Bath & North East Somerset Council

Democratic Services
Riverside, Temple Street, Keynsham, Bristol BS31 1LA
Telephone: (01225) 477000 *main switchboard*
Direct Lines - Tel: 01225 394452 Fax: 01225 394439
Web-site - http://www.bathnes.gov.uk

Your ref:
Our ref:
Date: 10 January 2011
E-mail: Democratic_Services@bathnes.gov.uk

To: All Members of the Healthier Communities and Older People Overview and Scrutiny Panel

Councillor Adrian Inker (Chair), Councillor Sharon Ball, Councillor Loraine Brinkhurst MBE, Councillor Anthony Clarke, Councillor Lynda Hedges, Councillor Eleanor Jackson, Councillor Bryan Organ, Councillor Will Sandry, Councillor John Whittock, Councillor Stephen Willcox and Councillor Simon Allen

Chief Executive and other appropriate officers
Press and Public

Dear Member

Healthier Communities and Older People Overview and Scrutiny Panel: Tuesday, 18th January, 2011

You are invited to attend a meeting of the **Healthier Communities and Older People Overview and Scrutiny Panel**, to be held on **Tuesday, 18th January, 2011** at **2.00 pm** in the **Council Chamber - Guildhall.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

   Appendices to reports are available for inspection as follows:-

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

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

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

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

6. **Emergency Evacuation Procedure**

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

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

Healthier Communities and Older People Overview and Scrutiny Panel - Tuesday, 18th January, 2011

at 2.00 pm in the Council Chamber - Guildhall

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 UNDER THE LOCAL GOVERNMENT ACT 1972

   Members who have an interest to declare are asked to:

   a) State the Item Number in which they have the interest
   b) The nature of the interest
   c) Whether the interest is personal, or personal and prejudicial

   Any Member who is unsure about the above should seek advice from the Monitoring Officer prior to the meeting in order to expedite matters at the meeting itself.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

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

   At the time of publication no notifications had been received.

7. MINUTES OF PREVIOUS MEETINGS ON 28TH OCTOBER AND 9TH NOVEMBER 2010 (Pages 7 - 42)

   To confirm the minutes of the above meetings as correct records.

8. CABINET MEMBER UPDATE

   The Panel will have an opportunity to ask questions to the Cabinet Member and to receive an update on any current issues.

9. BATH AND NORTH EAST SOMERSET NHS ROUTINE UPDATE

   The Panel will receive an update from the BANES NHS on current issues.

10. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE

(Pages 43 - 46)

The Panel are asked to consider an update from the BANES Local Involvement Network.

11. SERVICE ACTION PLAN 2011-2012 ADULT SOCIAL CARE & HOUSING (Pages 47 - 102)

The Healthier Communities & Older People Overview & Scrutiny Panel is recommended to:

- Comment on the Service Action Plans, taking into account the matters referred to above.
- Identify any issues requiring further consideration at the special meeting of the CPR Overview and Scrutiny Panel in January and subsequently by Cabinet as part of the annual Service Action Planning and Budget process, in February.
- Identify any issues arising from the draft Service Action Plans it wishes to refer to the relevant portfolio holder for further consideration in advance of the Cabinet meeting in February.

12. FINAL RECOMMENDATIONS OF THE EAR, NOSE AND THROAT AND ORAL AND MAXILLOFACIAL HEAD AND NECK CANCERS SERVICES REVIEW (Pages 103 - 204)

The purpose of this paper is to provide BaNES' Healthier Communities and Older People Overview & Scrutiny Panel with sufficient information about the Head and Neck Cancers, Ear, Nose and Throat (ENT) and Oral and Maxillofacial (OMF) Services Review to allow the Panel to decide whether or not to support the proposals to implement the new clinical service model at University Hospitals Bristol NHS Foundation Trust (UH Bristol) in line with the service specification.

13. SHAPING UP, A HEALTHY WEIGHT STRATEGY FOR BATH AND NORTH EAST SOMERSET (Pages 205 - 234)

Obesity is a major health problem for people in Bath and North East Somerset. It is a major contributing factor for type II diabetes, cardiovascular disease, a contributory factor in hip and knee replacements as well as many other health problems. The rates are rising for both children and adults. There are a range of contributing factors in the rise in obesity and this strategy aims to address these where we can locally through preventing more people becoming overweight and obese and through the provision of treatment to those who are an unhealthy weight.

The Healthier Communities & Older People Overview & Scrutiny Panel is asked to agree that the strategy is approved for publication and implementation.

14. PROGRESS ON TACKLING WINTER HEALTH (Pages 235 - 242)

The latest publication in 2010 of the Local Authority Health Profiles identified B&NES

as an outlier with a high proportion of the total number of deaths taking place during the winter months. This paper updates the Committee on the actions being taken to tackle this and bring about improvement.

The Healthier Communities and Older People Overview & Scrutiny Panel is asked to agree that the Action Plan of the B&NES Affordable Warmth Action Group is proportionate and comprehensive.

15. GYNAECOLOGY CANCER SERVICES REVIEW (Pages 243 - 252)

A comprehensive review of gynaecological cancer services commenced in September 2008 and came to a close in September 2009. At the conclusion of the review the 6 Primary Care Trusts (PCTs) in the Avon & Wiltshire & Somerset Cancer Network made a recommendation that complex gynaecology cancers from the RUH should be transferred to UHB in the future in order to deliver a service that was compliant with the NICE Improving Outcome Guidance (IOG).

A Joint Overview and Scrutiny Committee was due to be held in June 2010 but following the general election these plans were postponed as the Secretary of State for Health set out new policy commitments on service reconfiguration. These are a set of 4 measures against which proposed service re-configurations should be tested and referred to as the "the four tests".

The attached paper informs the Healthier Communities & Older People Overview & Scrutiny Panel Committee of the outcome of a local assessment of the gynaecological cancer services review against the "four tests". It also informs the panel based on this assessment of the proposed next steps for a revised local solution to providing gynaecology cancer services.

16. YOUNG PEOPLE'S SUBSTANCE MISUSE SERVICES BRIEFING (Pages 253 - 258)

This is a briefing on young people's substance misuse issues in Bath and North East Somerset, including ketamine use.

The Healthier Communities and Older People Overview & Scrutiny Panel is asked to note the report.

17. PANEL FUTURE WORKPLAN (Pages 259 - 262)

This sets out the Panels future workplan for Panel members to discuss.

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

This page is intentionally left blank

Bath and North East Somerset Council

HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL

Minutes of the Meeting held

Thursday, 28th October, 2010, 2.00 pm

PRESENT:
Councillors: Councillor Adrian Inker (Chair), Councillor Simon Allen (In place of Councillor Sharon Ball), Councillor Loraine Brinkhurst MBE, Councillor Anthony Clarke, Councillor Lynda Hedges, Councillor Eleanor Jackson, Councillor Bryan Organ, Councillor Will Sandry, Councillor John Whittock and Councillor Stephen Willcox
Cabinet Member:

Also in attendance: Janet Rowse (Acting Chief Executive, NHS Banes; Director of Adult Health)

13 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

14 EMERGENCY EVACUATION PROCEDURE

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

15 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Apologies for absence were received from Councillor Sharon Ball and Joy Davis (Joint Trade Unions Secretary). Councillor Simon Allen was a substitute for Councillor Sharon Ball.

16 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

There were none.

17 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There were none.

The Chairman used this opportunity to inform the Panel that the Bristol Health Scrutiny Committee on its meeting on 19th October had GP Commissioning Consortia Consultation as one of the agenda items. Within the report there were number of options presented and the option 5 was 'One organisation covering the "Avon" area, to include Bristol, South Gloucestershire, North Somerset, and Bath and North East Somerset, with localities.' The Chairman also informed that this Council was not included in the list of stakeholders that were consulted whilst the

other 3 ex-Avon authorities were. The last day for consultation was 5th November 2010.

The Chairman felt that this was unacceptable approach and asked the Panel to agree with his recommendation to send a letter to the Bristol PCT and the Chair of the Bristol Health Scrutiny Committee expressing Panel's disappointment and stating that the Panel could not support Avon-wide consortium.

The Panel unanimously agreed with this recommendation.

It was **RESOLVED** that the Chairman will send a letter to the Bristol PCT and the Chair of the Bristol Health Scrutiny Committee on behalf of the Panel (note: all Panel Members will have to agree with the wording in the letter).

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

The Chairman informed the meeting that there were several speakers to address the Panel and they would all have the opportunity to do so as per the day order (mentioned later in the meeting).

19 MINUTES OF PREVIOUS MEETING - 14TH SEPTEMBER 2010

It was **RESOLVED** that the minutes from the meeting held on 14th September 2010 be confirmed as a correct record and signed by the Chairman.

20 COMMUNITY HEALTH AND SOCIAL CARE SERVICES - FUTURE PROVISION

The Chairman explained that this report focuses on the options for the future provision of health and social care services as a consequence of the PCT's requirement to divest themselves of directly provided community health services. The Council and the NHS Bath and North East Somerset Board would consider these options in November 2010.

An options re-appraisal is being undertaken at present and the views of this Panel are being sought prior to reporting to the meetings of the Council and the NHS B&NES Board.

This report to the Panel describes the options and provides the initial outcome of a qualitative options appraisal for the Panel to consider and add its views. A relative financial analysis of the short listed options is currently being undertaken and this would be reflected in the report to Council in November 2010.

The report would be introduced by Janet Rowse (Acting Chief Executive NHS BANES and Strategic Director for Adult Social Care and Housing) and Richard Szadziewski (Project Manager). The Panel will also hear from the Trade Unions representatives, Diana Hall Hall (Chair of the Bath and North East Somerset Local

Involvement Network) and members of the public (Anne Marie and Peter Jovcic-Sas). The Panel would then debate the report and consider issues highlighted at the meeting before making their views.

The Chairman invited Janet Rowse and Richard Szadziewski to give a presentation (a full presentation is available in the minute book at Democratic Services) and introduce the report. The Chairman informed the meeting that the background document 'Key Characteristics of Various New Organisational Forms' had been circulated to the Panel Members in advance of the meeting (attached as Appendix 1 to these minutes).

Janet Rowse and Richard Szadziewski gave a presentation where they highlighted following points:

- National Policy Context
- Local Context
- Benefits of Integrated Services
- Progress to date
- The Options
- Key Considerations
- The Short Listed Options
- Risks Common to all options
- Risks & Opportunities that vary between options
- Next Steps
- Project Governance

Janet Rowse and Richard Szadziewski also covered these points in their presentation at the later stage of the meeting:

- What is a Social Enterprise?
- If Social Enterprise – Requirements
- If Social Enterprise – Options
- Community Interest Company limited by guarantee explanation
- Charity limited by guarantee explanation
- Potential constituencies of interest represented within Social Enterprise
- Principles for Social Enterprise governance.

Councillor Brinkhurst asked about the GP Commissioning Consortia role as a replacement for the Primary Care Trust (PCT) in commissioning services.
Janet Rowse responded that when the Primary Care Trust (PCT) cease to exist from April 2013, the Council would need to decide how best to engage with the new GP Commissioning Consortia, which would replace the PCT, and determine whether or not to retain the current commissioning arrangement that exists between the Council and PCT.

Bridget Musselwhite from the RUH Bath asked if the legal and financial matters for the RUH integration option business case would be completed by the PCT and the Council.

Janet Rowse confirmed that the PCT and the Council would provide legal and financial information related to the RUH integration option. The key date for the transfer of community services is 11th April 2011 and the NHS and Council would be looking at which configuration would be the best for the community.

Councillor Sandry asked who in the Council made the decision on the shared costs for corporate governance on this matter.

Janet Rowse replied that £350k had been allocated from the Council's Change Programme resources.

Peter Jovcic-Sas asked if the Royal National Hospital for Rheumatic Diseases in Bath had been considered as one of the options.

Janet Rowse replied that the Royal National Hospital for Rheumatic Diseases in Bath had been included in the original list. However, the services delivered by that hospital were mainly secondary care.

Councillor John Bull said that the weighting scores were quite close to each other when the assessment of options was conducted in October 2010. He asked what made social enterprise the preferred option.

Richard Szadziewski replied that the scoring criteria and the analysis used for the assessment indicated that the social enterprise option had been in a slight advantage to other options.

Councillor Sandry asked about the outcome of the consultation with the staff.
Janet Rowse replied that there was understandable anxiety between members of the staff on employment issues and anger that people had no choice to have their say on whether or not they want Transfer of Community Services. There was also some anxiety that some of the options were the first step towards a profit organisation. However, in some instances, people showed enthusiasm about the whole issue.

Councillor Brinkhurst quoted paragraph 2.2 of the cover report where it said that 'The Council will be required to take over the public health services currently within the PCT and to establish a new Partnership Board which amongst other duties takes over the statutory function of the Health O&S Committee'. Councillor Brinkhurst expressed her concern that the Panel would not be able to represent residents' views on health issues in the future.

Janet Rowse replied that although the report was on Transfer of Communities Services it also focuses on the outcome of the White Paper. She also said that she would be the lead officer on the set up and implementation of the new Partnership Board and that she personally thinks that the Overview and Scrutiny adds a value to the decision making process and that the Panel should continue to exist.

The Chairman asked what would happen if the decision of the PCT Board (which meets on 18th November) is different from the decision made by the Full Council (which meets on 16th November) in terms of the preferred option.
Janet Rowse replied that she hopes there would be no different decisions between the PCT Board and the Council. If that happens it would put at risk both services and it would lead to the failure of the system. A consensus would be made if there were two different decisions.

The Chairman asked if the timescales were set only on the health aspect.
Janet Rowse responded that although the timescale had been directed by the NHS nationally, the aim is also to meet local authority timescales.

The Chairman asked if there had been any hard evidence showing the benefits of integration. Janet Rowse replied that more time was needed to see the full benefits.

The Chairman invited Richard Gurney (UNISON branch representative) to address the Panel.

Richard Gurney gave apology for Joy Davis (Joint Trade Unions Secretary) and read a statement on behalf of the Joint Trade Unions.

In his statement Richard Gurney said that the staff expressed their concerns about the way in which the requirements for the Transfer of Community Services had been interpreted and that the options appraisal process did not fully consider all of the options. The Trade Unions believed that there could be 'an engagement without a marriage' which would preserve all the benefits of working together without a formal merger. The Trade Unions also believed that this was driven by the national policy regarding the NHS and the Council that had been asked to make a leap into unknown in order to preserve a partnership with the NHS. The Trade Unions also believed that this was driven more by the needs of senior managers than being an absolute requirement. Staff Side also had major concerns that a Social Enterprise was really back door privatisation, for which there was no mandate or desire from the public. There were no guarantees as to what would happen if the Social Enterprise did not work and went bankrupt. There was a considerable pride in both social services and the NHS in providing a public service, but when the service is taken out of the public sector the quality of the service could suffer due to the loss of pride in working for a business. Richard Gurney concluded his statement by saying that the Staff Side was proposing that council staff should remain with the Council and colleagues from the health sector should remain with the NHS.

