset Council		
MEETING/ DECISION MAKER	**Policy Development & Scrutiny Panel** **Committee**	
MEETING/ DECISION DATE:	**21.2.14**	
TITLE:	**Healthwatch Bath and North East Somerset update**	
WARD:	All	
AN OPEN PUBLIC ITEM LIKELY TO BE TAKEN IN EXEMPT SESSION		
List of attachments to this report: Please list all the appendices here, clearly indicating any which are exempt and the reasons for exemption		

1 THE ISSUE

1.1 Update report from Healthwatch Bath and North East Somerset

2 RECOMMENDATION

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

5 THE REPORT

healthwatch Bath and North East Somerset

Report to the Wellbeing Policy Development and Scrutiny Panel 21st February 2014

Healthwatch Advisory Group meeting 30.1.2014

- Heard a report from Jon Poole re JSNA and feeding information into the new format
- Agreed Healthwatch Advisory Group Terms of Reference
- Agreed the Healthwatch Communication Strategy
- Agreed the Healthwatch Community Engagement Strategy and Action Plan
- Scope of the Health and Wellbeing Strategy, NHS England priorities, CCG priorities, JSNA, Health inequalities to inform the Healthwatch work plan – actions to be agreed at the next meeting on 27.2.2104 at Saltford Hall
- Once the Healthwatch plan actions are agreed a programme of enter and view visits can be planned
- Asked for nominations for chair and vice chair of the Healthwatch Advisory group and there will be a vote at the next meeting

Local Authority Meetings

- Healthwatch attended and fed into the Local Authority Peer review meetings on 27.1.2014 and 30.1.2014
- Had a contract monitoring meeting on 10.2.2014
- Healthwatch volunteer attendance at the Health and Wellbeing Board on 29.1.2014

Healthwatch England

- Healthwatch Bath and North East Somerset attended a regional meeting on 29 1.2014 to discuss the proposed Healthwatch England consumer rights. These are out for consultation, visit them at **www.healthwatch.co.uk**

Health and Wellbeing network

- The Health and Wellbeing Network on 29.1.2014 for voluntary and community groups discussed the issues of Domestic Violence and feedback from the meeting was taken to the Health and Wellbeing Board meeting on the same day. This was difficult and now we are negotiating how we can feedback from the network to the board. The next Health and Wellbeing meeting is in March and will be on the CCG five year plan.

Community Engagement

- Continue to work in partnership with the Village Agents and attended a session at West Harptree to hear issues and concerns
- Attended the Keynsham and Chew Valley Multi Agency meeting
- Agreement with pharmacies to take 'Patient Story' leaflets
- Attended the Community empowerment Fund meeting made good contacts for future work to reach the LGBT community in Bath and North East Somerset
- Attended the Market Place event at the Guild Hall
- Met with Diversity Trust to begin to scope how to work together to reach LGBT community

- Attended a CQC listening event for inspection of OOH and GP
- Healthwatch volunteer attending the CCG Quality meetings has been asked to extend his remit and attend meetings of the Mental Health Collaborative group which is being reinstated to look at issues around mental health at the RUH

Communication – 70% of engagement through social media Dec 2013 figures

- 4637 website page views
- 106 visits from social media
- 237 visits to 'Your Stories' page
- 115 friends on Facebook
- 681 Twitter followers
- 287 tweets with 77 retweets with a potential reach of 326,078
- February e bulletin sent out
- Healthwatch wrote a statement for the RUH following the CQC report on their visit in December

Issues and Concerns

- Healthwatch have given the NHS England local team a reminder that our question needs to be answered within the statutory 20 days. We are asking if a parent has the right to appeal if the treatment required for her child with asphergers is not a funded service, particularly as there is a national strategy on children's vision that states that therapeutic services should be considered.

Pat Foster
General Manager - Healthwatch
The Care Forum

6 RATIONALE

7 OTHER OPTIONS CONSIDERED

8 CONSULTATION

9 RISK MANAGEMENT

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

Contact person	**Pat Foster – General Manager** **The Care Forum** **Tel: 0117 9589344** **Email: patfoster@thecareforum.org.uk**

Background papers	*List here any background papers not included with this report because they are already in the public domain, and where/how they are available for inspection.*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development & Scrutiny Panel	
MEETING DATE:	Friday 21st March 2014	
TITLE:	**Update on NHS 111 Service**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1: Briefing Paper		

1 THE ISSUE

1.1 To update the Wellbeing Policy Development & Scrutiny Panel members on the implementation of the new NHS111 Service to the Bath & North East Somerset area and to report on current performance.

1.2 Panel Members received a briefing in September 2013, at a time when an Improvement Plan was in place to improve performance following problems during the launch of NHS 111. The Briefing Paper explains progress made and how the service performance continues to improve to meet the needs of local people.

2 RECOMMENDATION

2.1 The Panel is asked to note the latest performance of the NHS 111 Service.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 None to note as part of this Briefing Paper.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Not applicable for this Report.

5 THE REPORT

5.1 The attached Report summarises performance and progress to date.

6 CONSULTATION

6.1 This Paper has been prepared in consultation with Harmoni.

7 ISSUES TO CONSIDER IN REACHING THE DECISION

7.1 Not applicable to this Report.

8 ADVICE SOUGHT

8.1 Not applicable to this Report.

9 RISK MANAGEMENT

9.1 Risk Management processes and systems remain in place as part of the NHS111 governance arrangements to monitor the effectiveness of the service.

9.2 Information on complaints, incidents and feedback from healthcare professionals is collated and reviewed by Harmoni and shared with the CCG's Clinical Governance Lead for NHS111, Dr Elizabeth Hersch, and with the CCG's Quality Team.

9.3 Discussions are currently underway to agree the process for ongoing monitoring and service across Avon, Gloucestershire and Wiltshire.

Contact person	Tracey Cox, Chief Operating Officer, BaNES Clinical Commissioning Group. Telephone: 01225 831736 Dr Elizabeth Hersch, GP and NHS111 Clinical Governance Lead for BaNES and Wiltshire CCGs. Telephone 01225 831760
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Briefing Paper – NHS 111 Services in BaNES

Introduction

1.1 The objective of the NHS 111 service is to support the delivery of urgent and emergency care by directing patients to the right service first time with clinical assessment and referral taking place within the same telephone call. The service also encourages different providers of urgent and emergency care to come together to consider ways to improve the patient's experience of care. Currently the service is commissioned locally, but to a national specification to ensure a consistent approach to quality across the country.

1.2 To support further transformation of urgent and emergency care, NHS England and CCGs will produce a new NHS 111 service specification to support future commissioning of a comprehensive service, but it is not yet clear how this will impact on services locally.

NHS 111 in BaNES

2.1 Panel Members will be aware that the service had a challenging start in February 2013 with poor performance across a range of measures which meant that the service was not meeting the national Key Performance Targets. Following the development of a Rectification Plan with weekly monitoring meetings, steady progress was made and the service progressed to full service commencement in October 2013.

NHS 111 Monitoring in BaNES

3.1 Contract monitoring is now carried out monthly and steady progress has been made except for Warm Transfer Rates (calls which require direct transfer to a Clinical Adviser without having to call the patient back) and Ambulance Dispatches.

3.2 Difficulty in the recruitment and retention of Clinical Advisers has contributed to the poor Warm Transfer Rate and Harmoni is continuing the drive to recruit and train good quality clinicians (Nurses and Paramedics).

3.3 Steps taken to address the ambulance dispatch rate includes listening to calls that resulted in an ambulance dispatch and using the learning to inform training and feedback to staff. Clinical Shift Leads have been appointed to monitor ambulance dispatches during shifts and the impact of this will be monitored during the next few months.

Clinical Governance

4.1 The Quality Monitoring Review Group focuses on clinical effectiveness, patient safety and patient experience. The monthly quality report provides updates on call audits carried out, number of complaints and incidents, and feedback from health care professionals as well as other reports e.g. Safeguarding Adults and Children.

4.2 All front line staff have 5% of their calls audited each month and feedback is given individually with further training and support as required.

4.3 The number of complaints and incidents are decreasing and there is evidence that the investigations of complaints and incidents are more robust and that the learning from these is used to improve the service.

Developments

5.1 Special Patient Notes (SPNs) provide specific information relevant to a patient with complex health and/or social care needs e.g. patients on the End of Life Care Register. SPNs are available to NHS 111 and GP Out Of Hours services to ensure that the patient is appropriately assessed, referred and treated. Many of the current SPNs are outdated and the quality is variable and not all are visible to NHS 111. There are also IT issues which do not allow SPNs to be added directly to the Adastra IT system. A proposal is being considered to address these issues and to support ongoing administration and quality assurance.

5.2 Post Event Messages (PEMs) are sent by NHS 111 to a GP Practice when one of their patients contacts the NHS 111 service. The message is transmitted electronically, but feedback from GPs indicated that messages are duplicated (GPs are also informed if the same patient is seen by the Out Of Hours Service) and do not always provide useful information. GPs now receive one message from the Out of Hours service stating that the patient was referred by NHS 111. Harmoni are required to audit the outcome of this change.

5.3 Directory of Services (DoS) - the DoS is the application which holds information that describes the services, care or referral available to the patient following as assessment by NHS 111. This can include referral to the Out of Hours Service or an appointment can be made directly into a Primary Care Centre. Due to the DoS and IT limitations the instructions regarding appointments are not always clear which can cause confusion for staff and poor patient experience when appointments cannot be made.

5.4 Changes to the DoS appointment booking across to Out of Hours Services across Avon, Gloucestershire and Wiltshire has been proposed and will be discussed at Avon, Gloucestershire and Wiltshire level.

5.5 Commissioners have agreed additional support for the DoS Lead to take these developments forward.

5.6 Audit of Minor Illness Unit (MIU) – an audit of referrals to the Paulton MIU was carried out in January 2014, due to a number of inappropriate referrals to the Unit, causing frustration to staff and poor patient experience. It was agreed to review how the MIU is profiled in the DoS and review all referrals from NHS 111. The impact of this will be reviewed in April 2014.

5.7 Contingency Arrangements - It has been agreed that the contingency process, for health care professionals who may need to access the NHS111 service as part of managing a patient's care pathway, which was introduced in March 2013 will continue beyond April 2014.

5.8 Ongoing Monitoring Arrangements - At the end of the Rectification Process it was agreed that the NHS 111 contract would continue to be monitored across Avon, Gloucestershire and Wiltshire (AGW) with a parallel process for clinical governance.

Going forward into 2014/2015, the intention was to move to quarterly reviews with clinical governance feeding into the overarching contract review and reporting by exception in line with other contracts. This approach may need to be revisited because of the ongoing performance concerns around Ambulance Dispatches and Warm Transfers. Meanwhile discussions are underway to formalise the governance and reporting arrangements to clarify decision making across AGW.

5.9 Panel members are asked to confirm whether any further updates on the progress of the NHS 111 service are required at a future date.

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Bath & North East Somerset Council		
MEETING	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING	**Friday 21st March 2014**	
TITLE:	**Arriva Transport Solutions Ltd Non-Emergency Patient Services**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Report on Arriva Transport Solutions Ltd Non-Emergency Patient Services		

1 THE ISSUE

1.1 To present a full report to the Panel on the contract with Arriva Transport Solutions Ltd for non-emergency patient transport services following the request made at the Panel's meeting on 17th January 2014.

2 RECOMMENDATION

2.1 The Panel is asked to note this report and consider when it would wish to receive a further update.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 There are no financial implications for the Council in relation to this report.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Not applicable for this report.

5 THE REPORT

5.1 Following the questions and concerns raised by Panel members at the meeting on 17th January, a full report about the new service model and contract performance since service launch is attached as appendix 1.

6 RATIONALE

6.1 Not applicable for this report.

7 OTHER OPTIONS CONSIDERED

7.1 None.

8 CONSULTATION

8.1 As stated in the report.

9 RISK MANAGEMENT

9.1 Not applicable for this report.

Contact person	Corinne Edwards, Senior Commissioning Manager, NHS BaNES CCG, Tel: 01225 831868
Background papers	Department of Health National Eligibility Criteria for Non-Emergency Patient Transport Services, 2007 (revised)
Please contact the report author if you need to access this report in an alternative format	

NHS
Bath and North East Somerset
Clinical Commissioning Group

Report on Arriva Transport Solutions Ltd Non-Emergency Patient Services for The Wellbeing Policy Development & Scrutiny Panel

Friday 21st March 2014

Contents

Executive Summary
In February 2012 the former Primary Care Trusts (PCTs) for BaNES and Wiltshire approved a review of existing non-emergency patient transport services (NEPTS). This was on the basis the provision across the two areas was split over at least 20 different providers with very limited contractual coverage and financial or clinical governance processes in place.

