Bath & North East Somerset Council

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Date: 19th January 2016
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To: All Members of the Health and Wellbeing Select Committee

Councillor Francine Haeberling
Councillor Geoff Ward
Councillor Bryan Organ
Councillor Paul May
Councillor Eleanor Jackson
Councillor Tim Ball
Councillor Lin Patterson

Cabinet Member for Adult Social Care & Health: Councillor Vic Pritchard

Chief Executive and other appropriate officers
Press and Public

Dear Member

Health and Wellbeing Select Committee: Wednesday, 27th January, 2016

You are invited to attend a meeting of the **Health and Wellbeing Select Committee**, to be held on **Wednesday, 27th January, 2016** at **10.00 am** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Mark Durnford
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 Mark Durnford who is available by telephoning Bath 01225 394458 or by calling at the Guildhall Bath (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 Mark Durnford 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 Mark Durnford as above.

   Appendices to reports are available for inspection as follows:-

   Public Access points – Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central, and Midsomer Norton public libraries.

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

4. **Recording at Meetings**:-

   The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control.

   Some of our meetings are webcast. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed. If you would prefer not to be filmed for the webcast, please make yourself known to the camera operators.

   To comply with the Data Protection Act 1998, we require the consent of parents or guardians before filming children or young people. For more information, please speak to the camera operator

   The Council will broadcast the images and sound live via the internet www.bathnes.gov.uk/webcast An archived recording of the proceedings will also be available for viewing after the meeting. The Council may also use the images/sound recordings on its social media site or share with other organisations, such as broadcasters.

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

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

7. **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.

Health and Wellbeing Select Committee - Wednesday, 27th January, 2016

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

   Pam Richards has registered to make a statement to the Select Committee.

7. MINUTES - 25TH NOVEMBER 2015 (Pages 7 - 16)

8. CLINICAL COMMISSIONING GROUP UPDATE

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

9. CABINET MEMBER UPDATE

The Cabinet Member will update the Select Committee on any relevant issues. Select Committee members may ask questions on the update provided.

10. PUBLIC HEALTH UPDATE

Members are asked to consider the information presented within the report and note the key issues described.

11. HEALTHWATCH UPDATE

Members are asked to consider the information presented within the report and note the key issues described.

12. THE STRATEGIC DIRECTION OF THE RUH (Pages 17 - 26)

This paper is presented to the Health and Wellbeing Select Committee for information. It provides an overview of future planning for the Royal United Hospitals Bath NHS Foundation Trust across the next five years, including details of new national guidance and local developments that influence the approach.

13. RUH / RNHRD INTEGRATION (Pages 27 - 54)

This paper has been prepared to ensure that the B&NES Health and Wellbeing Select Committee are kept up-to-date with proposals to relocate Royal National Hospital for Rheumatic Diseases (RNHRD) clinical services from their current location at the Mineral Water Hospital site to ensure sustainable high quality service delivery.

14. AWP - JOINT HEALTH SCRUTINY WORKING GROUP (Pages 55 - 72)

This report provides an initial response from mental health commissioners and from AWP's Bath and North East Somerset Locality Team, to key recommendations in the report of the joint scrutiny.

15. INTRODUCTION TO NHS SPECIALISED SERVICES

The Panel will receive a presentation regarding this item from Dr Lou Farbus, Head of Stakeholder Engagement, Specialised Commissioning.

16. YOUR CARE, YOUR WAY UPDATE (Pages 73 - 94)

An update presentation is provided for the Select Committee.

17. SELECT COMMITTEE WORKPLAN (Pages 95 - 98)

This report presents the latest workplan for the Select Committee. Any suggestions for further items or amendments to the current programme will be logged and scheduled in consultation with the Chair of the Select Committee and supporting officers.

The Committee Administrator for this meeting is Mark Durnford who can be contacted on 01225 394458.

HEALTH AND WELLBEING SELECT COMMITTEE

Minutes of the Meeting held

Wednesday, 25th November, 2015, 10.00 am

Councillor Francine Haeberling	-	Bath & North East Somerset Council
Councillor Karen Warrington (In place of Councillor Geoff Ward)	-	Bath and North East Somerset Council
Councillor Bryan Organ	-	Bath & North East Somerset Council
Councillor Paul May	-	Bath & North East Somerset Council
Councillor Eleanor Jackson	-	Bath & North East Somerset Council
Councillor Tim Ball	-	Bath & North East Somerset Council
Councillor Lin Patterson	-	Bath & North East Somerset Council

32 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

33 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

34 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillors Geoff Ward had sent his apologies to the Panel. Councillor Karen Warrington was his substitute.

35 DECLARATIONS OF INTEREST

Councillor Paul May declared an other interest as he is Sirona board member.

36 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none. The Chairman informed the meeting that she would move some agenda items forward to accommodate officer's availability for the meeting.

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

The Chairman invited Brook Wheelan (from People Against Sugar Tax Group) to give his statement.

Brook Wheelan read out the following statement:

'I would just like to thank you for allowing me to speak at the meeting. 'People

against Sugar Tax' is a new campaign group opposed to a sugar tax. I would like to add that we are not funded by any food or drinks companies.

We are campaigning to get a more balanced debate about sugar. You all are probably receiving lots of views about a sugar tax, and our job is to get a more balanced debate on this important issue.

We're not saying sugar is healthy. It does cause tooth decay, and eating it in large amounts can contribute to heart disease too, but we feel that the link between sugar and obesity has not yet been proven.

We feel there are other solutions that both local and national politicians can consider such as smaller portion sizes, simplified nutritional labelling, and an end to 'buy one, get one free' offers.

In terms of the nutritional labelling, we want to see a more simplified nutritional labelling system. At the moment, it is very confusing. One brand's portion size on the label might say 23 grams, and another brand's portion size might say 40 grams. A standardized labelling system might help.

A sugar tax is a scattergun approach which would fail to help the small numbers of people who need support to eat healthier. It does though penalise the rest of us.

More effort needs to be targeted at the small numbers of people who need to eat and drink healthier, the ones who drink seven or eight fizzy drinks a day.

A sugar tax could be considered as a very last resort, but we really need to be looking at all other ways of solving the obesity issues before it can be considered.'

On a question from the Committee about the high levels of sugar in foods Brook Wheelan said that he had seen an article recently which suggested that the reason why there is now so much sugar in our foods is because the food manufacturers have had to take out fats from their foods in recent years, and have needed to replace it with something else, namely sugar. He had not been able to clarify whether this is definitive or not though.

The Chairman thanked Brook Wheelan for his statement.

38 **MINUTES - 30TH SEPTEMBER 2015**

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

39 **CLINICAL COMMISSIONING GROUP UPDATE**

The Chairman invited Dr Ian Orpen (CCG) to give an update.

Dr Ian Orpen gave the Select Committee an update on behalf of the Clinical Commissioning Group (CCG), a summary is set out below.

Councillor Organ asked about the outcome of the work with the GPs in terms of the Antibiotic Guardian campaign.

Dr Ian Orpen replied that, in Bath and North East Somerset, GP practice prescribing of antibiotics has reduced from 124,500 prescriptions in 2013 to 112,157 prescriptions for antibiotics in 2015. Even so, one in four patients registered with a local GP, a total of 47,176 patients, was prescribed at least one course of antibiotics in the past year.

Councillor Ball asked if pharmacies had been monitoring, and reporting, prescriptions issued by local GPs.

Dr Ian Orpen responded that it would be hard for pharmacies to monitor regularly prescriptions issued by local GPs. However, all prescribing by GPs is carefully monitored nationally and this data is fed back to CCGs to analyse, including on antibiotic prescribing.

Councillor May asked how the CCG could make local GPs work together.

Dr Orpen responded that while the CCG could not make GPs work together as independent businesses, it had been trying to describe to local GPs the advantages of doing so and it is down to GPs to take on that advice.

Councillor Jackson expressed her concern on the appointment of young GPs in Bath and North East Somerset area.

Councillors Jackson and May also asked about the launch of the Primary Care Transformation Fund (a four year £1 billion investment programme to help general practice make improvements including in premises and technology) and if that money could be used for getting GPs into areas with no GP provision.

Dr Orpen responded that there had been a national campaign to get more GPs. Dr Orpen added that Your Care Your Way would influence how community health and social care services in Bath and North East Somerset would be delivered, including provision of GPs in areas such as Whitchurch.

The Chairman thanked Dr Ian Orpen for an update.

40 PUBLIC HEALTH UPDATE

The Chairman invited Bruce Laurence (Director of Public Health) to give an update.

Bruce Laurence gave the Select Committee an update, a summary is set out below.

Members of the Panel welcomed a survey of health behaviours and attitudes in schoolchildren.

Councillor Patterson asked about approach to self-harming and why is it that only girls were included in survey.

Councillor Organ about Sun safety under Secondary schools areas for development.

Bruce Laurence explained that the survey had picked up higher level of self- harming in girls than in boys. A system for helping people who go to the hospital with self-harming related injuries to have a rapid assessment had been developed. There was an increase in self-harming over the last two years in BANES which could be either because self-harming had increased or because services that picked up on self-harming had become better, or some combination of these effects.

Bruce Laurence also said that Sun safety had been important part of the survey highlighting the risk of the skin cancer but that it was also important that children were encouraged to be outside in the sunlight for their general wellbeing and so that they produced enough vitamin D. Thus as with other public health messages it is about getting a balance right..

Councillor May asked Bruce Laurence if Members of the Council had embraced Public Health in the way they should.

Bruce Laurence responded that Council had been excellent and Members and officers of the Council had had very good understanding in terms of the Public Health, although there is always an opportunity to do more and be more engaged.

Councillor Ball expressed his concern on cuts within Public Health and asked if Public Health budget would be protected. Councillor Ball also asked what percentages of surveys were statutory.

Bruce Laurence replied that the in-year cut had been confirmed as being just over £542k which is very slightly (about £1k) less than the original figure in the consultation document. There had been a concern that, while the NHS budget has been protected in the spending review, the public health grant to local authorities may be cut despite the fact that it commissions a range of services that were very much within the NHS provision like “NHS health checks”, sexual health services, drug and alcohol treatment services, health visiting and school nursing. This was at the same time as some new preventive work like the diabetes prevention programme is being developed through the NHS.

Bruce Laurence also said that, in terms of surveys, the only statutory survey was National Child Measurement Programme. The other surveys were voluntary, the SHEU survey being something the Council does every two years.

The Chairman thanked Bruce Laurence for an update.

41 CABINET MEMBER UPDATE

The Chairman invited Councillor Vic Pritchard (Cabinet Member for Adult Social Services and Health) to give an update.

Councillor Pritchard gave the Select Committee an update, a summary is set out below. Councillor Pritchard also highlighted the launch of PAD project (Post Alcohol Detox). The project would help people to sustain their recovery through detox.

Councillor Ball welcomed PAD Project and asked Councillor Pritchard if he would

lobby Licencing services on clampdown on premises who stuck up cans of special brew for cheap purchase.

Councillor Pritchard responded that he would support any measures to deny easy access to cheap alcohol.

Councillor Jackson asked about AWP report and also about CQC's report on Roswell Court.

Councillor Pritchard informed the Committee that AWP had received poor report from the CQC in the past. As a result of that there were series of meetings between AWP and Members of neighbouring Councils as part of a joint Scrutiny panel, led by Wiltshire. Councillor Pritchard explained that this joint review had progressed slowly but the report has now been shared with all the participating scrutiny panels and would be presented, with initial responses to the conclusions and recommendations, at the January meeting of the Select Committee.

Councillor Pritchard also said that Rosewell Court had been subject of three safeguarding allegations, one of which was reported in a local newspaper. One allegation had not been substantiated; the Police continue to investigate two further allegations. In the meantime Rosewell has taken appropriate action and is responding appropriately to the investigations.

Lesley Hutchinson (Head of Safeguarding & Quality Assurance) added that safeguarding team works closely with the contract and commissioning team, alongside CQC, to respond to any safety or quality concerns in Care Homes.

Councillor May asked how planning application process could include health and wellbeing issues of the population, such as GP provision.

Councillor Prichard responded that health and wellbeing, including supporting active lifestyles, has been gaining profile as part of the planning process.

The Chairman thanked Councillor Pritchard for an update.

42 HEALTHWATCH UPDATE

The Committee noted an update as set out below.

The Committee thanked Healthwatch officers for such apprehensive update.

43 RNHRD - SERVICE MOVES, ENGAGEMENT & CONSULTATION

The Chairman invited Tracey Cox (CCG Chief Officer) and Clare O'Farrell (Associate Director for Integration, RUH) to introduce the report.

The Committee highlighted the following points:

Councillor Patterson asked about hydrotherapy provision and if there would be in reduction in staff.

Claire O'Farrell responded that page 5 of the report highlights number of consultations held, including location of hydrotherapy pool. A plan for a single larger hydrotherapy pool, which could be divided in two pools, had been set. That would be located with therapy services, within the new built at the front of the hospital. Claire O'Farrell also said that there would be no staff reduction for these services.

Councillor May asked about long term funding.

Claire O'Farrell replied that the RUH had been working quite closely with the CCG in order to provide the best service to the community.

Tracey Cox added that three year plan was realistic. The CCG would be having ongoing dialogues for two to three years after the three year plan end, taking into consideration demographic changes in the area.

It was **RESOLVED** to note the update and to note next steps and the opportunities for patients, carers and the public to influence any service change proposal.

44 DIRECTORATE PLAN FOR PEOPLE & COMMUNITIES

The Chairman invited Jane Shayler (Director, Adult Care & Health Commissioning) to introduce the report.

Jane Shayler explained that this report sets out the framework for the service planning and budget processes which lead up to the statutory and legal requirement for the Council to set a budget in February 2016. Proportionate equality analysis is being carried out on the proposals within the Directorate Plans.

Jane Shayler explained that there is a single Directorate Plan for People & Communities, which covers all ages. It has also been presented by Ashley Ayre to the Children & Young Peoples' PDS Panel. She would, therefore, focus on the Adult Care and Community Health part of the plan which encompasses provision of statutory services under the Care Act 2014, provision of residential and nursing care, re-ablement, domiciliary care, community mental health services, drug & alcohol treatment, rehabilitation and preventative support, and social work services for people with learning disability or mental health needs and those in intensive supported living and extra care services. I would also provide the provision of preventative services which prevent, reduce or delay care and support needs and slow the escalation of costs in meeting individual care and support needs; delivery of services which support the effective functioning of the wider NHS system and prevent unnecessary hospital admissions or delays to discharge from hospital; securing either directly or through commissioning of the services required to discharge all duties.

Jane Shayler took the Panel through Appendix 4 of the report (Finance & Resource Impacts) and highlighted £450k proposal for Substance Misuse which would involve contract re-negotiation and overall would be likely to impact on provider organisations with some reduction of staff in those organisations.

The Panel highlighted the following points:

Councillor Ball expressed his concern in reduction of Substance Misuse services. Councillor Ball added that he was aware that the DHI (Developing Health and Independence) had struggled to cope with existing pressure, especially with people who were on waiting list for the programme. It would have a knock on effect if people would not be able to access services. Councillor Ball said the taking £450k out of Substance Misuse services could have large impact on the community where people, who were in detox, live. Councillor Ball concluded by saying that some reduction in services must be considered, but £450k may be a little bit too much for Substance Misuse services.

Jane Shayler acknowledged that there is a risk in terms of increased waiting times for services and on wider implications. Both providers and the commissioners were satisfied that proposals could mitigate those impacts through service redesign, efficiencies from co-location of services to reduce accommodation costs, some reduction in management costs, and a shift from residential to community detox and rehabilitation. People who go through detox would need to be properly motivated, whether it is residential or community detox.

Councillor Gerrish (Cabinet Member for Finance and Resources) commented that he viewed the changes as improvements and cited the proposal to offer fewer one-to-one sessions and more group work where peers could support each other. Councillor Gerrish also said that there would be a reduction in management side by bringing two organisations to work together, which would not result in reduction of the front line staff.

Councillor May said that he had worked with Councillor Gerrish on the Council's budget. Councillor May also said that officers should be given credit for setting up these proposals and that practical approach in working with people in detox in the community was, in his experience, preferable to placing people in residential institutions away from their community.

Councillor Organ asked if Transition services (from childhood to adulthood) had improved.

Jane Shayler responded that Transition services had improved significantly. Some years ago, after one Government assessment, B&NES had been placed in the bottom quartile. However, after the last assessment B&NES had moved to the top quartile.

Councillor Jackson expressed her concern on the last paragraph of page 56 of the report 'Greater targeting of prevention and early-intervention services may impact on access to such services for those people with lower level needs. There is also likely to be a reduction in the range and type of services offered and, therefore, the options given to individuals over the type of service put in place to meet their assessed, eligible care and support needs.' Councillor Jackson believed that this could result in increased Delayed Transfers of Care from hospital

Councillor Jackson asked what we would lose under service redesign in 'Healthy lives, healthy people: community small grants scheme £22k' (page 57).

Councillor Jackson also asked how Public Health intelligence work and remodelling public health programme would save £13k.

Jane Shayler replied that there had been challenges on the delayed transfers of care and this was a particular issue in relation to community hospitals discharge as the community hospitals play an important part in facilitating discharge from the RUH but then it can prove difficult to identify a package or placement as the people being discharged from the community hospitals have complex needs and require ongoing intensive support Jane acknowledged that there are growing difficulties in Domiciliary Care capacity, particularly in some geographical areas within B&NES and for people with particularly complex needs. Recently, an cloud-based IT system had been developed to match individual need with available domiciliary care capacity. The system had improved the speed at which an individual's assessed needs are matched with a domiciliary care providers able to meet those needs. The system is also gathering valuable information on the geographical shortfall in domiciliary care provision as well as the sorts of complex needs that are proving difficult to meet through "standard" domiciliary care and this will inform future commissioning intentions. Jane emphasised that B&NES still has less of a problem than neighbouring areas in terms of domiciliary care provision.
Jane Shayler commented that Public Health intelligence work and remodelling public health programme saving of £13k would be achieved through sharing and anlysise of intelligence between the Council and CCG (ie "in-house") teams rather than contracting with external NHS organisations.