A full copy of the statement from Trade Unions is available in the minute book at Democratic Services.

Councillor Sandry asked how many staff, out of 1,700, were Trade Union members.

Richard Gurney replied that out of 1,700 staff 700 of them were from the Council. However, not all of them were in any of Trade Unions. 25% of staff turned up at consultation events and the majority of feedbacks were that everything was happening very quickly.

Councillor Organ asked what is the view from the NHS Trade Unions was on these issues.

Richard Gurney replied that the NHS Trade Unions would prefer to stay with the NHS after the PCT cease to exist.

Councillor Sandry asked was the view from the NHS on suggestion of having Council staff staying with the Council and the NHS staff to stay with the NHS. Janet Rowse replied that although the Council has commissioning resources to employ the staff, once the PCT cease to exist the successor body would not be licensed to commission work.

Councillor Brinkhurst commented that the statutory duty of the Council is to provide services for vulnerable people and therefore the Council would have to keep some of the social services in-house. The Panel already voiced their concerns about the short timescales on these important issues but the Council and the NHS have no choice other than to go ahead with the transfer of services due to the directives from the government.

The Chairman invited Diana Hall Hall, Bath and North East Somerset Local Involvement Network (LINk) Chair to address the Panel.

Diana Hall Hall said that it has been extremely difficult for the LINk to formulate comments on these option proposals within the time between receiving the report and the meeting today. The LINk recognised the pressure that the PCT had been under to produce these proposals in the circumstances of a new Coalition Government with an urgent agenda, but they felt that this is no way to reconfigure health services that were critically important to the people of Bath and North East Somerset. The problems that can arise when different agencies have responsibility for health care and for social care have in the past created huge problems for patients and their families. The LINk considers it an absolute priority that the great steps forward that have been made under joint commissioning arrangements should not be lost or diminished under any new arrangements. The LINk asked following questions:

What steps have been taken to ensure that the future commissioners - the GP Consortium - will be prepared to take responsibility for any proposed model of service when they become responsible for its effectiveness and risks?

Why two of the Options that were excluded in March (Integration with RUH Trust, and Integration with Mental Health Trust) have been re-included in the current option proposal?

Would the option on the integration with GP Services be included now if the assessment had been purely on the grounds of quality of services provided for patients?

Diana Hall Hall also read out LINk's views on the assessment of all options and process issues related to the move towards Social Enterprises. She concluded her statement by saying that the LINk should be involved in the governance arrangements of any Social Enterprise, if that is the preferred option, in its representative role for the people of Bath and North East Somerset.

A full copy of the statement from LINk is available in the minute book at Democratic Services.

Janet Rowse replied that the GP Consortiums have only just started to explore their new roles. They were interested in their role as providers of services. However, it was still too early to engage them as commissioners as well because they need to learn more about investing in services, understanding the market and similar. The Council and the PCT worked with the existing mechanisms but they would also consider GP Consortiums once they learn their role. Current understandings were that after some period GPs would start to understand the provision of services.

Peter Jovcic-Sas commented that the Coalition have made rushed decision on these issues.

The Chairman invited Anne Marie Jovcic-Sas to address the Panel.

Anne Marie Jovcic-Sas read out her statement in which she highlighted the needs of the hard to reach and black and ethnic minority (BME) communities. She was concerned with the sketchy outline describing the process by which the Council was planning to conduct Equality Impact Assessment on this matter. Anne Marie Jovcic-Sas made a plea for the inclusion of a dedicated Health Improvement Officer for BME communities in these plans. The new arrangement aiming to improve the quality of care, better experience of services, as well as safer services and that the ability to respond quickly to the latest practice in health and social care would only be achieved in the case of vulnerable BME communities through the offices of a dedicated Health Improvement Officer.

A full copy of the statement from Anne Marie Jovcic-Sas is available in the minute book at Democratic Services.

The Chairman invited Peter Jovcic-Sas to address the Panel.

Peter Jovcic-Sas informed the meeting that he would address the Panel as the member of the public and also as the Chair of the Co-operative Party South West Regional Council. He introduced the UK's co-operative business sector which has a combined annual turnover of £33.5bn (2009), employing 237,800 people and has 12.9m members. Co-operatives generate £644m per week. Co-operatives are run according to seven key principles: voluntary and open membership; democratic member control; member economic participation; autonomy and independence; education, training and information; co-operation among co-operatives; and concern for the community. Peter Jovcic-Sas read out what the different co-operative business models were, principles of management and decision making within the co-operative company, funding and tax, legal and financial issues related to the co-operative companies. Profit distribution would be decided by the members. Typically it would be a third distributed to members, a third retained for growth and a third used to benefit the community.

A full copy of the statement from Peter Jovcic-Sas is available in the minute book at Democratic Services.

Councillor Jackson commented that the last paragraph under Cooperative Society on page 89 of the report seemed like missing few words.

Richard Szadziewski apologised for the way how the paragraph was written and explained that the Council and the PCT would have no intention to distribute profits.

Richard Szadziewski introduced the rest of the presentation related to Social Enterprise.

The Chairman commented that the timescale was an issue on this matter. He reminded the Panel when the Council commissioned its services to the Somer Housing it took 6-12 months of consultation before an option was agreed whilst on this matter the Council had much less time.

Councillor Sandry asked if the co-operative society could be a charity.

Richard Szadziewski responded that a charity status could be included in the constitution of the co-operative society.

4.10pm - At this point the Chairman adjourned the meeting for 15 minutes comfort break.

4.25pm – Meeting reconvened.

The Chairman thanked to all contributors who participated and opened the meeting for a general debate.

Councillor Brinkhurst felt that some speakers raised national political issues at this forum. She felt that this was wrong place to do so as the Panel was here to represent their residents and do what is best for them.

Councillor Clarke agreed with this comment by saying that primary job of this Panel is to represent their residents.

The Chairman commented that the role of the Panel was to be non-political and that any political issues should be raised at the Full Council meeting.

Councillor Jackson said that the principal responsibility of the Council was to get the best deal for their residents. She said that it was quite unacceptable to have such a short timescale for a very important issue. Councillor Jackson questioned if there was enough accountability on this issue and she expressed her concern on how the safeguarding, which was one of Council's main responsibilities for its residents, would be delivered from other source. Councillor Jackson welcomed what the LINk said in their statement about the trust in awarding a contract with a value of £50m to a new organisation with no trading or financial management record.

Councillor Sandry thanked Janet Rowse and Richard Szadziewski for the comprehensive report. He also said that he was impressed with the input from all of

the contributors today. He recalled that Trade Unions stated that the decision had been made considering officers recommendations for Social Enterprise. Councillor Sandry concluded that for him, based on the evidence heard today, integration with an NHS Trust was quite interesting option as well as the Council as the Social Enterprise.

Councillor Organ said that the integration between the Council and the PCT had been quite successful and that he doubt that anything suggested in the report and presentation would go wrong. He said that, based on the evidence heard today, he would support social enterprise, non profit, non charity, community interest company limited by guarantee.

The Chairman informed the Panel that the Panel should not make recommendations on the options as this should be decided at the Full Council meeting on 16th November. However, the Panel should make their views based on the evidence heard today and those views would be presented to the Full Council along with the report.

Janet Rowse said that each of the options would have the same quality of services regulator in Care Quality Commission. There would also be a number of financial regulators and quite a number of ways to hold any organisation to account.

The Chairman said that his concern about Social Enterprise was based on how viable it would be in the long term, security for service users and provision of social care. He felt that the integration with an NHS Trust (such as the RUH) seems to be the better option. He also felt that the co-operative society should be considered as an option. The Chairman concluded by saying that the issues raised by the Trade Unions should require more discussion.

Councillor Jackson said that at the end of the day the community would need something with the proven track record. She also said that we would need to keep the expertise from the Council and the NHS staff. Councillor Jackson concluded that the preferred option for the community would be integration with the RUH.

Councillor Brinkhurst felt that she would not be comfortable with the co-operative option and she asked that this should not be part of the Panel's general view. The Chairman agreed with the view from Councillor Brinkhurst.

The Chairman thanked to everyone who participated in the debate.

The Panel **AGREED** with the following scrutiny:

1) The Panel noted the national timescale to which the NHS is required to work and acknowledged the efforts on the part of the Partnership to work within this, but remained concerned that lack of time might hamper effective decision making;

2) The Panel considered the advantages and disadvantages of the range of options presented in the report and by the contributors at the meeting;

3) The Panel supported the following range of options for the current health and social care services to be assessed:

   a. Standalone community provider services: Social Enterprise

   b. Integration with local authority

   c. Integration with an NHS Trust (Possible integration with the Royal United Hospital was discussed at some length)

   Note: The Panel want to be clear that the support for those options was based only on evidence provided at the meeting including submissions from the NHS, Trade Unions, Bath and North East Somerset Local Involvement Network and members of the public. The Panel are aware that the final decision on preferred option/s would be made at the full Council meeting on 16th November and the PCT Board meeting on 18th November. For both meetings it is expected that the report would contain more information, including financial;

4) The Panel considered and noted the principles to be used in establishing the governance arrangements should a social enterprise be chosen as the way forward by the Council and the PCT. The Panel felt that the Council and Service Users should be represented in the membership and trustee arrangements of such organisation;

5) The Panel noted the project governance arrangements and next steps and welcomed its role in the implementation of any solution prior to the establishment of any new Partnership Board under the Coalition Government's proposals as contained in the recent NHS White Paper;

6) The Panel welcomed comprehensive report from Janet Rowse (Acting Chief Executive NHS BANES and Strategic Director for Adult Social Care and Housing); and

7) The Panel welcomed contributions from the Trade Unions, Bath and North East Somerset Local Involvement Network and members of the public.

Appendix 1

The meeting ended at 5.15 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council

Healthier Communities and Older People Overview and Scrutiny Panel

28 October 2010

Community Health and Social Care Services – Future Provision

Background Paper to Appendix 4 – Key Characteristics of Various New Organisational Forms

COMMUNITY INTEREST COMPANIES LIMITED BY SHARES

Summary overview

A community interest company ("CIC") limited by shares has community-based objectives that it must solely focus on. It also has the ability to provide limited dividends and was created as a compromise between a charity and a company limited by shares (i.e. it is a company that is demonstrably acting for the community whilst also having the ability to pay directors and leverage in funding through equity investment).

Key characteristics

A CIC is a company with certain unique characteristics that place restrictions on what actions the company can take. The key characteristics of a CIC are the asset lock and the community interest test.

Asset Lock

The main elements of the asset lock are as follows:

- CICs may not transfer assets at less than full market value unless they are either transferred to another asset locked body or transferred for the benefit of the community. An 'asset locked body' is defined as a CIC or a charity.

- If its constitution allows a CIC to pay dividends (other than to another asset locked body – another CIC or a charity) these will be subject to a cap that limits the amount of dividend payable (the "**Dividend Cap**"). A similar cap applies to performance related interest rates on loans where the rate of interest is linked to the CIC's performance.

- On dissolution of a CIC any surplus assets must be transferred to another asset locked body.

There is no statutory definition of 'assets' within the legislation governing CICs. However, the CIC Regulator has stated that 'assets' must be given a wide interpretation and would include land, cash and revenue streams. This means, for example, that payments to staff and directors must not be disproportionately high.

A CIC can raise debt finance for its activities in the same way as any other corporate body, provided that the loans are subject to commercially reasonable interest rates. However, an "interest cap" applies where the rate of return for the lender is performance related. Any loan where the rate of interest charged on the loan is

linked partially or fully to the profitability of the CIC, its activities as a whole or any particular activity will be classed as a performance-related loan and the cap will apply. The cap is currently set at the Bank of England Base Rate + 4%.

Community Interest Test

In order to qualify as a CIC, a company must satisfy the community interest test. The test is that: "*a reasonable person might consider that its activities are being carried on for the benefit of the community*".

The test is one of the underlying purposes of a company's activities and it is a question of what ultimately the activities are directed at. "Community" is given a wide meaning and can include a section of the community defined by geography, interest or need. However, it is necessary that the community is not an unduly restricted group of beneficiaries. This is a much wider and simpler test to satisfy than that required for an organisation to be a charity and the provider of health services to the general public has been held to satisfy the test.

A statement setting out how the community interest test will be met must be lodged with the initial application to form a CIC, along with the usual documents required for company registration. Compliance with the community interest test is an ongoing requirement. The CIC Regulator will monitor how the CIC is satisfying the community interest test via the annual form that the CIC has to submit to the CIC Regulator setting out its activities in the preceding year.

If ultimately the CIC Regulator is not satisfied that the community interest test is being met it has wide powers including the power to appoint and remove directors, appoint a manager of the CIC and in extreme situations order the transfer of shares or present a petition to the Court for the winding up of a CIC.

There is a clear inter-relationship between the asset lock and the community interest test in that the test may not be met if a reasonable person might consider that the activities of the CIC are being carried on for the benefit of the company's directors, employees or service providers rather than for the benefit of the community. This is on the basis that in such an eventuality the assets are being used to provide benefit to third parties rather than being used for the community. This will be monitored through the annual report.

Governance structure

A CIC limited by shares has a governance structure of shareholders and directors in the same way as a normal share company. Directors have the role of managing and running the day to day business of the company usually associated with company directors. In addition directors of a CIC will have the responsibility (along with shareholders when they take collective decisions about the company) for ensuring that the CIC continues to satisfy the community interest test. Unlike with charitable companies directors can be paid.

The shareholders of a CIC will have the same rights as normal shareholders, that is they will retain ultimate control over the CIC and have responsibility for major policy and decisions. For example, the shareholders will have the right to dismiss the directors, delegate powers to the directors, declare dividends, approve major transactions and change the constitution of the company.

Constitution

In the same way as normal companies CICs are governed by memorandum and articles of association which are prepared by the promoters of the CIC and can be subsequently amended by the shareholders of the CIC. The articles will include all substantive provisions including the community interest statement and the details of the asset lock.

Regulators

CICs are registered with the CIC Regulator (an independent office). The CIC Regulator is a light touch regulator and will principally rely on CIC shareholders and other interested parties to draw matters of concern to its attention. The CIC Regulator has significant enforcement powers, but these are only intended to be used in serious circumstances.

The CIC Regulator's powers include the power to appoint and remove directors, appoint a manager of the CIC and, in extreme situations, order the transfer of shares or present a petition to the Court for the winding up of a CIC. The consent of the CIC Regulator must also be obtained in relation to matters such as proposed changes in a CIC's objects.

CICs have to produce an annual CIC report, which will be delivered with their accounts to Companies House and placed on the public record. The report must record what the CIC has done to pursue the community interest and involve its stakeholders during the year. Stakeholders would be people or groups that are affected by the activities that the CIC pursues. The annual report must also contain additional financial information such as any payments to directors or declarations of dividends in the preceding year.

CICs are also subject to Companies House regulation. Companies House is a very light touch regulator. A company would typically only interact with Companies House through the requirement to file annual accounts / directors' reports as well as notices following various actions, such as a name change or appointing or removing a director.