While some acute providers operated a central transport booking facility within their own Trust, there was no central booking facility at a PCT level, nor was there any mechanism for capturing and recording all patient journey activity. This made it extremely difficult, almost impossible, to measure NEPTS service performance, understand the volume of patient journeys, monitor standards, patient quality, safety and experience and understand costs of the service.

Subsequently Swindon and Gloucestershire PCTs engaged with the review on the basis of the same issues and concerns. In 2011/12 over £8.2 million was spent on NEPTS across BaNES, Gloucestershire, Swindon and Wiltshire (BGSW). This was split over at least 30 different providers. The four PCTs also faced increasing charges from the NEPTS providers and were incurring significant expenditure outside the scope of the contracts.

Following the review, the four PCT's approved a single joint procurement process in May 2012. This included a competitive dialogue process to provide the PCTs with the opportunity to openly develop a service specification, discuss service issues and experiences in detail with providers. It was also agreed four contracts would be awarded to a single accountable provider to manage the service more effectively, capturing journey information in a single database providing service intelligence that the PCTs had never had.

The procurement process commenced on 17th July 2012, and was concluded with contract award in June 2013 and contract signature in August 2013. Overlaying this was 18 months of stakeholder engagement and consultation. All stages were assessed by a panel of representatives from acute providers, commissioners and patient representatives.

Service Launch
The new NEPTS contract with Arriva went live on 1st December 2013, replacing a multitude of contract and ad-hoc arrangements. Initial weeks were characterised by:

- an extremely high volume of calls
- problems arising from the incomplete or inaccurate nature of bookings information inherited from the previous providers
- a journey volume that exceeded the expected level
- a significant variation to the expected journey mix (different patient mobility and vehicle types required)
- early winter pressures being experienced within the acute trusts
- some significant issues regarding arrangements for the movement of out-of-area patients to/from acute trusts within the contract area
- the need for acute trusts to revise their internal processes in a much more significant way than had been appreciated

Despite a comprehensive mobilisation process, the combination of these issues meant that there was considerable concern at the outset of the contract. Much of this was based on

information, which though in part unsubstantiated, has been challenging to refute, given that at the same time, there have also been some examples of poor performance as a result of the impact of the factors described (typically excessively long waits, sometimes resulting in overnight re-admissions or potentially detrimental impact on patients). Within this context, the following summarises some of the improvements that have taken place during the first three months of the contract.

Booking Centre – Call Taking

- Initial call-taking capacity was increased by 60%, including experienced Arriva staff from other NEPTS call centres, to cope with the anticipated volume of calls, and to reduce call wait times.
- Call volume has reduced from 5,500 per week to 3,500 per week (1st Dec to 14th Feb).
- Call abandonment rate has reduced from >30% to <10% (1st Dec to 14th Feb).
- Average call wait time has reduced from >3 minutes to <2 minutes (1st Dec to 14th Feb).
- Maximum call wait time has reduced from >25 minutes to <5 minutes (1st Dec to 14th Feb).
- Improved internal call handler training and individual performance management now taking place.

Online Booking

- Arriva trainers have attended acute trust sites to train up hospital staff and to train internal trainers on using the on-line booking system, Cleric.
- Ad-hoc issues with using online booking have been addressed and resolved.
- The proportion of bookings, amendments, cancellations and "make ready" actions made online has increased steadily and is now >30% (14th Feb 2014). This reduces the burden on the call centre, meaning faster call answering; and also provides real-time visibility of bookings, for hospital staff.
- The benefits of the online system are becoming progressively clearer for hospital staff, including the ability to review lists of booked journeys, and to take ad-hoc snapshots of outstanding patient journeys including those not booked ready.

Journey Timings

- Journey time and patient drop-off/collection performance has improved. Across the four CCGs, time on vehicle performance exceeds KPI level for all journeys over 10 miles, and is 1% below target for journeys under 10 miles (BaNES specific values are shown in appendix 2).
- On-time drop-off (in-bound) has consistently improved but is still below KPI target.
- On-day collection (within four hours) out-bound exceeds KPI target.
- Planned out-bound collection (within 60 minutes) has improved but is still below KPI target.

Capacity & Resources

- Total patient carrying capacity has been increased by 15% since day one.
- Front-line staffing is planned to increase by 15% with five new staff already in post.
- Accredited sub-contractors are now receiving their work through an innovative online tool.
- Significant re-profiling of Arriva vehicle shift patterns is resulting in increased capacity at critical times of the day, mainly weekday afternoons.

Dialysis

- A renal hotline has been implemented to provide direct renal-dedicated assistance.
- Two planners have been assigned on a dedicated basis.
- Progress has been made to move to dedicated drivers for renal dialysis patients.
- Ambulances fulfilling dialysis journeys now have in-built buffer (catch-up) time in their schedules to increase reliability and on-time performance.
- A “renal champion” operational support manager has been appointed and is now in post to address the various issues impacting renal dialysis patients, and to manage the implementation of Arriva service for Wiltshire patients attending SFT for dialysis; and to manage the relocation of the dialysis unit within Southmead for GBSW patients.

Acute Trust Action Plans

- Diagnostic visits conducted by Arriva and joint action plans produced by Arriva, in conjunction with the acute Trusts. These identify the main issues and concerns experienced within each Trust, and a series of actions that will resolve those issues. These plans are reviewed and updated weekly.
- Joint performance information is now provided weekly to acute Trusts, to further assist in embedding new processes and help build confidence in the new service.
- Where fixed time slots are required eg for home visits, or regular reliable clinic timings, these are now booked on a throughput time, to reduce delays.
- Arriva checks all open bookings daily with the acute trusts, between 3-4pm, to confirm if the journeys are still required / ready to proceed / are to be cancelled, to reduce late afternoon/early evening delays.
- Where phone numbers are provided, patients are being called in advance to ensure they are more likely to be ready when their transport arrives.

Communications & Engagement

- A communications pack including points of contact, FAQs, escalation arrangements, guidance on booking requirements, etc. has been distributed widely to healthcare professionals, including acute trusts, community providers, and GP practices.
- A monthly bulletin has begun to be distributed.

Complaints

- A full-time patient experience manager joined Arriva on 3rd March 2014 and has a clear mandate to review and refine the complaints handling process across the entire organisation.
- Arriva is also appointing a local complaints administrator by the end of March 2014.

1. Context & Background

1.1 In February 2012 the former Primary Care Trusts for BaNES and Wiltshire approved a review of existing non-emergency patient transport services (NEPTS). This was on the basis the provision across BaNES and Wiltshire was split over at least 20 different providers with very limited contractual coverage and financial or clinical governance processes in place.

1.2 While some acute providers operated a central transport booking facility within their own Trust, there was no central booking facility at a PCT level, nor was there any mechanism for capturing and recording all patient journey activity. This made it extremely difficult, almost impossible, to measure NEPTS service performance, understand the volume of patient journeys, monitor standards, patient quality, safety and experience and understand costs of the service.

1.3 In BaNES at the time patients were receiving transport from various providers. The RUH held a direct contract with a non-NHS provider (E-zec) for RUH related journeys only (new & follow up out-patients, discharges and transfers from the RUH). They also used other non-NHS providers for ad-hoc transport requirements. The PCT held a contract with Bristol Ambulance Emergency Medical Service (Bristol Ambulance EMS) for the provision of Sirona's PTS activity as well as out of area activity, ie patient choice or transport to specialist units. The booking function for this activity was provided by the RUH transport booking office.

1.4 Transport to and from renal dialysis units and renal outpatient clinics was also provided by Bristol Ambulance EMS and CTS taxis provided the transport for the non-complex renal patients. Great Western Ambulance Service (now South West Ambulance NHS Foundation Trust) provided the transport for the patients discharged and transferred from the Bristol Acute Trusts as well as follow up out-patient activity.

1.5 Subsequently, Swindon and Gloucestershire PCTs engaged with the review on the basis of the same issues and concerns. In 2011/12 over £8.2 million was spent on NEPTS across BaNES, Gloucestershire, Swindon and Wiltshire (BGSW). This was split over at least 30 different providers. Each of the acute hospitals across BGSW had booking facilities that linked in with their current NEPTS Providers; these may have made a positive impact at a local level but all had different manual processes and systems that required significant investment and integration with provider solutions, if they were to offer a central booking solution for the region. The four PCTs also faced increasing charges from the NEPTS providers and were incurring significant expenditure outside the scope of the contracts.

2. Non-Emergency Patient Transport Definition

2.1 Non-emergency patient transport services are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from premises providing NHS health care and between NHS health care providers. It encompasses a wide range of vehicle types and levels of care consistent with the patients' medical needs.

2.2 In 2007, the Department of Health published revised national eligibility criteria (http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078373

) to ensure that NEPTS is available to those who have a genuine need for transport and whose medical condition prevents them from travelling to or from their appointment/s by any other means. Patients are eligible for transport when:

- The medical condition of the patient is such that they require the skills or support of NEPTS staff during the journey and where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
- The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare or it would be detrimental to the patient's condition or recovery to travel by other means.

2.3 NEPTS can also be provided to a patient's escort or carer where their particular skills or support is needed during the journey. For example, this might be appropriate for those accompanying a person with physical or mental incapacity, vulnerable adults or to act as a translator during the journey. Only one escort should travel with a patient under such circumstances. Such discretionary provision would need to be agreed in advance, when transport is booked. The eligibility criteria for PTS have not been extended to include visitors. All children under the age of 18 are required to have an escort for their journey.

2.4 The distance to be travelled and frequency of travel should also be taken into account, as the medical need for NEPTS may be affected by these factors.

2.5 Financial or social grounds are not reasons for granting NEPTS. When assessing patients for NEPTS they should be routinely asked about their normal means of travel. If a patient can normally get around without support and assistance they should not be offered transport.

2.6 A patient's eligibility for NEPTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:

- Clinically supervised and/or working within locally agreed protocols or guidelines, and
- Employed by the NHS or working under contract for the NHS.

2.1 Other Health Related Transport that is not NEPTS

2.1.1 There are a number of other health related transport arrangements that are often confused with NEPTS they are:

- The Healthcare Travel Costs Scheme is for individuals who are on a low income and have made an additional journey to receive NHS care following a referral.
- Emergency and urgent ambulance services.
- Various types of community transport such as:
    - Dial-a-ride
    - Mini bus schemes
    - Voluntary care schemes

3. BGSW Non-Emergency Patient Transport Service Review

3.1 The review identified several cross-cutting issues and concerns as follows:

- Inconsistent provision of NEPTS across the BGSW area.
- Concerns around the clinical governance of the current arrangements.
- Relatively high levels of enquiries to patient advice & liaison services regarding NEPTS services.
- The application of the Department of Health eligibility criteria was not consistently adhered to by requesting staff and providers were not required to assess patient eligibility, consequently some patients received NEPTS when they should have found another mode of transport, for example private or community transport.
- A number of NEPTS providers were not performance managed due to the lack of information.
- There was a significant lack of clarity regarding the levels of activity delivered through the multiple commissioning arrangements.
- Different booking and authorising arrangements required dependent upon time of day, distance, patient needs e.g. out-of-hours, out-of-area, bariatric.
- The cost of NEPTS services were increasing with several providers requesting increased funding in 2012/13 without a clear rationale for the uplift.
- Increased demand for NEPTS as a result of an ageing population, the number of bariatric patients and NHS services provided in the community.
- Ad-hoc patient transport requests which were not under contract.
- NHS Gloucestershire commissioned and funded a separate call handling and booking service for journeys outside the Ambulance Trust block contract – a temporary arrangement with additional cost.

3.2 As part of this review a number of off-site and on-site informal meetings with existing and potential suppliers were undertaken to understand the NEPTS market. This culminated in a NEPTS supplier day with a number of providers presenting their approaches to the commissioning teams and addressing a number of pertinent questions around operational approaches. This also identified NEPTS providers who were managing their services well and considering innovative models for the future. An options appraisal with a preferred option for the service model was then set out to provide:

- a single point of contact offering patient transport advice;
- assessment of eligibility for NHS funded transport based on medical need following Department of Health guidance;
- a 365 day 24/7 service;
- patient transport booking facilities;
- sign posting for non-eligible patients;
- a minimum 10% of activity to be sub-contracted with third party providers to support capacity and the development of the market and;
- the continued use of volunteer car drivers.

4. The Procurement Process

4.1 Following the service review, the four PCT's approved a single joint procurement process in May 2012. This included a competitive dialogue process to provide the PCTs with the opportunity to openly develop a service specification, discuss service issues and experiences in detail with providers. It was also agreed four contracts would be awarded to a single accountable provider to manage the service more effectively, capturing journey information in a single database providing service intelligence that the PCTs had never had.