Jane Shayler also said that Healthy lives, healthy people: community small grants scheme of £22k would be a reduction in service as this sum was made available to voluntary organisations to help them achieve various public health related goals. The Public Health team believed that this saving could be achieved without significant impact on service users. Jane Shayler emphasised that despite this relatively small reduction, the Council has, over a long period of time, invested significantly in prevention, early-intervention and self-management and is committed to continuing this as a key priority.

It was **RESOLVED** to:

1) Note the report;
2) Forward Committee's comments and concerns (about the knock on effect) to the Cabinet to consider;
3) Note mitigation steps taken by officers; and
4) Commend officers for their work and acknowledge that further work has been undertaken in forecasting future budget.

45 LSAB ANNUAL REPORT

The Chairman invited Lesley Hutchinson and Robin Cowen (recent Independent Chair B&NES Local Safeguarding Adult Board) to introduce the report.

Robin Cowen introduced the report by saying that this annual report shows the vast amount of work that is taking place in Bath and North East Somerset to support, deliver and promote adult safeguarding. The scale and complexity of this work had increased year on year and the Care Act had broadened it further. While welcoming the recognition the Act gives to safeguarding it also reminded that this shifting

landscape had been hard enough for people involved in the work to comprehend and work with, let for alone people who need support who are trying to navigate the system.

The Committee congratulated Lesley Hutchinson, Robin Cowen and the team for an excellent report.

Councillor May asked about transition services (from child to adult) development.

Lesley Hutchinson responded that she had identified a number of areas to be looked at.

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

46 **SELECT COMMITTEE WORKPLAN**

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

- Report from Domiciliary Care Commissioners – May 2016

The meeting ended at 1.40 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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Report to Bath and North East Somerset Health and Wellbeing Select Committee
RUH Strategic Planning
January 2016

Introduction

This paper is presented to the Health and Wellbeing Select Committee for information. It provides an overview of future planning for the Royal United Hospitals Bath NHS Foundation Trust across the next five years, including details of new national guidance and local developments that influence the approach.

National context – *NHS Five Year Forward View and planning guidance*

The *NHS Five Year Forward View*, published in October 2014, set out a new mandate for health services across England. The challenge of managing the rising demand for healthcare as a result of age and poor health choices combined with variation in quality and service provision was clearly stated; with a requirement for organisations to look at ways in which the consequent funding deficit could be addressed. Over the last 12-18 months all healthcare organisations have been examining ways in which they can deliver this new mandate, in the context of three 'gaps':

- The health and wellbeing gap: focusing on better preventative and proactive healthcare in communities, supported by health, social care and voluntary sector organisations
- The care and quality gap: providing access to the best healthcare and treatment for local populations at the right time and in the right place, delivered by people with the right skills, values and behaviours
- The finance and efficiency gap: returning the NHS to financial balance by tackling variation, service transformation and managing demand

NHS England published its planning guidance on 22nd December 2015. This focuses on planning across whole health systems (rather than individual organisations), led by Clinical Commissioning Groups and Health and Wellbeing Boards. Communities will need to produce a *Sustainability and Transformation Plan* (STP) by June 2016, which will address the three principle 'gaps' outlined in the *NHS Five Year Forward View*.

Provider organisations, including the RUH, will need to contribute to this plan and to make sure that there is good alignment between the system wide plan and our own internal five year strategy. Alongside this wider strategic plan, all healthcare organisations (including providers) are expected to develop a detailed operational plan that establishes the delivery of the first year of this 5 year plan.

Developing the RUH Strategy

Considerable work has been carried out over the last year to establish our potential as an organisation, aligning to the overall direction of travel of the NHS to transform itself and what we already know of local challenges, opportunities and stakeholder feedback, but also leaving flexibility for further refinement as integrated local health system plans develop.

The local systems which the RUH serves are similar to many others across the country, with growing pressure on services from an increasingly elderly and more complex patient population. We have responded to this in a variety of ways including:

- Participating in the national Patient Flow Programme, including a project to develop a better pathway for patients aged >75 with multiple conditions
- Improving services that enable more patients to be assessed treated and transferred back home on the same day
- Implementing a new Discharge Service which is more inter-connected with colleagues from community and social care services across our local health system

To support these programmes and other new ways of working across the Trust, we have invested £3.1m in nursing posts over the last two years. Alongside this, we have also made changes in our existing skill mix, recruiting to new roles such as Assistant Practitioners to provide continuity of care from non-qualified but more highly skilled support staff. This has released clinical nursing time to support improved care of patients and supervision for more junior staff.

In all of this, we seek to work closely with partners across our system, and we use Governor, member, staff and patient feedback to support this. We have used this to develop our new Trust vision

To care, To innovate, To inspire

Underpinned by three strategic ambitions:

1. We will be **Provider of Choice**: as a member owned organisation, patients will be confident in our ability to provide safe, effective care and will have an excellent experience of our services – every time. Our care pathways will be co-developed with patients and other stakeholders and will focus on providing the best care, every time
2. We will be a **System Leader**: a driver of and ambitious for local change, delivering innovation in service provision. As a pilot site for new models of care we will have a national and international reputation.
3. We will be a **Provider without Walls**: a willing collaborative partner, working beyond the hospital campus and with other organisations in our health system to deliver a more integrated and local approach to care for our population

Over the last six months, we have also carried out a comprehensive refresh of our Trust values. Co-created with staff, patients and members, we will be launching these at the end of January.

Teams across the Trust have been working to develop their plans aligned with our vision and strategic ambitions, and we have already started to deliver some of the change we want to see. Examples of new service models include our integrated Diabetes service, where we have been working together with primary care in B&NES to deliver a more joined up approach to provision for people with Diabetes; and our recent successful collaborative bid to help transform Wiltshire Adult Community Services. Having acquired the RNHRD in February 2015 we are also supporting their continued system leadership in areas such as fibromyalgia - building plans to improve access to innovative models of care which improve quality of life and long term health costs at a national level. Our patient empowerment programme this year will focus particularly on our mechanisms for effective patient engagement in service

design and the accessibility of information we provide to patients – sharing best practice and evidencing the tangible impact that this has in building the quality of care we are focused on providing.

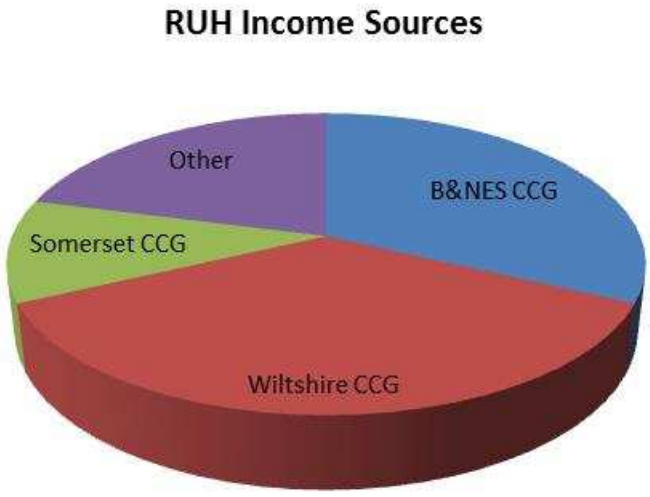
We recognise, learning from our teams on the ground and our experience in working with colleagues across the system, that the challenges we face cannot be overcome alone and we will need to work in new ways to deliver more services closer to home and in partnership with wider health and social care system colleagues.

In December 2015, we held a joint Council of Governors and Trust Board away day, where a range of strategic priorities were discussed and debated. From this, the following priorities were also proposed for future planning consideration:

- Patient empowerment
- Eliminating (on the day) cancellations
- Streamlining administrative processes
- Improving communications
- Empowering, valuing and respecting staff
- Providing patient centric services
- Improving discharge planning and processes
- Maximising the use of IT to improve communications
- Focusing public and patient education

Our local system and future change

The RUH catchment spans a wide urban and rural catchment with three predominant Clinical Commissioning Groups (CCGs):



Each CCG, together with Health and Wellbeing Boards, have developed a vision for the future, and have a clear appreciation of the transformation and financial challenges to the system which lie ahead. They are taking a range of approaches to integrated commissioning to design and procure the best system solutions.

Despite the challenge for the RUH, in addressing the different needs of each population our strategic plans and partnerships are both tailored to each community

and include a set of underpinning enablers which will remain common across each CCG area.

B&NES CCG

A key priority for B&NES CCG in the coming year will be the recommissioning of community services. Spanning both children's and adult's services, the *Your Care Your Way* programme is focusing on a new model that delivers greater integration between community based services, primary and secondary care and improves patient outcomes in every way. The RUH has been working closely with colleagues across B&NES to help develop an integrated response to this new model.

Wiltshire CCG

We have developed a new organisation – Wiltshire Health and Care – in partnership with Great Western Hospitals NHS FT and Salisbury NHS FT to help transform the future of Wiltshire Adult Community Services. We believe that this will be both better for the health and wellbeing of the population of Wiltshire and also enable improvements in pathways through our acute hospital services which will benefit all patients attending the RUH.

Somerset CCG

Somerset CCG has been working with NHS England to develop a new model of care for Somerset. Like B&NES CCG, the focus of this is to deliver improved outcomes for patients across a suite of indicators. It is supported by a new contracting model, where organisations come together to deliver services supported by a single payment per head of population served rather than for activity delivered. We are working with colleagues across health and social care in East Somerset to better understand the demand risks for the future and to develop a more integrated approach to care and prevention across the county, particularly looking at ways in which the third sector can be more positively and proactively engaged.

All of the above will directly influence local Sustainability and Transformation Plans, driving increasingly integrated care and less rigid boundaries between GP, hospital and community services.

What does this mean for the RUH?

The level of national and local change requires a new approach to care delivery. Our local community has and continues to face unprecedented financial challenge across both health and social care services. Whilst the RUH is recognised as being one of the top ten most financially efficient Trusts in the most recent Lord Carter Review of Operational Productivity in NHS Providers, we know that delivering the level of savings required to meet the future funding gap across our community will require an alternative approach to service delivery and more efficient models of care. Our local population will need to be empowered to take greater responsibility for their own health with an increased focus on supported in self-care and management. Our five year strategy will reflect this, recognising that we need to work in partnership with colleagues in our community to deliver this level of change, and reduce the impact of increasing age and illness.

Clinical teams have already started on this transformation journey, working with colleagues in other organisations. The detailed clinical vision for the next five years

will be developed across the next few months, what we do know now however is that we will as a system need to deliver increasing amounts of care in the community and to achieve this, we will need to adapt and develop our enabling strategies including:

- Our Workforce Strategy
- Our Informatics Strategy
- Our Patient Empowerment and Engagement programme
- Our Quality Strategy
- Our Estates Strategy

Workforce Strategy

Our greatest asset is our staff and in order to meet our stated objectives and fulfil our commitment to provide safe, compassionate, high quality care to our patients we need a highly skilled, committed and engaged workforce. Through this strategy we describe the support and opportunities we provide for our staff to enable them to fulfil the Trusts ambitions and their personal ambitions.

In developing this strategy we have been mindful of key national and local drivers, and the scale of change needed to ensure financial stability across the national and local health economy; our workforce strategy is realistic and in line with the scale of change required.

The RUH has a made a bold statement in its intentions to be a hospital without walls, a system leader and a provider of choice.

We are already working with community colleagues to identify ways in which we can create and develop more roles to operate across primary, community and secondary care. We recognise, however, that this is one step in our longer term plans and we are keen to develop new roles across all aspects of the care pathway that ensure effective seven day services, delivered by staff who share the values and behaviours essential for the NHS of today and tomorrow.

Informatics Strategy

The RUH has a five year Digital Informatics Strategy to align service delivery with the national NHS Five Year Forward View and to enable the organisation to deliver the objectives of a high performing Foundation Trust.

The Vision of the RUH's Digital Informatics Strategy is that the Trust's investment in Informatics transformation, development and services must deliver and support the modern clinical records; corporate systems and technology infrastructure required to facilitate information processing that improves and proves the quality of care and patient experience delivered in an increasingly competitive and integrated health and social care economy.

Years 1-3 of the Digital Strategy are focussed predominantly on achieving a digital, integrated patient record with the associated technological infrastructure required to achieve a paperless clinical workforce in line with national Informatics Strategy.

In line with the national informatics model, such electronic patient records (EPR) centric work facilitates improvements in health outcomes and the patient care experience. Improvements in our patient record keeping system, achieved through the acquisition of robust and contemporaneous clinical data, can lead to improved professional decision-making, better informed service users and an increase in

transparency and standardisation across the whole healthcare system interactions with patients and clinicians.

Such advantages to be achieved include:

- Helping patients and carers to make the right, healthy choices through access to their care records and by using digital tools to more effectively administer and manage their care;
- Giving all care professionals the data they need through real-time digital access to patient records and improved data on outcomes; and
- Making the quality of care transparent by publishing comparative information.

While the Cerner Millennium solution will form the majority of the Trust's EPR, other departmental systems will integrate with Millennium to form the Trust's complete EPR. We will use mobile and fixed devices to support the use of a secure EPR by all clinicians.

The RUH has made significant progress toward achieving such vision with Quarter 1, 2 and 3 of the first year of the digital informatics (eHealth) programme already delivered. Our Digital Informatics Strategy sets out the roadmap to deliver our EPR and other organisational digital ambitions over the 2015-20 period. Year 1 to 3 milestones of the eHealth programme include:

2015/16	Transition from the national programme (BT) datacentre Migration to 2015 Millennium code Implementation of Millennium across the Royal National Hospital for Rheumatic Diseases Implementation of further Millennium Nursing e-forms Replacement of the RUH network (core and wireless) Initiation of CCG interoperability programmes Server and PC replacements and other IT infrastructure improvements
2016/17	Implementation of Millennium within the RUH Emergency Department Implementation of Millennium e-prescribing solution for RUH services Implementation of Millennium order communications for RUH services Further Millennium e-forms implementation Patient interoperability solutions delivered Further delivery of CCG interoperability programmes Commencement of paperless outpatients
2017/18	Completion of e-prescribing rollout across all RUH services Completion of paperless outpatients across all RUH services Completion of Millennium e-forms programme e-self check-in following delivery of RUH physical estate programme Completion of rollout of e-whiteboards and other digital boards

Our plans are supported by eleven Chief Clinical Information Officers (CCIOs). These are clinicians who work across all areas of the Trust and who test and challenge our proposals, ensuring that what we develop is fit for purpose and applicable to current models of care delivery across our services.

Patient empowerment and engagement

An underpinning principle of all our delivery and enabling strategies is a new drive towards patient empowerment and engagement. There is strong evidence that where patients feel empowered to manage their own condition, they take more proactive steps to avoid ill health and are better able to deal with short term deterioration in their conditions. This, in turn, reduces demand for hospital and community based services. Our vision over the next five years is to develop systems, processes and organisational culture to support patients to move from passive recipient of care to core member of the care team. Our core principles are to create an environment with:

Patients and carers as partners

- Patients and carers are confident of being well informed and supported to make their own decisions about their care – "no decisions about me without me".
- Equal access to information held about them, sharing responsibility in keeping this current and enabling it to be shared appropriately to support their care.

Patients helping themselves

- Understanding personal responsibility for health and wellbeing, and motivated to protect it – maintaining healthy lifestyles, monitoring their condition, making and keeping appointments, feeling informed and acting upon expert advice.

Patients and carers helping each other

- Motivated and enabled to support others who may share their experiences, including expert patients.
- Patients and carers continuously influencing design and delivery of care to enhance its quality.

Person Centred Care

- Always treated with dignity, respect and compassion, with co-ordinated care provided across an integrated care pathway that offers choice.
- Care tailored to the needs and aspirations of each individual.

To achieve all this we have developed and started to implement our Patient Empowerment and Engagement Strategy over the last twelve months, and we will be working with colleagues across the community to align this with the wider programme of self-help and illness prevention. Key schemes of work include:

Involving patients and carers in service redesign
Maximising engagement of patients and carers when planning new services or redesigning existing services, for example through our RUH redevelopment programme.

Improving patient and carer information
Reviewing together the content and communication methods of information across the patient pathway, ensuring that it supports the concept of informed and engaged patients and carers, and empowers self-management

Learning and improving from patient and carer experience
Enhancing the value of patient and carer feedback in improvement of services, including feedback on improvements made and developing a staff culture of continuous learning from feedback.

Culture and communications
Supporting a partnership culture between patients, carers and staff which develops health coaching, self-help and self-management skills as the expected norm

Quality Strategy

The Trust has a clear ambition to be recognised for delivering the highest quality of hospital care and to ensure patient safety and quality are at the heart of everything we do. Our Quality Improvement Strategy focusses on improving our structures and systems so that they support safer practice and enable improvements in individual and team standards and effectiveness, leading to the best outcomes for patients. Our Strategy details key areas of focus for the Trust and supports the delivery of the annual Quality Account priorities.

In order to deliver the strategy we need a workforce that is both able to recognise the need for change and capable of delivering improvement. Our aim is that all our staff have the skills to deliver continuous quality improvement, respond well to change, embrace initiatives, are open to and generate new ideas and encourage forward thinking. To empower and support staff to embrace continuous learning and personal development we have established a training programme.

The Quality Service Improvement and Redesign (QSIR) Train the trainer course was designed and developed by NHS Improving Quality (NHSIQ). On completion of the course Trainers become accredited associate members of the QSIR teaching faculty. In April 2015, two senior clinicians completed the training and have subsequently delivered the 4-day Quality Improvement training (QSIR) to 2 cohorts of staff (36 in total) with a third cohort planned for March 2016. The aim of the QSIR course 'is to develop core quality improvement skills and knowledge through the use of practical tools in the delivery of service improvement. The QI team is currently working with the Advancing Care team from NHS Improvement (formerly NHS IQ) and the West of England Academic Health Science Network (WEAHSN) to develop a Quality Improvement training matrix to support the delivery of QI capability to all levels of staff in the organisation.