Brief comparisons with other social enterprise models

A CIC limited by shares represents a compromise between a conventional company limited by shares and a charitable company in that it can distribute profit, pay directors and is subject to light touch regulators whilst at the same time it has to satisfy a community interest test, has an asset lock and is accountable to the CIC Regulator for its conduct as a CIC.

A CIC limited by shares is therefore more flexible than any of the charitable models whilst, by virtue of the asset lock and community interest test, being more restrictive than a company limited by shares. The fact that it can distribute profit (albeit that any distributions are restricted) means it does not qualify for national non domestic rates ("**NNDR**") relief or for VAT exemptions available to non profit distributing organisations ("**NPDO**") (i.e. charities, CICs limited by guarantee or non-charitable companies limited by guarantee) and has much more limited opportunities to benefit from grant funding. In addition as a CIC it does not benefit from the tax exemptions available to charities.

COMMUNITY INTEREST COMPANY LIMITED BY GUARANTEE

Summary overview

A CIC limited by guarantee has community based objectives that it must solely focus on. In the same way as a company limited by guarantee, rather than shareholders it has members who guarantee to contribute a nominal sum in the event that the company is wound up. A CIC limited by guarantee is prohibited from distributing profits. There is a very broad range of organisations formed as CICs, many of which are involved in service delivery at a community level – including in particular health, as set out above.

Key characteristics

A CIC is a company with certain unique characteristics that place restrictions on what actions the company can take. The key characteristics of a CIC are, as set out above, the asset lock and the community interest test.

A CIC limited by guarantee does not have share capital and is not able to provide dividends. In other respects the organisational form is the same as a CIC limited by shares.

Brief comparisons with other social enterprise models

A CIC limited by guarantee is less restrictive than any of the charitable models as it is not subject to charity law or the regulation of the Charity Commission. It nevertheless does have an asset lock (including a prohibition on providing any dividends), has to satisfy the community interest test and is subject to the regulation of the CIC Regulator.

The difference to a CIC limited by shares is that a CIC limited by guarantee cannot distribute any profit (a CIC limited by shares may distribute up to 35% per annum), a fact that qualifies it as an NPDO. As an NPDO a CIC limited by guarantee is eligible for 100% discretionary NNDR relief in the same way as a non-charitable company limited by guarantee is. As it is not a charity it does not benefit from the tax benefits associated with charitable status (including exemption from corporation tax).

In terms of tax / VAT treatment a CIC limited by guarantee is therefore in the same position as a non-charitable company limited by guarantee. However, a CIC has the additional requirements of an asset lock, satisfying the community interest test and is subject to additional regulation and an additional regulator. These factors may facilitate engagement with the wider third sector, allow for more opportunities of grant funding and offer greater comfort to government agencies as to the community focus of the company.

COOPERATIVE SOCIETY

Summary overview

A co-operative society is an industrial and provident society that is being conducted for the benefit of its members. A co-operative society is significantly different from other social enterprise models in that the entire rationale for a co-operative is to operate for the benefit of its members rather than for the benefit of the public. As a cooperative is explicitly set up for the benefit of its members it cannot be a charity because it does not provide sufficient public benefit.

Key characteristics

A co-operative society is a corporate body. As a corporate body it has its own legal personality meaning that it may enter into contracts in its own name and be sued by and sue third parties in its own name. This means that the members of the society benefit from limited liability and can only be pursued personally for their actions where they have acted in breach of their duties.

In order to be established as a co-operative society the society must be a bona-fide co-operative society. There is no statutory definition of a 'bona fide co-operative' society but there are criteria laid down by the Financial Services Authority. The criteria are:

- conduct of the business must be for the mutual benefit of the members with the benefits they receive deriving mainly from their participation in the business;
- control of the society must be vested in the members equally, the principle of 'one man, one vote' is fundamental;
- interest on capital will not exceed a rate necessary to obtain and retain sufficient capital to carry out the society's objects;
- profits, if distributable amongst the members, will be distributed in relation to the extent members have either traded with the society or taken part in the society's business; and
- membership must not be artificially restricted with the aim of increasing the value of any proprietary rights and interests.

Governance structure

A co-operative society has a two tier governing structure broadly analogous to a company. It comprises of members in the society who appoint committee members who have responsibility for the day to day operation of the society.

The members of the co-operative are, in some ways, analogous to shareholders with capital payable in order to become a member and dividends payable from profits of the cooperative. However, whilst dividends can be paid, the purpose of a co-operative cannot be to provide dividend payments to members and in practice it may be more typical for the membership to decide to reinvest all profits into the business of the cooperative.

As noted above, the principle of one man one vote is fundamental to the concept of a cooperative.

Constitution

A co-operative society's constitution is known as its 'rules'. The rules deal with the same items that are dealt with in a company's memorandum and articles of association including the society's objects, place of its registered office, the terms of admission of members, the holding of meetings and voting rights.

Regulator

A co-operative society is registered with and regulated by the Financial Services Authority to whom it must submit annual accounts and an annual report. The FSA is a relatively light-touch regulator in respect of cooperatives not providing financial services with its resources focused on other forms that it regulates, in particular those operating within the financial sector.

Brief comparison with other social enterprise models

A co-operative society is a distinctly different type of social enterprise vehicle in that it is by definition run for the mutual benefit of its members rather than for the benefit of society. As a profit distributing organisation it would not be eligible for NNDR relief and would not benefit from tax exemptions available to charities.

CHARITABLE COMPANY LIMITED BY GUARANTEE

Summary of legal form

A charitable company limited by guarantee is a company limited by guarantee with exclusively charitable objects. As a limited company it is subject to company law (in particular the Companies Act 2006) and as a charity it is subject to charity law (in particular the Charities Act 1993 and Charities Act 2006).

A company limited by guarantee is the legal format most widely used for charities. This is because it offers limited liability for the directors and members of the company and is a widely known form that both the public and private sector are used to working with and are comfortable with.

Key characteristics

A company limited by guarantee has its own legal personality meaning that it may enter into contracts in its own name and be sued by and sue third parties in its own name. This means that the directors and members of the company benefit from limited liability and can only be pursued personally for their actions where they have acted in breach of their duties, for example wrongful trading.

In order to be established as a charity a company must have:

- exclusively charitable objects;
- demonstrate sufficient public benefit.

These tests would be assessed by the Charity Commission upon registration and would need to be complied with on an on-going basis. A charity's objectives are stated within its memorandum of association and must be exclusively charitable in order for the company to qualify as a charity. A charity can only undertake activities that further its stated objectives. The Charities Act 2006 sets out 13 different purposes that are accepted as being charitable. These include, for these purposes, the advancement of education, the advancement of health and the advancement of community development.

The Charities Act 2006 introduced a requirement for all charities to positively demonstrate what public benefit they provide. There are two elements to the public benefit test:

- there must be an identifiable benefit or benefits;

- the benefit must be to the public or a section of the public.

In assessing whether the benefit is to the public the Charity Commission will assess the level of private benefit that the charity would provide. 'Private benefits' are benefits that people or organisations receive other than as beneficiaries of the charity. Such benefits must be no more than incidental.

A fundamental feature of a charity is that it cannot distribute profits. All profits of a charitable company must therefore be reinvested into the activities of the charity. A charity may only transfer its assets to third parties either for full market value or in furtherance of its charitable purposes.

Governance structure

A charitable company limited by guarantee is primarily run by a board of directors. The directors of a charitable company are also, by virtue of having the overall control and responsibility for the company, trustees of the charity (the term director will be used in this paper unless specially referring to a point that applies to an individual by virtue of him or her being a trustee). There is a general prohibition on charity trustees being remunerated for their role as trustee meaning that directors / trustees of a charitable company are invariably non-executive.

The directors, as charity trustees, are under various duties under charity law. At its broadest there is a duty to act independently and only in the best interests of the charity. Directors are also subject to duties under company law including the duties introduced by the Companies Act 2006 (these include a duty to promote the best interests of the company and a duty to avoid conflicts of interests).

The duty to avoid conflicts of interests exists under both company and charity law. It is important to note that it is not as easy for either non-conflicted directors or members to authorise conflicts for directors of a charitable company in the same way as it is for normal companies. This is as a result of the additional duties of independence associated with trusteeship and the additional regulation of the Charity Commission.

Depending on the size of the charity the executive functions of a charitable company would ordinarily be delegated to a senior management team who would be full time employees of the charity and responsible for overseeing the charitable company's day to day activities and managing the rest of the staff. However, importantly the directors retain overall responsibility for the activities of the charity and senior management would be accountable to and controlled by the board of directors.

A company limited by guarantee has members rather than shareholders so that the governance structure is of members and directors. Members do not own the company in the same way that shareholders do but rather provide a guarantee (usually a nominal £1) to contribute to the company in the eventuality that it is wound up. The members retain ultimate control over the company through the power to appoint and remove directors and to change the memorandum and articles of association.

Constitution

A charitable company limited by guarantee is governed by its memorandum and articles of association. The memorandum of association states that the subscribers wish to form a company and agree to become members of the company.

The articles of association sets out all substantive provisions relating to the company including the governance structure of the company; the provisions governing conduct of meetings and decision making by both the directors and members; the charitable objects of the company; the powers of the company; dissolution provisions; a prohibition on distribution of profits; and what benefits the directors and members of the company are permitted to receive.

Regulator

Charitable companies are subject to regulation by Companies House and the Charity Commission.

Companies House is a very light touch regulator. A charitable company would typically only interact with Companies House through the requirement to file annual accounts and directors' reports as well as notices following various actions, such as a name change or appointing or removing a director.

The Charity Commission is a much more proactive and powerful regulator than Companies House. In the same way as with Companies House, annual accounts and reports have to be filed with the Charity Commission. This includes a report on how the charitable objectives of the charity have been pursued in the previous year and how public benefit has been provided. In addition the consent of the Charity Commission is required for various actions, such as changing the charitable objectives of the company, or the sale of land between connected parties.

The Charity Commission has the power to carry out inquiries into charities where it has concerns over the conduct of the charity and in extreme cases has the power to remove and appoint trustees, freeze bank accounts and seize documents.

NON-CHARITABLE COMPANY LIMITED BY GUARANTEE

Summary of legal form

A company limited by guarantee is a limited company that has members who, rather than purchase shares, provide a nominal guarantee in the eventuality that the company is wound up. It is established under and subject to company law in the same way as companies limited by shares with the exception of law relating to shares.

Although not a legal requirement, a company limited by guarantee would typically have restricted objects and a prohibition on distribution of profits. In this paper only a company limited by guarantee with these characteristics will be considered. This is because without these characteristics the company would not offer any material benefits compared to a company limited by shares and if the company is to distribute profits a company limited by shares would be the more appropriate model, though this is unlikely to be considered appropriate in the context of a health-related social enterprise.

Key characteristics

A company limited by guarantee has its own legal personality meaning that it may enter into contracts in its own name and be sued by and sue third parties in its own name. This means that the directors and members of the company benefit from limited liability and can only be pursued personally for their actions where they have acted in breach of their legal duties, for example wrongful trading.

Although not a legal requirement of the form, a company limited by guarantee typically has a prohibition within its memorandum of association on the distribution of profits. The prohibition on distribution of profits enables a company limited by guarantee to qualify as a NPDO. Qualifying as an NPDO enables a company to be eligible for NNDR relief and also possible VAT savings.

A company may only pursue activities that are within or reasonably incidental to its stated objects. A company limited by guarantee would typically have more specific objects than the general commercial objects used in a conventional company limited by shares. The company's objects would ordinarily relate to the particular community that it is being established to work within. This, together with the prohibition on distribution of profits, is used to ensure, and demonstrate to third parties, that surpluses will only be used for the particular purposes stated in the objects.

Please note that there is no legal requirement for this nor would the community objects have to satisfy any particular test (as is the case with charitable companies and community interest companies). Nevertheless, it is unlikely to be considered appropriate not to adopt these arrangements for a health-related social enterprise. In any event, the objects could be changed by the members without the need of a regulator's consent.

It is possible for a company limited by guarantee to be used in a flexible and commercial way as part of a group structure. For example, it can be possible for a parent company to exercise control over the company and directors connected to parent or other companies being appointed to the board. The requirements of independence associated with charities and community interest companies do not allow for this with charitable companies or CICs. It is important to note, however, that in order to qualify for NNDR relief the company in question needs to be in control and occupation of the premises and therefore reasonable commercial terms should be in place between the company limited by guarantee and the rest of the structure. Equally, in order to benefit from certain VAT exemptions that are available to companies limited by guarantee, the company must be independent of third party control or commercial influence.

Governance structure

A company limited by guarantee has a governing structure of members and directors. Directors have the role of managing and running the day to day business of the company usually associated with company directors. Unlike with charitable companies directors can be paid and there are not the same requirements in relation to independence that directors of charities and CICs are subject to. This means that directors of a company limited by guarantee could for example be connected with associated third parties and individuals can be paid for carrying out their role as directors.

The members of a company limited by guarantee do not own the company in the same way that shareholders do in respect of a company limited by shares as there is

no notion of equity. Rather than having a shareholding, the members guarantee to provide a sum (usually a nominal £1) in the eventuality that the company is wound up. The members of a company limited by guarantee do however otherwise have the role given to shareholders (i.e. they can appoint and remove directors and have the sole power to amend the memorandum and articles of association).

Constitution

A company limited by guarantee is governed by its memorandum and articles of association. The memorandum of association will state that the subscribers wish to form a company and agree to become members of the company.

The articles of association sets out the: governance structure of the company; the provisions governing conduct of meetings and decision making by both the directors and members; the charitable objects of the company; the powers of the company; dissolution provisions; a prohibition on distribution of profits; and what benefits the directors and members of the company are permitted to receive.

Regulator

Companies limited by guarantee are subject to the regulation of Companies House.

Companies House is a very light touch regulator. A company would typically only interact with Companies House through the requirement to file annual accounts/directors' reports as well as notices following various actions, such as a name change or appointing or removing a director.

Brief comparisons with other social enterprise models

A non-charitable company limited by guarantee is a lot less restrictive than any of the charitable models or either form of CIC, for the following reasons:

- there is no additional regulator, such as the Charity Commission or CIC Regulator, which has to be satisfied upon registration, and on an on-going basis, as to the proper conduct and independence of the company;
- there is no specific test to be met in relation to the objects of the company;
- the directors are under no additional legal duties regarding independence; and
- there are not the same restrictions on transferring assets to third parties as there are with charities and CICs.

A company limited by guarantee would not have the same opportunities for grant funding as a CIC or charity and would not be eligible for mandatory NNDR relief in the same way as a charity. However, it would be eligible for discretionary NNDR relief and as a NPDO may still be able to benefit from certain social enterprise funding opportunities.