4.2 The key objectives of the procurement were to secure:

- **Quality** – patient-centred services delivered in a safe, friendly and effective manner by trained staff in clean, comfortable vehicles. This included keeping journey times low and ensuring promptness of arrival and pick-up.
- **Flexible & Responsive** – flexibility to respond to changing needs, e.g. new healthcare locations, on-the-day requests, flexible times for pick-up and delivery including evenings and weekends.
- **Communication & Performance Information** – high-quality communication with commissioners to discuss flexible and innovative approaches. Clear and complete information must be provided regularly on activity, finance and quality of service provision.
- **Value for Money** – affordable and provide value for money.
- **Green** – take action to reduce the carbon footprint of patient journeys wherever possible.
- **Innovation & Use of Information Technology** – innovative service approach using best practice to respond to future needs. It needed to make the most effective use of technology for the scheduling of journeys.

4.3 The procurement process commenced on 17th July 2012, and was concluded with contract award in June 2013 and contract signature in August 2013. Overlaying this was 18 months of stakeholder engagement and consultation. All stages were assessed by a panel of representatives from acute providers, commissioners and patient representatives.

5. Contract Summary

5.1 Arriva Transport Solutions Ltd (Arriva) was awarded the contract in summer 2013 and the service went live on 1st December 2013. Go-live was preceded by six months of planning and mobilisation work between the four CCGs and Arriva to:

- transfer 176 staff from incumbent providers;
- recruit and train new staff;
- procure and equip ambulances;
- establish ambulance base stations and a control centre;
- establish on-line booking systems and processes for transferring existing journeys and;
- engage with the acute Trusts and community providers across BGSW to provide information about changes in the booking processes, etc.

5.2 Arriva's contract covers NEPTS for patients travelling to and from out-patient appointments, day case in-patient admissions, discharges, inter-hospital (including time critical), A&E/Minor Injury home returners, end of life patients, renal dialysis patients and on-site interdepartmental hospital transfer.

5.3 It is primarily for patients (and escorts where appropriate) who are GP-registered in the area covered by the CCG areas of BGSW. These patients must also meet the agreed eligibility criteria for PTS, as laid out by the Department of Health. It also includes some patients from other health communities where discharge or transfers are required. There may be a requirement for transport to anywhere within England,

Scotland or Wales and to specialist centres outside the specified area anywhere within the country.

5.4 Arriva are responsible for the safe, timely and comfortable transport of patients between their place of residence and the healthcare facility, between healthcare facilities and from the healthcare facility to their place of residence. They also maintain a comprehensive directory of service, detailing alternative providers of transport for those patients ineligible for NEPTS.

5.5 All staff are easily identifiable as working in NEPTS, and are qualified and/or trained in accordance with NHS guidelines for national job profiles in vehicle management, health, safety, safeguarding of patients, risk and incident management, security, equality and diversity, confidentiality and complaints procedures.

5.6 An appropriately-graded crew, operating dedicated vehicles equipped with internal equipment appropriate for the task, and detailed in the contracts, (serviced in accordance with manufacturers' specifications and fulfilling legal requirements) are available at all times. The vehicle type and crew available are required to meet the needs of the patients including, for example, general aids, safety and specialist equipment.

5.7 The contract includes a requirement for Arriva to sub-contract a minimum of 10% of journeys with third party providers across each contract. Arriva are also maintaining volunteer car drivers who are required to meet minimum standards and sign up to the volunteer car driver handbook.

5.8 Relevant data and progress reports are presented at intervals (e.g. weekly, monthly, quarterly) as specified by the CCGs, supported by quarterly user surveys and annual staff surveys. An official incidents and complaints procedure is in place within the Arriva structure and includes the CCGs within the escalation process for complaints that cannot be dealt with locally.

5.9 Key performance indicators (KPIs) are as follows:

PTS01 – Patients travelling less than 10 miles should not spend more than 60 minutes on any one journey;
PTS02 – Patients travelling between 10 and 35 miles should not spend more than 90 minutes on any one journey;
PTS03 – Patients travelling between 35 and 50 miles should not spend more than 120 minutes on any one journey;
PTS04 – Arrival within 45 minutes before or within 15 minutes after scheduled appointment time;
PTS05 – Patients should not wait more than 60 minutes for their outbound journey (where booked at least a day in advance) from the point of booked ready by the HCP;
PTS06 – Patients will be collected within four hours where booked on the day (within two hours for end of life);
PTS07 – Percentage of journeys cancelled by Arriva to be below an agreed %;
PTS08 – Percentage of journey collections missed (aborted journeys) to be below an agreed %;

PTS09 – Percentage of in-bound calls to Arriva call centre answered within 30 seconds to be above an agreed %;
PTS10 – Application of eligibility criteria;
PTS11 – Percentage of complaints acknowledged within one working day;
PTS12 – Compliance with agreed complaints procedure (full response within 25 days);
PTS16 – Availability of on-line booking system; and
PTS17 – Availability of telephone booking system.

5.10 An agreed KPI penalty regime commences from 1st April 2014 and performance will be reviewed monthly. This has not been applied for the first four months of the contract, to ensure that Arriva was afforded the opportunity to align the multiple incumbent resources and allow time for staff to settle into their new roles. Equally, there is quality incentive uplift earnable across the year one period against KPIs PTS01, 04, 06, 09 and 10.

5.11 Penalties and incentives will be imposed/rewarded on a quarterly basis and will be calculated as a percentage of the block contract value.

6. Service Model

6.1 The service has been commissioned to operate 24 hours a day, 7 days a week, 365 days of the year including all statutory and discretionary bank holidays. It includes a single point of contact which has a dedicated phone number for the receipt of all patient transport requests, to manage and apply the eligibility criteria and process, arrange appropriate transport and provide advice and support for patients who are ineligible for patient transport but still need help in getting to and from their relevant healthcare facilities.

6.2 Bookings for transport can also be made on-line and a key objective of the contract is to encourage health care professionals to book on-line wherever possible as the process is simple, accurate and quick. The on-line system, called Cleric, is available 24 hours a day, as is the call centre, so that bookings can be made at any time.

6.3 To ensure a timely and efficient service, all bookings, whether made by telephone or on-line should be made before 15:00 hours on the working day prior to the day of travel. Bookings may still be made after this time, but there is a time limit on the total number that can be accepted and different response times will be applied.

6.4 If journeys have to be booked at short notice on the day, then this should be done at least four hours before the time the transport is required. Any bookings made on the day of travel will be subject to a four hour response window (two hours for end of life patients).

6.5 Before Arriva started the service, return journeys from hospitals, etc, were booked in advance based upon the time that the patient was expected to have completed their appointment. The new contract has introduced a ‘book when ready’ service which requires staff to book the return journey when the patient is ready to go home. Once a patient is ‘booked ready’, Arriva aim to pick them up within an hour. In this way patients do not have to wait for long periods because their appointment finished sooner than anticipated and ambulance trips are not wasted if the patient is not ready to go when the ambulance arrives.

6.6 Patients can be 'booked ready' either on-line or by telephone. Telephone bookings are confirmed with a booking number during the call; on-line bookings automatically generate a booking number. This aids health care professional staff and Arriva's staff to easily identify the patient and their journey details should they need to be changed or cancelled.

6.7 In order to assess eligibility, health care professionals and patents will be asked four main questions:

- Pre-screening questions to assess if the patient is registered with a GP practice in the BGSW area;
- Exemption questions – exempt patients are those travelling for renal dialysis treatment, oncology patients receiving a course or programme of chemotherapy or radiotherapy treatment; and patients who must lie down for at least part of the journey;
- Mobility questions to determine the type of transport required; and
- Medical questions to identify the level of care required during the journey.

6.8 For those patients who are ineligible for NEPTS, they will be signposted to other suitable transport providers within the community. They may also be able to access the Healthcare Travel Costs Scheme.

6.9 The transport and mobility guidance is set out in the table below:

Code Used When Booking	Description
C1	For patients who can travel in a car without the assistance of anyone
C1A	For patients who will require assistance of one person to and from the vehicle
C2	For patients who require the assistance of two crew members
W1	For patients who must travel in their own wheelchair for the journey with the assistance of one person
W2	For patients who must travel in their own wheelchair for the journey with the assistance of two people
Stretcher	For patients who must lie down for at least part of the journey
Bariatric Vehicle	For patients who are 25 stone & over
NB Oxygen Therapy	Patients requiring oxygen must travel on a vehicle with two crew members.

7. Governance

7.1 An evolving series of governance arrangements have been used, tailored to the precise needs at the time, from the initial procurement phase through to post go-live and routine contract management as follows:

- Following contract award, a mobilisation group with representatives for the four CCGs, plus Arriva, plus South Central Commissioning Support Unit (and predecessor organisations which led and co-ordinated the procurement work on

behalf of the PCTs/CCGs) met weekly, to agree the Arriva mobilisation plan and to review progress, address issues, and manage risk.

- The PTS Procurement Board transitioned into a Mobilisation Board with CCG Governing Body level representation, which met monthly. Key risks and issues were escalated as appropriate.
- Each CCG took the lead for coordination and engagement with one of the four acute trusts, to help provide focus to acute trust concerns.
- For the first month following go-live, daily conference calls were carried out between commissioners and Arriva to review progress and address issues.
- Mobilisation meetings of Arriva and commissioners continued to be held weekly until the end of January and are now held twice monthly.
- Mobilisation Boards continue monthly.
- Lead commissioners have engaged directly with respective acute trusts to help address issues.
- Arriva locality managers are based at and work closely with each hospital trust to address issues and an Arriva escalation process enables healthcare staff to escalate issues as required
- From March, routine contract performance monitoring and quality review meetings will replace the mobilisation meetings (NB majority of the existing attendees will be unchanged; CCG quality leads will in future meet bi-monthly to review relevant issues), coordinated by South Central Commissioning Support Unit.
- Performance and activity data is provided by Arriva monthly and weekly, by CCG, and specific acute trust level dashboards are also now in place.

8. Service Launch

8.1 The new NEPTS contract with Arriva went live on 1st December 2013, replacing a multitude of contract and ad hoc arrangements. Initial weeks were characterised by:

- an extremely high volume of calls;
- problems arising from the incomplete or inaccurate nature of bookings information inherited from the previous providers;
- a journey volume that exceeded the expected level;
- a significant variation to the expected journey mix (different patient mobility and vehicle types required);
- early winter pressures being experienced within the acute trusts;
- some significant issues regarding arrangements for the movement of out-of-area patients to/from acute trusts within the contract area and;
- the need for acute trusts to revise their internal processes in a much more significant way than had been appreciated.

8.2 Despite a comprehensive mobilisation process, the combination of these issues meant that there was considerable concern at the outset of the contract. Much of this was based on information, which though in part unsubstantiated, has been challenging to refute, given that at the same time, there have also been some examples of poor performance as a result of the impact of the factors described (typically excessively long waits, sometimes resulting in overnight re-admissions or potentially detrimental impact on patients).

8.1 Support to Acute Hospitals

8.1.1 As a result of the issues identified in the early weeks of the contract, Arriva have completed reviews at all the acute Trust sites in BGSW and developed action plans in response to the findings of these reviews. These action plans are jointly owned between Arriva and the acute Trust. The RUH action plan was created at the end of December 2013 and agreed with the Trust prior to the Christmas break. Good progress has been made against the actions delivered.

8.1.2 The Trust management has engaged in supporting staff to use the booking system and the local Arriva management team have been proactive in supporting the Trust staff. A weekly acute Trust dashboard has also been developed which helps the Trusts understand its role in helping to deliver improvements in the service.

8.2 Support to Renal Dialysis Units

8.2.1 BaNES and Wiltshire renal dialysis patients can receive their treatment either at the Richard Bright Renal Unit at Southmead Hospital which is part of North Bristol NHS Trust (NBT) or at one of NBT's satellite units at the RUH, Weston-super-Mare, Southmead, South Bristol, Taunton, Frome and Kingswood.

8.2.2 Arriva are carrying out approximately 1,400 regular weekly dialysis patient journeys across BGSW. 1,200 of these are automatically planned to a combination of taxi providers and volunteer car drivers. The remainder are patients with higher mobility needs and are generally transported by Arriva vehicles.

8.2.3 Given the issues experienced by renal dialysis patients and the staff of the units, particularly at the beginning of the contract, Arriva implemented two full-time planners from 3rd February 2014 to provide dedicated planning of dialysis journeys. A dedicated renal hotline was set up in December and continues to provide a direct, dedicated route to the dispatch desk for the units across the BGSW area.

8.2.4 To provide further support for this group of patients, a full-time operational support manager joined the Arriva team on 24th February 2014 with a remit to provide central support for planners and the locality managers in oversight and quality assurance of all renal dialysis NEPTS activity. Key tasks will include daily reconciliation of planned journeys against actual activity, pro-active engagement with renal unit staff, and on-going refinements of auto and manual planning arrangements in conjunction with the planners.