Estates Strategy

We are proud of our track record in improving and developing the RUH estate, demonstrated in major projects such as our award winning Neonatal Intensive Care Unit, IM&T building and Pathology Laboratory and Mortuary Our strategy for the next five years has been established for some time now and is critical to support the benefits case which we have promised for the future of RNHRD services.

We understand that with advances in models of care, we will need to further develop the existing estate making sure that we have a site that is fit for purpose and sustainable. Key elements of our plan include:

- The construction of a new pharmacy and aseptic suites (for the manufacture of cancer drugs). This £7M project commenced in November 2015 and will be completed in August releasing space for new building stock.
- The construction of a new 300 space car park for patients/visitors which we hope to complete this spring.
- The construction of a new RNHRD and Therapies Centre on the site of the existing pharmacy which will bring together all therapy activities in a bespoke unit and allow for the transfer of clinical services from the existing RNHRD.

- The construction of a new Cancer Centre on the site of the existing 'RUH North' providing new facilities for almost all of our cancer in-patient and out-patient services.

These projects will not only transform the RUH site but will provide a quality patient environment that will improve our clinical services, staff productivity and day to day efficiencies. This level of investment with demolition of old buildings will virtually eliminate our backlog maintenance liability which stood at £43M in 2009. However, the emphasis will also be on quality of design producing new buildings which enhance the reputation of our hospital and create civic pride in the RUH.

Through careful design and a high level of user/commissioner consultation we shall ensure that the new facilities support future service strategy and build in flexibility of use.

Conclusion

There is work still to be done to develop and refine our strategy, in partnership with colleagues across our local health system. Our enabling strategies are in place, and we are well-placed to deliver a comprehensive clinical service strategy for the next 5 years that will sit alongside these as a fully integrated strategic plan.

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Bath & North East Somerset Council

MEETING/ DECISION MAKER:	**Health & Wellbeing Select Committee**	
MEETING/ DECISION DATE:	**27th January 2016**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Royal United Hospitals Bath NHS Foundation Trust update on the proposed Royal National Hospital for Rheumatic Diseases clinical service relocations**	
WARD:	All	

AN OPEN PUBLIC ITEM

List of attachments to this report: None

Appendix 1: Report on the outcomes of Patient and Public Engagement activities on the proposal to relocate the Specialist Paediatric CFS/ME and Paediatric Rheumatology services from the Mineral Water Hospital.

Appendix 2: Equality Impact Assessments

Appendix 3: Summary Impact Assessments

1 THE ISSUE

This paper has been prepared to ensure that the B&NES Health and Wellbeing Select Committee are kept up-to-date with proposals to relocate Royal National Hospital for Rheumatic Diseases (RNHRD) clinical services from their current location at the Mineral Water Hospital site to ensure sustainable high quality service delivery.

The attached report (see appendix 1) provides the Committee with the outcomes of Patient and Public Engagement activities completed relating to the proposed relocation of the Paediatric Specialist CFS/ME and Paediatric Rheumatology services from their current location. This paper includes an Impact Assessment and Equality Impact Assessments for both service areas (see appendices 2 and 3).

Panel members have received previous reports and briefings which outlined the rationale for change and provided an update on activities at their July 2015 and November 2015 committee meetings. The Royal United Hospital (RUH) Commercial Director also invited panel members to suggest any questions they would like asked during patient and public engagement activities in a letter dated 6th October 2015 and circulated via the Committee's Policy Development and Scrutiny Project Officer.

2 RECOMMENDATION

The committee are asked to: Note the outcome of the impact assessments and patient and public engagement activities which provided opportunities for patients, carers and the public to influence the proposals, and which confirmed that the effects of this change are considered minimal and that there are a number of positive aspects to the change.

The committee are asked to: Endorse the proposal to relocate the Paediatric Specialist CFS/ME and Paediatric Rheumatology Services from the Mineral Water Hospital to the dedicated children's unit on the RUH site.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

In order to ensure the continued sustainability of the services currently provided at the Mineral Water Hospital site the ability to fully integrate and align services on a single site was a core component of the original business case for the acquisition of the RNHRD by the Royal United Hospitals Bath (RUH). It will improve efficiency and effectiveness, improving patient experience, ensuring continuity of care, and quality of service delivery as well as increasing value for money from the public purse. Clinicians continue to be integral to planning the future of their services to ensure the delivery of high quality effective services.

4 STATUTORY CONSIDERATIONS AND BASIS FOR PROPOSAL

Patient and Public Engagement (PPE) activities will be conducted in line with the Government's Consultation Principles for Public Bodies (October 2013), the Equality Act (2010) and Section 242, Subsection (1B)(b) of the Health Act 2006 (as amended).

5 THE REPORT

A phased approach to support Patient and Public Engagement (PPE) relating to the continued integration of the two hospitals is considered most appropriate by the Local Health Economy (LHE) Forum, providing general context of the full relocation at the outset but planning and completing each programme of PPE service by service. The RUH is working with CCG and NHS England Engagement leads, and patients to ensure PPE is carried out in line with the Government's Consultation Principles for Public Bodies (October 2013). The first phase of activities related to PPE activities on proposals to relocate the Paediatric Rheumatology and Specialist Paediatric CFS/ME services is now complete.

Relocating the Specialist Paediatric CFS/ME and Paediatric Rheumatology Services service to the RUH site would ensure continuity of care for patients and their families, enable the services to be co-located with wider paediatric services in a designated paediatric department, and provide an improved environment and dedicated facilities for younger patients.

As part of a larger acute hospital, it also further strengthens governance and safe guarding processes and increases the clinical team's access to peer support and clinical guidance. There will be no impact to patients accessing the Specialist Paediatric CFS/ME community or satellite clinics, all of these clinics will continue in their usual location, only the location of the Mineral Water Hospital based service and the administrative base will change.

There will be no change in the level of service provision for Paediatric CFS/ME and Rheumatology patients they will have access to the same clinical teams and benefit from wider clinical support. There are no impacts on patient choice for either service by the proposal to relocate the services to the RUH site and there is support from senior clinicians whose services will be affected.

Scale and scope

The RNHRD Paediatric Specialist CFS/ME and Paediatric Rheumatology services are relatively small services. The CFS/ME service provides 2-3 outpatient clinics a week from the Mineral Water Hospital site, with the Paediatric Rheumatology service providing 2 outpatient clinics per month from this site.

In 2014/15 the Paediatric Rheumatology service served approx. 30 patients from B&NES, with the Paediatric CFS/ME service serving 55 patients from B&NES over the same period. Activity information for each of these services is highlighted in the tables below:

Paediatric Rheumatology

CCG	2013/14	2014/15	2015/16 (Part year)
	Number of Patients	Number of Patients	Number of Patients
NHS WILTSHIRE CCG	41	53	24
NHS BATH AND NORTH EAST SOMERSET CCG	27	30	11
NHS SOMERSET CCG	12	13	7
NHS SOUTH GLOUCESTERSHIRE CCG	2	4	0
NHS GLOUCESTERSHIRE CCG	2	2	0
NHS BRISTOL CCG	1	2	1
NHS SWINDON CCG	1	1	1
All CCGs	**91**	**111**	**49**
All Specialised	**41**	**42**	**30**
All Commissioner types	**129**	**150**	**79**

Paediatric CFS/ME Services

CCG	2013/14	2014/15	2015/16 (Part year)
	Number of Patients	Number of Patients	Number of Patients
NHS WILTSHIRE CCG	47	72	58
NHS GLOUCESTERSHIRE CCG	32	68	56
NHS SOMERSET CCG	34	53	50
NHS BATH AND NORTH EAST SOMERSET CCG	46	55	44
NHS BRISTOL CCG	21	38	26
NHS SOUTH GLOUCESTERSHIRE CCG	18	35	16
NHS NORTH SOMERSET CCG	22	22	24
NHS SWINDON CCG	8	11	8
All Commissioner Types	**291**	**461**	**333**

Impact of proposals to relocate the Paediatric Rheumatology and Specialist Paediatric CFS/ME services

Focused clinical and patient and public engagement on the relocation of the Paediatric Rheumatology and Paediatric CFS/ME services from the Mineral Hospital site commenced in October 2015 and ceased on 6th January 2016.

During this period of public and patient engagement the requirement to relocate the paediatric services from the Mineral Water hospital site, with one proposed new home being the dedicated

children's unit on the RUH site. Where clinically appropriate and to maximise patient benefit, suitable community settings could also be considered.

During Patient and Public Engagement activities 350 past and current paediatric CFS/ME patients and 120 past and current paediatric rheumatology patients were sent a letter outlining the proposals, the rationale for change and inviting them to the service specific engagement events held in December 2015. A survey was also attached with the option to complete hard copy or online.

Overall respondent's feedback positively on the service they are currently receiving, and there have been positive comments in relation to the proposed new location in the dedicated children's unit on the RUH site.

- *"I think they will get a better service here because there are more facilities at RUH and more services we can access – we don't know yet if she just has one thing or several things wrong with her so we don't know what services we might need."*

- *"I can't wait to move to RUH because they have patients my own age here. The Min is full of old people."*

- *"…RUH is more accessible, which is what we need…"*

The majority of respondents felt that the level of expertise of the people treating the patient was the most important thing to consider in relation to the care of young people with CFS/ME.

- *"We have received excellent care and advice from the specialist team so far and we hope that the service will continue to provide the same into the future."*

- *"They have been really supportive and have helped me use methods to try and cope with CFS/ME."*

The Impact and Equality Impact Assessments indicate no adverse impact to patients in relocating the services to the RUH site, and feedback obtained during PPE activities indicate that some service users felt that access would improve in relation to parking. Parking at the Mineral Hospital site was mentioned by several patients and carers as an issue, particularly when considering that often patients are unable to walk long distances.

- *"RNHRD is an awful location – parking isn't on site and ill children with CFS/ME have to walk too far from the car to the hospital. The difficulty in parking and then getting my child to hospital has been too much for her in the past."*

Throughout the period of patient and public engagement just one respondent specifically said that they would prefer the service to remain at the RNHRD.

- *"Attending RNHRD is the best place for this service as it's more relaxed than a main hospital setting…. Keep it the same as now."*

Further details, an outline of PPE activities and feedback can be found in Appendix 1.

Next steps:
Subject to the Committee's endorsement of the proposal to relocate these two paediatric services to the RUH, the Specialist Paediatric CFS/ME service will relocate from its current location on the Mineral Water Hospital site to the dedicated children's unit at the RUH at the end of the 2015/16 financial year. The Paediatric Rheumatology service may relocate slightly later than this.

The next phase of Public and Patient Engagement activities relate to proposals to relocate the RUH Sexual Health services and the RNHRD Adult Fatigue Management services. PPE activities will commence in February 2016.

6 RATIONALE

This paper has been prepared to ensure that the committee are kept up-to-date with the integration of the two hospitals post-acquisition, and the outcomes of impact and equality impact assessments and Public and Patient Engagement activities completed relating to the proposed relocation of the Paediatric Specialist CFS/ME and Paediatric Rheumatology services from their current location.

7 OTHER OPTIONS CONSIDERED

As part of original business case for acquisition of the RNHRD options were considered in relation to services continuing on the Mineral Hospital site or relocating services. The ability to fully integrate and align services on a single site, when clinically appropriate, was a core component of the original business case for acquisition and sustainability of services.

8 CONSULTATION

In addition to the service related public and patient engagement activity outlined in this report, the RUH is working with the Local Health Economy (LHE) Forum, whose membership includes Executives from B&NES, Wiltshire and Somerset Clinical Commissioning Groups (CCGs), NHS England, RUH Governor and patient representation, to agree the process for communication and engagement activities to support the potential relocation of clinical services over the next three years.

To support this activity, the RUH has established an LHE Communications Working Group (which is comprised of RUH and NHS England and CCG communications and engagement leads and a patient representative) to ensure all service related PPE is conducted in line with the Government's Consultation Principles for Public Bodies (Oct 2013).

9 RISK MANAGEMENT

An integration programme governance structure is in place to ensure that any programme issues are identified and, if required, added to the RUH risk register.

Contact person	*Clare O'Farrell, Associate Director for Integration, RUH* *Tracey Cox, Chief Officer, NHS Bath and North East Somerset Clinical Commissioning Group*
Background papers	*Update to Health and Wellbeing Select Committee 29th July 2015* *Update to Health and Wellbeing Select Committee 25th November 2015*
Please contact the report author if you need to access this report in an alternative format	

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Relocation of RNHRD's Specialist Paediatric CFS/ME and Paediatric Rheumatology Services

Introduction

The following report details the outcomes of Patient and Public Engagement activities on the proposal to relocate the Specialist Paediatric CFS/ME and Paediatric Rheumatology services from the Mineral Water Hospital site.

Background to the engagement

The Royal National Hospital for Rheumatic Diseases (RNHRD) was acquired by the Royal United Hospitals Bath (RUH) on the 1 February 2015 in order to resolve its long standing financial challenges and to preserve the valued services currently provided at the Mineral Hospital Site (also known as The Min). Throughout the acquisition process, which has spanned a number of years the RUH has clearly stated its intention to relocate services from the RNHRD's Mineral Hospital site to the RUH site or, where clinically appropriate and to maximise patient benefit, to suitable community settings. The relocation of services from the Mineral Hospital site will allow a number of promised benefits to be realised for the patients and communities served:

- **Integration**: Improved integration of services and skills will support further expansion of shared care models, particularly for patients with multiple, and complex long term conditions. In time, this is expected to lead to further development of new service models in areas such as therapies and self-management in line with the national direction of travel. Access to specialist expertise and diagnostics will also be extended.

- **Sustainability**: Through integration of service models and closer working with community partners, services will be sustainable for the future, both financially and operationally. All clinical services are expected to continue in line with commissioner requirements.

  The ability to fully integrate and align services on a single site was a core component of the original business case for acquisition and sustainability of services. It will improve efficiency and effectiveness, maintaining patient experience and quality of service delivery as well as increasing value for money from the public purse.

- **Profile and people**: The profile and brand of the RNHRD is both nationally and internationally recognised. This will continue to be maintained and further developed as part of the RUH to ensure that high quality, innovative service models are supported and in turn, promote further research investment in the local area that will ensure the strong track record of and ability to recruit high calibre staff can continue.

- **Service development:** The plans for the future development of services have been produced jointly with clinical teams. These plans take into account both local concerns such as ensuring the development and delivery of a long-term strategy for valued local amenities e.g. hydrotherapy, as well as the wider direction of travel from commissioners, focusing on:

- Delivering innovative and outcomes oriented care for patients across our community.
- Reducing reliance on bed-based models of care where appropriate and safe.
- Increasing self-care through empowering our patients and supporting them with community based delivery.
- Delivering quality and operational performance standards across all services, aligned with national best practice.
- Through delivery of all of the above, containing the costs of service provision now and in the future to enable services to better keep up with increased demand.

- **Research and Development:** The combined (RNHRD & RUH) organisation has the second largest R&D portfolio amongst medium-sized hospitals in the NHS. Bringing together the expertise and diverse research areas through the acquisition has resulted initially at a simple level in the pure addition of the studies of both hospitals whilst maintaining recognition of both RUH and RNHRD brands. The joining and co-location is however expected to also provide significant growth in research as bid writing, research culture and fund management are further strengthened alongside access to a larger population for clinical trials.

- **Environment:** It is recognised that whilst the Mineral Hospital building is highly regarded by the patients it serves; in the longer term it is not a suitable or cost effective base for high quality service provision.

About the Specialist Paediatric CFS/ME service

The Specialist Paediatric CFS/ME service at the Mineral Water Hospital currently provides the following:

- Initial assessment and outpatient treatment programme tailored to individual needs.
- Treatment is offered via 3-12 follow up appointments, these are a mixture of CBT, therapies and active management.
- Support for families
- Support for schools/education.
- Access to research and evidence based treatment
- Transitional clinic with the adult fatigue service

In addition, the following clinics are provided in the community:

1. Salisbury
2. Cadbury Heath (South Gloucester)
3. Wrington
4. Wells
5. Dursley
6. Castle Cary
7. Yeovil
8. Swindon
9. Macclesfield
10. Warminster
11. Southville (Bristol)
12. Eastgate (Bristol)

13. Cheltenham
14. Cirencester
15. Bridgwater
16. Taunton

There are 2-3 clinics a week for all patients, which need to be delivered in an acute setting and be accessible to all patients.

About the Paediatric Rheumatology service

The Paediatric Rheumatology service at the Mineral Water Hospital currently provides a dedicated outpatient paediatric and adolescent rheumatology service. The service aims to maintain the function and independence of any child or adolescent with rheumatic disease and musculoskeletal problems by reducing disease activity, helping to prevent any disability, and supporting them to achieve their full potential socially, educationally and psychologically. It provides:

- Two outpatient based clinics per month from RNHRD site with Consultant, Registrar and Nurse present.
- All patients will are reviewed by the Consultant.
- Access is via GP or consultant referral

The service offers:

- Initial assessment and outpatient treatment programme for children and adolescents tailored to individual needs.
- Expertise in case management and outreach consultations to support local teams, the family and schools.
- Management of common and specialised musculoskeletal and soft tissue conditions.
- Management of acute and long-term musculoskeletal and rheumatological conditions.
- Prevention and management of osteoporosis in children.
- MDT – Consultant/Nurse Specialist/ Physiotherapy Support.
- Support for families.
- Access to Research and evidence based treatment.

Relocating the Specialist Paediatric CFS/ME and Paediatric Rheumatology services to the RUH site would ensure continuity of care for patients and their families, enable the services to be co-located with wider paediatric services in a designated paediatric department, and provide an improved environment and dedicated facilities for younger patients.