Bath and North East Somerset Council

HEALTHIER COMMUNITIES AND OLDER PEOPLE OVERVIEW AND SCRUTINY PANEL

Minutes of the Meeting held

Tuesday, 9th November, 2010, 2.00 pm

PRESENT:
Councillors: Councillor Adrian Inker (Chair), Councillor Sharon Ball, Councillor Anthony Clarke, Councillor Eleanor Jackson, Councillor Bryan Organ, Councillor Will Sandry, Councillor Stephen Willcox and Councillor Brian Webber (In place of Councillor John Whittock)
Cabinet Member: Councillor Vic Pritchard (Cabinet Member for Adult Social Services and Housing)

Also in attendance: Jo Gray, Janet Rowse (Acting Chief Executive, NHS Banes; Director of Adult Health) and Derek Thorne (Assistant Director - Health Improvement)

21 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

22 EMERGENCY EVACUATION PROCEDURE

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

23 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Apologies for absence were received from Councillors John Whittock and Loraine Brinkhurst. Councillor Brian Webber was substitute for Councillor Whittock.

The Chairman informed the meeting that Councillor Brinkhurst was not at the meeting because of the death of her father. The Panel offered its condolence to Councillor Brinkhurst and her family.

24 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

There were none.

25 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There were none.

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

There were none.

27 CABINET MEMBER UPDATE (15 MINUTES)

The Chairman invited Councillor Vic Pritchard (Cabinet Member for Adult Social Services and Housing) to update the Panel on current issues within his portfolio (attached as Appendix 1 to these minutes).

The Panel asked the following questions and made the following points:

Councillor Sandry said that there was a perception that Housing Team had poor correspondence with the Planning Team in terms of the New Homes Bonus scheme and asked for assurance that those two teams do talk to each other.

Councillor Pritchard responded that there was a close liaison between those two departments.

Councillor Sandry asked Councillor Pritchard if he had knowledge of how many individuals were in Julian House now, in particular if there was overflow in number of people staying.

Councillor Pritchard responded that Julian House was not populated to its full capacity.

Councillor Jackson asked if the £400 cap on housing benefit would affect Bath and North East Somerset area and how many people would be affected.

Councillor Pritchard responded that he would not be able to give a specific answer to that question. He added that rents had been assessed on monthly basis.

The Chairman said that he was not sure how changes to new social tenancies including fixed term reviews and increasing social rents to 80% or even 90% of market rents (calculated using housing benefit rates) would work. He asked if there was any conversation with the Somer Housing on that issue.

Councillor Pritchard responded that no announcement had been made so far and he would provide more information, if available, to the Panel at the next meeting.

The Chairman asked that the Care Quality Commission assessment results be sent to the Panel once they become public document.

Councillor Pritchard agreed with this suggestion.

The Chairman thanked Councillor Pritchard for the update.

28 BATH AND NORTH EAST SOMERSET NHS ROUTINE UPDATE (15 MINUTES)

The Chairman invited Janet Rowse to update the Panel on current issues in NHS BANES (attached as Appendix 2 to these minutes).

The Panel asked the following questions and made the following points:

Councillor Organ shared his positive personal experience on Health Checks in his surgery in Keynsham. He also said that he was impressed that the hospital beds freed up as people go home more quickly because of effective community services.

Councillor Sandry asked what form of screening would be commissioned by the Council in future and whether the Council would commission sexual health services.

Janet Rowse replied that the DH guidance was not yet published but that it was expected that most screening programs would be commissioned by the Council. She also said that a number of services currently commissioned by the NHS were expected to be transferred to the Council and one of those services is likely to be sexual health.

Councillor Sandry asked what would be the option recommended by the NHS presented to the Council and Transfer of Community Services.

Janet Rowse replied that the recommendation was consistent with the presentation to the last HCOP Scrutiny Panel and proposed Social Enterprise as the direction of travel.

The Panel congratulated on the Health and Social Care Award for 'Clinic on the move' multi-agency partnership which brought sexual health services into the community, taking services from clinical settings into non-clinical environments.

The Chairman thanked Janet Rowse for the update.

29 BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (10 MINUTES)

The Chairman invited Diana Hall Hall and Mike Vousden to update the Panel on current issues involving Bath and North East Somerset Local Involvement Network (BANES LINk) as per the report.

Note: A revised update from the BANES LINk is available on the Panel's agenda website and also at the minute book in Democratic Services.

The Chairman commented that the future of BANES LINk, to act as a Health Watch, should be resolved with the Health White Paper.

Janet Rowse commented that there were ongoing conversations between the Partnership and LINk about their future status. Janet Rowse also said that she had been asked by the Chief Executive of the Council to consider the future of Health Scrutiny as part of the establishment of the new statutory Partnership Board

Councillor Jackson raised the point about the Ketamine abuse amongst young people and suggested that the Panel should look into this issue. Diana Hall supported that suggestion.

Janet Rowse suggested that the officer from Drug Services could come at the next meeting and brief the Panel on that issue.

The Panel agreed to discuss 'Ketamine abuse amongst young people' at the next meeting.

The Chairman thanked Diana Hall Hall and Mike Vousden for the update.

30 MEDIUM TERM PLAN FOR ADULT SOCIAL CARE AND HOUSING (1 HOUR)

The Chairman invited Janet Rowse to introduce the report.

Janet Rowse gave a presentation (attached as Appendix 3 to these minutes) in which she highlighted the following points:

- Background – Budget Savings Targets
- Adult Social Care and Housing – The Financial Challenge
- Summary Proposals for 2011/12
    - Productivity and Efficiency
    - Service Re-design
    - Changing the offer
- Risks

The Panel asked the following questions and made the following points:

Janet Rowse said that safeguarding would remain a priority for the Council. Jo Gray added that the Lean Review currently taking place is expected to identify opportunities for greater productivity and this is likely to inform plans for future staff numbers. Within the plans 50% of the proposed staff reductions (10 in total) relate to Lean Reviews.

Councillor Sandry asked about Community Meals issue and if there were any criteria for people to get them free.

Janet Rowse replied that the service users had been charged at the same level of £3.90 per meal although the actual cost of the provision of a meal was £5.20. The difference between the annual cost of providing the meals service and income from charging for the service was approximately £125,000. That difference was met from the adult social care budget through a subsidy.

Councillor Sandry asked for more details/information on reduction in commissioning of services from the third/voluntary sector to be available within the Service Action Plan at the next meeting of the Panel. The Panel agreed with this request.

Councillor Sandry asked what amount of budget control had been obtained with the vacancy management. Councillor Sandry said that the Panel was told in past that the vacancy management cost could not be used to cover an increase in social care.

Janet Rowse and Jo Gray replied that this would be monitored.

The Chairman said that the Community Learning Services had been quite positive and powerful service for the community. He felt that those services should be provided by the Policy and Partnerships.

Jo Gray agreed with the Chairman on the role of the Community Learning Services in the community and that the role of the service should be looked across the whole Council. However, difficult decisions would need to be made in these times.

The Chairman asked for more details and information on the Community Learning Services to be available within the Service Action Plan at the next meeting of the Panel. The Panel agreed with this request.

The Chairman also asked for more details and information on Housing Savings to be available within the Service Action Plan at the next meeting of the Panel. The Panel agreed with this request.

It was **RESOLVED** that:

1) The Panel noted the report; and
2) The Panel identified the following issues requiring further consideration and highlighting as part of the service action plans and budget reports to be considered in January 2011:
    a. Reduction in commissioning of services from the third/voluntary sector
    b. Community Learning Services; and
    c. Housing Savings.

31 UPDATE ON RESIDENTIAL ADMISSIONS (20 MINUTES)

The Chairman informed the meeting that the officer who meant to present this report had not been able to attend the meeting due to ill health. The Panel would have an opportunity to debate this item in the officer's absence and the questions from the Panel would be answered at the next meeting if those questions could not be answered by Janet Rowse or Derek Thorne.

Councillor Sandry asked if the stretch targets were set by the government or locally.

Janet Rowse replied that stretch targets were set locally as part of the Local Area Agreement.

Councillor Clarke expressed his concerns on excessive number of older people dying in Bath and North East Somerset during winter months. He also said that the area was now in the position for being the worst in England for excess winter deaths and that something had to be done to reduce this figure and improve the overall mortality rate for the area.

Janet Rowse replied that there was a big debate on this matter and that some deaths could be prevented, but that it was important to note that life expectancy in B&NES is well above average. The issue is the proportion of people who die in winter since this suggests some deaths may be preventable. Given the advice from public health colleagues that there is an association with poorly heated homes, her view was that these deaths were unlikely to be in residential homes although it was noted that this has not been tested.

The Panel agreed to have a report on 'Excessive number of older people dying in Bath and North East Somerset during winter months' for the next meeting.

Janet Rowse also said that although there would be no more Care Quality Commission Annual Performance Assessment, the Council would continue to monitor commissioning of care locally. The Panel welcomed this information.

It was **RESOLVED** to note the findings of the investigation that took place in relation to residential admissions and to receive a report on 'Excessive number of older people dying in Bath and North East Somerset during winter months' at the meeting in January 2011.

32 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) UPDATE (30 MINUTES)

The Chairman invited Liz Price and Paul Sheffield (Assistant Service Director-CAMHS for Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust) to introduce the report.

Liz Price and Paul Sheffield went through the report. Paul Sheffield also gave an overview of the referral criteria for the child and adolescent mental services that would be screened through the single point of access in Bath and North East Somerset. These include Specialist CAMHS Community Service, Outreach Service for Children and Adolescents (OSCA) and CAMHS Learning Disability Service.

Leaflets explaining the work of CAMHS and OSCA in Bath and North East Somerset together with the referral criteria for Bath and North East Somerset CAMHS community services are available on the minute book in Democratic Services.

Councillor Organ said that it was nice to hear that the referral form was made simple. He asked how many people from Bath and North East Somerset needed patient admission.

Paul Sheffield replied that there were 6 cases from Bath and North East Somerset which needed patient admission and that there were 2 patients at the moment at the inpatient facilities in Swindon.

Councillor Sally Davis (Chair of the Children and Young People Overview and Scrutiny Panel) welcomed the report and information provided by the officers at the meeting. She asked that the further update should be presented to the Children and Young People Panel.

Councillor Sandry asked if it would be possible for the Panel to have a list of tiers and functions of each tier. Liz Price said that she would send this information to the Panel.

Councillor Sandry asked about planned tier 2 service.

Liz Price explained that tier 2 service would co-ordinate the emotional help and wellbeing referrals and to provide capacity to avoid tier 3 referrals.

Janet Rowse commented that the funding for this service was in place and the funding on behalf of the NHS and Council had been agreed to enable this to commence as from April 2011.

Councillor Sandry asked if there was a case that patients were not able to be accommodated in Swindon and instead moved to Oxford.

Paul Sheffield said that it was never the case so far although there was no guarantee that it would never happen in future.

Councillor Jackson said that it was very difficult to get mental health support quickly enough for a child. She asked about the referral process and who was involved in it.

Paul Sheffield replied that the usual practice was to have referrals from GP. He also said that referrals could also come from youth worker. Paul Sheffield commented that the service knew that there were a lot of young people who need help and that no child should wait more than 4 weeks to get help. Anything longer than 4 weeks would be a loss.

Councillor Sandry asked about the transitions of patients from the CAMHS to Avon and Wiltshire Mental Health Partnership (AWP).

Paul Sheffield replied that both services had been working on transition policy.

Councillor Willcox asked if the emergency callout for people who needed an immediate assistance.

Paul Sheffield replied that there were 2 emergency services set – one for the same day assistance and one for assistance within 5 days.

The Chairman asked what engagements schools, GPs and youth workers had with parents/carers of young children. He also asked what would happen if parents/carers would not co-operate.

Paul Sheffield said that there must be understanding that parents/carers would co-operate on this matter because nobody could enforce the treatment.

The Chairman asked what the CAMHS role was in the family support.

Paul Sheffield replied that the CAMHS did provide family support by working with the other agencies who were aware of their role in this.

Councillor Sandry asked about the performance measures and targets and whether those were, or would be, monitored by the Overview and Scrutiny Panel/s.

Liz Price responded that there was quite a long list of targets on this matter. Some information might be available from December and the service would discuss with the relevant O&S Chairs which info would be available to appropriate Panels.

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

33 PANEL FUTURE WORKPLAN

The Panel noted their future workplan with the following additions:

- 'Ketamine abuse amongst young people' – for January 2011
- 'Excessive number of older people dying in Bath and North East Somerset during winter months ' – January 2011

The meeting ended at 4.25 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Cllr Vic Pritchard, Cabinet Member for Adult Social Services & Housing
Key Issues Briefing Note

Overview and Scrutiny Panel – 9th November 2010

---

1. PUBLIC ISSUES

Comprehensive Spending Review

The coalition government have introduced a range of proposed changes and decisions that directly impact upon housing. The Comprehensive Spending Review has further expanded upon these changes. Whilst it is not practical to cover all the detail of the changes here, or more importantly their full impact, some of the key points to note include:

- Significant changes to housing benefit including: raising the age that single people are restricted to a single room rate from 25 years old to 35 years old; calculating the allowance on the 30th percentile market rent rather than mean rents; reducing the allowance by 10% for claimants on jobseekers allowance for more than one year.

- Changes to new social tenancies including fixed term reviews and increasing social rents to 80% or even 90% of market rents (calculated using housing benefit rates)

- Stopping Private Sector Renewal funding, reducing funding for social housing developed by 50% and Supporting People by 11.5%, though protecting funding for the mortgage rescue scheme, homelessness grant and disabled facilities grants.

- Introducing the New Homes Bonus scheme which provides 7 years council tax funding for each new property produced and as recently announced for “properties brought back into use”.

- Changes to the regulatory regime for social housing including the abolition of the Tenant Services Agency & a reduction in the scope and function of the Homes & community Agency.

The impact of these and other changes will now need to be further evaluated and responses determined.

2. PERFORMANCE

Temporary Accommodation for Homeless Households

September's briefing note highlighted that there had been a significant increase in the number of people presenting as homeless who, because of their personal circumstances, require the provision of temporary accommodation. It was reported that the Housing Services team had implemented a number of actions to mitigate against this increase.

The most recent data shows an improvement and a reversal of the previous trend. The numbers of households in temporary accommodation have now dropped from the high of 43 households, recorded on the 24th September, to the current figure of 34 households (5th November). Whilst this is encouraging it should be noted that demand for services remains high and the drop in temporary accommodation usage has primarily been achieved by moving households out of temporary accommodation and into permanent accommodation rather than actually reducing demand.

Care Quality Commission Annual Performance Assessment

Last week the Minister of State for Care Services announced that the Care Quality Commission (CQC) will no longer conduct an annual performance assessment of councils' commissioning of care under the existing framework.

This decision, announced at the National Children and Adult Services Conference, comes as the coalition Government reviews its approach to the regulation and assessment of local public services. This new approach will see a shift towards more sector-led assessment, with councils holding greater responsibility for driving improvement.

The discontinuation of the annual performance assessment will take place with immediate affect. Councils will not be required to collate or submit data against the *Our Health, Our Care, Our Say* outcomes framework for the 2010/11 assessment year.

The results of the 2009/10 CQC assessment will be released at the end of November.