8.2.5 The CCGs and Arriva also met with NBT's service manager for the renal and transplant directorate and the clinical matron at the beginning of February to discuss their issues and concerns. A further meeting has been arranged in April to review progress as well as discuss the impending move of the Richard Bright Dialysis Unit into the new NBT hospital building.

9. Activity

9.1 Activity has been recorded by Arriva since the start of the contract. Having a single provider has meant that for the first time, a comprehensive view of total NEPTS activity can be achieved. This in turn helps to inform decisions about the provision of service by location, by mobility category, and by journey type and distance. It also helps to inform the position in terms of how well KPIs are achieved.

9.2 Detailed charts are provided at appendix 1 which shows the total BaNES NEPTS activity between 1st December 2013 and 28th February 2014. These are NEPTS journeys, conducted by Arriva, for patients registered to a GP practice within BaNES CCG. The journeys are a combination of actual journeys completed, plus aborted journeys, but excluding cancelled journeys.

9.3 Aborted journeys are chargeable, since they are journeys where NEPTS resource has been committed to the task, but the task was not completed. This can be for one of a multitude of reasons (e.g. patient not ready / patient too ill to travel / patient no longer requires transport / appointment cancelled but transport was not / patient too ill to travel / patient used own transport / patient had been admitted but transport not cancelled / etc.)

9.4 Cancelled journeys are those for which a booking was made but, are cancelled prior to the start of the journey, by the person/organisation that made the booking. Cancellations are not chargeable.

9.5 Total activity including aborted journeys, is typically slightly above the expected level, per week (excluding the bank holiday Christmas and New Year weeks). However patient mobility is also a function of activity, as is average mileage per journey.

9.6 The average mileage per journey is below that which was identified during the tender process. However, in the other CCG areas this is not the case which has an impact on resourcing, since longer journeys last longer and therefore require a higher level of resource than expected in order to complete the same number of journeys.

9.7 The tender process also described the existing activity in terms of patient mobility (and therefore the numbers of each type of NEPTS resource required). The reality seen since 1st December 2013 is that the actual mix per type of NEPTS resource required, reflecting patient mobility, is in some regards significantly different:

Definition	Average Weekly Baseline (bid) Activity	Average Weekly Actual Activity	Percentage of Expected Volume
Car, one crew	319	269	84%
Car, two crew	53	171	323%
Wheelchair, one crew	21	112	533%
Wheelchair, two crew	140	37	378%
Stretcher	48	51	106%

9.8 Arriva were resourced to provide the service according to the expected mix of patient mobility. The Arriva resourcing was also established based on the expected mobility mix of all four CCGs who have contracted their service. Thus variances in the volume, mileage and mobility mix of other CCGs' activity also have a bearing. These variances mean that Arriva began the contract with a level and type of resource, across the area that did not fully match the requirement.

10. Performance

10.1 Performance is being reported within the context of the total activity, average journey distance, and mobility mix compared to that which was expected, for BaNES CCG and other CCGs, as described above.

10.2 Detailed key performance indicator (KPI) charts are shown at appendix 2 showing performance for:

- all BaNES CCG patients transported by Arriva
- all BaNES CCG dialysis patients transported by Arriva
- all BaNES patients attending the RUH to which the majority of BaNES patients attend, transported by Arriva.

10.3 The main key performance indicator (KPI) measures shown look at three aspects of patient experience:

- time spent on vehicle
- on-time in-bound journeys
- on-time collection for out-bound journeys

10.4 Time on vehicle – overall, performance is being achieved in line with KPIs for time on vehicle. The dips in performance for the longer distance journeys generally reflect a small or very small number of journeys in these categories (graphs 1 to 3).

10.5 In-bound on time – is an area where performance is improving but requires continuing improvement to get to KPI level (graph 4).

10.6 Out-bound on time (for on-day bookings) – is generally being achieved or exceeded (graph 6). The response timeframe for these journeys is four hours from the time the patient is "made ready." The area requiring greatest improvement is on-time collection for pre-booked outbound journeys (graph 5). The response timeframe for these is one hour from the time the patient is "made ready."

10.7 Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys and the knowledge that transport is critical for this group of patients.

10.8 There are a range of other KPI measures, and these include average and maximum telephone waiting time for booking requests made by phone. Although patients are able to make telephone bookings direct with Arriva, it is not possible to break out BaNES only calls, or patient-only calls, from the total, for KPI reporting purposes. Therefore telephone responsiveness figures are not included; although it is understood that in BaNES the volume of patient-generated telephone bookings is low. Nonetheless, average call wait time has reduced from over 3 minutes to less than 2 minutes; and the maximum daily call wait time across the areas served by Arriva has reduced from >25 minutes to <5 minutes.

10.9 KPI performance reflects some of the issues that have been found since the start of the contract, and which Arriva, Commissioners, and acute Trusts, are continuing to work to address. The main issues with service delivery that have led to complaints from patients and problems for acute trusts have been:

- Periods, particularly early in the contract, but still the case currently, when on-time pick-ups for out-bound journeys was significantly below KPI, meaning many

patients had long or very long waits. This arose from a combination of many factors, these include: incomplete journey data inherited from the outgoing incumbent providers; lack of familiarity in the acute trusts with the "make ready" process; inherited bookings being of an incorrect mobility, meaning on the spot reallocation of appropriate resources, which inevitably take longer to become available; wrong vehicle mix for the overall total actual activity identified, meaning insufficient resource for certain categories of patients. Although performance is improving, there is more to be done on this.

- Delays for in-bound journeys, typically those later in the day where a knock-on effect from late out-bound journeys earlier in the day, as described above. Again, although performance is improving, there is more to be done on this.

- Difficulty and long waits to get through when healthcare staff calling the booking centre. Initially this was a result of low levels of uptake of the on-line booking tool among healthcare staff; as well as an extremely high call volume due to the need to chase up "missing" or incorrect inherited journey bookings as described above; and lack of confidence in and familiarity with the new NEPTS arrangements; but is now much improved.

- Problems with incorrect mobility with healthcare staff getting used to the mobility categories used by Arriva this is now much improved.

10.10 All of these and a range of other operational issues are being addressed, and progress is being made. A patient satisfaction survey will be undertaken in quarter two of 2014/15. The content and sample size is currently being agreed between the four CCGs and Arriva.

11. Complaints

11.1 Complaints received by Arriva are handled by a central complaints team and are acknowledged within one day of receipt. Each complaint is graded according to its severity and impact. Thereafter, each complaint is directed to the appropriate Locality Manager, Area Manage or the Head of Service according to the locality to which the complaint relates and the severity rating. Every complaint should receive a full written response within 25 days.

11.2 For all CCGs, the highest volume of complaints relates to long waiting times. Since the commencement of the contract, and in the context of high volumes of activity, there is a reducing trend in all categories of complaint. Total complaints since the launch of the contract for BaNES are as follows:

Month	Number of Complaints
December	31
January	26
February	20

12. Improvements Made Since Service Launch

12.1 Booking Centre – Call Taking

- Initial call-taking capacity was increased by 60%, including experienced Arriva staff from other NEPTS call centres, to cope with the anticipated volume of calls, and to reduce call wait times.
- Call volume has reduced from 5,500 per week to 3,500 per week (1st Dec to 14th Feb).
- Call abandonment rate has reduced from >30% to <10% (1st Dec to 14th Feb).
- Average call wait time has reduced from >3 minutes to <2 minutes (1st Dec to 14th Feb).
- Maximum call wait time has reduced from >25 minutes to <5 minutes (1st Dec to 14th Feb).
- Improved internal call handler training and individual performance management now taking place.

12.2 Online Booking

- Arriva trainers have attended acute Trust sites to train up hospital staff and to train internal trainers.
- Ad-hoc issues with using online booking have been addressed and resolved.
- The proportion of bookings, amendments, cancellations and "make ready" actions made online has increased steadily and is now >30% (14th Feb 2014). This reduces the burden on the call centre, meaning faster call answering; and also provides real-time visibility of bookings, for hospital staff.
- The benefits of the online system are becoming progressively clearer for hospital staff, including the ability to review lists of booked journeys, and to take ad-hoc snapshots of outstanding patient journeys including those not booked ready.

12.3 Journey Timings

- Journey time and patient drop-off/collection performance has improved. Across the four CCGs, time on vehicle performance exceeds KPI level for all journeys over 10 miles, and is 1% below target for journeys under 10 miles.
- On-time drop-off (in-bound) has consistently improved but is still below KPI target.
- On-day collection (within four hours) out-bound exceeds KPI target.
- Planned out-bound collection (within 60 minutes) has improved but is still below KPI target.

12.4 Capacity & Resources

- Total patient carrying capacity has been increased by 15% since day one.
- Front-line staffing is planned to increase by 15% with five new staff already in post.
- Accredited sub-contractors are now receiving their work through an innovative online tool.
- Significant re-profiling of Arriva vehicle shift patterns is resulting in increased capacity at critical times of the day, mainly weekday afternoons.

12.5 Dialysis

- A renal hotline has been implemented to provide direct renal-dedicated assistance.
- Two planners have been assigned on a dedicated basis.
- Progress has been made to move to dedicated drivers for renal dialysis patients.
- Ambulances fulfilling dialysis journeys now have in-built buffer (catch-up) time in their schedules to increase reliability and on-time performance.

- A “renal champion” operational support manager has been appointed and is now in post to address the various issues impacting renal dialysis patients, and to manage the implementation of Arriva service for Wiltshire patients attending SFT for dialysis; and to manage the relocation of the dialysis unit within Southmead for GBSW patients.

12.6 Acute Trust Action Plans

- Diagnostic visits conducted by Arriva and joint action plans produced by Arriva, developed jointly with the acute Trusts. These identify the main issues and concerns experienced within each Trust, and a series of actions that will resolve those issues. These plans are reviewed and updated weekly.
- Joint performance information is now provided weekly to acute Trusts, to further assist in embedding new processes and help build confidence in the new service.
- Where fixed time slots are required eg for home visits, or regular reliable clinic timings, these are now booked on a throughput time, to reduce delays.
- Arriva checks all open bookings daily with the acute Trusts, between 3-4pm, to confirm if the journeys are still required/ ready to proceed / are to be cancelled, to reduce late afternoon/early evening delays.
- Where phone numbers are provided, patients are being called in advance to ensure they are more likely to be ready when their transport arrives.

12.7 Communications & Engagement

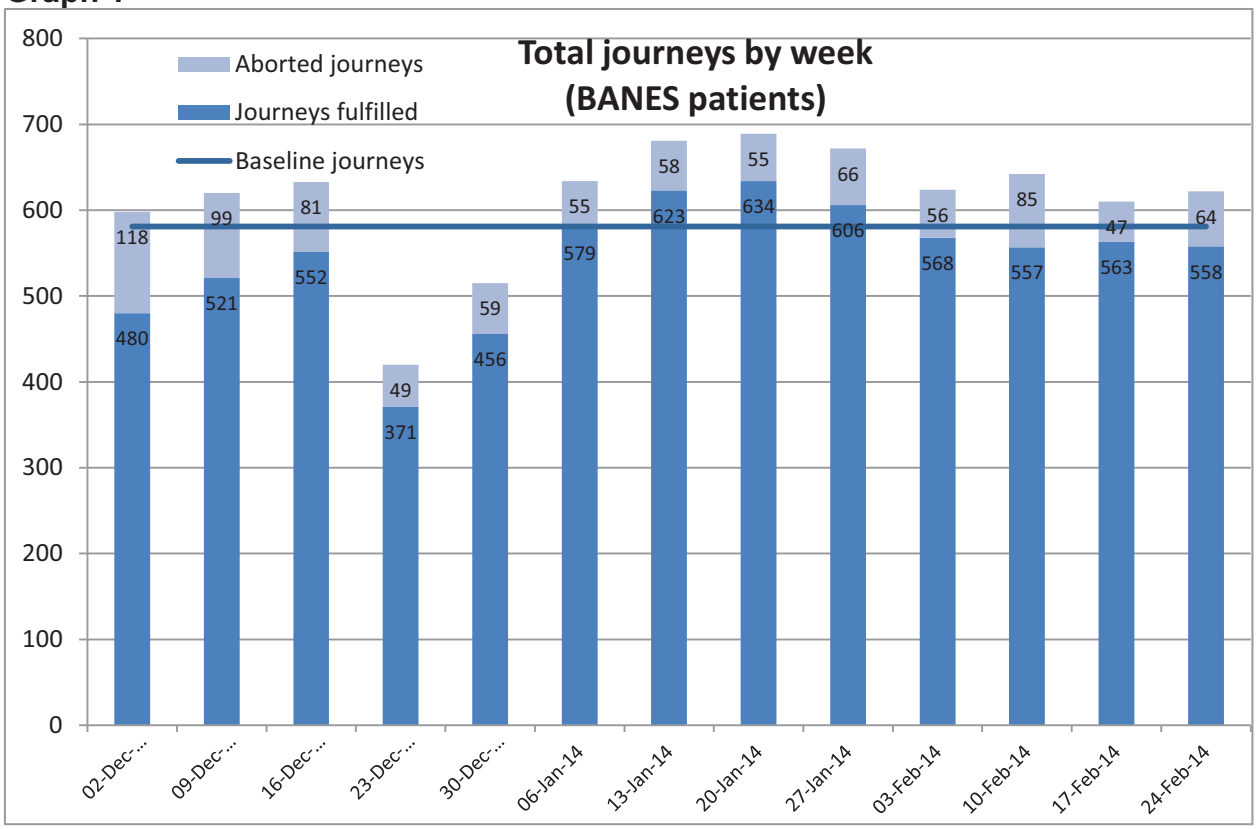
- A communications pack including points of contact, FAQs, escalation arrangements, guidance on booking requirements, etc. has been distributed widely to healthcare professionals, including acute trusts, community providers, and GP practices.
- A monthly bulletin has begun to be distributed.