As part of a larger acute hospital, it also further strengthens governance and safe guarding processes and increases the clinical team's access to peer support and clinical guidance. There will be no impact to patients accessing the Specialist Paediatric CFS/ME community or satellite clinics, all of these clinics will continue in their usual location, only the location of the RNHRD based service and the administrative base will change. There will be no change in the level of service provision for Specialist Paediatric CFS/ME and Paediatric Rheumatology patients, they will have access to the same clinical teams and benefit from wider clinical support.

Methodology

A programme of Public and Patient Engagement was carried out to determine people's views about the proposal to move the service, delivered by the same staff as currently, to new premises at the Children's Unit at the RUH site. Broad engagement activity regarding the proposals to relocate RNHRD service out of the Mineral Water Hospital Building commenced in September 2015, and outlined the Specialist Paediatric CFS/ME and Paediatric Rheumatology services as the first to potentially relocate to the RUH site. A dedicated email (ruh-tr.haveyoursay@nhs.net) to seek feedback at any point in the process has been established and published on the RUH website and in all communications materials.

Methods used to obtain feedback

A number of communication and engagement activities have been undertaken in order to obtain feedback from a wide range of people including; service users, relatives and carers, staff and other healthcare professionals and support groups.

The aim of the activity was to raise patient and the public awareness of proposal to relocate the service, outline the rationale for change and highlight how people could influence the proposal and encourage feedback.

A period of focussed communications and engagement activities on the proposal to relocate the Specialist CFS/ME service was launched in October 2015 and people had the opportunity to feedback until 6th January 2016.

Key activities undertaken to obtain feedback during this period are outlined below:

Activity	Purpose
Dedicated email address for feedback established ruh-tr.haveyoursay@nhs.net	Provide a dedicated channel for stakeholder feedback.
Information about the proposals to relocate services from the Mineral Hospital site is available on the homepage of B&NES CCG website.	Wider circulation of information regarding proposals and signposting for further details and opportunities to feedback directly to the CCG or the RUH.
B&NES CCG Annual General Meeting 17 September 2015.	RUH Chief Operating Officer presented proposals to relocate RNHRD clinical services from their current location along with potential timings for relocations and inviting feedback on proposals. The slides and the minutes from this meeting are available on B&NES CCG website: http://www.bathandnortheastsomersetccg.nhs.uk
B&NES GP Forum 24 September 2015.	B&NES CCG Clinical Chair update on proposals
RUH Annual General Meeting 30 September 2015.	RUH Chief Executive outlined proposals for RNHRD service relocations and invited feedback on proposals.

	Presentation from Clinical lead for the Paediatric CFS/ME service outlined proposal and rationale for service relocation. Information stands relating to service relocations and the RUH estates redevelopment programme were available and manned during the event. Opportunities to discuss proposals and ask questions or provide feedback anonymously through a feedback box. The slides and the minutes from this meeting are available on the RUH Website www.ruh.nhs.uk
Letter from RUH Commercial Director (dated 6 October 2015, circulated to the Health & Wellbeing Select Committee via Policy Development and Scrutiny Project Officer).	Provide an update on proposals, timings and activity information for the proposal to relocate this service relocation, and provide the opportunity to suggest any questions the committee would like asked during PPE.
October 2015, service specific information about the proposals to relocate the paediatric rheumatology and CFS services available on the RUH and RNHRD websites.	Inform current and future patients of proposals and signpost opportunities to feedback and influence.
October 2015, information about the Paediatric service relocations was made available in the outpatient area at both the Min and RUH children's unit.	Raise awareness amongst current patients, relatives and carers.
October 2015, Information about proposals on BaNES and Wiltshire Clinical Commissioning Group websites	Raise awareness amongst current patients, relatives and carers. Signpost to how people can provide feedback
November 2015, Wiltshire Clinical Executive meeting	Briefing on proposal to clinical Chair and Clinical Executives from the three main GP localities.
15th November 2015, media release issued.	Raise awareness of the proposals, channels for feedback and to advertise the engagement event. Features online and in print in Bath Chronicle
Wc 16th November 2015, online service specific questionnaire available on RUH and RNHRD websites.	Capture feedback on proposals.
23rd November 2015. Letters and	To encourage feedback to identify what is

questionnaires sent to 350 past and current Paediatric CFS patients to outline: • the proposal to relocate the service • the rationale for change • supporting background information • inform them about the engagement event • provide channels to feedback, email address, survey link (a hard copy of the survey was also enclosed).	important to maintain or improve in relocating the service, and also reassure patients that they will still have access to the service and be cared for by the same clinical teams.
November 2015, information on the NHE England Youth Forum	To invite feedback and advertise engagement events
November 2015 issue of the RUH staff Newsletter @RUHBath, (available to all staff and publically available across the Trust) featured the proposals to relocate the service and the rationale for the proposed move.	To outline information about Paediatric CFS/ME service relocation, how to feedback and signpost to where further information could be found.
25th November 2015, report and update on activities at the Health & Wellbeing Select Committee meeting held in public	Update on activities.
November 2015, Association of Young People with ME published information on the homepage of their website.	Raise awareness and promote the engagement event
December 2015. Winter edition of Insight, the RUH Community Magazine issued to approx. 8,000 stakeholders at the end of November	Outlined information about proposal, rationale for change, signpost to further information and invite feedback.
December 2015, inclusion in Healthwatch Wiltshire and Healthwatch B&NES newsletters	Outlined information about proposal, rationale for change, signpost to further information and invite feedback.
2nd December 2015, an engagement event was held in the dedicated children's area on the RUH site. The event was facilitated by the Head of Stakeholder Engagement	To capture feedback from patients, carers, staff and other interested stakeholders on the proposal to relocate the service and enable them to see the proposed future location for the service.

Specialised Commissioning - NHS England South.	
w/c 2nd December 2015. Letters and questionnaires sent to 120 past and current Paediatric CFS patients to outline: • the proposal to relocate the service • the rationale for change • supporting background information • inform them about the engagement event • provide channels to feedback, email address, survey link (a hard copy of the survey was also enclosed).	To encourage feedback to identify what is important to maintain or improve in relocating the service, and also reassure patients that they will still have access to the service and be cared for by the same clinical teams.
14th December 2015, an engagement event was held in the dedicated children's area on the RUH site.	To capture feedback from patients, carers, staff and other interested stakeholders on the proposal to relocate the service and enable them to see the proposed future location for the service.

What did we ask people during patient and public engagement activities?

Patient and Public Engagement activities undertaken outlined; what was changing and why, how patients and public could influence proposals and the channels for feedback. It highlighted the fact that the Paediatric CFS/ME service had to relocate out of the Mineral Water Hospital building (as part of a careful and phased programme of service relocations) and that one proposal was to move it to the dedicated Paediatric Department on the RUH site. It was also outlined that the proposed relocation only affected the Paediatric CFS/ME service provided from the Mineral Water Hospital Site and that the satellite clinics (outlined earlier in this document) would continue in their current locations.

During patient and public engagement feedback was invited on how people would like to see the service provided now and in the future, specifically:

- To identify the potential benefits of moving location
- To highlight any concerns they may have.
- Outline what they think is good about the service so far?
- Indicate what could be improved about the service they have received?

In addition, feedback on travel and parking, the physical environment and the range of services available, and what they felt the most important things for us to consider in relation to the care of people with this condition was sought.

How did we let people know about the public and patient engagement activities?

In addition to the activities outlined in the table above, other ways in which patient and public engagement activities were outlined through this period included; social media channels such

as Twitter and Facebook. Local Health Economy communications Working Group colleagues and other partner organisations including BaNES and Wiltshire Clinical Commissioning Groups and voluntary sector organisations such as the Association of Young People with ME also cascade information out to their patient populations and signposted to further details and channels for feedback. Information was also circulated to other relevant supporting charities including Action for ME, Arthritis Research UK, NRAS and local support groups. Information relating to the proposals and how to influence them was also published on the Careforum and BaNES Healthwatch websites.

Steps taken to ensure equalities duties were met

A number of steps were taken to ensure that engagement and consultation activities were accessible to all. The RUH is working with the Local Health Economy (LHE) Forum, whose membership includes Executives from B&NES, Wiltshire and Somerset Clinical Commissioning Groups (CCGs), NHS England, RUH Governor and patient representation, to agree the process for communication and engagement activities to support the potential relocation of clinical services from the Mineral Water Hospital site over the next three years.

To support this activity, the RUH has established an LHE Communications Working Group (which is comprised of RUH and NHS England and CCG communications and engagement leads and a patient representative) to ensure all service related PPE is conducted in line with the Government's Consultation Principles for Public Bodies (Oct 2013).

The RUH Equality and Diversity lead scrutinised the questionnaire, and all patients families were contacted and given the opportunity to feedback and attend the engagement event. The lead clinician for the service has been involved in planning the Public and Patient Engagement strategy and developing supporting communications and engagement materials.

Impact Assessment and Equality Impact Assessments have been completed for both service areas. There will be no change in the level of service provision for Paediatric CFS/ME and Rheumatology patients they will have access to the same clinical teams and benefit from wider clinical support. There are no impacts on patient choice for either service by the proposal to relocate the services to the RUH site and there is support from senior clinicians whose services will be affected.

Results (You said):

The engagement event for the Specialist Paediatric CFS/ME service held on 2nd December 2015 was attended by a range of individuals; seven families, parents of children with CFS/ME, the CEO of Association of Young People with ME, a CFS/ME researcher, the Specialist CFS/ME Paediatric service lead and the RUH Divisional Manager for Women and Children.

The engagement event for the Paediatric Rheumatology Service held on the 14th December 2015 was attended by three people, an NHS Lay Patient Rep, a Specialist Commissioner and a representative from Wiltshire Parent Carer Council.

17 completed surveys were received for the Specialist Paediatric CFS/ME service. Six of these had been completed by relatives or carers of a young person with CFS/ME. Ten young people with CFS/ME and one retired GP. Eleven people provided the first part of their postcode which breaks down as follows:

First part of postcode	Number of people
BA	5
BS	2
SN	1
GU	1
GL	1
SO	1

Respondents were predominantly accessing services at the RNHRD, other locations included Swindon, Bristol, Cirencester, Cheltenham and Gloucester and Skype consultation.

Eleven people completed the equality and diversity questions at the end of the survey, details below:

Age	Disability	Type	Religion	Language	Ethnic Group
1 - Under 12 9 - 13-17	4	1 – physical 2 Long term illness 1 – sensory	Christianity- 6 Hinduism -1 No religion -2 Not stated -1	English- 10	White British - 8 Indian- 1 White Irish- 1 Not stated -1

2 completed surveys were received for the Paediatric Rheumatology service. One had been completed by a patient and the other respondent was a carer of a young person with a rheumatic condition. Both respondents provided the first part of their postcode which breaks down as follows:

First part of postcode	Number of people
BA3	1
TN11	1

No respondent completed the equality and diversity questions at the end of the survey.

Feedback received through Patient and Public Engagement activities

Feedback received for the Specialist Paediatric CFS/ME Service:

During Patient and Public Engagement activities overall respondent's feedback positively on the service they were currently receiving, and there have been positive comments in relation to the proposed new location in the dedicated children's unit on the RUH site.

- *"I think they will get a better service here because there are more facilities at RUH and more services we can access – we don't know yet if she just has one thing or several things wrong with her so we don't know what services we might need. "*

- *"I can't wait to move to RUH because they have patients my own age here. The Min is full of old people."*
- *"…RUH is more accessible, which is what we need…"*

The majority of respondents felt that the level of expertise of the people treating the patient was the most important thing to consider in relation to the care of young people with CFS/ME.

- *"We have received excellent care and advice from the specialist team so far and we hope that the service will continue to provide the same into the future."*
- *"They have been really supportive and have helped me use methods to try and cope with CFS/ME."*

Parking at the Mineral Hospital site was mentioned by several patients and carers as an issue, particularly when considering that often patients are unable to walk long distances

- *"RNHRD is an awful location – parking isn't on site and ill children with CFS/ME have to walk too far from the car to the hospital. The difficulty in parking and then getting my child to hospital has been too much for her in the past."*
- *"Awful, there is nowhere near enough to the hospital to park, especially when walking is a problem."*
- *"In the middle of Bath and there is no parking so involves a considerable walk"*
- *"Moving the service here is better for me as I work at RUH. I know the staff, they know us, and they're all so friendly at both hospitals so it is good that the kids will have continuity of care. There's also a good bus service to RUH so the parking doesn't affect us."*

Respondents also identified improved communication between healthcare professionals and a child friendly environment as additional factors to consider.

- *"Better ways of communicating with other healthcare professionals to improve continuity of care. Improved communication with schools – education provision is poorly managed."*
- *"I think it would be really important for my children to visit an environment that is not too clinical but child friendly, inviting and peaceful."*

A minority of respondents felt that there were some aspects of care that they would prefer not to have delivered in a hospital setting.

- *"I would prefer to avoid a hospital setting wherever possible. Remote access from home is desirable."*
- *"The catch up appointments do not need to be in a hospital setting."*

Most respondents agreed that they would be prepared to travel more than ten miles for the very best care, with around a third saying they would travel 50 miles or more.

- *"Travelling is tiring, but if it makes be better it's worth it up to a certain distance."*
- *"I want to get better so I will travel a long way."*

Suggestions for how the service could be improved in the future included better education in the wider community, opportunities to take part in research and continued emphasis on continuity of care.

- *"Please provide literature for schools, there is no understanding of this illness in the education sector. We want to be part of the research into the cause and potential cure for this illness. How can the CFS/Me service provide input for medical trials?"*
- *"I think that seeing the same group of professionals is good, but having a group of multi agencies linking together is an advantage."*
- *"It takes time for a child to trust the professional they are talking to and so seeing the same person each visit is hugely important. It is an invaluable service."*
- *"…I would like to talk to someone like a psychologist about how I feel and I would like to be able to meet other siblings to share our experiences and have a break and some activities that are just about us for a change."*
- *"We would like family therapy to help relieve our stress and we need time in private as mums and dads to be able to say things and ask questions, but not in front of our children."*
- *"It would be good if every service had meeting groups for young people the same age to talk to each other about what it is like to have CF and we can tell each other how we're feeling and support each other. Tonight is good because we are able to meet each other and there's time to have fun."*

Only one respondent specifically said that they would prefer the service to remain at the RNHRD.

- *"Attending RNHRD is the best place for this service as it's more relaxed than a main hospital setting…. Keep it the same as now."*

Feedback received for the Paediatric Rheumatology Service:
The respondents indicated they are happy with high standard of care currently received (includes treatment at RNHRD)

Comments on what is good about the service so far:

- *"Excellent service for the last seven years and for other family members for longer"*
- *"Prompt appointments. Prompt return of phone calls when questions arise. Generally efficient and good service."*

Respondents were prepared to travel any distance for the very best care:

- *"Relocating 'Min' is v. much a good idea, seems v. dated and needs to be in a new environment."*

An area of suggested improvement was:

- *"treatment for adolescents, sometimes the treatment was insensitive and ill-informed about the difficulties teenagers have with treatment"*

Comments on important things to consider in relation to care for young people with rheumatic and musculoskeletal conditions:

- *"Essential for young people to be treated separately from old- psychologically very hard for them to be experiencing the same illness as them."*
- *"Sensitive consultants"*
- *"Psychological support"*

Next Steps (we did):

The Paediatric Specialist CFS/ME service is currently in the process of a number of activities which will address some of the comments above:

- The service is in the final stages of employing a part time Child Psychiatrist and two further Psychologists. This will increase capacity and increase the opportunity for patients to see the same clinician when it is clinically appropriate, and will increase multi-professional links.
- In December 2015 the service published research which looked at the needs of siblings, and aims, within the next 12 months, to produce information for siblings which will include signposting to places they can get help.
- A website will be launched over the next couple of months to support access to research trials, and the service works hard to ensure that patients and their families have access to research opportunities. The service has a patient advisory group which enables service user input into the design of research trials.
- A research trial with a family therapy model is due to commence in November 2016.
- Further signposting the Association of Young People with ME (AYME) will continue so young people with this condition can meet others.

Equality Impact Assessment (EIA) Template

1. Title of document/service for assessment	Specialist Paediatric CFS/ME Service
2. Date of assessment	14/01/16
3. Date for review	
4. Directorate/Service	RUH Women and Children's Division
5. Approval Committee	Local Health Economy Forum

6. Does the document/service affect one group less or more favourably than another on the basis of:

Protected characteristic:	Yes/No	Rationale
• Age	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to age
• Disability	N	No major change. The service will be universally applied to patients and is not expected to have an negative impact relating to disability. There may be a positive impact, with improved access and increased availability of blue badge parking.
• Gender reassignment	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to gender reassignment
• Pregnancy and maternity	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to pregnancy and maternity
• Race	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to race
• Religion and belief	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to religion and belief
• Sex	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to sex
• Sexual orientation	N	No major change. The service is universally applied to patients and is not expected to have an impact relating to sexual orientation
• Marriage and civil partnership	N	No major change . The service is universally applied to patients and is not expected to have an impact relating to marriage and civil partnership

7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?N/A

8. If the answers to the above question is 'no' then adjust the element of the document / service to remove the disadvantage identified.