NHS B&NES Key Issues Briefing Note

Overview and Scrutiny Panel – 9th November 2010

---

1. PUBLIC ISSUES

Transformation Projects
The change agenda currently facing the Partnership resulting from the Health White Paper is substantial. For clarity and to enable effective management the structural change programme has been broken down into four main work streams each with a project management lead and reporting arrangements. The work streams are as follows:

1. Transforming Community Services (TCS)
2. Transforming commissioning
3. Transforming Public Health
4. Implementing the Council's new statutory duties

- **Transforming Community Services**

Objective
To identify and establish new organisational model/s for integrated B&NES Community Heath & Social Care service in light of PCT closure & Department of Health directive to divest community services.

Scope
All front line services currently within B&NES CHSC & the commissioning of such on behalf of B&NES residents [circa £80m commissioning spend & 1,700 staff affected].

Current Status
This project is now well advanced, outline plans have been approved by the SHA, Commissioner Case for Change and Commissioning Intentions have been submitted to the Department of Health, engagement with staff and other stakeholders has taken place and decision making on the appropriate organisational form is timetabled for mid November.

- **Transforming Commissioning**

Objective
To transfer the current PCT commissioning function to:

NHS Commissioning Board (Specialist, Maternity, Primary Care)

B&NES Council (Public Health, Health Improvement, Sexual Health, Screening)

GP Commissioning Consortia (Hospital & Community health services)

To determine the future of the current integrated health, social care & housing commissioning capability in light of the above and the aspirations of GP Commissioners & Core Council. To put in place integrated or aligned commissioning arrangements that are affordable within given management cost allowance and fit with the Core Council concept / strategic direction.

Scope
Consistent with the scope of the current Commissioning Partnership for Adult Health, Social Care & Housing and Children's health commissioning. Business continuity of circa £280m PCT Commissioning Business & circa £53m Council Adult Social Care & Housing business.

Current status
This is a very complex work stream and is currently in the early stages of development. GPs in B&NES have formed themselves into a transitional body currently led by a group of 9

individuals: 2 practice managers & 7 GPs working across the 28 practices in B&NES. Conversations are underway across the South West in respect of local consortia establishing themselves in shadow form on a pathfinder basis and the best configuration for achieving this.

- **Transforming Public Health**

Objective
To respond to the legislative framework expected in Dec 10, to transfer public health capability and capacity from NHS B&NES to B&NES Council. To ensure that the LA is well placed to meet its new statutory duty re health improvement and to undertake Organisational Development to embed the principles of improving public health & well being across the wider Council & public sector partners business.

Scope
To be determined by the White Paper expected Dec 2010

Current Status
This work programme is in the very early stages and activity is on hold until the white paper on Public Health is published in December.

- **New Statutory Duties for Local Authorities**

Objective
To put in place the infrastructure and organisational development to ensure that B&NES council can effectively meet the new statutory requirements resulting from the Health White Paper / legislation.

Scope
Establishing statutory Partnership Board in line with legislation (due Dec 2010). To ensure ongoing capacity & capability to create JSNA to inform local partnership planning. Establishing capability & capacity to take on population based strategic oversight of health service planning. Establishing overview & scrutiny arrangements within the new Partnership Board. Putting in place arrangements for commissioning local Health Watch.

Current status
This work programme is in the early stages and will develop following the publication of legislation. The programme links to work already taking place on the Intelligence Project and the Strategic Commissioning Project within the Council.

Pharmacy needs assessment
NHS Bath and North East Somerset is required to undertake an assessment of local pharmacy services and make this available to the public. The Pharmaceutical Needs Assessment (PNA) presents a snap shot of community pharmacies and dispensing services in Bath and North East Somerset (B&NES), it is also an assessment of the health and social care needs of the people living within the boundaries of Bath and North East Somerset and how pharmaceutical services are meeting, or could meet these needs. The PNA states commissioning intentions and once finalised will be used to inform decisions regarding applications for new pharmacy premises or services. A draft PNA has been prepared and is now subject to public consultation. The consultation is being made available to stakeholders and the public through NHS B&NES website. Panel members are invited to contribute to the consultation.

Health and Social Care Award for 'Clinic on the move'
Each year the Health and Social Care Awards highlight and celebrate innovation and excellence across health and social care. A team from within the Partnership has been recognised for their achievements at this year's award. 'Clinic on the move' is a multi-agency partnership bringing sexual health services into the community, taking services from clinical settings into non-clinical environments. This is enabling accessible contraception, counselling and support to be delivered to young people in their own environment. Evidence shows that

early access to contraceptive services is the most important factor in reducing teenage conception rates. The success of the project has been put down to the multi-agency collaboration from a wide range of groups including youth clubs, the young people's drugs and alcohol awareness group Project 28, the youth offending team, teenage parenting groups and schools. The team were presented with their award at the regional ceremony held in Yeovil.

2. PERFORMANCE

Stroke Every 2 years stroke services are subject to a Sentinel Audit undertaken by the royal college of physicians which audits against the national clinical guidelines. This has now taken place with the RUH performing well placing them in the upper quartile nationally. The audit covered both inpatient services and community services in both B&NES and Wiltshire. RUH met all 7 criteria for acute stroke management a position reached by only 37% of trusts nationally. Further improvements in areas such as communication, linkages with other professionals and aspects of team working were identified. These findings have been reviewed by the Bath Health Community Stroke Network in and an action plan established in response.

Health Checks
The national programme of free NHS Health Checks aims to identify people at risk of vascular disease given that it is the biggest cause of death in the UK. Locally the programme is being rolled out in a phased way with seven practices from across the geographical area of Bath and North East Somerset involved in the first phase. All of the practices have identified eligible patients (those aged 50, 55 and 60 who are not on a disease register). The practices write to patients and invite them in for a 20-30 minute appointment with the practice nurse. A range of simple health checks are performed including an instant cholesterol check which enables patients to get their results during the consultation. Practices are already identifying people with high BP and cholesterol and are bringing them back for further investigations. Those patients who have not attended will receive a reminder letter in due course and practices are looking to run evening and Saturday morning clinics to encourage up take. The general feedback is very positive particularly from patients. The aim is to roll the programme out to all practices in 2011/12.

Hospital waiting times and winter planning
In line with Department of Health guidance and in preparation for winter the winter plan for 2010/2011 has been developed jointly with providers in the Bath Health Community. The plan seeks to prepare health and social services across the community for a co-ordinated response to increased service demands over the winter. We are better prepared this year than ever before, specifically the following are in place to help ensure that we provide effective care:

- GPs working at the front door of A&E out of hours
- Hospital beds freed up as people go home more quickly because of effective community services
- Integrated infection control to manage the impact of things such as flu epidemic or outbreaks of seasonal D&V in the community
- Discharge planned early and managed effectively
- Escalation planning in response to critical demand\so that beds can be opened if we need them.

3. OTHER ITEMS

Older people's strategy

The draft older peoples strategy was previously circulated to O&S members for information and to provide opportunity to comment wit the expectation that the strategy would be taken to November partnership Board for approval. A recent assessment by a visiting team from the Department for Works and Pensions in collaboration with the Older Peoples Strategic Partnership Group has complimented the draft document and also made some observations on improvements. These are currently being incorporated. The strategy will now be amended and submitted to the partnership board in February. This provides an extended opportunity for O&S members to comment on the document.

GP led health centre

A briefing was circulated to members during October reporting changes to the Out Of Hours GP service being relocated at the RUH emergency department and an alteration to the management of registered patients. These proposals were developed through the urgent care group and incorporated stakeholder engagement. As indicated in the briefing the proposals went to the PCT Board on October 14th. for consideration. The Board approved the proposals.

Bath & North East Somerset Council

Medium Term Service & Resource Plans (MTS&RP)

Janet Rowse
Strategic Director
Adult Social Services & Housing
(Acting)

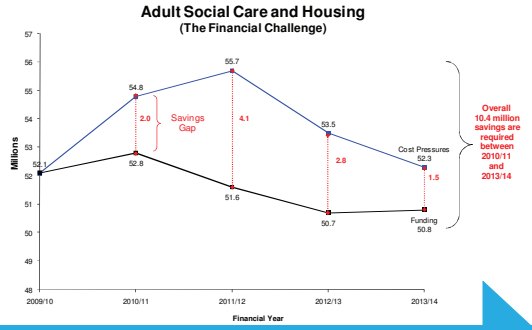
Bath & North East Somerset Council

MTS&RP Savings Proposals 2011/12
Adult Social Care & Housing

Background – Budget Savings Targets

	2011/12	2012/13	2013/14
Gross Budget	£85.5m	£84.7m	£84.8m
Net Budget	£51.6m	£50.7m	£50.8m
Savings Requirement (Base)	£4.090m	£2.802m	£1.413m
Savings Requirement (Stretched)	£3.102m	£3.102m	

Bath & North East Somerset Council



Bath & North East Somerset Council

Summary Proposals 2011/12

Productivity & efficiency
»Lean review of social care
»Re-negotiation placements & packages
»Supporting People contracts re-negotiated
»Streamline commissioning of 3rd Sector

Service Redesign
»LD Day Care – supporting employment
»Community based alternatives to institutional care

Bath & North East Somerset Council

Summary Proposals 2011/12

Changing the offer

- » Full implementation Fairer Contributions (Charging)
- » Provision of care for private clients (income generation)
- » Removal of subsidy from community meals
- » Reduction in employment development schemes for LD & MH clients
- » Reduced capacity in housing & tenancy support (longer waiting times)

Bath & North East Somerset Council

Adult Social Care & Housing
MTSRP Savings Proposals 2011/12 - Risks

- » Less prevention / early intervention could result in increased demand for social care services
- » Longer waits for housing & tenancy support increases risk of crisis solutions being required
- » Reduced income to in-house provider relating to removal meal subsidy
- » Increased safeguarding vigilance required as unit cost / placement reduces
- » Skills gap re reducing placement spend combined with reduced management capacity
- » Reliance on Lean review delivering 50% of staffing reduction

This page is intentionally left blank

Bath and North East Somerset

Local Involvement Network

Report to B&NES Healthier Communities and Older People Overview & Scrutiny Panel, 18 January 2011

1. LINk's Relationship with Care Quality Commission

In anticipation of the strengthened role of public involvement proposed in the Health White Paper, the LINk has held discussions with the Care Quality Commission, and is planning regular future meetings with them over the next year as the arrangements for Local HealthWatch are developed. In line with the White Paper proposals, the CQC and the LINk are seeing this as a key relationship for the future.

2. Urgent Care Review

The LINk continues to be involved in the Urgent Care Redesign Group. At the last meeting, the Group accepted the need for the changes for the Riverside Walk-In Health Centre. The changes being proposed by the Group to the PCT Board are:

- The removal of some non-urgent services;
- Changing opening-hours to avoid duplication of cover with Out-of-Hours services;
- Reorganising the Walk-in-Centre to provide a true "walk-in and wait" service, without a need for prior appointments.

We also commented on a questionnaire designed to be given to patients who have been transferred from A&E to the B&NES Emergency Medical Service (BEMS) as part of the out-of-hours pilot.

3. Pharmacy Services Review

All PCTs are required to produce Pharmaceutical Needs Assessments for their populations, describing the current provision and identifying any future needs in the area. As a part of this, they must consult with appropriate local organisations and stakeholders. The LINk made the following comments as a response to this consultation:

(i) Public Awareness and Accessibility

- Community Pharmacists are highly skilled, and represent an under-utilised resource. Greater public awareness of this resource is essential, and the public should be encouraged to view these professionals as a part of the overall primary

care teams. Change is needed to the public's reluctance to question and challenge primary care professionals, so that patients can fully understand the treatment they are receiving. We think that there should be concerted publicity for this.

- Consultation Rooms must be available wherever local premises arrangements make this possible.
- Shop premises and consultation rooms should be fully accessible for the disabled and for wheelchair-users wherever local circumstances allow, although we recognise that there are difficulties in full DDA compliance in some older premises.

(ii) Availability of Services and Opening Hours

- Much more attention is needed to public knowledge of Pharmacy opening-hours. Each Pharmacy should clearly display its opening-hours in its window, and this should also show the location of the nearest dispensing point when it is itself closed (or at least show where this information can be obtained at any time of day or night).
- GP surgeries should also show information on local pharmacy locations and opening-hours. Out-of hours GP services, including Locum doctors, should always give patients information on how urgent medication can be obtained at any time.
- Careful consideration should be given to the overall availability of Pharmacy services, including throughout weekends. Patients' needs do not confine themselves to normal business hours, and, sometimes, people will be in great need of pain relief or other medication, for example on Sundays. We feel that in these days of 24-hour bank services, shopping facilities, etc, a critical service such as the supply of urgent medication should be available in the same way. There is little point in having 24-hour emergency GP services, if prescribed medication cannot also be obtained.
- Delivery Services – the LINk appreciates that delivery services for prescribed medication are currently operated on a "good-will" basis by retail pharmacies, and that this provision is a commercial consideration for them. However, PCTs now have the power to commission additional services such as these, and NHS B&NES should consider expanding the current provision of such services to the public on a commissioned basis.

(iii) Geographical Considerations

- The fact that some people do not have access to cars should be an important decision in deciding the geographical distribution of pharmacy outlets. Public transport can also be poor or non-existent in rural areas. Some people are exempt from prescription charges on income grounds, and for them, even if they do have cars, or access to public transport, the costs of travel to collect medication can be prohibitive. These problems could be addressed jointly with the issue of the availability of delivery services already noted.
- For many of our members, and particularly for less mobile people, the availability of car-parking close to Pharmacies is an important consideration.

(iv) Medicine User Reviews

- Many people do not know about these, and we feel that they should be prominently publicised in Pharmacies. We assume that there is coordination between Pharmacists and GP Practices in the review of medication.

(v) Information Technology

- Are Pharmacists' electronically linked to GP Practice records?

4. Head & Neck Services Review

Joan Bayliss of the Bristol LINk has been representing all local LINks on the Independent Panel of the Head & Neck Services Review. The B&NES LINk considered the recommendations of the Review at its November meeting, and expressed its support for the proposal of a "hub and spoke" model of service, with UH Bristol as the hub. This will be considered by the HOSP later in the meeting, and Joan will be present.

5. Excess Winter Mortality in Bath & North East Somerset

The LINk continues to engage with the PCT's Public Health Department in the effort to explain the uniquely high rates of unexpected winter deaths in Bath & North East Somerset. We met with Professor Philip Milner on 3 December, and made some suggestions on further lines of enquiry. We hope to continue our involvement in this important piece of work.

Diana Hall Hall
Chair, B&NES Local Involvement Network
23 December 2010

This page is intentionally left blank

Bath & North East Somerset Council		
MEETING:	Healthier Communities & Older People Overview & Scrutiny Panel	
MEETING DATE:	18 January 2011	**AGENDA ITEM NUMBER**
TITLE:	Service Action Plan	
WARD:	ALL	
AN OPEN PUBLIC ITEM		

List of attachments to this report:

- Service Action Plan 2011-2012 Adult Social Care & Housing
- Appendix 1: Community Health & Social Care Services Workforce Planning Strategy
- Appendix 2: Equalities Impact Assessment – Medium Term Service & resource Plan 2011/12-2013/14, Adult Social Care & Housing

1 THE ISSUE

1.1 The Service Action Plan to support the Adult Social Care & Housing Medium Term Service & Resource Plan are presented for consideration by the Panel:

- to enable issues to be highlighted for consideration by Cabinet in February as part of the annual budget setting process.