12.8 Complaints

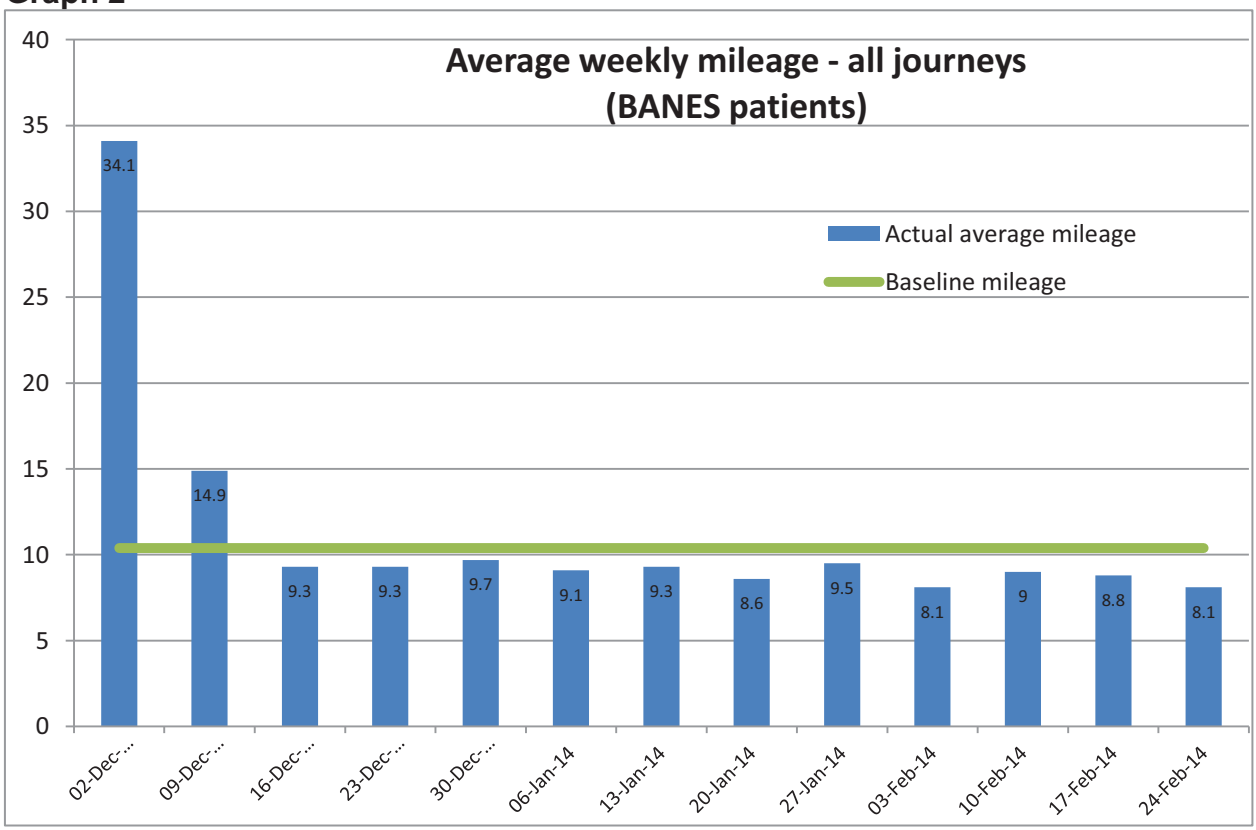
- A full-time patient experience manager joined Arriva on 3rd March 2014 and has a clear mandate to review and refine the complaints handling process across the entire organisation.
- Arriva is also appointing a local complaints administrator by the end of March 2014.

Appendix 1 - Activity

Graph 1

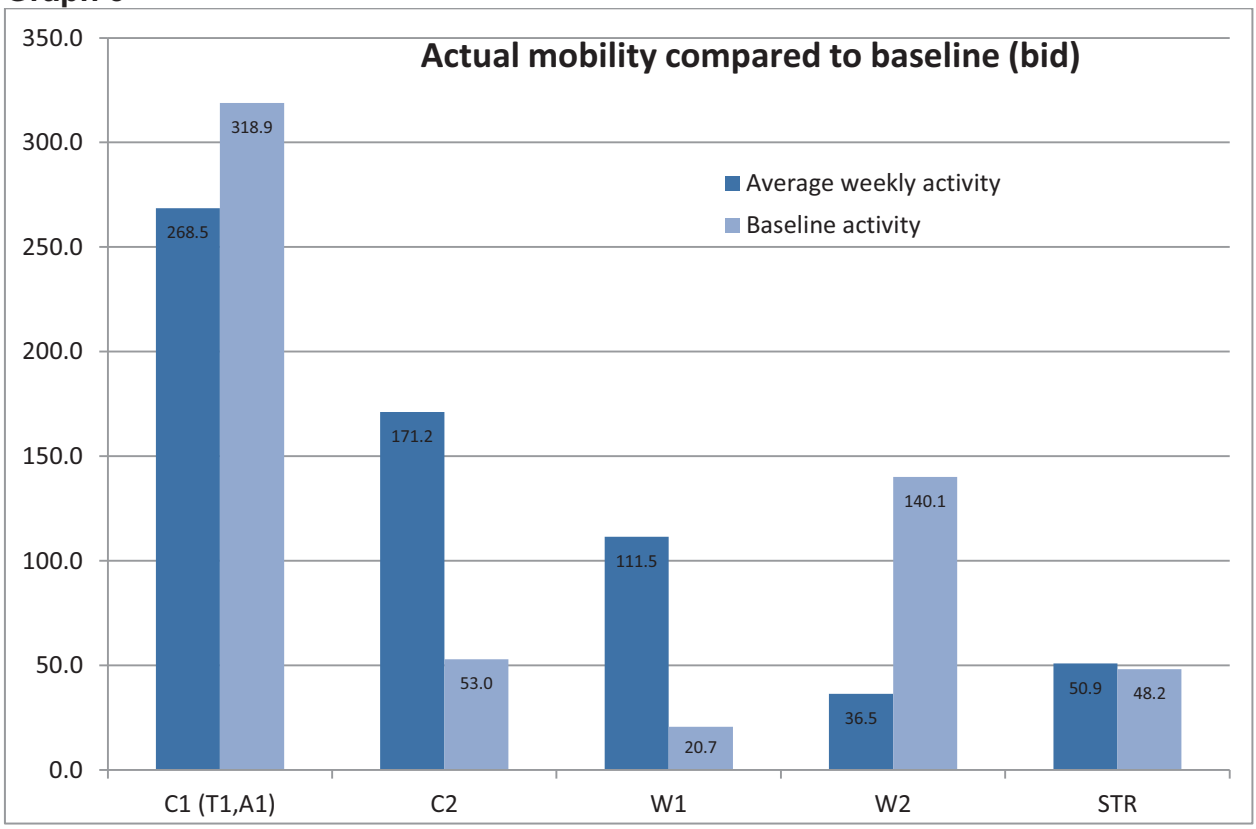


Graph 2



Data represents average weekly mileage for all chargeable journeys. Data is based on "planned mileage," an assumption made by Cleric software which represents the shortest viable route by road.

Graph 3



Data represents average weekly activity by mobility category using 11 weeks of data (02/12/13 to 02/03/14 excluding 23/12/13 to 05/01/14 inclusive). All mobility codes relating to walking patients (including A1, T1) are shown in the C1 category.

Mobility definitions

C1 - able to walk unaccompanied or with assistance of one person. Generally suitable for travel by taxi or car.

C2 - able to walk but with assistance of two people; or requires a wheelchair to be provided for transport purposes. Generally will travel by ambulance.

W1 - wheelchair user who is generally suitable for travel in a wheelchair-adapted car.

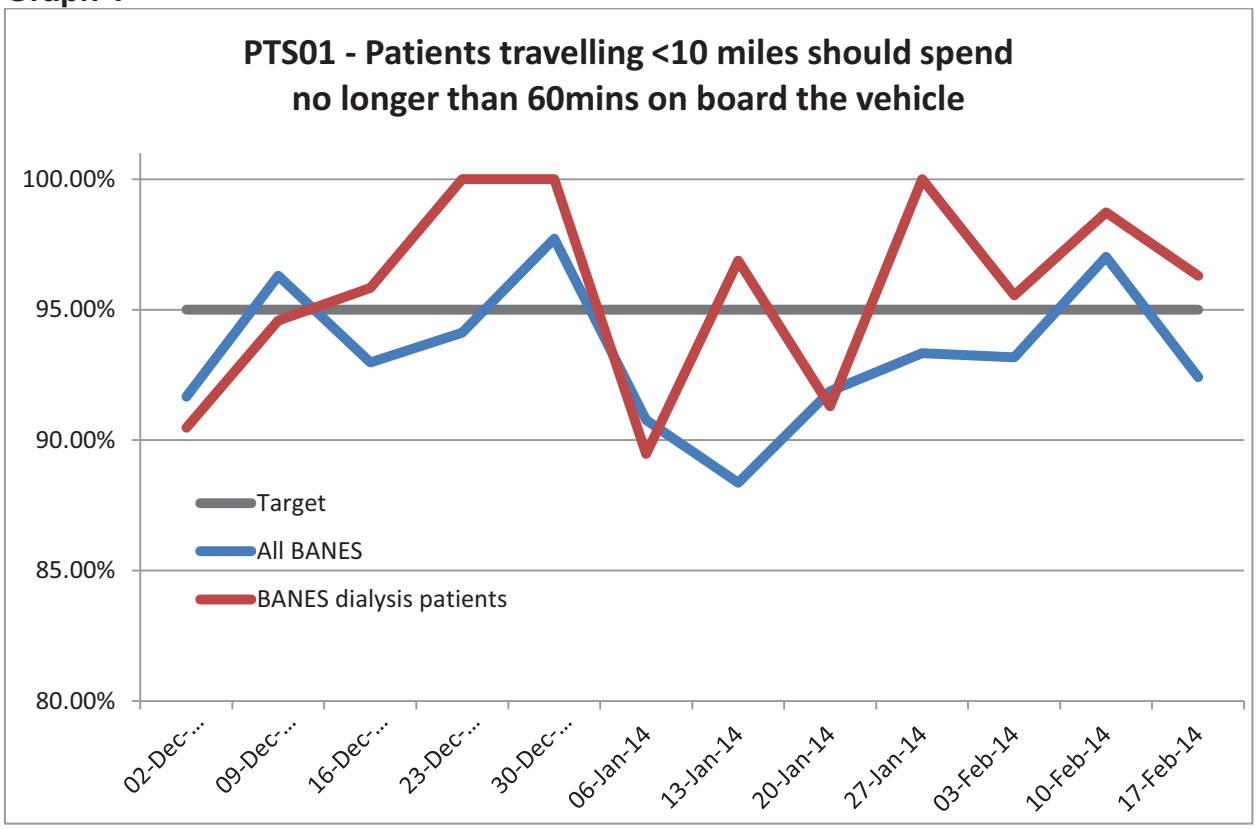
W2 - wheelchair user who is generally suitable for travel by ambulance; requires assistance of two people.

STR - only able to travel on a stretcher. Ambulance patient.