9. If neither of the above is possible, take no further action until you have contacted your EIA Divisional / Directorate link for review and support

Signature of person completing the Equality Impact Assessment	
Name	Clare O'Farrell, Associate Director for Integration, RUH

Time	
Date	14/01/16

Chair of decision making Board / Group / Committee approval and sign off	
Name	Tracey Cox, Chief Officer NHS Bath and North East Somerset Clinical Commissioning Group and Chair of the Local Health Economy Forum. Approval on behalf of the Local Health Economy Forum.
Time	
Date	15/01/16

Equality Impact Assessment (EIA) Template

1. Title of document/service for assessment	Paediatric Rheumatology Service
2. Date of assessment	14/01/16
3. Date for review	
4. Directorate/Service	RUH Women and Children's Division
5. Approval Committee	Local Health Economy Forum

6. Does the document/service affect one group less or more favourably than another on the basis of:

Protected characteristic:	Yes/No	Rationale
• Age	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to age
• Disability	N	No major change. The service will be universally applied to patients and is not expected to have an negative impact relating to disability. There may be a positive impact, with improved access and increased availability of blue badge parking.
• Gender reassignment	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to gender reassignment
• Pregnancy and maternity	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to pregnancy and maternity
• Race	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to race
• Religion and belief	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to religion and belief
• Sex	N	No major change. The service will be universally applied to patients and is not expected to have an impact relating to sex
• Sexual orientation	N	No major change. The service is universally applied to patients and is not expected to have an impact relating to sexual orientation
• Marriage and civil partnership	N	No major change . The service is universally applied to patients and is not expected to have an impact relating to marriage and civil partnership

7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?N/A

8. If the answers to the above question is 'no' then adjust the element of the document / service to remove the disadvantage identified.

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Signature of person completing the Equality Impact Assessment	
Name	Clare O'Farrell, Associate Director for Integration, RUH

Time	
Date	14/01/16

Chair of decision making Board / Group / Committee approval and sign off	
Name	Tracey Cox, Chief Officer NHS Bath and North East Somerset Clinical Commissioning Group and Chair of the Local Health Economy Forum. Approval on behalf of the Local Health Economy Forum.
Time	
Date	15/01/16

Appendix 3: Summary Impact Assessments

Patients, carers and public representative views – summary of the potential impact of proposed service changes

Patients, carers and public representatives are asked to comment on the following areas, in relation to the proposed service changes:

Specialist Paediatric CFS/ME Service:

Benefits of the proposed service changes	Patients will have access to the same clinical teams and benefit from wider clinical support. Patients will have access to a wider range of facilities. *"I think they will get a better service here because there are more facilities at RUH and more services we can access – we don't know yet if she just has one thing or several things wrong with her so we don't know what services we might need."* Services will be provided in a dedicated and age appropriate environment. *"I can't wait to move to RUH because they have patients my own age here. The Min is full of old people."* *"Relocating 'Min' is v. much a good idea, seems v. dated and needs to be in a new environment."*
Any disbenefits, including how you think these could be managed	None identified during PPE activities.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	Patients were willing to travel to receive the best possible care for their condition. The RUH is 1.71 miles from the Mineral Water Hospital. *"Travelling is tiring, but if it makes be better it's worth it up to a certain distance."* *"I want to get better so I will travel a long way."* Improved access for patients. *"RNHRD is an awful location – parking*

	isn't on site and ill children with CFS/ME have to walk too far from the car to the hospital. The difficulty in parking and then getting my child to hospital has been too much for her in the past." *"…RUH is more accessible, which is what we need…"*
How do you think the proposed changes will affect the quality of the service	Age appropriate environment will have a positive impact on quality of service.
Impact of the proposed changes on health inequalities	Improved access for patients.
If you are a representative of an organisation, such as Healthwatch LINKs, please indicate how you have drawn on the views of others from your group	PPE activities have included presentation and information included in BaNES and Wiltshire Healthwatch newsletters.
Who have you engaged with in drawing together these views?	Patients Carers and relatives Public Clinicians Voluntary and charitable organisations
When was this consultation made?	PPE ran from October 2015 to January 2016.
Involvement of 'protected' equality groups	All patients families were contacted and given the opportunity to feedback and attend an engagement event. The lead clinician for the service has been involved in planning the Public and Patient Engagement strategy and developing supporting communications and engagement materials.
Summarise the outcomes of stakeholder involvement carried out to date	Feedback obtained during PPE activities indicate no adverse impact to patients in relocating the services to the RUH site and indicate that some service users felt that access would improve in relation to parking.
Any other comments	There will be no change in the level of service provision for Paediatric CFS/ME patients they will have access to the same clinical teams and benefit from wider clinical support. There are no impacts on patient choice for this service by the proposal to relocate the services to the RUH site and there is support from senior

	clinicians.

Notes: The RUH has completed this summary impact form on the basis of the responses received through the engagement activities. PART THREE – Impacts at a glance

Impacts	***NHS View***	***Patient/carer/public representatives' view***
Impact on patients	● = positive impact	● = positive impact
Impact on carers	● = positive impact	● = positive impact
Impact on health inequalities	● = positive impact	● = positive impact
Impact on local health community	● = positive impact	● = positive impact

● = significant negative impact
● = negative impact for some
● = positive impact

GLOSSARY

- list definitions of any technical terms, acronyms etc

Paediatric Rheumatology Service:

Benefits of the proposed service changes	Patients will have access to the same clinical teams and benefit from wider clinical support. Patients will have access to a wider range of facilities. Services will be provided in a dedicated and age appropriate environment. *"Relocating 'Min' is v. much a good idea, seems v. dated and needs to be in a new environment."*
Any disbenefits, including how you think these could be managed	None identified during PPE activities.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	None identified during PPE activities.

How do you think the proposed changes will affect the quality of the service	Age appropriate environment will have a positive impact on quality of service *"Essential for young people to be treated separately from old- psychologically very hard for them to be experiencing the same illness as them."*
Impact of the proposed changes on health inequalities	Improved access for patients.
If you are a representative of an organisation, such as Healthwatch LINKs, please indicate how you have drawn on the views of others from your group	PPE activities have included a presentation and information included in BaNES and Wiltshire Healthwatch newsletters.
Who have you engaged with in drawing together these views?	Patients Carers and relatives Public Clinicians Voluntary and charitable organisations
When was this consultation made?	PPE ran from October 2015 to January 2016.
Involvement of 'protected' equality groups	All patients families were contacted and given the opportunity to feedback and attend an engagement event. The lead clinician for the service has been involved in planning the Public and Patient Engagement strategy and developing supporting communications and engagement materials.
Summarise the outcomes of stakeholder involvement carried out to date	Feedback obtained during PPE activities indicate no adverse impact to patients in relocating the services to the RUH site
Any other comments	There will be no change in the level of service provision for Paediatric Rheumatology patients they will have access to the same clinical teams and benefit from wider clinical support. There are no impacts on patient choice for this service by the proposal to relocate the service to the RUH site.

Notes: The RUH has completed this summary impact form on the basis of the responses received through the engagement activities. PART THREE – Impacts at a glance

Impacts	***NHS View***	***Patient/carer/public representatives' view***
Impact on patients	● = positive impact	● = positive impact
Impact on carers	● = positive impact	● = positive impact
Impact on health inequalities	● = positive impact	● = positive impact
Impact on local health community	● = positive impact	● = positive impact

● = significant negative impact
● = negative impact for some
● = positive impact

GLOSSARY

- list definitions of any technical terms, acronyms etc

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Bath & North East Somerset Council		
MEETING/ DECISION MAKER:	**Health and Wellbeing Select Committee**	
MEETING/ DECISION DATE:	**27 January 2016**	EXECUTIVE FORWARD PLAN REFERENCE:
TITLE:	**Final Report of the Joint Health Scrutiny Working Group – Avon and Wiltshire Mental Health Partnership NHS Trust**	
WARD:	All	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Annex A – Final Report of the Joint Health Scrutiny Working Group – Avon and Wiltshire Mental Health Partnership NHS Trust		

1 THE ISSUE

1.1 In Spring 2015 the health scrutiny committees of four local authorities, including Bath and North East Somerset Council agreed to undertake a review of the response of Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) to a CQC inspection report published in 2014.

1.2 The joint scrutiny was led by Wiltshire Council and the report of this joint scrutiny is attached at Annex A.

1.3 This covering report provides an initial response from mental health commissioners and from AWP's Bath and North East Somerset Locality Team, to key recommendations in the report of the joint scrutiny.

2 RECOMMENDATION

2.1 Recommendations from the joint scrutiny panel report attached as Annex A are that the working group:

1. Recognises and appreciates AWP's positive and open engagement in the process.

2. Recognise that improvement measures were underway prior to the CQC inspection report being published and these appear to being followed through.

3. Notes the changes in leadership at both executive and board level, shortly before and after publication of the CQC report.

4. That Cabinet Members and Health and Wellbeing Boards respond to

a) The concerns reported that Delayed Transfers of Care (DToCs) equate to a significant percentage of out-of-Trust placement bed days for older people and of out-of-Trust bed days for adults requiring acute inpatient care,
b) Provides information of what is being done to address this.

5. Recommends that CCGs collectively assess with AWP the requirement for a common Section 136 Protocol in line with the Mental Health Act Code of Practice. At the same time, that consideration is given to realigning those places of safety with the appropriate constabularies as custody suite sites are reviewed.

6. That Cabinet Members and Health and Wellbeing Boards investigate the concerns reported by AWP regarding housing or step-down accommodation for patients with no fixed abode and the impact on Delayed Transfers of Care (DToCs) so that appropriate action can be taken if necessary.

7. That CCGs and Health and Wellbeing Boards respond to concerns highlighted by the CQC report and echoed by AWP regarding:
   - Limited availability of beds being a Trust-wide issue, with intensive, acute and older people's beds always being in demand;
   - Bed pressures meaning that care has sometimes been provided away from patients' home area, making it difficult to maintain the support of loved ones.

8. Invites participating health scrutiny committees to hold discussions regarding the merits of a longer term cross-authority scrutiny group to monitor the AWP improvement programme and the Trust's performance in the future.

2.2 In addition to the recommendations of the joint scrutiny panel, that Bath and North East Somerset Health and Wellbeing Select Committee use the B&NES specific information provided in this covering report to inform the response to the joint scrutiny panel's recommendations.

3 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

3.1 None directly related to this report.

4 THE REPORT

4.1 Bath and North East Somerset (B&NES) has been reshaping its mental health services incrementally and engaging with both the community and professionals to identify where change needs to take place. An explicit review and description of this work is contained in the B&NES Mental Health Crisis Care Concordat. B&NES was one of the first areas in the country to submit a comprehensive Crisis Care Concordat Action Plan.

4.2 Recent Improvements described include:

- Mental Health liaison services available and operating effectively at primary care, acute hospital, community hospital and care home interfaces.
- Primary Care Talking Therapies services closely aligned to Primary Care Liaison and other community services with excellent access and recovery rates.
- STEPPS group treatment programme introduced to support people with personality disorders in Primary Care.

- Creation of a peer development program, enabling peers to recognise their progression and be supported in the process.
- A new social prescribing service. Starting in January 2015 the service works with frequent attendees at GP Practices (first phase) and improves access to community based support and learning to improve quality of life.
- B&NES Wellbeing College – offering 95 different learning opportunities.
- Increased individual control of personal budgets. Allowing people to have more control and choice over their recovery and encouraging creativity and signposting in services.
- Continuing to strengthen successful partnership working e.g. World Mental Health Day, Fresh Arts activities, opening of the Wellbeing House (providing an early intervention service in the form of brief respite to prevent crises).
- Providing mental health support and training to emergency services such as the police and ambulance service.
- Registered Mental Health Nurses (RMNs) trained in physical health to be able to better look after patients' whole needs.
- The Court Assessment and Referral Service (CARS) which works across adult and young people's services supporting offenders with mental health issues.
- A dual diagnosis supervision group where clinical discussions are held to ensure the needs of complex mental health and substance misuse clients are met.

4.3 Throughout the reshaping process, partners in the Mental Health and Wellbeing Forum have recognised gaps or challenges in services that need to be taken into consideration and addressed. The main challenges identified are:

- Continuing to build on early intervention and self-care initiatives in order to reduce long term serious mental health problems.
- Ensuring children and young people's services are more closely commissioned with adult services in order to increase more jointly provided pathways of care especially for families.
- Improving the perinatal mental health pathways for accessing treatment and support.
- Producing a clearer model of mental health services that allows a more joined up way of working with other non-specialist community and hospital services (including with GPs and maternity services). This would incorporate a clear navigational path for service users, standardization between services and shared notes. This is especially important for perinatal services and people with long term conditions such as dementia or diabetes.
- Working closely with police and ambulance colleagues to evidence the benefits of mental health liaison and triage systems in improving the service user experience of emergency services.
- Improving access and working protocols/practice between statutory services for urgent mental health care to include s136 detentions and identified places of safety.
- Making group work accessible throughout the whole of B&NES, including those living in rural areas, and engaging service users in group work
- Improving the understanding and availability of supported living and accommodation based services.
- Introducing innovative ways to combat potential reduced funding such as having rewards for collaborative working and shared budgets. Support has

also been requested to ensure smaller partners are not lost in the competitive tendering process.

4.4 2016/17 Commissioning Intentions for Bath and North East Somerset inform health and care providers and partners about the priorities for 2016/17. These priorities have been informed by feedback gathered during consultation for the Your Care, Your Way community services redesign programme. The intentions indicate where resources will be focused to deliver national and local priorities, reduce inequalities and improve the health and wellbeing of the people of Bath and North East Somerset.

4.5 Both the Mental Health Crisis Concordat and Commissioning Intentions include specific improvements, actions and intentions that are particularly relevant to the recommendations of the joint scrutiny panel. These are set out in paragraphs 4.6 – 4.14.

Delayed Transfers of Care (DToCs)

4.6 Mental health liaison services for people with dementia and adults of working age funded by BaNES CCG, provided by AWP based in the Royal United Hospital have enabled the earlier identification and treatment of people with mental health problems and supported diagnosis and care of older clients with dementia as well as supporting discharge from hospital. This active management of the care pathway ensures that there are very low numbers of patients considered to be DToCs in the RUH attributable to mental health needs. In addition there are very low numbers of DToCs on the Dementia Assessment & Treatment Ward 4 (St Martins) as a result of close engagement between the ward and community provision. Managing risk and hospital capacity/flow for those clients needing a Mental Health Act assessment, especially out of hours remains a challenge, which partner agencies continue to work on.

4.7 Community Hospital and Care Home liaison service provided by AWP and funded by BaNES CCG and also, from Dementia Challenge funding has increased the capacity in the care home sector to manage complex clients thereby preventing admission into hospital or delay in hospital discharge.

4.8 Review and agree Special Patient Notes usage across the local health system to ensure people with mental health problems are able to receive joined up care at the point of crisis or emergency.

Section 136 Protocol, assessment suite and places of safety

4.9 There was insufficient capacity for assessments under Section 136. Avon commissioners and all associated provider organisations agreed a shared protocol and the four CCGs provided increased funding to operate a 4 bedded assessment suite based in Southmead.

4.10 The assessment suite is receiving many clients who are assessed as having no mental health problems where there is no further follow-up and a proportion of these clients are intoxicated. An action in the Mental Health Crisis Concordat is to investigate new provision/an alternative pathway for intoxicated clients making best effective use of both specialist and community services.

4.11 The potential for provision of an assessment suite in Bath and North East Somerset in the longer term is being considered as part of the redesign inpatient services and the provision of a new mental health in-patient unit to replace Hillview Lodge.

Specialist accommodation and in-patient beds provision

4.12 The new mental health in-patient unit on the RUH site to improve facilities for the delivery of mental health in-patient and dementia services is planned for completion in Spring 2018.

4.13 All community mental health and social care services are being aligned with the new community services model developed as part of the *Your Care, Your Way* programme to ensure fully integrated and accessible community services for the local population.

4.14 It is the intention to review the specialist accommodation pathway during 2016/17. This review will encompass supported living, residential and nursing care services for under 65s so that people are living in the best environment to support recovery with improved quality and value for money accommodation related social support services.

Longer term cross-authority scrutiny of AWP

4.15 Wiltshire Health Select Committee considered the report of joint health scrutiny of AWP at its 17 November 2015 meeting. Councillor John Noeken who chaired the joint working group presented the report. Support was expressed for continuing a cross-authority scrutiny group to monitor AWP's improvement programme and performance. It was explained that Councillor Noeken would be unable to continue taking on the workload from the working group due to commitments elsewhere. Wiltshire Health Select Committee is currently seeking to fill this vacancy.

5 RATIONALE

5.1 Providing information specific to Bath and North East Somerset, in addition to the report presented by the joint scrutiny panel led by Wiltshire Council is intended to assist the Health and Wellbeing Select Committee in considering its response to the recommendations.

6 OTHER OPTIONS CONSIDERED

6.1 None

7 CONSULTATION

7.1 None

8 RISK MANAGEMENT

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

Annex A: Final Report of the Joint Health Scrutiny Working Group – Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Purpose

1. To present the conclusions and recommendations of the Joint Health Scrutiny Working Group – Avon and Wiltshire Mental Health Partnership NHS Trust (AWP).
2. To present, at Appendix 5, information specific to Bath and North East Somerset, provided by B&NES Mental Health Commissioners and AWP Locality Team.

Background

3. In September 2014 the Care Quality Commission published a quality report on AWP as part of their mental health inspection programme. This followed an inspection in June when a team inspected 39 wards and 27 community services, as well as other specialist services. The CQC found that AWP must take significant steps to improve the quality of their services and were then in breach of regulations. CQC issued four warning notices requiring the trust to take urgent action to improve. Further detail of the concerns identified are included where appropriate within this report.

4. The working group notes that AWP had asked to be part of the mental health pilot inspections being undertaken by the CQC and that many of the issues identified were known to the Trust with actions for improvement already in place.

5. A joint working group to look at AWP's response to the CQC inspection report was first mooted at a meeting of the South West Overview and Scrutiny Network. In Spring 2015 the health scrutiny committees of the following local authorities formally agreed to undertake this exercise:

   Bath & North East Somerset Council
   Bristol City Council
   North Somerset District Council
   Wiltshire Council

6. The following members took part:

Cllr Lesley Alexander	Bristol
Cllr Jenny Smith	Bristol
Cllr Eleanor Jackson	B&NES
Cllr Vic Pritchard	B&NES
Cllr Catherine Gibbons	North Somerset
Cllr Tom Leimdorfer	North Somerset
Cllr Chris Caswill	Wiltshire
Cllr John Noeken (Chairman)	Wiltshire

7. The working group adopted the following terms of reference:

   a) To consider the CQC report of AWP mental health facilities (September 2014) and the strengths and weaknesses identified.

   b) To consider AWP's past, current and planned responses to the concerns identified in the CQC report, focusing on agreed areas of most significant concern.

c) To identify (as appropriate) where AWP's response has been robust, and where it could be strengthened further.

d) To agree (as appropriate) recommendations regarding areas for improvement or for further scrutiny monitoring of the improvement programme. (These would be taken for endorsement by individual Health Scrutiny Committees).