- to enable issues to be referred to the relevant portfolio holder in advance of Cabinet's consideration of the overall budget.

1.2 It should be noted that there is a special meeting of the Corporate Performance & Resources Overview & Scrutiny Panel on 31st January, at which time it is intended to take an overview of all of the comments that have been submitted by each of the Overview & Scrutiny Panels. This will be the final opportunity for the CPR Overview and Scrutiny Panel to highlight issues and options for Cabinet.

1.3 At all times it is crucial to apply financial rigour to the Service and Resource Planning process. This means that where Panels identify aspirations to increase activity or expenditure they need to be clear about how such a change will be resourced and, in particular, to identify compensating savings or sources of finance.

1.4 At the November meeting consideration was given to the medium term plan for Adult Social Care & Housing which sets out:

(1) The financial challenge over the next 3 years

(2) The strategic context for service planning

(3) The implications of the Change Programme which is encapsulated in the Future Council report considered by Council in November

1.5 Common issues for all service action plans are:

(1) Equalities and workforce impact of reducing service budgets

(2) Need for clear prioritisation especially where specific external funding (grant) is being lost

(3) Impact of new Government legislation, and planned legislation, such as changes affecting schools (Academies) and Health & Social Care (changes to commissioning with greater role for GP's, public health, and arms length delivery arrangements)

1.6 The financial settlement has now been received in draft, although the Council will be submitting a response, and the headline number is a 13.5% reduction in Government Formula Grant. The numbers are complicated by the inclusion of several specific grants in formula grant, but not all. It is not yet entirely clear which grants are included, which are being separately announced, and which have stopped. Cabinet will be considering this in detail. The headline reduction in Government Grant (about a third of the Council's non-schools funding) is between 15% and 20% and the number should become clear during January.

1.7 A specific grant to compensate for 'freezing' Council Tax has been confirmed. This will cover the cost for 2011/12 for the duration of the settlement – 2 years – and possibly longer.

1.8 The Financial plans allowed for most of the implications of the settlement although up to £2M of funding will be affected by specific grants disappearing especially affecting Children's Services but it now appears not affecting Drug Action in Adult Services.

1.9 Medium Term plans will need to be revisited in the light of the settlement to see what adjustment to year 2 (2012/13) figures are needed. The annual budget report will refer to this and the need for Service Prioritisation in addition to further efficiencies to accommodate the effect.

1.10 The Future Council report referred to £30M of ongoing savings being required by year 4 (2014/15) with approximately 300 job losses. These figures remain broadly right but are now possibly understated. The uncertainty about some specific grants and the fact that the Government settlement is only for 2 years (not 4 as had been indicated) means there is a high level of uncertainty about these numbers. This is compounded by the effect of the review of Local Government Finance which will affect 2013/14 onwards including the potentially positive impact of the return of (some) business rates to local control (and local finances, Council finances).

2 RECOMMENDATION

The Healthier Communities & Older People Overview & Scrutiny Panel is recommended to:

2.1 Comment on the Service Action Plans, taking into account the matters referred to above.

2.2 Identify any issues requiring further consideration at the special meeting of the CPR Overview and Scrutiny Panel in January and subsequently by Cabinet as part of the annual Service Action Planning and Budget process, in February.

2.3 Identify any issues arising from the draft Service Action Plans it wishes to refer to the relevant portfolio holder for further consideration in advance of the Cabinet meeting in February.

3 FINANCIAL IMPLICATIONS

3.1 The financial context for Service Planning was set out in the reports to the November meetings of Overview and Scrutiny Panels.

3.2 Further information about the Government settlement has been set out above.

3.3 The financial implication of each service action plan are set out within each of the plans and achieve the financial targets discussed in November - that equates to about an 8% reduction in gross costs having absorbed growth such as contract and pay inflation – which means that real reduction significantly exceed 10%.

4 THE REPORT

4.1 This report forms part of the Service and Resource Planning process. The next steps include:

- Overview and Scrutiny review of other Service Action Plans - January meetings.
- CPR Overview & Scrutiny takes overview of O&S comments – 31st January 2011
- Cabinet recommendations to Council to enable budget setting - 3rd February 2011
- Council approval of budget - 15th February 2011

4.2 There is a reserve date for Council to reconsider the budget if there are any major amendments which cannot be dealt with on 15th February. The reserve date is 24th February.

4.3 At its meeting in February the Cabinet will consider:

- The draft annual budget report so that recommendations can be made to Council
- There will be no revision of the Corporate Plan this year as it will be important to review priorities after the next local elections in May 2011.
- Medium Term Service & Resource Plans and Annual Service Action Plans will be important background documents

4.4 It is imperative at each stage to view the proposed budgets and Service Action Planning proposals in the context of the Council's priorities and the Sustainable Community Strategy.

4.5 These plans form part of the Council's Service Delivery Programme which is part of its performance framework. The Comprehensive Area Assessment external (audit) review no longer continues, and neither does the Use of Resources assessment. In addition the Audit Commission is being abolished and a new simplified national performance monitoring regime and benchmarking framework is being discussed. At this stage no agreement has been reached about what the new requirements for Local Government will look like. Nevertheless the format of these plans reflects best practice and should work well in the new context.

4.6 Each Service Action Plan contains commitments for the year ahead. Those commitments support the Medium Term Plans which cover the next 3 years, but also refer to the following 7.

4.7 Service Action Plans and Medium Term Service & Resource Plans will be ratified by the February meeting of Council but will not be presented to the meeting of Council. They will be a relevant background paper. With that in mind it is timely for Overview and Scrutiny Panels to consider matters that need highlighting and to raise such matters with portfolio holders in advance of the February Cabinet meeting.

4.8 Issues highlighted by Overview & Scrutiny Panels will be collated and summarised for the CPR Overview and Scrutiny Panel meeting in January. This information will also be included with the papers presented to both Cabinet and Council when the budget is considered.

5 RISK MANAGEMENT

5.1 A risk assessment of the Council's budgets and reserves will be contained in the final budget papers to be presented to Cabinet and Council in February.

6 EQUALITIES

6.1 Service Action Plans contain relevant references to equalities. A consideration for this Panel is whether those Service Action Plans contain the right actions to help the Council consistent with its new status (for equalities issues) as an "achieving Council". The impact of cuts in budgets on staff and customers is pertinent. Service Action Plans contain relevant references to equalities. An Equalities Impact Assessment of the Adult Social Care & Housing MTSRP 2011/12-2013/14 is attached at Appendix 2.

7 CONSULTATION

7.1 The corporate implications of this report have been considered by Strategic Directors Group (SDG), including the Section 151 Finance Officer; Chief Executive and Monitoring Officer.

7.2 Further consultation has previously taken place as part of the Corporate Plan and Sustainable Community Strategy process. A budget fair was run in October and the feedback was reflected in medium term plans.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 All the following issues are relevant to Service Action Planning: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate Plan; Health & Safety; Impact on Staff; the Legal Considerations.*

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Strategic Director - Resources and Support Services) have had the opportunity to input to this report.

Contact person	Jane Shayler, Tel 01225 396120
Background papers	*Draft Medium Term Service & Resource Plan 2011/12-2013/14 Adult Social Care & Housing*, Healthier Communities & Older People Overview & Scrutiny Panel, 9th November 2010.
Please contact the report author if you need to access this report in an alternative format	

This page is intentionally left blank

Service Action Plan 2011-2012

Service Name	**Adult Social Care & Housing**
Lead Portfolio Holder	**Councillor Vic Pritchard**
Staffing Establishment	
Year	**2011-2012**

Key Objectives of Service :

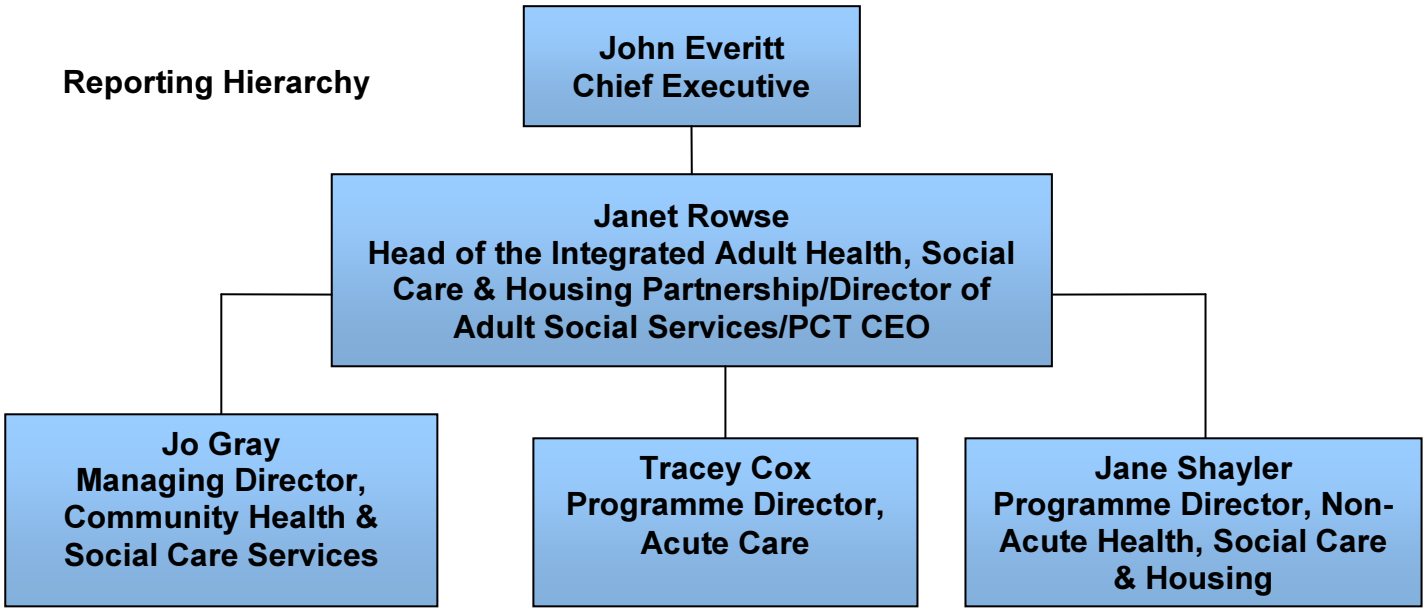
The Health & Wellbeing Partnership has nine long-term strategic goals:

1. **Improving Health and Keeping Well**
2. **Developing independence and choice**
3. **Improving access to services**
4. **Improving quality and safety**
5. **Improving effectiveness and value for money**
6. **Being better informed**
7. **Reducing inequalities and social exclusion**
8. **Improving services to vulnerable people**
9. **Effective organisations**

Our programme for transforming community health & social care focuses particularly on working towards these goals in nine service areas:

1. **Staying Healthy**
2. **Maternity & Newborn Care**
3. **Children & Young People**
4. **Long Term Conditions**
5. **Acute (urgent) care**
6. **Planned care**
7. **Mental Health**
8. **Learning Disabilities**
9. **End of Life Care**

Reporting Hierarchy



SERVICE ACTION PLAN FINANCIAL ITEMS:

Summary from Medium Term Service & Resource Plan			
MTS&RP Items	**2011/12 £'000**	**2012/13 £'000**	**2013/14 £'000**
Base Budget	**52,783**	**51,573**	**50,624**
Service Proposed Reductions to Balance Budgets*	**(3,228)**	**(2,802)**	**(1,413)**
Service Proposed Growth	**2,018**	**1,853**	**1,569**
Proposed Budget	**51,573**	**50,624**	**50,780**
Sources: Corporate Net Cash Limit	**51,573**	**50,624**	**50,780**
Deficit / (Surplus)	**0**	**0**	**0**

Please also see the Service Action Plan Financial Summary in Annex A.

Service Priorities – High level action plan

The overall service strategy for Adult Health, Social Care & Housing, under the umbrella of the Health & Wellbeing Partnership, is to sustain greater numbers of people in community settings by:

- Improving information, advice, guidance and advocacy so that people know about all the options available to them and are able to make informed choices;
- Supporting and promoting access to universally available services, including leisure, culture and learning opportunities;
- Supporting the development of sustainable, connected communities;
- Promoting early identification and diagnosis of conditions like dementia to enable early intervention, including support to carers;
- Encouraging approaches that delay or prevent an escalation of individual needs, including: supporting people into employment or other forms of meaningful occupation; a range of supported and extra-care housing; community equipment, assistive technology and adaptations that enable people to remain in their own home; and support to carers;
- Developing services that evidence tells us encourage a shift to the lowest appropriate level of intervention/support, including services focused on re-ablement, rehabilitation and recovery;
- Improving access to mainstream services whilst also ensuring that people who really need to access specialist services are able to do so; and
- Ensuring that an individual or family in crisis is able to get help quickly.

We anticipate that as we achieve a sustainable shift to a greater community focus there will be a slowing or even reversal of the flow of people to acute hospitals, secondary and specialist services, and nursing and residential care. This will be evidenced by a corresponding shift of resources, including a reduction in the number of residential and nursing care placements we are purchasing.

We are committed to this strategy because people have told us that it is what they want and because it is supported by evidence of what works and learning from best-practice. We know that we must deliver this strategy in an efficient and cost-effective way because we are facing considerable challenges over the next 5-years.