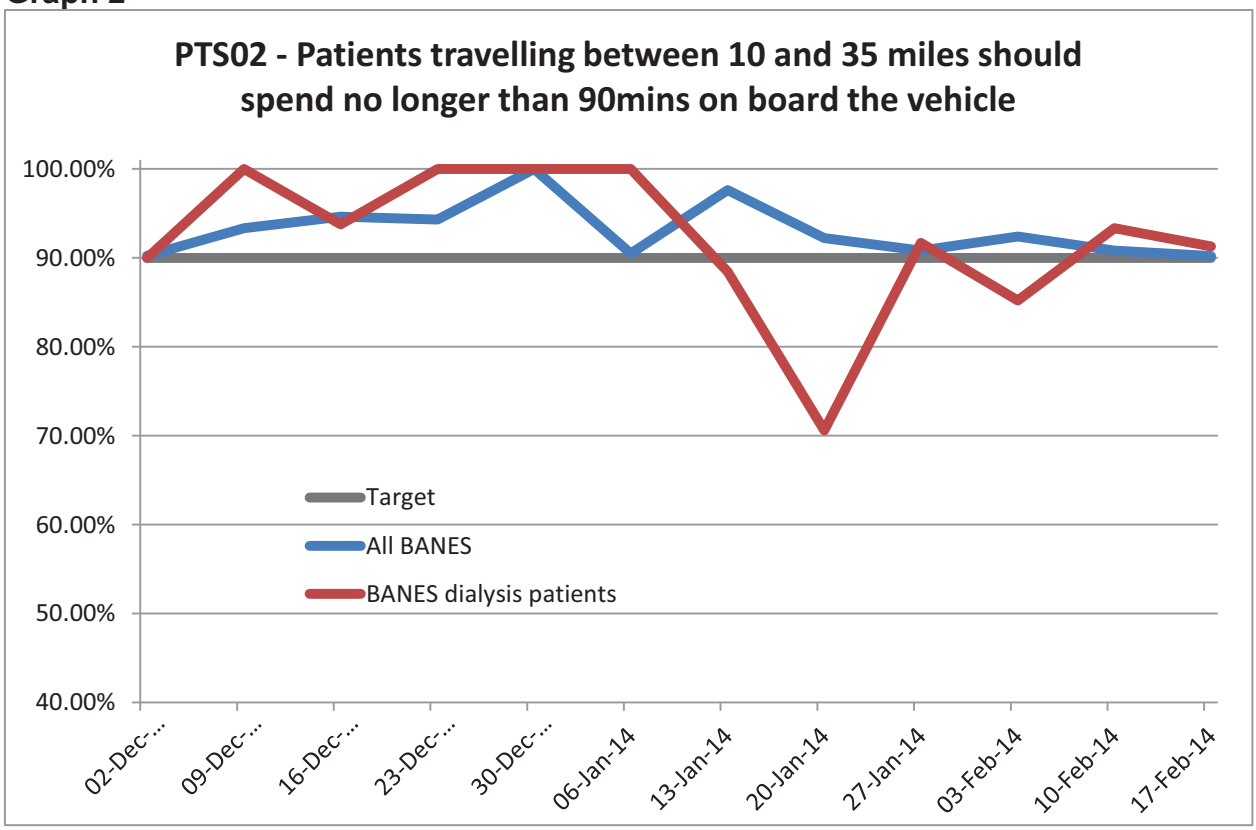
Appendix 2 – Performance

The data provided in the following graphs, is based on journeys for which complete journey time information is known.