8. The working group met with representatives from AWP on two occasions (20 March and 7 April), receiving a presentation on AWP's response to the inspection report and having a round table discussion of key concerns and priorities. The working group chose to delay agreement and circulation of its report until after the May local elections taking place in some of the participating authorities. The Chairman subsequently met with AWP representatives in July and spoke with the CQC in October to discuss the working group's initial findings.

9. The working group wishes to express their gratitude to AWP for engaging positively in the process.

Evidence

AWP reported the following to the Working Group:

Response to the CQC inspection report

10. On receipt of the report, AWP disseminated the report's findings across the Trust and paused to reflected on the outcomes. External advice and an external review were sought, including a review of AWP's structure, processes and governance arrangements. The revised arrangements put in place reflected a philosophy of assurance and controls and outcomes over process.

11. Some of the issues identified in the report were Trust-wide while some were locality based. Each locality developed a local action plan to address issues identified, but these were also disseminated across all areas to maximise any opportunities for learning across the Trust.

12. The CQC inspection report had found that "while performance improvement tools and governance structures had been put in place, these had not always facilitated effective learning or brought about improvement to practices." Following its publication, AWP implemented improvement measures that were monitored by a RAG-rating system of indicators as a quick and easy way of monitoring progress (see Appendix 1). A system of 'check and challenge' was also introduced, including:

- Sitting down with managers and discussing issues, with a focus on ensuring there was evidence of compliance. It was ensured that the notes and outcomes of these meetings were properly recorded.
- A system of peer review across different areas was introduced including shared challenge, but more importantly learning from each other.
- Since the inspection, the internal 'IQ' electronic information system has been redesigned so that localities and services are risk-rated against each of the five CQC domains and outliers are immediately evident.

13. Assurance processes include executive 'walk-arounds' and mini-inspections following the CQC methodology. Reports were then produced with accompanying improvement action plans.

14. Following the CQC report a non-executive director was appointed. There have also been significant changes in AWP's executive leadership and some changes to its Board.

Buildings and environmental safety

15. AWP work out of approximately 90 sites across B&NES, Bristol, North Somerset, South Gloucestershire, Swindon and Wiltshire. All six areas have of their own particular needs and population make-up.

16. The CQC inspection report found that, "the design of some wards made it difficult for staff to observe vulnerable patients and some wards had ligature points that could endanger people at risk of suicide. There were also wards where male and female accommodation was not fully segregated. These concerns were raised at the time of the inspection and immediate remedial action was taken."

17. A full external estates review was undertaken on behalf of AWP and a report completed with recommendations. The report's overall recommendation was to maximise the use of AWP's existing PFI buildings through retrofitting (as appropriate), and to decommission old buildings that could not be brought up to standard economically. AWP currently operates out of 8 PFI buildings and in some of these retrofitting is difficult, but has been done where appropriate.

18. AWP currently has several major estates work-streams, including:

    a) The Daisy Project: New inpatient and supported living provision for people with learning disabilities and severely challenging behaviour (in Wiltshire).
    b) Hillview Lodge re-provision on the Royal United Hospital (RUH) campus: This building was not compliant with CQC standards and AWP will apply for capital investment loan through Department of Health (DoH) for the full cost of replacement.
    c) Continuing work to improve safety through the removal of ligature points.
    d) Improving the quality and safety of Section 136 suite provision (in Wiltshire and other areas).

19. AWP also recognised the urgent need to address the quality of the built environment in Juniper ward (North Somerset) and Amblescroft (Wiltshire), where improvements are required to offer an appropriate therapeutic setting and appropriate gender division.

20. Work to remove ligature risks and other urgent improvements were prioritised, meaning that other areas of the capital programme had to be delayed. The additional investment required was on top of a 2.5–3% per year efficiency programme already in place and the additional pressures on the service.

21. The report from the full external estates review also included recommendations about where certain units should be cited. At present it is difficult to staff units in certain locations, particularly those requiring more specialised skills, and in some cases relocation may be required.

22. It was noted that when buildings are fit-for-purpose fewer staff are generally required to provide good patient care.

23. AWP are currently looking at the option of co-locating with other public sector organisations where feasible and appropriate.

Staffing

24. The CQC inspection report found that "Some staff had not received their mandatory training and many staff had not received regular supervision and appraisal." AWP reported that following the inspection 88% of its staff have received an appraisal and 100 staff will undertake the Institute of Leadership and Management (ILM) programme in 2015, with 26 of AWP's most senior leaders in learning and development programmes with NHS England.

25. The working group felt it was a significant positive that CQC reported how "staff were kind, caring and responsive to people and were skilled in the delivery of care" and that the CQC observed "some very positive examples of staff providing emotional support to people, despite the challenges of staffing levels and some poor ward environments."

26. The inspection report reported concerns that "staffing levels were not always sufficient to meet the needs of patients and meant that activities, leave and other tasks were not always delivered." In discussion with the working group, AWP acknowledged that attracting staff in certain fields and localities is an issue and as is the case nationally, staff sometimes leave to work more flexibly and for higher rates of pay through agencies. Improving recruitment and retention of mental health staff is being led by NHS England and conversations between AWP and academic partners are ongoing.

27. AWP is currently exploring various ways of addressing this. For example, it has introduced a £3,000 premia for new staff and is exploring other incentives, such as nursery care for staff's children, retention rewards and incentives to existing staff when friends are recruited ('Recruit a friend'). The Trust is represented at recruitment fares and university open days and has also sought nurses overseas. As of 15 July 2015, a further 40 staff had been recruited and are pending deployment.

Provision for homeless patients

28. AWP reported concerns that sometimes a lack of housing or step-down accommodation for patients with no fixed abode can have significant impact on Delayed Transfers of Care (DToCs). AWP has a duty of care and discharging patents to no particular destination or local authority is not considered a safe option. The working group did not have access to quantified evidence of a lack of housing or step-down accommodation for patients with no fixed abode in the four local authority areas. However, members are aware that it has been an issue in some areas and therefore needs further investigation.

Mental Health Act assessments following a Section 136

29. The CQC inspection report found that, "Mental Health Act assessments following a Section 136 were often delayed out of hours, on bank holidays and at weekends. We

also saw some significant delays in people moving on to the appropriate service once their assessment had been completed. We noted that two different section 136 protocols were being used in the different places of safety, one of which contained a set target time for people to be assessed as required by the Mental Health Act (MHA) Code of Practice and one which did not."

30. AWP acknowledged these delays, but added that often the delay is after assessment when an admission bed is required with wards operating over the recommended 85% capacity, with DToCs contributing to this directly. Challenges can also occur when under 16's are admitted to custody suites, when delays in discharging to other provision means the young person being held in a less than optimal environment.

Inpatient capacity

31. The inspection report stated that "A lack of availability of beds was a trust-wide issue, with intensive, acute and older people's beds always in demand. This meant that people did not always receive the right care at the right time and sometimes people may have been moved, discharged early or managed within an inappropriate service." The report also stated that "People spoke about the impact that bed pressures had on their care meaning that beds were often provided away from people's home area, meaning people found it difficult to maintain the support of loved ones." AWP echoed these concerns that sending patients as far away as Harrogate cannot represent good care and presents greater risks to patient welfare.

32. In discussions with the working group, AWP reported that the South West is in the lowest quartile nationally in terms of the number of acute adult beds by 100,000 of population. The region also has a lower than average number of psychiatrists and psychiatry trainees compared with the rest of the country.

33. AWP also reported that by far the highest users of older person inpatient capacity is by patients with dementia (see Appendix 2) and reducing these admissions could therefore release significant inpatient capacity. It was suggested that this could be addressed through:

- Greater care home liaison service that could intervene and deliver care to people with dementia living in care homes. AWP suggests that care home liaison can provide in-reach, education, support, assessment and advice to care home staff and residents to reduce admission to hospital. Care home liaison is not well developed everywhere, but is an effective intervention.
- A direct pathway to enable direct transfer from care home to a more complex care home placement
- Consideration of a specialist community personality disorder provision to cope with the cases that currently use a high proportion of PICU and Adult Acute inpatient capacity.

34. AWP reported that its commissioned bed base, per 100,000 of the mental health population by age range, is in the lowest quartile nationally (see Appendix 3). AWP suggested this could addressed through additional alternative acute capacity through, for example, crisis houses, and intensive day programmes, to meet the existing demand within the system.

Delayed Transfers of Care (DToCs)

35. AWP reported that across the Trust days lost to Delayed Transfers of Care (DToC's) equates to over 100% of out-of-Trust placement bed days for older people and 25% of out-of-Trust bed days for adults requiring acute inpatient care (see Appendix 4). The volume of DToCs varies widely across the four authorities on the working group but it was agreed that whole system collaboration and support is needed to address this issue.

Summary of AWP's response to the CQC Inspection report

36. In summary, AWP reported that it:

- Recognised and accepted the findings of the CQC inspection report and associated enforcement notices;
- Is focused on achieving full compliance with CQC standards
- Is focused on closing the 'gap on assurance'
- Is focused on the Organisational Development programme
- Is focused on improving recruitment and retention
- Is focused on contributing to system-wide action where it is needed.

37. The CQC has confirmed that the working group's findings are an accurate reflection of the current position in terms of AWP's improvement programme. The working group notes that these indications of progress will need to be borne out at AWP's next CQC inspection.

Recommendations

That the Working Group,

9. **Recognises and appreciates AWP's positive and open engagement in the process.**

10. **Recognise that improvement measures were underway prior to the CQC inspection report being published and these appear to being followed through.**

11. **Notes the changes in leadership at both executive and board level, shortly before and after publication of the CQC report.**

12. **That Cabinet Members and Health and Wellbeing Boards respond to**
    c) **The concerns reported that Delayed Transfers of Care (DTOC's) equate to a significant percentage of out-of-Trust placement bed days for older people and of out-of-Trust bed days for adults requiring acute inpatient care,**
    d) **Provides information of what is being done to address this.**

13. **Recommends that CCGs collectively assess with AWP the requirement for a common Section 136 Protocol in line with the Mental Health Act Code of Practice. At the same time, that consideration is given to realigning those places of safety with the appropriate constabularies as custody suite sites are reviewed.**

14. **That Cabinet Members and Health and Wellbeing Boards investigate the concerns reported by AWP regarding housing or step-down accommodation for patients with no fixed abode and the impact on Delayed Transfers of Care (DToCs) so that appropriate action can be taken if necessary.**

15. **That CCGs and Health and Wellbeing Boards respond to concerns highlighted by the CQC report and echoed by AWP regarding:**

    - **Limited availability of beds being a Trust-wide issue, with intensive, acute and older people's beds always being in demand;**
    - **Bed pressures meaning that care has sometimes been provided away from patients' home area, making it difficult to maintain the support of loved ones.**

16. **Invites participating health scrutiny committees to hold discussions regarding the merits of a longer term cross-authority scrutiny group to monitor the AWP improvement programme and the Trust's performance in the future.**

Appendix 1

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trustwide Monitor Compliance Dashboard - February 2015

	2014-15									
1. National Access and Outcome Indicators	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Follow Up within 7 days of Discharge	96%	96.5%	96.4%	96.4%	96%	96.2%	97.1%	97.6%	97%	96.4%
% of Admissions (16-64 years) gate-kept by Intensive teams	94.8%	95.5%	96.5%	97.6%	97%	95.6%	95.5%	95.6%	95.7%	95%
Access to Healthcare for People with Learning Disabilities	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Delayed Transfers of Care kept to a minimum	7%	7.8%	9.1%	10.1%	9.9%	9.4%	9.8%	10%	10%	9.7%
Service Users Receiving a Review (those on CPA for 12 months or more only)	97.1%	97.6%	97.6%	96.8%	96%	95.5%	94.9%	95.4%	94.9%	94.4%
Data Quality (Monitor): completeness of identifier fields	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%
Data Quality (Monitor): completeness of outcome fields	82.8%	83.1%	82.2%	81.4%	81.1%	81.8%	81.4%	80.9%	79.7%	79.1%
No. of new cases of psychosis in Early Intervention Services (cumulative)	75	80	73	88	117	135	151	179	208	231
Number of Concerns Raised	0	0	0	0	0	0	0	0	0	1

A concern is raised for each indicator below target for 9 or more months in a row

2. CQC Judgements - Warning Notices (enforcement action)	0	0	0	1	1	1	1	0	0	0

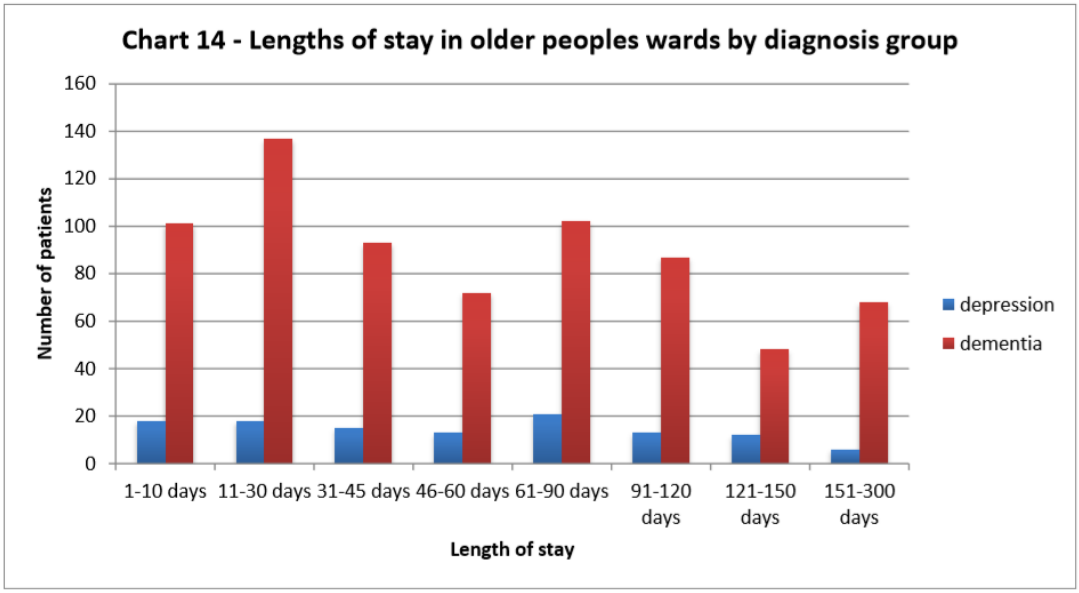
3. Continuity of Services Risk Rating	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Liquidity Ratio (days)	7	0	3	3	2	0	3	11	12	
Liquidity Ratio score	4	4	4	4	4	4	4	4	4	
Capital servicing capacity (time)	16	17	16	17	16	16	16	17	16	
Capital servicing capacity score	2	2	2	2	2	2	2	2	2	
Overall risk rating	3	3	3	3	3	3	3	3	3	

Appendix 2

NB. These figures relate to the **whole AWP Trust area**.

5. Avoiding admission of older people with Dementia

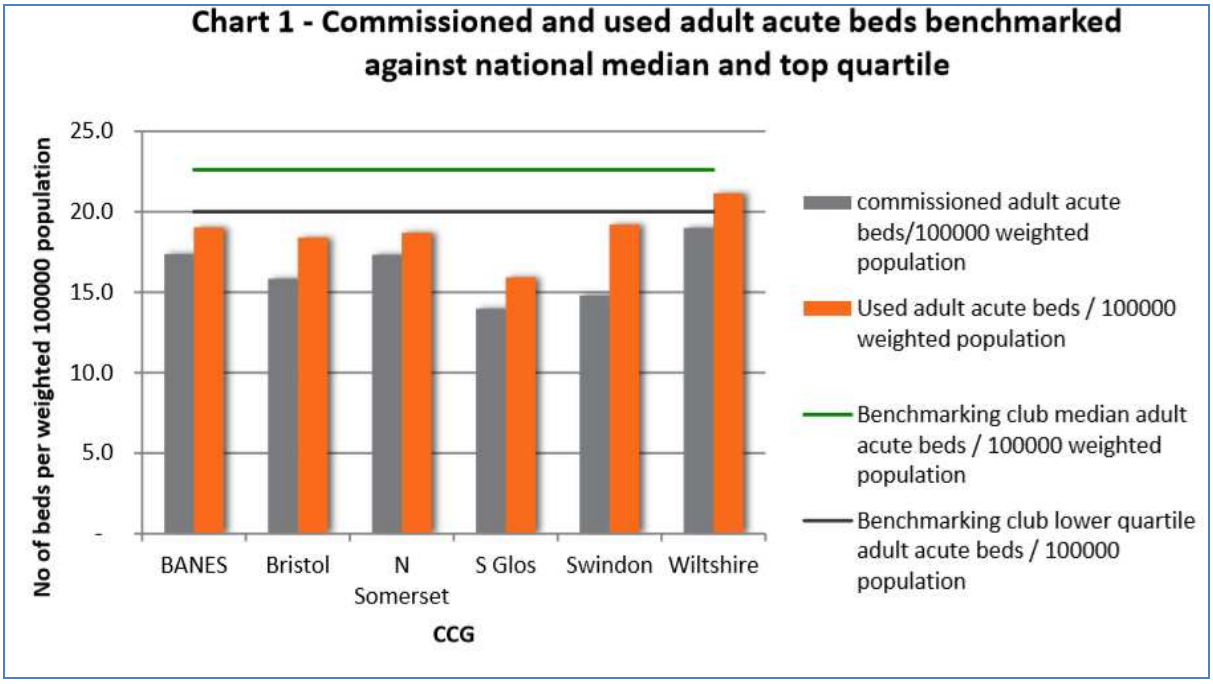
By far the highest users of older peoples inpatient capacity are people with dementia. The next highest diagnosis group in older people is depression.