Headline Summary of Commitments for 2010/11

Key Corporate Deliverables	Top SERVICE commitments	Key impact(s) of achieving commitments
1. Sustainable Community Strategy Delivery Plan	Mitigate the impact of the loss of the Regional Housing Pot Grant which has been withdrawn with effect from April 2011. The grant has been used to provide essential repairs and improvements to the homes of low-income, elderly & otherwise vulnerable residents to enable them to live independently and in relative comfort.	Whilst every effort will be made to mitigate the impact, it is the case that there will be reduced level of service with fewer residents will be able to access financial assistance to help with essential repairs, home security measures, energy efficiency improvements, community care alarms and minor fire precaution improvements.
2. Change Programme	Vanguard-facilitated lean systems thinking review of the social care system.	• Improved service-user experience • Streamlined, efficient processes, cutting out wasteful activity and duplication • Reduced costs
3. Medium-Term Financial Plan	Reduction in spend on residential and nursing care placement costs – all service user groups	• Consistency and equity in level of service in relation to need across all client groups • Consistency in fee levels between providers • Fee levels and overall spend in line with benchmark
	Reduction in spend on residential and nursing care placements for adults with learning difficulties through re-commissioning and extension of community based options	• There will be an increase in the number of people living in settled accommodation and reduction in number of people living in registered care • People will be supported to use personal budgets to purchase a wider range of short break and day services. • There will be an overall reduction in the total number of hours of support that are purchased

Key Corporate Deliverables	Top SERVICE commitments	Key impact(s) of achieving commitments
Medium Term Financial Plan Continued	Improved access to mainstream services/reduction in specialist services for adults with learning difficulties	• The existing (mainstream) joint community teams within the provider arm and the procedures they use will be applied to a number of adults with learning disabilities. • The care management responsibilities for adults with learning difficulties will be accepted by the joint community teams • A greater number of adults with LD will receive services from adult social care and the joint community teams rather than from a specialist LD service
	Reduction in number of residential/nursing care placements for older people by sustaining older people in their own homes through the development of early intervention and preventative services	• Reduction in number of older people admitted to residential or nursing care • Increased proportion of older people sustaining their independence • Possible reduction in DToC (Delayed Transfer of Care)
	Reduction in number of residential/nursing care placements for older people through the development of new extra care housing	• Increase in community-based housing options for older people • Reduction in number of older people admitted to residential and nursing care • More older people supported to live independently
	Reduction in number of residential/nursing care placements for people with mental health needs by improving the care pathway	• Service users will be able to access intensive support over 6-8 week period to prevent admission to hospital and to stabilise an early discharge from hospital. • People will remain in their own homes with support packages that are tailored to their needs (personalised services). • Increased numbers of people enabled to be part of peer led and community based, recovery orientated activities and support. • Improved care pathway with greater focus on working towards independence

Key Corporate Deliverables	Top SERVICE commitments	Key impact(s) of achieving commitments
Medium Term Financial Plan Continued	Learning Difficulties service – reconfiguration of management and day services	• Day services to develop closer links with the Employment Inclusion service with a focus on supporting people to move onto employment. • Fewer people with learning difficulties will access day services, but there will be stronger individual pathways and support plans. • Day services will limit access to adults of working age with older adults supported to access with alternative options using their personal budgets. • Services will be configured on a locality basis with stronger links to the joint community teams
	Community resource Centres – increased productivity/ expanding the service offer	• People living in the vicinity of a CRC will be able to access support from CRC staff to continue to live in their own homes • The CRCs will have increased capacity to provide dementia care
	Reduction in commissioning of services from third/ voluntary sector organisations – seeking efficiencies/reduction in duplication and prioritisation of funding for services that are consistent with strategy	• Plans are already well progressed to achieve the target for 2011/12. • Delivery of the savings target will be achieved mainly through efficiencies without impact on service provision
	Community Learning – funding reduced to grant level	• Reduction in funding will impact specifically on the Community Development Workers, reducing the capacity of the Council for this area of work
	Employment and Training – funding reduced to closer to grant level	• Fewer job coaching hours available, less resource for specific projects
4. Equalities	Ensure allocation of resources at an individual level is equitable and consistent between service user groups – particularly in relation to the range of services funded through a Personal Budget	• Living within our means • Equitable distribution of available resources

Workforce Planning

During these times of public sector reduction and service redesign it is very important that we can develop a workforce of the correct size and with the correct skills to provide the service our citizens require.

The Community Health & Social Care Workforce Plan is attached as Appendix 1

Key Commitments for the year ahead to:

1. Deliver the second year of the Sustainable Community Strategy 3 year delivery plan (2009-2012)

Key Commitment	Mitigate the impact of the loss of the Regional Housing Pot Grant which has been withdrawn with effect from April 2011. The capital grant is usually around £575,000 p.a. However, following a successful additional bid we received £689,000 for 2010/11. The grant has been used to provide essential repairs and improvements to the homes of low-income, elderly & otherwise vulnerable residents to enable them to live independently and in relative comfort.
Impact (What will be different as a result)	Whilst every effort will be made to mitigate the impact, it is the case that there will be reduced level of service with fewer residents will be able to access financial assistance to help with essential repairs, home security measures, energy efficiency improvements, community care alarms and minor fire precaution improvements. In addition, it will no longer be possible to use a proportion of this to "top up" the mandatory Disabled Facilities Grant pot.
As measured by	In 2009/10 Housing Services assisted over 500 households through the above measures. Whilst it is currently unclear how many households we will be able to assist in the future it will be significantly less and also to a lower level of assistance.
Specific Targets developed	• Reducing 2011/12 "Housing Renewal" Policy expenditure from the non-bid level of £575,000 p.a. to an estimated £60,000 - £70,000 p.a. • Provide in-house recurring financial income/savings of £45,000 p.a.

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Adopting full cost recovery for issuing mandatory HMO licenses. This is expected to generate an additional £25,000 p.a. averaged over 5 years.	1 April 2011	
2	Revenue savings through a further reduction in capacity partially mitigated through moving to a more strategic and commissioning model for service provision. Expected to release an additional £20,000 p.a.	1 April 2011	
3	Reviewing Housing Renewal Policy in light of reduced funding and emerging national evidence on independent living strategies.	1 April 2011 (Interim position)	

	What	By When	Who
4	Utilising the Wessex Loan pot that has been established to fund loans to residents to fund all financial elements for the loans scheme, that is, up front capital cost, interest subsidy and Wessex loan administration fess. This will effectively end the self supporting nature of this scheme and as such can only be used in the short-medium term, possibly 1-2 years.	1 April 2011	
5	Identify further funding options to close the funding gap between the new reduced Housing Renewal Policy (item 3) and the additional funding identified in items 1 & 2.	1 April 2011	

2. Change Programme

- Work stream specific activity
- Directorate level change programme
- Diagnostic business cases

Key Commitment	**Vanguard-facilitated lean systems thinking review of the social care system**.
Impact (What will be different as a result)	• Improved service-user experience • Streamlined, efficient processes, cutting out wasteful activity and duplication • Reduced costs
As measured by	• Reduction in process-related activity, including length and number of assessment forms • Service user feedback
Specific Targets developed	• Achievement of target saving of £600,000 in the period April 2011-March 2013

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Increase capacity and use of re-ablement service	March 2011	Stella Doble
2	Increase skills, capability and capacity at point of referral to address service user needs	March 2011	Stella Doble
3	Review of workforce skills and capacity and reduction in staff in line with reconfigured service	December 2011	Stella Doble

3. Mid Term Financial Plan – actions required in services to achieve targets (year 1 actions for year 2 budget)

Key Commitment	**Reduction in spend on residential and nursing care placement costs – all service user groups**
Impact (What will be different as a result)	• Consistency and equity in level of service in relation to need across all client groups • Consistency in fee levels between providers • Fee levels and overall spend in line with benchmark
As measured by	• Comparison of fee structures between providers and, particularly overhead and profit margin as proportion of overall fee • Benchmark spend
Specific Targets developed	• Achievement of target saving of £415,000 in the period April 2011-March 2012

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Implementation of single funding panel for all client groups	April 2011	Sarah Shatwell
2	Negotiation of efficiency and/or productivity targets with each provider	March 2011	Associate Directors
3	Training for all staff arranging individual placements	March 2011	Natalie Reilly

Key Commitment	Reduction in spend on residential and nursing care placements for adults with learning difficulties through re-commissioning and extension of community based options
Impact (What will be different as a result)	• There will be an increase in the number of people living in settled accommodation and reduction in number of people living in registered care • People will be supported to use personal budgets to purchase a wider range of short break and day services. • There will be an overall reduction in the total number of hours of support that are purchased

As measured by	• Number of adults in registered care and nursing home placements

	• Increase in number of adults in settled accommodation • Number of people using personal budgets • Total number of hours of support purchased in registered care/nursing care
Specific Targets developed	• 10% increase in adults in settled accommodation against 09/10 baseline • 10% of short breaks to be purchased using DP personal budget • 10% of day services to be purchased using DP personal budget • 5 people in high cost placements to move to their own homes • 30% in crease in contact time for people with complex needs from 09/10 baseline

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Complete reprovision of Maple Grove to supported living	May 2011	Mike MacCallam
2	Complete deregistration of River Street (Dimensions) to supported living	May 2011	Mike MacCallam
3	Complete deregistration of The Avenue (Keynsham Mencap) to supported living	Oct 2011	Mike MacCallam
4	Implementation of revised service specification for short break service at Tanners Walk (Dimensions)	May 2011	Mike MacCallam

Key Commitment	Improved access to mainstream services/reduction in specialist services for adults with learning difficulties
Impact (What will be different as a result)	• The existing (mainstream) joint community teams within the provider arm and the procedures they use will be applied to a number of adults with learning disabilities. • The care management responsibilities for adults with learning difficulties will be accepted by the joint community teams • A greater number of adults with LD will receive services from adult social care and the joint community teams rather than from a specialist LD service

As measured by	• Number of people referred and assessed through single point of access

	• Number of people referred and accepted by specialist community learning difficulties service
Specific Targets developed	• 100% of adults with LD to be referred through the single point of access by June 2011 • 10% of adults with LD newly assessed as eligible for services to be supported by joint community team rather than CLDT by March 2012

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Implement revised specification for joint community teams and the learning difficulties service	June 2011	Mike MacCallam
2	All referrals for learning disabilities services to go though access team	From April 2011	Jenny Theed

Key Commitment	Reduction in number of residential/nursing care placements for older people by sustaining older people in their own homes through the development of early intervention and preventative services
Impact (What will be different as a result)	• Reduction in number of older people admitted to residential or nursing care • Increased proportion of older people sustaining their independence • Possible reduction in DToC (Delayed Transfer of Care)
As measured by	C73 shows the rate per 10,000 of people age 65+ permanently admitted to residential or nursing care (Current average numbers per month is around 25 (CH&SC & AWP))
Specific Targets developed	Achievement of target saving of £150,000 from the purchasing budget in the period April 2011-March 2013

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	New performance target for C73 agreed with CH&SC and AWP	December 2010	Sarah Shatwell
2	Older Peoples' Independent Living Scheme is operational	January 2011	Sarah Shatwell
3	Re-ablement pilot to commence	January 2011	Sarah Shatwell/ Corinne Edwards

Key Commitment	Reduction in number of residential/nursing care placements for older people through the development of new extra care housing
Impact (What will be different as a result)	• Increase in community-based housing options for older people • Reduction in number of older people admitted to residential and nursing care • More older people supported to live independently
As measured by	No specific measure for extra care but should reflect in stabilised residential target C73
Specific Targets developed	Target is 7 new units per year to achieve saving

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Agreement with two sheltered housing providers to allow access to units of accommodation as they become vacant for the delivery of extra care in partnership with Community Health & Social Care	December 2010	Sarah Shatwell
2	Targets to increase availability of extra care housing agreed with providers	January 2011	Sarah Shatwell

Key Commitment	**Mental Health – improved care pathways**
Impact (What will be different as a result)	• Service users will be able to access intensive support over 6-8week period to prevent

	admission to hospital and to stabilise an early discharge from hospital. • People will remain in their own homes with support packages that are tailored to their needs (personalised services). • Increased numbers of people enabled to be part of peer led and community based, recovery orientated activities and support. • Improved care pathway with greater focus on working towards independence
As measured by	• More people with a serious mental health problem in employment. • More people with a serious mental health problem in settled accommodation • Reduction in costs of supported living provision • Numbers of clients accessing reablement services from Primary/community care and Specialist mental health services. • Achievement of facilitation of discharge targets within AWP through community intervention • Reduced length of stay in adults of working age in-patient unit • Increased number of meaningful day activities that are peer led or initiated with support.
Specific Targets developed	Continue local use of: NI 150 service users with a serious mental illness in employment – 20% N149 services users with a serious mental illness in settled accommodation – 92% Facilitation of discharge - 70% of in-patient admissions Length of stay – reduction by at least one day on 10-11 baseline

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Establishment of a mental health reablement service with pilot model for delivery as part of the community health and social care services to be operational from April 2011	April 2011	AM/CHSC
2	Alignment of floating support services alongside developing reablement model	April 2010	AM/CHSC
3	Specification and tendering of community facilitation activity for service start	End of Q1	SP&C team
4	Development of integrated pathway with specialist mental health provider	End of Q1	AM/RB/RS

Key Commitment	**Learning Difficulties service – reconfiguration of management and day services**
Impact (What will be different as a result)	• Day services to develop closer links with the Employment Inclusion service with a

	focus on supporting people to move onto employment. • Fewer people with learning difficulties will access day services, but there will be stronger individual pathways and support plans. • Day services will limit access to adults of working age with older adults supported to access with alternative options using their personal budgets. • Services will be configured on a locality basis with stronger links to the joint community teams
As measured by	• The number and age of adults using day services. • The number of people moving on from day services into employment • The number of adults referred, assessed, and supported by the joint community teams (as above) rather than by the specialist learning difficulties service.
Specific Targets developed	• 10% increase in number of adults in paid employment against 10/11 baseline • 10% reduction in number of users of day services against 10/11 baseline

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Identify cohort of users of day services who are working towards employment	May 2011	BHSCS
2	Produce strategy for supporting people into employment	July 2011	MM and BHSCS
3	Identify users of services who are aged 63 and over and complete person centred plans to identify future options	July 2011	MM and BHSCS

Key Commitment	**Community Resource Centres (CRC) – increased productivity/ expanding the service offer**
Impact (What will be different as a result)	• People living in the vicinity of a CRC will be able to access support from CRC staff to continue to live in their own homes • The CRCs will have increased capacity to provide dementia care
As measured by	• Increase in the number of people supported on an outreach basis by the CRCs • Increase in the proportion of people with dementia provided with care in the CRCs
Specific Targets developed	• Number of additional outreach clients supported by each CRC • 80% of all CRC residents to be dementia care by March 31st 2012

Community Resource Centres (CRC) – increased productivity/ expanding the service offer
Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Agreement of 2011/12 targets with CH&SCS	January 2011	Sarah Shatwell
2	Provision of any additional training of CRC staff to provide dementia care	March 2011 (& ongoing)	Julie Sharma

Key Commitment	**Reduction in commissioning of services from third/ voluntary sector organisations – seeking efficiencies/reduction in duplication and prioritisation of funding for services that are consistent with strategy**
Impact (What will be different as a result)	Plans are already well progressed to achieve the target for 2011/12. Delivery of the savings target will be achieved mainly through efficiencies without impact on service provision
As measured by	Total spend on Supporting People and Communities funded organisations with quality measures set out in the Quality Assessment Framework
Specific Targets developed	Achievement of target saving of £200,000 recurrently from Community Funding

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	All new contracts in place	March 2011	Sarah Shatwell

Key Commitment	**Community Learning – funding reduced to level of grant**
Impact (What will be different as a result)	Reduction in funding will impact specifically on the Community Development Workers, reducing the capacity of the Council for this area of work
As measured by	
Specific Targets developed	Achievement of target saving of £125,000 in 2011/12

Community Learning – funding reduced to level of grant
Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Informal and individual discussions with affected staff (Community Development Workers)	16/11/2010	Stella Doble
2	Formal notice to affected staff	December 2010	Jenny Staples
3	Explore redeployment options and support to staff through accessing Workout Solutions	March 2011	Stella Doble