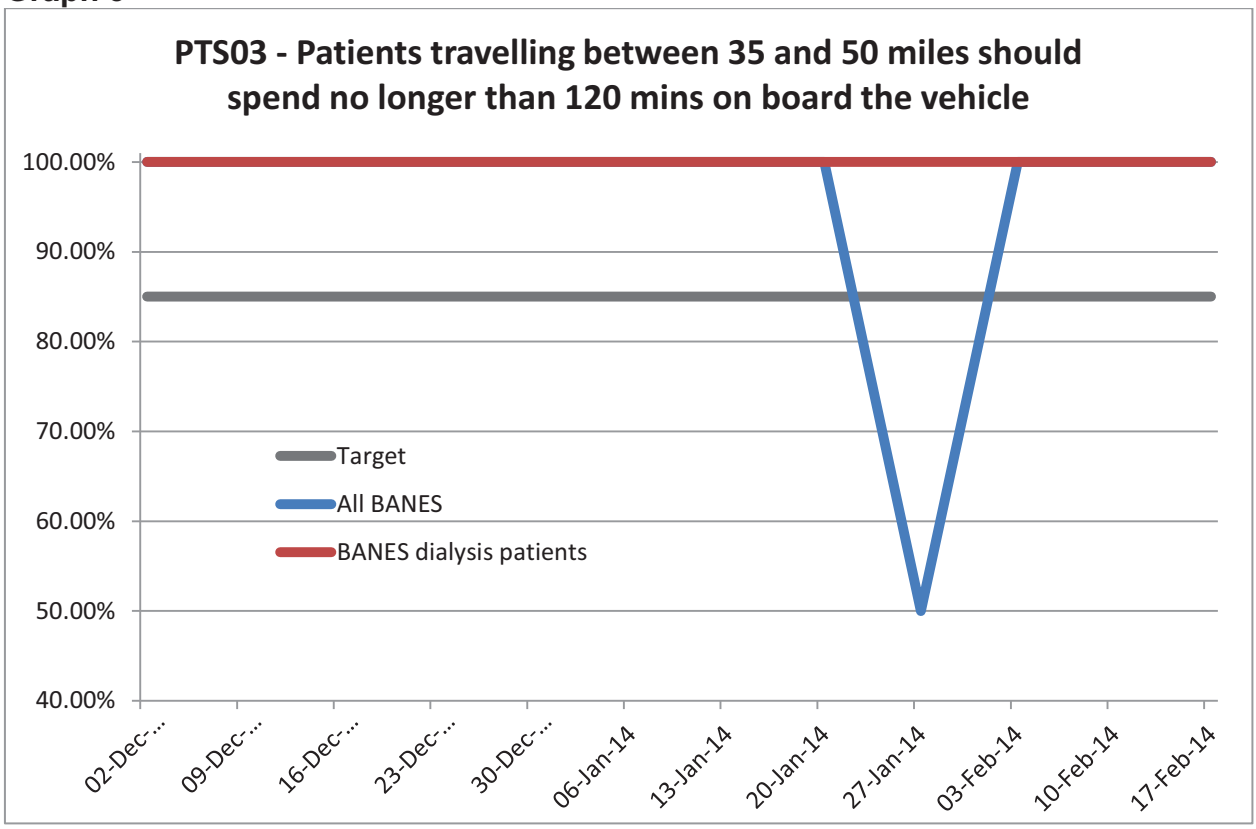
Graph 1



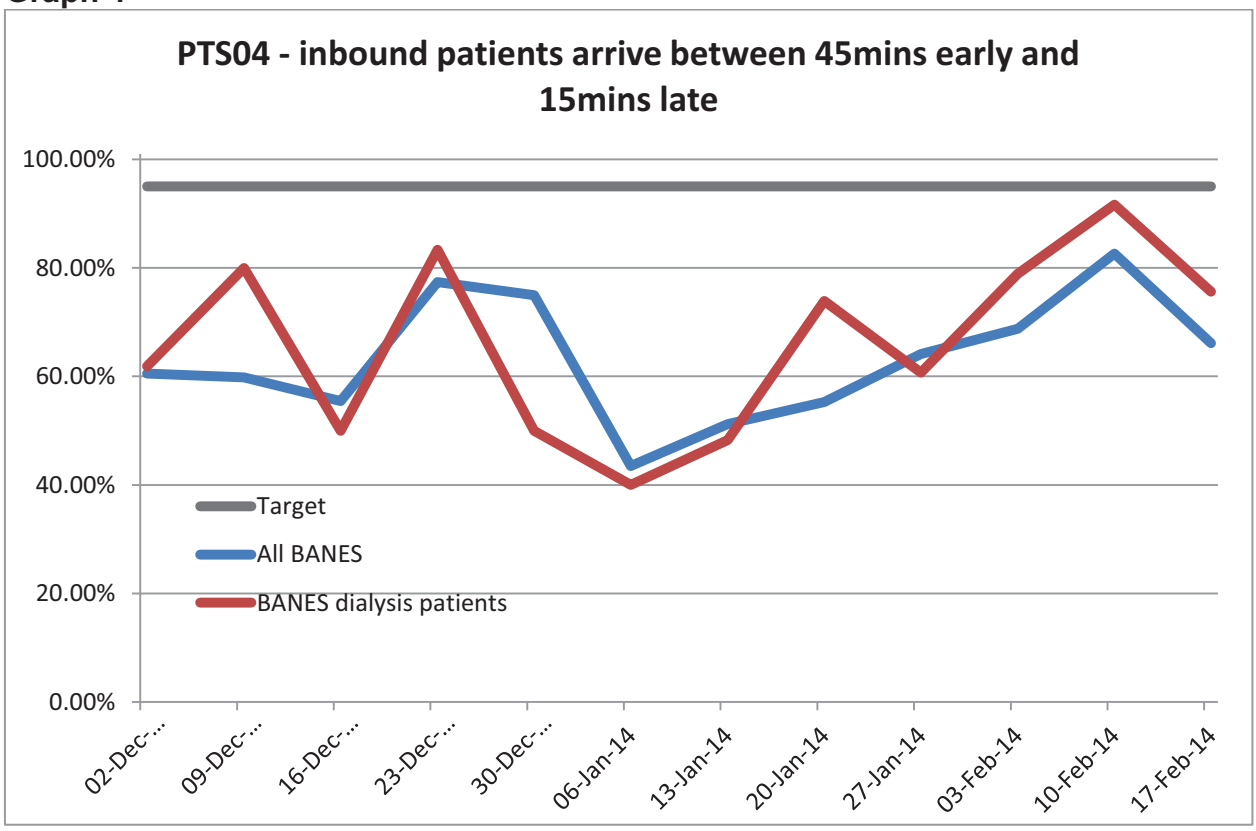
Graph 2



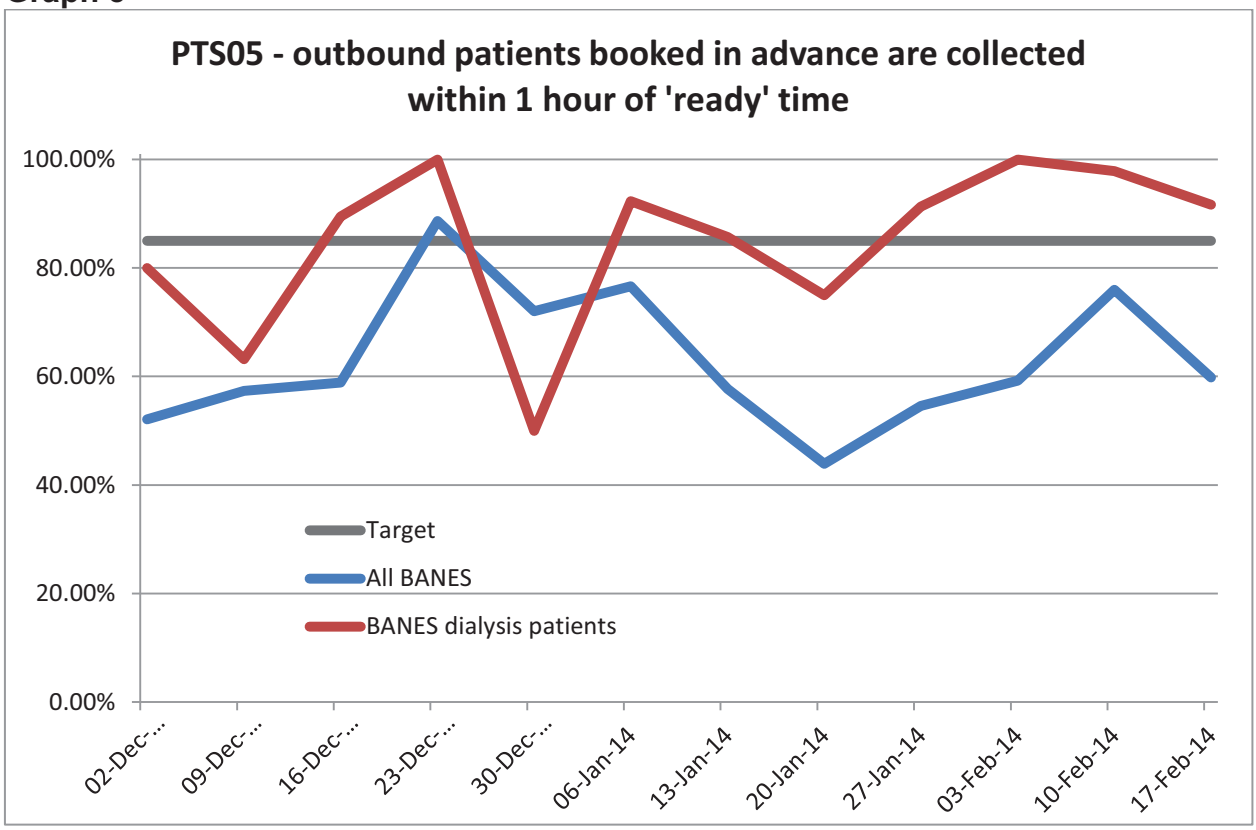
Graph 3



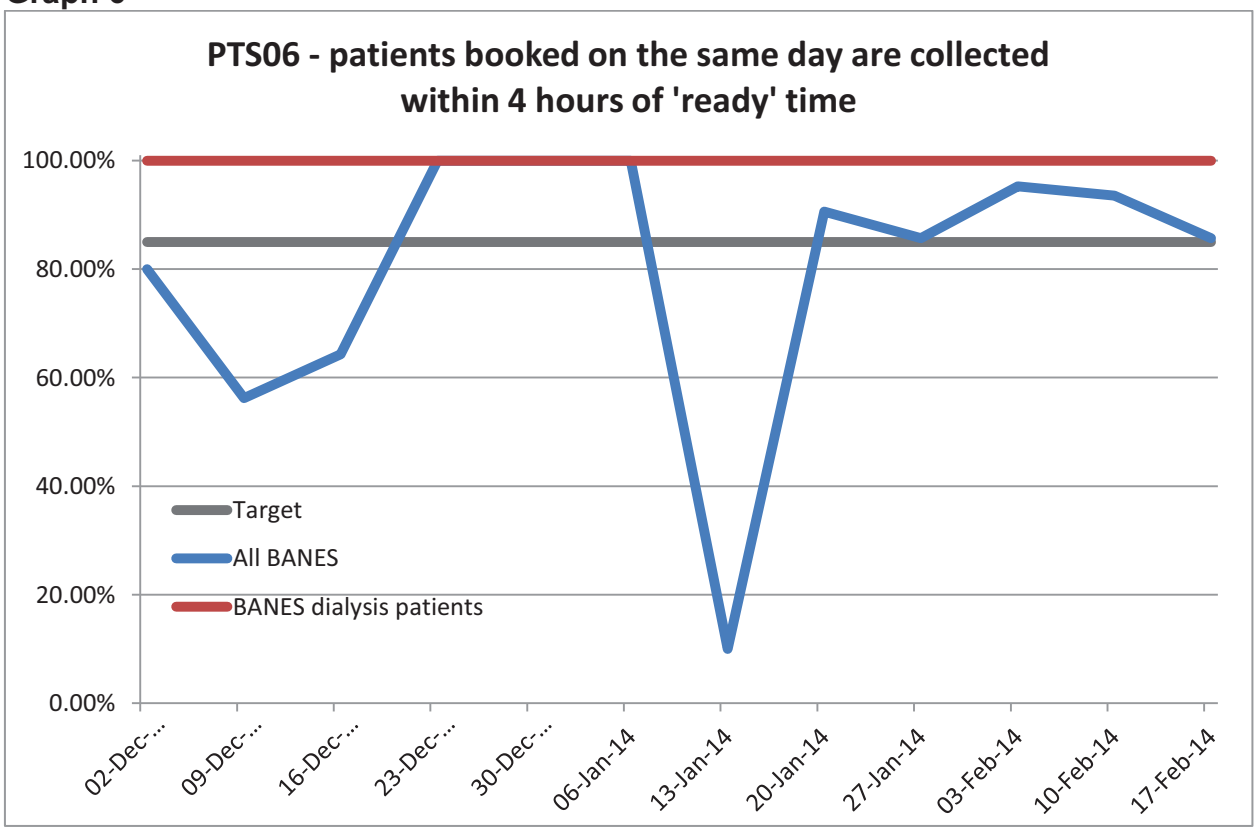
Graph 4



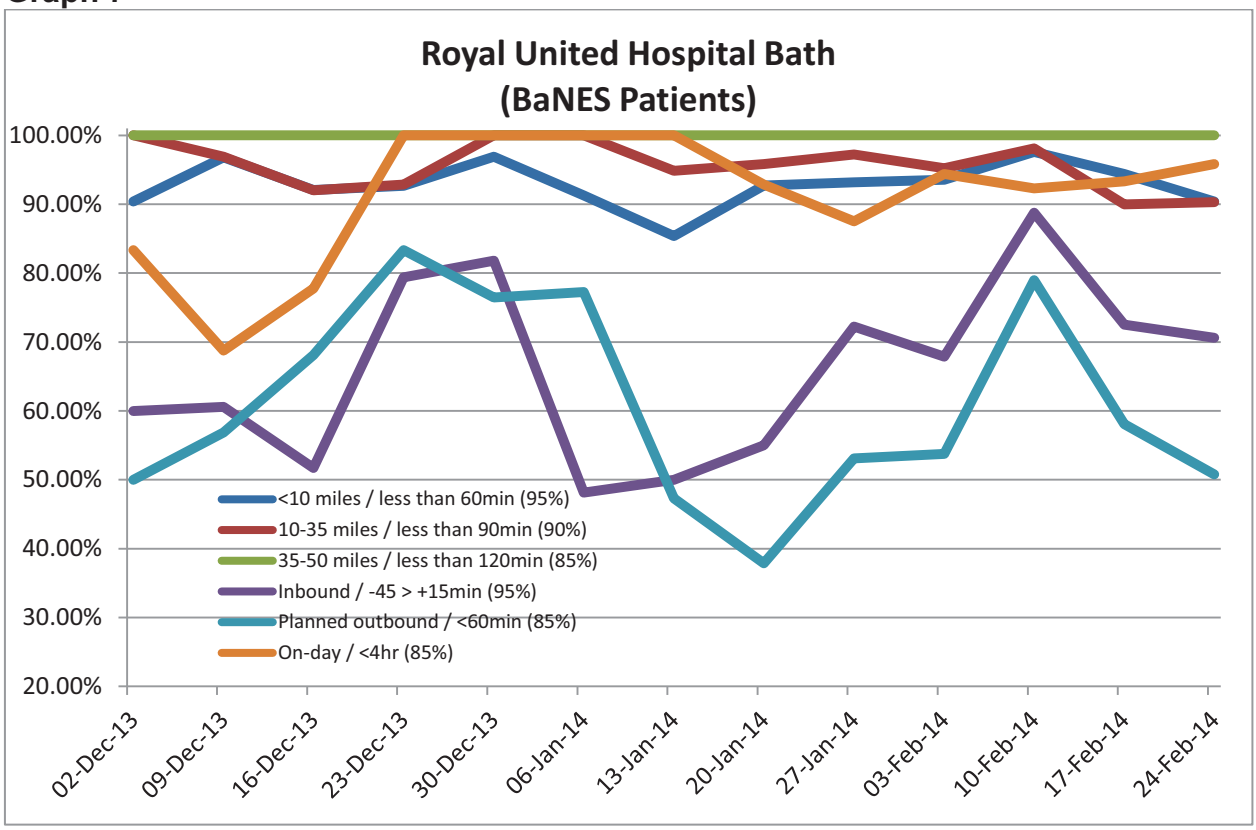
Graph 5



Graph 6



Graph 7


Royal United Hospital Bath
(BaNES Patients)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
02-Dec-13
09-Dec-13
16-Dec-13
23-Dec-13
30-Dec-13
06-Jan-14
13-Jan-14
20-Jan-14
27-Jan-14
03-Feb-14
10-Feb-14
17-Feb-14
24-Feb-14

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Bath & North East Somerset Council		
MEETING	**Wellbeing Policy Development & Scrutiny Panel**	
MEETING DATE:	**21 March 2014**	
TITLE:	**Public Health "Direction of Travel"**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Nil		

1 THE ISSUE

1.1 The Director of Public health has been invited to attend the Wellbeing Policy Development and Scrutiny (PDS) Panel to discuss the "direction of travel" for public health over the next few years, now that it is embedded within the Council.

2 RECOMMENDATION

2.1 Proposal 1 That the panel notes the contents of the presentation, endorses the general approach of the DPH and his team, and comments on any areas for further consideration.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 The public health team has a ring-fenced budget at least for two further years, which it will work within, and there is an agreed staffing level. No further resources are sought, although the DPH would aim to influence planning and therefore resource allocation across any parts of the council whose activities impact on the health and wellbeing of the public.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 The statutory and non-statutory duties and responsibilities of the Director of public health are laid out in guidance that can be found here:

https://www.gov.uk/government/publications/role-of-the-director-of-public-health-in-local-authorities

The panel is not being asked to decide on any specific policy of programme so no legal questions arise at this time.

5 THE REPORT

5.1 No report is attached but copies of the presentation are available to the panel.

6 RATIONALE

6.1 The public health team's work is affected by many different "drivers" and the presentation identifies these and their effects.

7 OTHER OPTIONS CONSIDERED

8 CONSULTATION

8.1 This presentation was prepared with input from the Council's public health team. Public health intentions have been developed based on a variety of consultation processes including that around the Health and Wellbeing Strategy and discussions with other council departments and partners in other sectors, particularly the NHS.

9 RISK MANAGEMENT

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

9.2 A public health risk register has been prepared and submitted to the council's risk management team.

Contact person	*Dr. Bruce Laurence, director of public health, BaNES*
Background papers	*Health and Wellbeing Strategy: on Council website* *Joint Strategic Needs Assessment: on Council website* *Public Health commissioning intentions: on request from DPH* *Public Health service action plan: on request from DPH* *Role of DPH in local government:* *https://www.gov.uk/government/publications/role-of-the-director-of-public-health-in-local-authorities*
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council		
MEETING:	**Wellbeing Policy Development and Scrutiny Panel**	
MEETING DATE:	**21st March 2014**	EXECUTIVE FORWARD PLAN REFERENCE: E 2566
TITLE:	**Alcohol Harm Reduction Scrutiny Inquiry Day**	
WARD:	**All**	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 Recommendations Response table		

1 THE ISSUE

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

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

1.3 The purpose of the Scrutiny Inquiry Day ('SID') was to provide the opportunity to formulate policy approaches with relevant experts and stakeholders on:

(1) The B&NES Alcohol Harm Reduction Strategy (with a view to refreshing its desired outcomes); and

(2) To consider the new powers being introduced through the Government's Alcohol Strategy.

The SID was held on the 10th October 2013.

1.4 Cllr Brett, Vice Chair of the Planning, Transport & Environment (PTE) Panel led a steering group with councillors representing four PDS panels: Early Years,

Children & Youth (EYCY), Planning, Transport & Environment (PTE), Economic & Community Development (ECD) and Wellbeing.

1.5 The Wellbeing PDS Panel may be aware that the Health and Wellbeing Board previously identified alcohol as a key priority within the Joint Health and Wellbeing Strategy (that was agreed by Council on 14th November 2013).

1.6 Members of all four relevant PDS Panels were invited to attend the Wellbeing Policy Development & Scrutiny Panel on the 22nd December 2013 to comment on the draft report, recommendations and equalities impact assessment. Minor amendments were made to refresh the report and recommendations table.

1.7 Cabinet members have been asked to consider the recommendations of the scrutiny inquiry day. Their response now returns to each of the respective PDS Panels for the consideration of members.

2 RECOMMENDATION

At the Wellbeing Policy Development and Scrutiny Panel on the 21st March 2014, the Panel are asked to:-

2.1 Consider the recommendations response table completed by the Cabinet Member for Wellbeing, Simon Allen; Cabinet Member for Community Resources, David Bellotti; Cabinet Member for Sustainable Development, Ben Stevens; Cabinet Member for Neighbourhoods, David Dixon and the Cabinet Member for Early Years, Children & Youth, Dine Romero as detailed in Appendix 1 to this report. To discuss in particular the recommendations flagged as falling within the Wellbeing PDS Panel's remit.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

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

3.2 A key consideration for the Cabinet members in determining their response to the recommendations has been resource requirements, in particular financial implications.

Where relevant, resource implications are acknowledged in the responses in two main ways:

(1) where a recommendation is accepted and there is a recognised resource requirement, the potential impact of this requirement and/or the potential solution has been included in the response

(2) where a recommendation is deferred or rejected due to (at least in part) resource issues, the barrier to delivery is explained.

The work to be carried out as a result of accepted recommendations will be undertaken within existing resources and there will be no financial impact.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

4.1 Equalities issues were considered by the Panel as part of their work in formulating the scope of this proposed investigation and further equalities work was undertaken during the course of consultation. For the full Equalities Impact Assessment for this work see the link in Background papers below.

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

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

5 THE REPORT

5.1 The full report for this review can be found through the link in the background papers below.

6 RATIONALE

6.1 Appendix 1 provides the Recommendations Response Table for this work

7 OTHER OPTIONS CONSIDERED

7.1 None

8 CONSULTATION

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

8.2 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have had the opportunity to input to this report and have cleared it for publication.