Tackling the number of admissions of people with Dementia to older people's wards, given their very long lengths of stay, has the potential to release significant inpatient capacity.

Appendix 3

NB. These figures relate to the **whole AWP Trust area**.



Appendix 4

2.1. Table 1. Adult Acute Inpatient usage 12 months (Dec '13 to Nov '14)

ADULT ACUTE CCG Locality	IN HOUSE USAGE (12 Months actual data)	Total DTOC days (pro rated 12 mnth)	Out of Trust usage (Pro rated 12 mnth)	TOTAL USAGE – bed days (In House + DTOC + OOT)	Total beds used	Commissioned Bed Base	Annual capacity (Bed base X 365) 100% util'n	Short fall Bed days (Commissioned annual capacity - total usage)	Short fall Beds	Short fall beds (85% util'n)
B&NES	6,617	135	1,247	7,998	22	20	7300	-698	-1.9	-4.9
Bristol	20,170	312	1,561	22,043	60	52	18980	-3,063	-8.4	-16.2
N Somerset	7,695	43	140	7,878	22	20	7300	-578	-1.6	-4.6
S Glos	4,972	0	433	5,405	15	13	4745	-660	-1.8	-3.8
Swindon	7,531	440	556	8,527	23	18	6570	-1,957	-5.4	-8.1
Wiltshire	13,966	1333	1,353	16,653	46	41	14965	-1,688	-4.6	-10.8
	60,951	**2,263**	**5,291**	**68,504**	**188**	**164**	**59,860**	**-8,644**	**-24**	**-48**

Table 1 shows the use of adult acute bed days by each locality within AWP and Out of Trust, as well as showing the capacity used by DTOC's. Every commissioner needed more bed days than they had commissioned when DTOC's and Out of trust usage were included.

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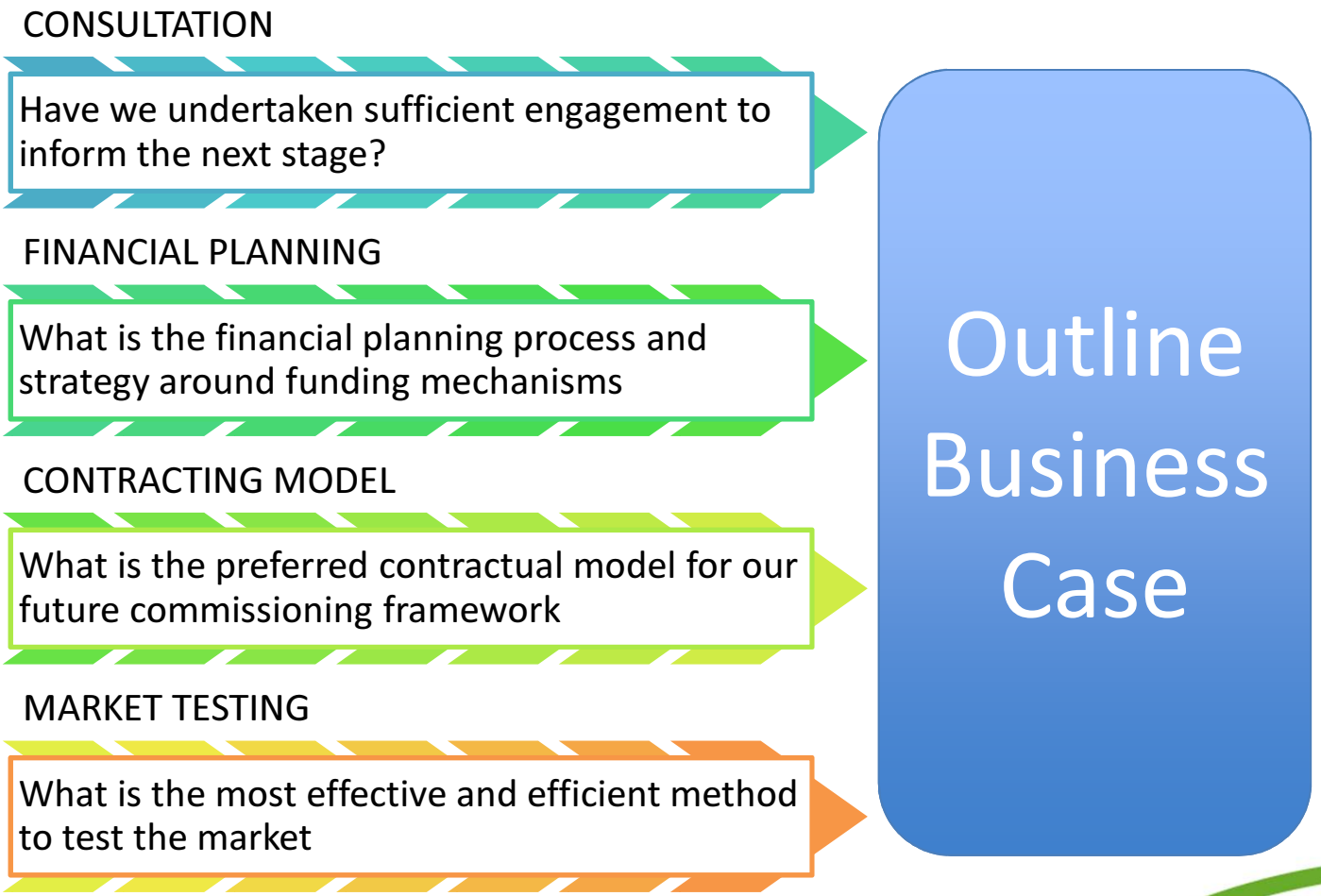
Your Care, Your Way

Project Update
Health & Wellbeing Select Committee

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Key decisions for Governing Bodies?



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Public Engagement & Consultation

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Engagement Approach

Method

- Workshops
- Surveys
- 1:1's

Stats

- Over 200 individuals reached
- In excess of 500 survey responses

Topics

- Vision
- Commissioning Models
- Priorities

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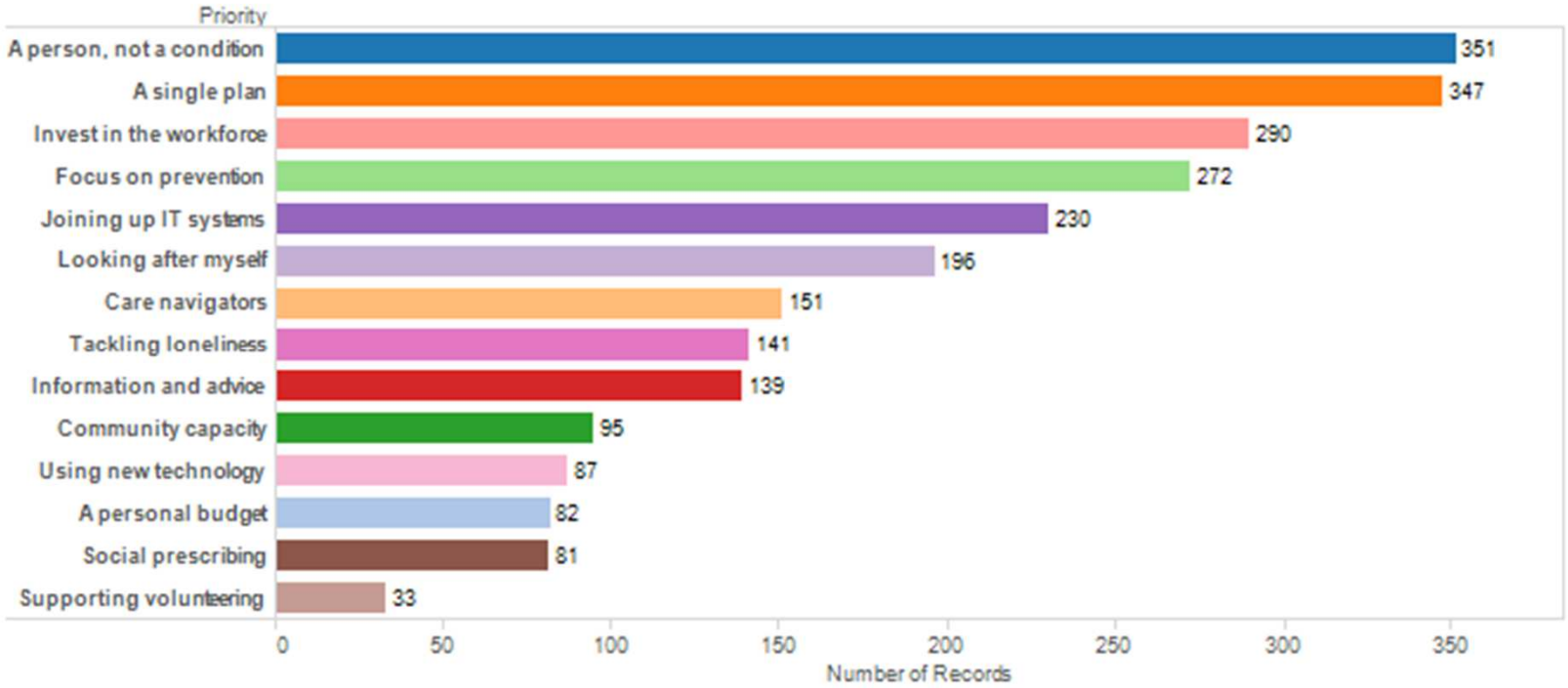
Public Engagement Analysis : Priorities



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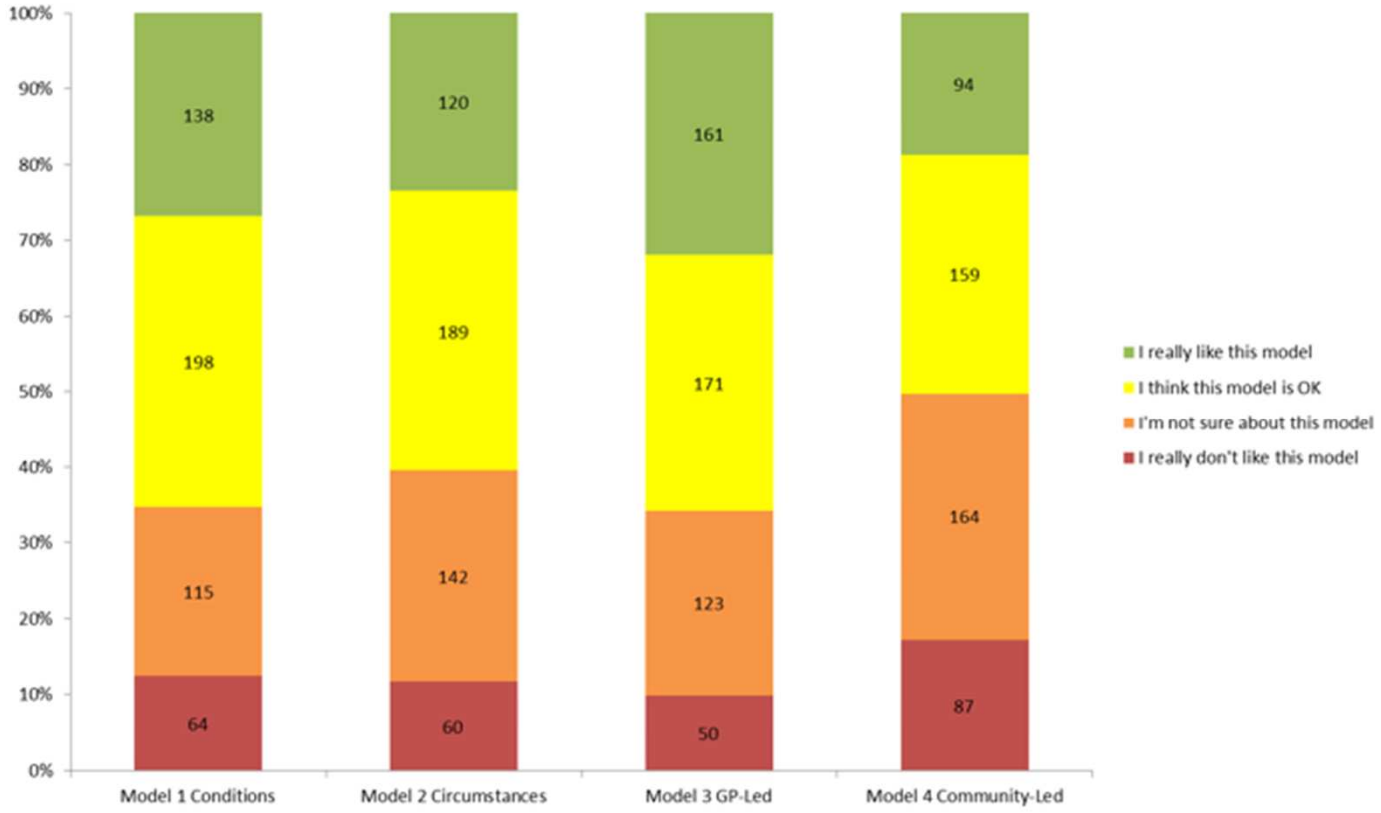
Public Engagement Analysis : Models



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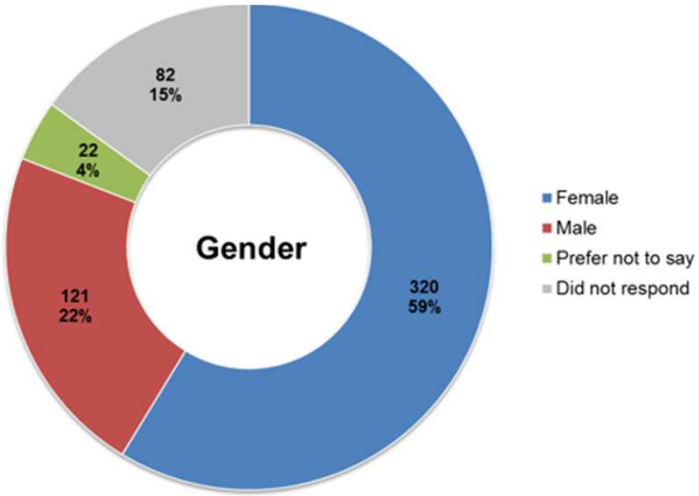
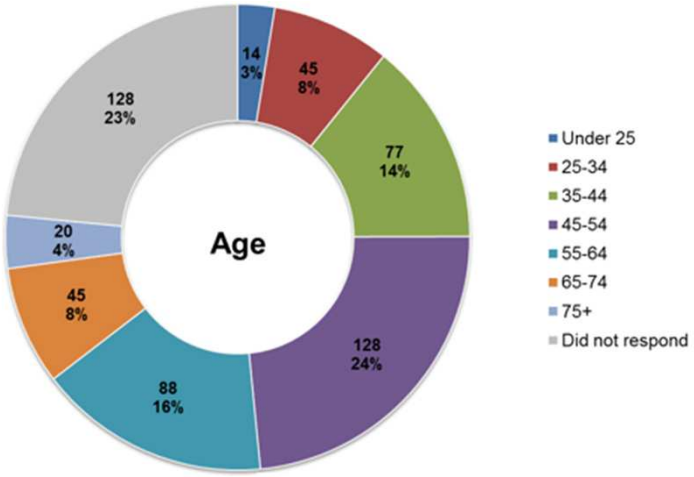
Public Engagement Analysis : Demographics





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Public Consultation: Key Findings

Wellbeing Hubs	• The GP-led Wellbeing Hub was the most popular model overall with trust and familiarity a key factor.
Access and equality	• Community-based models could lead to a “postcode lottery” across B&NES
Communication	• Better communication between providers will be needed to facilitate transformation
Resources	• There will be challenges around funding the new model given the financial pressures upon NHS and Council budgets.
Workforce	• More resources to be invested into front line care rather than creating new management and/or bureaucratic structures
Evolution, not revolution	• We must build on existing strengths and relationships rather than starting from scratch.
Evidence-based	• Changes to services must be based on clear evidence of what people have told us and what works already.
Technology	• We must join up data across providers.