9 RISK MANAGEMENT

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

Contact person	Emma Bagley/ Liz Richardson ext: 6410 / 6053
Background	Scrutiny Inquiry Day Report: http://democracy.bathnes.gov.uk/documents/s28027/App%201%2

papers	0Alcohol%20SID%20Report%20041113.pdf Equalities Impact Assessment http://democracy.bathnes.gov.uk/documents/s28029/App%203%20EIA%20Alcohol%20SID%20041113.pdf Minutes of Wellbeing PDS Panel meeting 22nd November 2014: http://democracy.bathnes.gov.uk/ieListDocuments.aspx?CId=460&MId=3329&Ver=4
Please contact the report author if you need to access this report in an alternative format	

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

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

Decision Response
The Cabinet has the following options:

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

Implementation Date

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

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

Alcohol harm reduction review: Recommendations

Recommendation	Cabinet Member	Decision Response	Implement ation Date	Rationale
More education programmes that encourage a voluntary shift in attitude to alcohol 1 To continue working in partnership with commissioned and statutory service providers to deliver a long-term education programme for professionals, parents and young people on the causes and effects of alcohol harm. In particular, develop targeted education programmes for specific vulnerable groups, including:	**Cllr Allen / Cllr Romero**			
a. younger children by encouraging schools to start introducing topics sensitively from primary school age;		**a.Accept**	**Ongoing**	**Vital part of primary PSHE (making healthy choices , avoiding risk, understanding effects of alcohol , knowing basic laws) Linked to DPH Award**
b. young people by encouraging schools to facilitate further work through Personal Social Health Education. To help facilitate this work it will be important to have a better knowledge of the causes of self-harm through alcohol use. To commission a piece of work that extends current knowledge and builds on previous SHEU evidence. This work to report back to the Wellbeing / EYCY Panel;		**b.Accept**	**Ongoing**	**Targeted work as directed by the SHEU survey , to be discussed and planned at Young People's Substance Misuse Group. Needs to be linked to self-esteem and looked at in terms of gender / pupil premium . Also introduce "Drinkthink Tool " to Sixth Forms in B&NES Schools**
c. older 'working age' and over 65s by supporting current initiatives of public protection; and		**c. Accept**	**April 2014 onwards**	**Public Health Workplace Wellbeing Charter is the holistic framework that is**

				currently commissioned as the mechanism for engaging with workplaces on health issues. Proposal for Council to pilot this approach to promoting staff wellbeing. In addition campaigns to promote sensible drinking amongst adults and training for professionals will be co-ordinated via Alcohol Harm Reduction Steering Group within existing resource.
d. parents by public health working together with schools. (EYCY / Wellbeing)		**d. Accept**	**Ongoing**	**To be discussed and planned at Young People's Substance Misuse Group**
<u>Improved and more frequent alcohol screening mechanisms</u> 2 (A)Develop and implement a quick screening method within front line services (including primary care such as pharmacies and waiting rooms - although potential scope for acute settings too). (B) Build on the existing AUDIT tool by exploring a potential 'app', scratch cards, themed bar mats or self-assessment pro-forma. (Wellbeing)	**Cllr Allen**	**(A) Defer** **(B) Accept**	**Nov 14**	**(A) Business case to be drawn up for further investment in primary care /pharmacy to undertake screening for target populations** **(B) Increased social marketing around alcohol issues will support Rec 1c above. Align launch with Alcohol Awareness Week Nov 14**
<u>Targeted interventions that deal with adverse effects of alcohol</u> 3.1 Build on in-situ interventions and street treatments in order to tackle isolated instances of inebriation in the night time economy. Support the ACPO initiative of 'drunk-tanks', and express an interest in hosting a pilot service in B&NES. (Wellbeing) 3.2 To provide 'wet house' supported	**Cllr Allen**	**3.1 Reject** **3.2 Defer**	**March 15**	**Current evidence regarding incidents in the NTE does not support need for drunk tanks. Approach does not encourage individual responsibility or culture change. We will continue to monitor local NTE data and national initiatives.** **B&NES Council Public Health & Drug and Alcohol team are currently working**

accommodation for patients requiring longer term health and social care rehabilitation or interventions. This recommendation to be implemented where there is the demand and an evidence base for this (Wellbeing)				**with Alcohol Concern and other partnerships across the country to explore approaches to working with 'treatment resistant drinkers'. This work will provide a range of options for working with this group that partners can consider, some of which may be suitable for new funding models like Social Impact Bonds.**
4 Encourage improved workplace health by developing a simple toolkit that local employers can use in the workplace. This initiative seeks to raise awareness about alcohol use in employees and colleagues. (Wellbeing)		**4. Accept**	**Ongoing**	**See 1c above re; Workplace Wellbeing Charter model**
<u>Greater emphasis on prevention of alcohol harm through national policy</u> 5 Health to be embedded as an alcohol licensing objective. The government to be lobbied about incorporating this into licensing legislation via the LGA. (PTE)	**Cllr Dixon**	**Accept**	**March 2014**	**Cllr Dixon accepts this recommendation. Licensing will work with Public Health to draft submission for the leader to send.**
<u>A local licensing policy that considers a broader range of issues and impacts</u> 6 Refresh the B&NES licensing policy to acknowledge prevention of alcohol harm with such inclusions as: a. Incorporate health into licensing policy at a local level;	**Cllr Dixon**	**a) Accept**	**July 2014**	**a) Yes – could be included in consultation on new policy (Spring 2014). Licensing Officers already researching other areas of good practice.**

b. A vision of what B&NES' night time economy will look like (including an overview of cultural expectations). This high-level vision to be supplemented by district level aspirations (such as Bath, Keynsham, Midsomer Norton, Radstock etc.);		**b) Accept**	**New Policy on forward plan. Currently July 2014.**	**b) Key elements would fit in strategy and could certainly be supported in an introduction to policy. Suggest area/district aspirations should be treated in a similar manner. Clear links between strategy and policy to be re-inforced through this. Date of Policy to Council may slip owing to consultation length**
c. Early Morning Restriction Orders in areas based on resident demand;		**c) Reject**		**c) Requires an evidence base to progress and formal consultation process. There is a very clear statutory requirement to demonstrate the need. (Likely resource requirement 1 x 1.0 FTE for 6 months).**
d. Appraisal of Cumulative Impact (CI) zones;		**d) Accept**	**d) No details on timescales yet.**	**d) Already in train Jon Poole and Natalia Urry (Policy and Strategy) are researching.**
e. Consideration of 'dry streets' where a community wishes to exclude licensed alcohol traders completely; and		**e) Reject**		**e) Insufficient information and evidence.**
f. The option of including a condition in a license around minimum unit pricing, high strength alcohol restrictions and/or irresponsible promotions where the evidence suggests this would be appropriate. (PTE/ ECD)		**f) Accept**	**f) July 2014**	**f) Yes – could be included in consultation on new policy. Could be based on Newcastle and/or Wakefield model.**

More accessible training that emphasises issues and effects of alcohol harm 7.1 Establish and deliver a local Best Bar None training scheme for trade staff. (PTE) 7.2 B&NES to express an interest in applying a business rate rebate to those premises successfully participating in the Best Bar None scheme. (PTE)	**Cllr Dixon** **Cllr Bellotti**	**7.1 Defer (Resource required)** **Reject**		**Model exists. Would need resource to take forward. Likely to require 1 x 1.0 FTE for 6 months and thereafter 1 day per week.** **All local authorities were given discretionary powers to remit business rates in the Localism Act. A rebate should be in the interest of local council tax payers. It would be wholly funded by the council.** **There would be some administrative costs depending on the nature of the scheme as there would need to be manual reports and inputs. There are 382 properties which could be effected and this does not include any shops. A 5% discount on business rates would cost the Council £558k per annum.** **The suggestion is therefore rejected on grounds of loss of income to the Council, administrative costs and it would be selecting one business sector for special treatment above others.**
Improved engagement at local level though more positive and proactive information sharing and publicity 8 Improve the information available to residents about making complaints and contributing to licensing reviews.	**Cllr Dixon**	**8) Accept**	**Sept 2014**	**a) Recommend becomes part of Customer Services workstream project (improving information for customers).**

Refresh existing information about licensing contacts and processes in the B&NES Connect magazine and on the B&NES website. Consider a 24hr answerphone line to gather evidence from residents about licensing concerns. Promote a direct telephone line within licenced premises if a customer wants to raise a concern or report issues. (PTE)		**Accept** **Defer**	**Sept 2014**	**b) As above** **Needs consideration as to whether this is part of the wider "report it" customer services workstream which is aiming to simplify the reporting process and reduce telephone lines into Council for customer contacts. Not just an issue for licensed premises – applies to other issues.**
<u>Communities that are safer from alcohol harm</u> 9.1 Build on existing work to prevent anti -social behaviour. Contain early issues through strong and clear enforcement presence in B&NES. Continue existing measures such as street marshals and police presence in 'hot spots'; as well as appropriate licensing enforcement action. Encourage greater information sharing between the police and council (e.g.101 and street marshal data) to guide enforcement. (PTE/ECD) 9.2 Extend existing initiatives, or foster new approaches in encouraging collective working between all alcohol traders (both on and off-trade). Encourage communication between businesses to allow them to work together optimally and, take a firm approach on sale of alcohol to people inebriated (legislation places licensees responsible for selling alcohol in this manner). (PTE/ECD)	**Cllr Dixon** **Cllr Dixon / Cllr Stevens**	**Reject** **Defer**		**Refer to Police Crime Commissioner** **Links to Best Bar None initiative and training for Licencees and staff. Resource implications.**

Communities that are safer from outcomes of alcohol harm	**Cllr Dixon**			
10.1 Encourage more integrated community safety work by rolling out further Community Alcohol Partnerships (CAPs) where underage drinking is a problem and residents want a CAP. (ECD)		**Reject**		**Community Safety is now a role for the Police Crime Commissioner.**
10.2 Tackle alcohol-fuelled domestic violence and abuse by exploring ways of introducing a CAP style model of integrated working across B&NES.		**Reject**		**Models already in place via the Multi-agency risk assessment conference (MARAC) ,safeguarding board and connecting families. Integrated Victim Service (PCC) includes domestic violence**. **There is now a twice yearly meeting being set up of the AG/LSAB/LSBC/HWB and Police and Crime Commissioner to ensure that Strategy of all the above groups is aligned**
To develop existing work by the council as part of the public service transformation network. Funding could potentially be earmarked through the community budget that covers this area of work. (ECD)		**Reject**		**DV Community Budget work is underway led by Andy Thomas through the PSTN and H&W**

Bath & North East Somerset Council

WELLBEING PDS FORWARD PLAN

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

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

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

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

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

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

Wellbeing PDS Forward Plan

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

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 21ST MARCH 2014				
21 Mar 2014	**Wellbeing PDS**	**NHS 111 update (including contingency arrangements)**		
21 Mar 2014	**Wellbeing PDS**	**Non-Emergency Patient Transport Services**	Clinical Commissioning Group	
21 Mar 2014	**Wellbeing PDS**	**The Royal United Hospital Bath update on results of the Care Quality Inspection held on 4-6 December 2013**	The Royal United Hospital representative	
21 Mar 2014	**Wellbeing PDS**	**Public Health - direction of travel**	Bruce Laurence Tel: 01225 39 4075	

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
Before 14 Feb 2014 4 Mar 2014 13 Mar 2014 21 Mar 2014 24 Mar 2014 **E2566**	**Cllr David Dixon, Cllr Dine Romero, Cllr Simon Allen** **PTE PDS** **ECD PDS** **Wellbeing PDS** **EYCY PDS**	**Policy Development and Scrutiny recommendations - Alcohol Harm Reduction Review**	Emma Bagley, Councillor Vic Pritchard Tel: 01225 396410,	Ashley Ayre Louise Fradd
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 16TH MAY 2014				
16 May 2014	**Wellbeing PDS**	**Further update on the Urgent Care provision (to include an update on all the relevant Primary and Urgent Care schemes)**		
16 May 2014	**Wellbeing PDS**	**Dentistry**	To be confirmed	
16 May 2014	**Wellbeing PDS**	**Homecare Update**	Officer tbc	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 25TH JULY 2014				
25 Jul 2014	**Wellbeing PDS**	**Avon and Wiltshire Mental Health Partnership (AWP) Pathway**	Andrea Morland	

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
25 Jul 2014	**Wellbeing PDS**	**Connecting Families - Health (to be confirmed)**	Paula Bromley Tel: 01225 396984	
25 Jul 2014	**Wellbeing PDS**	**Sexual Health (HIV)**	Public Health officer	
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 19TH SEPTEMBER 2014				
19 Sep 2014	**Wellbeing PDS**	**Update on Dementia**		
WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL; 28TH NOVEMBER 2014				
FUTURE ITEMS				
	Wellbeing PDS	**Public Health England**		
	Wellbeing PDS	**Briefing paper on reconfiguration of vascular services**	Tracey Cox	
	Wellbeing PDS	**Teenage Pregnancy**		
	Wellbeing PDS	**NHS Healthchecks**		

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
The Forward Plan is administered by **DEMOCRATIC SERVICES**: Jack Latkovic 01225 394452 Democratic_Services@bathnes.gov.uk				

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