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Financial Planning

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

The Funding Envelope

Category	CCG Current commissioner spend £000	Council Current commissioner spend £000	Total £000
Complex & Specialist	20,567	14,296	**34,863**
Early Intervention	2,714	23,120	**25,834**
Universal Information & Advice	5,067	3,472	**8,539**
TOTAL SPEND	**28,348**	**40,888**	**69,236**

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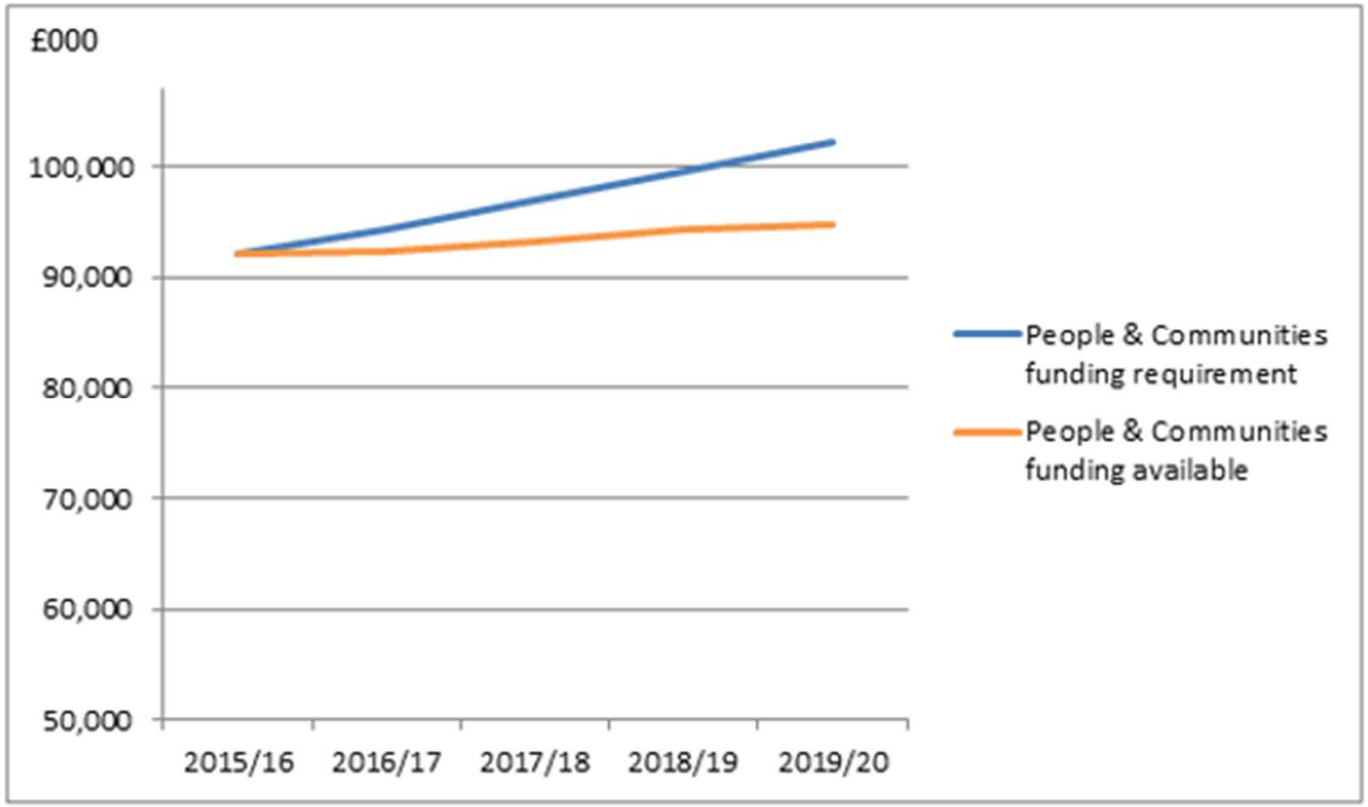
Council Funding



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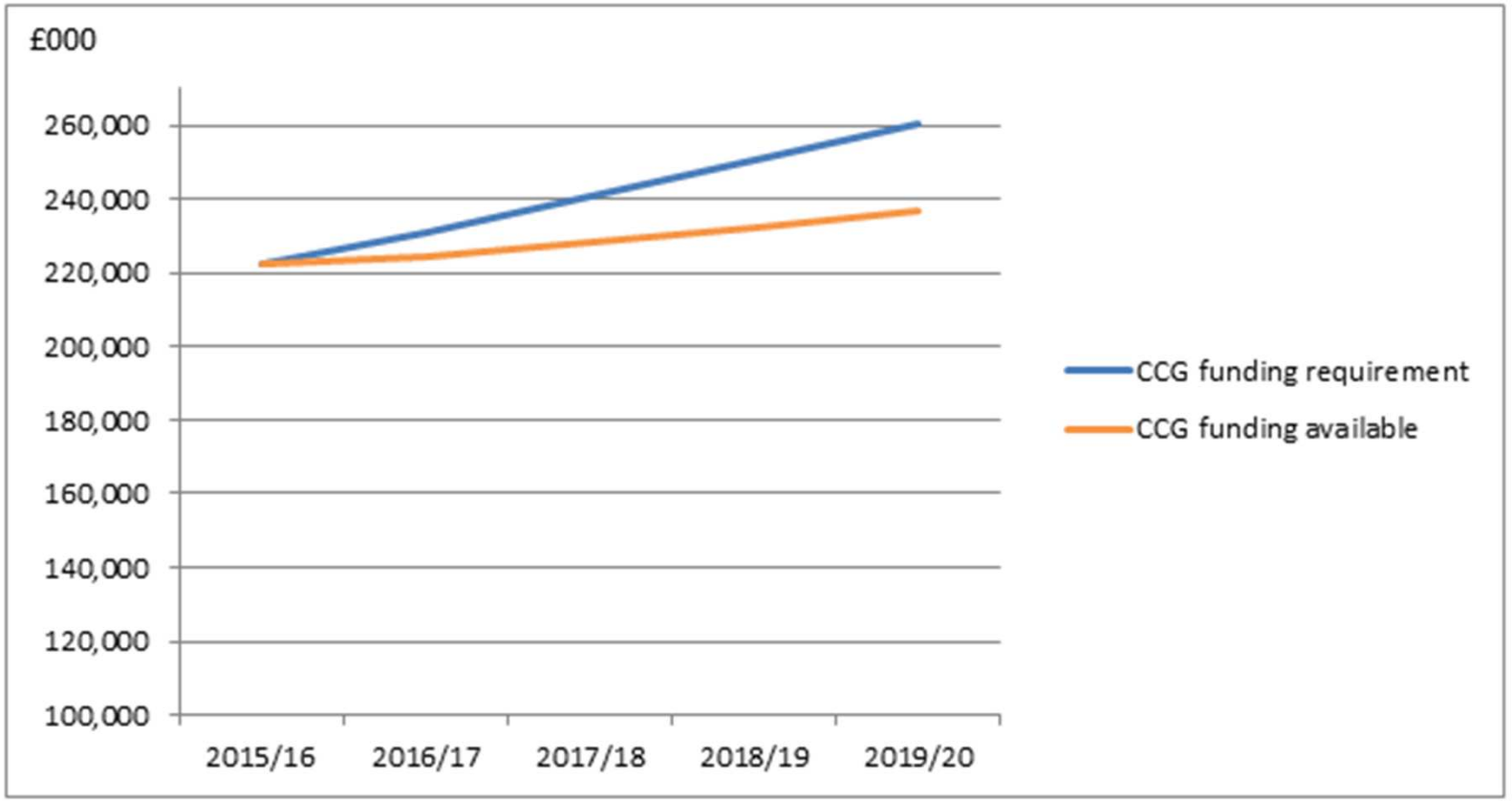
CCG Funding



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Key funding reduction principles

I. The funding envelope will be adjusted from the 2016/17 baseline to align with Council and CCG reductions in health and care funding arising from both organisations' financial planning and annual budget-setting processes.

II. Identified areas for cash-releasing efficiency savings or improving value will need to align to new commissioning & provider delivery models.

III. Demographic change pressures will need to be managed within available resources.

IV. New investment requests will reviewed on an individual basis and require sound quantitative and qualitative evidence of system benefits.

V. Commissioners and providers will continue to work in partnership to jointly identify areas of opportunity including back office efficiencies.

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Contractual Models

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NHS
Bath and North East Somerset Clinical Commissioning Group

Provider Engagement Approach

Method

- Workshops
- Surveys
- 1:1's

Stats

- 150 individuals
- 77 Organisations engaged

Topics

- Commissioning models
- Contracting methods
- Workforce Strategy
- Technology

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Provider Engagement: Messages

Models	• Support for locality based models but clearer guidance on how this may be phased or implemented is required
Relationships	• Mixed relationships between providers
Commercial Considerations	• Clarity required around contractual model and market testing approach
Role of Primary Care	• Strong consensus that primary care should form the basis of a locality based approach
Resilience and capacity	• Providers need time and help to establish sufficient resilience and capacity to play a meaningful part of the provider redesign process.

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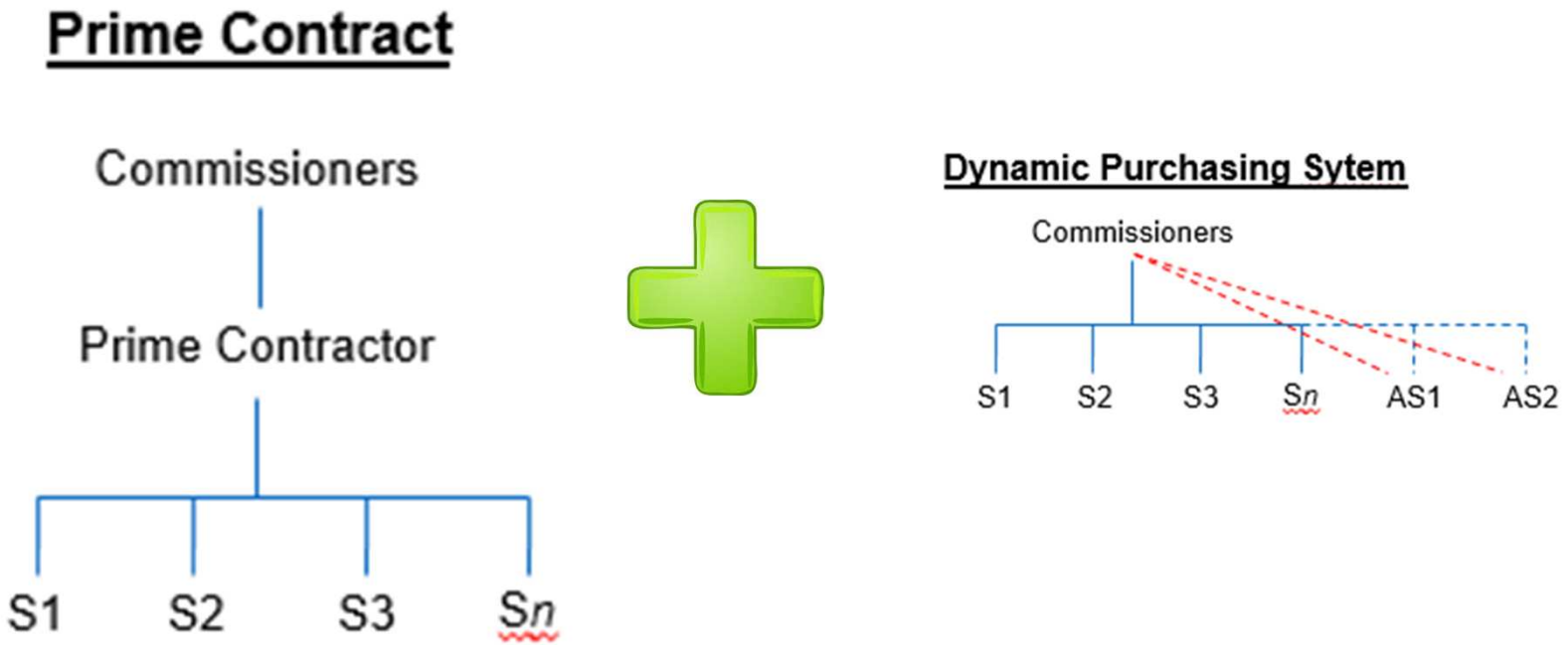
Recommended Approach



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Market Testing

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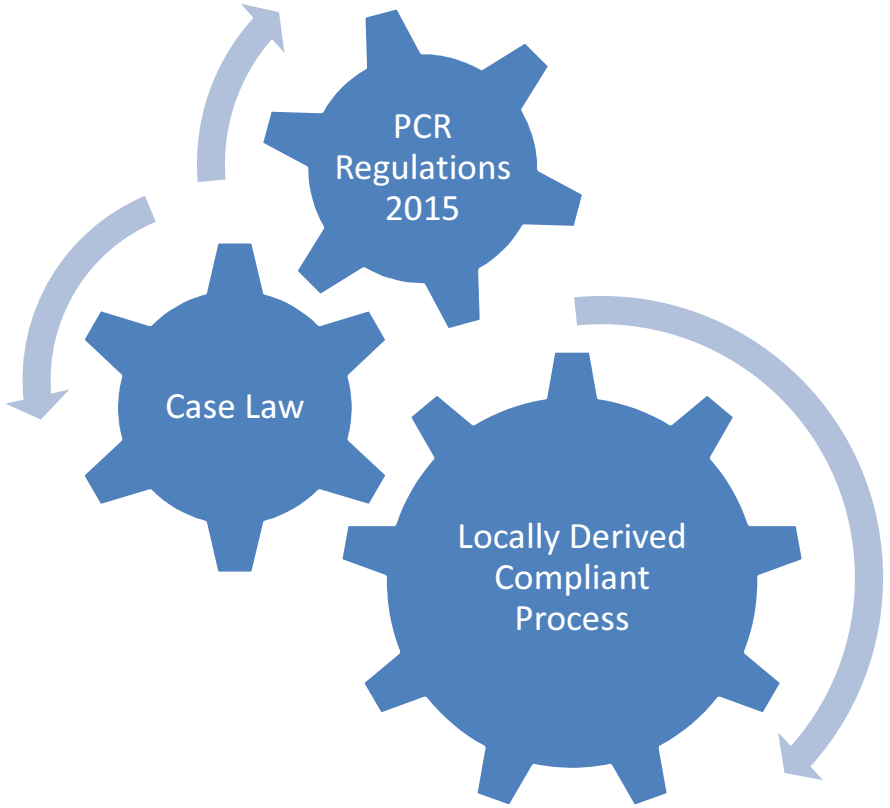
Key Considerations



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Approach

Open Procurement Process (Light Touch)

VS

Single or Consortium Provider Negotiation

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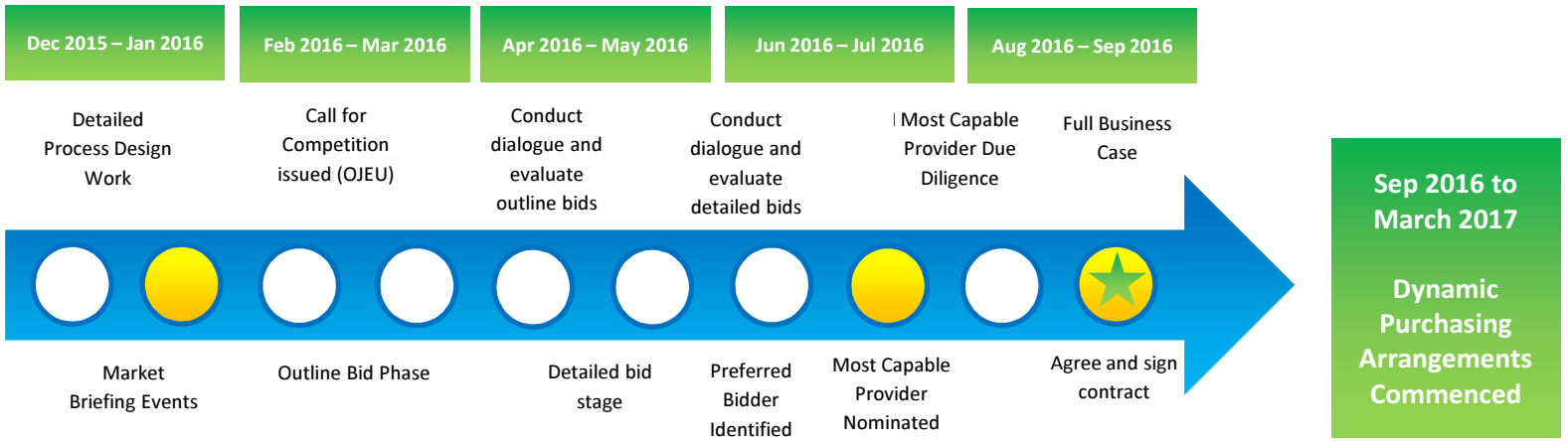
Timeline



key

Approval required by Governing Bodies to approve Full Business Case and proceed with contract award

Approval required by Joint Commissioning Committee at key milestones

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THANK YOU

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Bath & North East Somerset Council

HEALTH AND WELLBEING SELECT COMMITTEE

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 Mark Durnford, Democratic Services (01225 394458). 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), Civic Centre (Keynsham) and at Bath Central, Keynsham and Midsomer Norton public libraries.

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
27TH JANUARY 2016				
27 Jan 2016	**HWSC**	**The Strategic Direction of the RUH**	Jocelyn Foster Tel: 01225 824963	Tracey Cox
27 Jan 2016	**HWSC**	**RUH / RNHRD Integration**	Jocelyn Foster Tel: 01225 824963	Tracey Cox
27 Jan 2016	**HWSC**	**AWP - Joint Health Scrutiny Working Group**	Andrea Morland, Jane Shayler, William Bruce-Jones Tel: 01225 831513, Tel: 01225 396120,	Strategic Director - People
27 Jan 2016	**HWSC**	**Introduction to NHS Specialised Services**	Dr Lou Farbus, Head of Stakeholder Engagement, Specialised Commissioning	
27 Jan 2016	**HWSC**	**Your Care, Your Way Update**	Sue Blackman, Jane Shayler Tel: 01225 396180, Tel: 01225 396120	Strategic Director - People
30TH MARCH 2016				

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
30 Mar 2016	**HWSC**	**RUH Site Development Presentation**	Jocelyn Foster Tel: 01225 824963	Tracey Cox
30 Mar 2016	**HWSC**	**Alcohol / Substance Misuse Update**	Andrea Morland, Carol Stanaway Tel: 01225 831513,	Strategic Director - People
25TH MAY 2016				
25 May 2016	**HWSC**	**Report from Domiciliary Care Commissioners**	Jane Shayler Tel: 01225 396120	Strategic Director - People
20TH JULY 2016				
ITEMS YET TO BE SCHEDULED				
	HWSC	**Non-Emergency Patient Transport Service**		Tracey Cox
	HWSC	**NHS 111 update**		Tracey Cox
	HWSC	**Loneliness report - update**		Strategic Director - People
	HWSC	**Dentistry - after May 2015**		Tracey Cox

Ref Date	Decision Maker/s	Title	Report Author Contact	Strategic Director Lead
	HWSC	**Homecare Review update (for May 2017)**		Strategic Director - People

The Forward Plan is administered by **DEMOCRATIC SERVICES**: Mark Durnford 01225 394458 Democratic_Services@bathnes.gov.uk