Key Commitment	**Employment and Training – funding reduced to closer to grant level**
Impact (What will be different as a result)	Fewer job coaching hours available, less resource for specific projects
As measured by	• Number of adults with LD, physical and sensory impairments gaining paid employment • Reduction in users of day services
Specific Targets developed	• 5 adults with learning difficulties using day services to be supported to gain employment by March 2012. • Employment Inclusion service to support target of 20 people to gain paid employment by March 2012

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Referral process for eligibility for access to the Employment Inclusion service to be clarified	June 2011	BHSCS
2	Produce strategy for supporting people into employment	July 2011	MM and BHSCS

4. Equalities

Key Commitment	**Ensure allocation of resources at an individual level is equitable and consistent between service user groups – particularly in relation to the range of services funded through a Personal Budget**
Impact (What will be different as a result)	• Living within our means • Equitable distribution of available resources
As measured by	• Monitoring of Support Plans • Funding decisions through Single Panel Process
Specific Targets developed	

Significant milestones to be achieved over the next year to determine progress

	What	By When	Who
1	Analysis of activity and spend on Personal Budgets to track trends and understand causes of growth in activity/spend	December 2010	John Buist
2	Ensure clear guidance on and understanding of the range of services that can be funded through a PB and tight management control/assurance at key points in the process, including learning from lean systems review	January 2011	Jane Shayler/ Jo Gray
3	Implementation of Single Panel for funding decisions	April 2011	Sarah Shatwell
4	Review approach and arrangements in light of publication of Social Care legislation by the Law Commission in 2011 (date of publication yet to be confirmed)	April 2011?	Jane Shayler

ANNEX A - SERVICE ACTION PLAN SUMMARY

Service Action Plan Revenue Financial Items: Adult Social Care & Housing

1. Proposed reductions to balance budgets:

Description of Mitigation	11/12 Saving £'000s			12/13 Saving £'000s			13/14 Saving £'000s			Risk H/M/ L	Commentary	Impacts
	R	NR	Total	R	NR	Total	R	NR	Total			
Vanguard process	307		307	293		293				M	This Vanguard-facilitated review of the social care process is underway and although not complete confidence is high that the review will identify efficiencies, including streamlining of processes that will enable savings in staffing costs.	Will result in a reduction in staff, not possible to confirm numbers until review has been completed. There are likely to be redundancies associated with this reduction.
Learning Difficulties Services re-commissioning of placements	200		200	200		200	220		220	M	• Ongoing programme to extend range of community based housing options; • Deregistration of registered care homes and replacement with supported living where appropriate (cost of housing not social care funded) • Effective procurement delivering unit-cost savings.	Shifts some costs to central Government (Housing Benefit) This approach is consistent with Strategy.
Learning Difficulties – specialist services	100		100	100		100	100		100	L	• Completion of reconfiguration of LD services, which was commenced (with staff consultation on revised structure) in 2010. • Improve access to mainstream services, including health services in line with Valuing People Now.	Savings achieved through reduction in staffing numbers. Approach is consistent with Strategy. Could represent a reduction in service for some people.

Description of Mitigation	11/12 Saving £'000s			12/13 Saving £'000s			13/14 Saving £'000s			Risk H/M/L	Commentary	Impacts
	R	NR	Total	R	NR	Total	R	NR	Total			
Reduction in number of Older People placed in residential/ nursing care	150		150	80		80	80		80	H	Achieved by sustaining people in their own homes through early intervention and improving access to mainstream services, thus reducing the number of people admitted to residential and nursing care.	Consistent with overall OP Strategy. Enhancement of re-ablement services, including extended hours to be tested.
Mental Health Project costs	16		16							L	Saving from removal of increased management resource for the improvement to the accommodation elements to the mental health care pathway	Reduced management capacity to support development of new mental health supported living scheme(s)
Procurement savings	87		87							H	Target is 48k for non-placement commissioning budgets and 39k for delivery budgets	Not yet identified
Review of Disabled Facilities Grants assessment processes and DFG funding arrangements	25		25							L	• Agreement with Registered Social Landlords to fund greater proportion of DFGs for RSL tenants than is current the case.	• Financial impact for RSLs
Service savings on The Limes and Sunnyside	12		12							L	To fund the costs of capital attributable to the scheme	
Mental Health – improved care pathway	170		170	170		170	170		170	H	• Reconfiguration of mental health community support services on prevention, reablement and access to employment and mainstream housing. • Improved care pathway with greater focus on working towards independence	This approach is consistent with the overall MH Strategy.
Description of	**11/12 Saving**			**12/13 Saving**			**13/14 Saving**			**Risk**	**Commentary**	**Impacts**

Mitigation	£'000s			£'000s			£'000s			H/M/L		
	R	NR	Total	R	NR	Total	R	NR	Total			
OP Residential or Nursing Placement costs	115		115	58		58				H	Assumes move towards the regional average following benchmarking. 2010/11 performance to date suggests this is high risk but a short-term increase in procurement capacity/capability to support savings from placements is starting to impact positively.	
Physical Disabilities Residential or Nursing Placement costs	50		50	25		25				M	Assumes move towards the regional average following benchmarking. 2010/11. Recent increased activity increases the risk of delivery of this saving.	
Learning Difficulties Residential or Nursing Placement costs	150		150	75		75				M	Assumes move towards the regional average following benchmarking. 2010/11. Negotiations have delivered unit cost savings but this does continue to be a challenging saving to deliver.	
Mental Health Residential or Nursing Placement costs	100		100	50		50				H	Assumes move towards the regional average following benchmarking. 2010/11 performance to date suggests this is high risk but a short-term increase in procurement capacity/capability to support savings from placements is starting to impact positively.	
Residential care – in house	130		130							M	Increased efficiencies within the in-house staffing costs of the residential care services.	
Extra care – in-house service efficiencies	80		80							M		

Description of Mitigation	11/12 Saving £'000s			12/13 Saving £'000s			13/14 Saving £'000s			Risk H/M/L	Commentary	Impacts
	R	NR	Total	R	NR	Total	R	NR	Total			
Mental Health – Domiciliary care	60		60							H	Improved outcomes/ effectiveness from domiciliary care services through upskilling of workforce to meet needs of people with mental health needs, including older people with dementia.	
Mental Health – Direct payments	25		25							H	Implementation of a single panel process for agreeing resource allocation for all client groups is, in part, aimed at ensuring consistency and equity in the resource allocation for personal budgets. Benchmarking information suggests that current allocations to adults of working age with mental health needs are higher than average.	
Housing Savings	73		73	72		72				M	Reduction in staffing capacity.	Staff savings, may result in increased waiting times for some housing services and reduction in enforcement capacity.
LD reconfiguration	153		153							M	Completion of reconfiguration of LD services, which was commenced (with staff consultation on revised structure) in 2010.	Staff savings
Management costs – CH&SC	20		20							L	Part of staffing saving being delivered by Community Health & Social Care Services through reconfiguration.	Staff savings

Description of Mitigation	11/12 Saving £'000s			12/13 Saving £'000s			13/14 Saving £'000s			Risk H/M/L	Commentary	Impacts
	R	NR	Total	R	NR	Total		R	NR	Total		
Management costs - commissioning	130		130							M	Reduction achieved through restructuring across commissioning health, social care & housing. Deletion of vacant posts and ending of temporary contracts.	Staff savings
Interest on new pooling arrangements				75		75				H	Assumes c £40m new pooling arrangements and an interest rate of 0.75%.(Note: 2010/11 assumed 75k – not yet delivered.)	No service or staffing impacts
Roll-out of Revised Charging Policy	391		391	144		144				M	The revised charging policy has was consulted on and agreed to phased implementation starting September 2010.	It is anticipated that approximately 350 service users will be affected by changes to the charging policy. The revised Policy complies with guidance in *Fairer Contributions* and seeks to ensure that individual overall financial contributions to services received are fair and reasonable.
MH Service review	50		50	50		50				M		Staff reduction

Description of Mitigation	11/12 Saving £'000s	12/13 Saving £'000s	13/14 Saving £'000s	Risk H/M/L	Commentary	Impacts

	R	NR	Total	R	NR	Total	R	NR	Total			
Increase supply of Extra Care Housing for Older People	100		100	100		100				M	• Work with housing and care providers to adopt a new model of extra care housing provision, combining sheltered housing with domiciliary care provided by Strategic Partners • Need to ensure that this model of care is a real alternative to residential and nursing care as the saving comes from a reduction in the number of registered/ nursing care placements	This proposal is in line with the overall service strategy for older people.
Reduction in commissioning of services from the third/voluntary sector	200		200	100		100				H	Next phase implementation of a review of all commissioning from voluntary sector with a resultant reduction in contract values and, in some cases decommissioning of services that are not a priority when measured against strategic commissioning intentions	• Reduction in services currently freely available at the point of delivery • Likely to impact on providers, who would need to explore alternative sources of income/ funding • It is possible that this will result in closure of one or more existing provider(s) • Impact on people employed and/or volunteering in affected organisations

Description of Mitigation	**11/12 Saving £'000s**	**12/13 Saving £'000s**	**13/14 Saving £'000s**	**Risk H/M/ L**	**Commentary**	**Impacts**

	R	NR	Total	R	NR	Total	R	NR	Total			
Community Learning	125		125							L	Spending reduced to the level of specific grant funding.	Staffing reduction. Reduced level of service.
Employment and training schemes	83		83							L	Spending reduced to closer to the level of specific grant funding.	Service reduction will require different, more targeted approaches to supporting people to access employment

2. Proposed growth:

Description of Growth	11/12 Growth £'000s			12/13 Growth £'000s			13/14 Growth £'000s			Risk H/M/ L	Commentary	Actions to Mitigate
	R	NR	Total	R	NR	Total	R	NR	Total			
Inflation - pay	179		179	0		0	180		180	H	Assumes : pay inflation of 0% for 11/12 and 12/13 with 1% in 13/14. 2011/12 includes 1% uplift in employers NIC	
Inflation – placements	908		908	948		948	484		484	H	Non-pay inflation assumed of 2.3% across placements budgets	Work with providers to keep inflation on non-pay below RPI/CPI.
Inflation income	-40		-40	-42		-42	-42		-42	H	Increase on income recoveries anticipated in line with increased costs of placements	
Loss of interest on Learning Difficulties Health funds	12		12							H	The Council has agreed the transfer from the PCT of £3.15m in 10/11 in respect of a Vote Transfer on LD services. These funds will no longer come from health and so the LD pool will not receive the interest. Estimate based on 0.75% rate.	There remains further risk that not all the funds given up by health reach the local Council due to the application of the national funding formula.

Description of Growth	11/12 Growth £'000s			12/13 Growth £'000s			13/14 Growth £'000s			Risk H/M/L	Commentary	Actions to Mitigate
	R	NR	Total	R	NR	Total	R	NR	Total			
Social Care Reform Grant – end of funding										L	The end of this grant of £727k has been anticipated for some years and plans have been made accordingly during 2010/11 and so the baseline budget reflects this change.	Since this is a time limited grant to support implementation of social care transformation, plans already take account of end of grant in 2010/11
Supporting People Admin grant ending										L	This was announced in June 2010 and has been covered in 2010/11 on a recurring basis so the baseline budget reflects this change.	SP team reduced in size (vacant post deleted). Efficiency savings from programme to cover balancing amount.
Older People Demographic Growth including dementia	347		347	347		347	347		347	H	Where service users are eligible for social care services the council must fund their care. If this growth item is not included within the budget the budget will overspend	• Development of alternatives to residential & nursing care • Investment in preventative and early intervention services • Effective procurement of residential, nursing and domiciliary care services • Roll-out of revised Charging Policy • Refocusing of day services to support independence and access to employment • Support for Carers, including breaks services
Learning Difficulties	600			600		600	600		600	H		

Description of Growth	11/12 Growth £'000s			12/13 Growth £'000s			13/14 Growth £'000s			Risk H/M/ L	Commentary	Actions to Mitigate
	R	NR	Total	R	NR	Total	R	NR	Total			
Supported Housing for Social care – capital charges	12		12							H	Increase in capital charges associated with the Limes scheme – matched by service funded savings below	
Redundancy Costs										M	Estimated redundancy costs of £380k are based on assumed costs of 10 redundancies at a standard cost. It is currently assumed that these costs will be met from central Council reserves rather than by the Adult Social care and Housing Directorate.	Working estimate only. Every effort will be made to mitigate redundancies through delivery of staff reductions through staff turnover.

Workforce Planning Strategy

1. INTRODUCTION

Bath & North East Somerset Community Health and Social Care Services (CHSCS) was established in April 2008 as an arms length provider of Adult Community Health and Social Care Services and Healthcare Services for Children across Bath and North East Somerset. It is part of a wider Joint Working Agreement between NHS B&NES and Bath and North East Somerset Council known as the Health and Wellbeing Partnership. Over 90% of the income comes from our two main commissioners – NHS B&NES and B&NES Council.

A wide range of services are provided by Bath & North East Somerset Community Health and Social Care Services which include:

- Community health and social care services for adults and older people including community nursing, therapies, domiciliary services, community hospitals, community resource centres, outpatient services, specialist health and social care services in community settings
- Specialist mental health services including psychological therapies
- Community health and social care services for people with learning disabilities
- Community healthcare services for children including Health Visiting, specialist paediatric services, services for children with life limiting illnesses, therapy services and school nursing services.

A number of healthcare services are provided to areas wider than just Bath & North East Somerset. Most notably:

- Consultant Community Paediatrics, Child Health Administration services and Hearing Therapies are provided to two other areas (parts of Wiltshire and Somerset)
- Specialist Services for supporting seriously ill children at home are provided to five other areas (parts of Wiltshire and Somerset; Bristol, North Somerset and South Gloucestershire).

Our strategic thinking recognises that the future success of the organisation is dependant on having an empowered, involved and flexible workforce, focused on delivering high quality care.

This strategy is designed to set out the agenda for transforming our health and social care workforce across Bath & North East Somerset Community Health and Social Care Services. Transformation is needed to enable us to play our full role in delivering the vision of health and social care set out in the document *Transforming Community Health and Social Care in Bath and North East Somerset – Commissioning Intentions 2010/11 – 2014/15.*

Our intention is to set out the broad strategic directions which we will need to take in transforming our workforce leaving room for our staff to develop and lead detailed work to translate this plan into practical plans with sustainable change.

In developing the plan we have taken into account the nature and characteristics of B&NES both as a community and as a labour market. As a community, Bath and North East Somerset is a prospering area with health and social care indicators generally better than the average for England. However, there are areas of high deprivation and although life expectancy generally is good, there is a gap of nearly 9 years between the fifth most healthy and fifth least healthy wards across the area.

The areas ethnic make up is predominantly white with just over 92.7% of British/Irish descent (taken from the Joint Area Needs Assessment 2008).

Over the next 10 years the number of elderly people will rise significantly with those aged 85+ expected to double in number. Correspondingly, there is an anticipated drop in the proportion of people aged 50 – 64 who traditionally act as carers for older relatives.

Outcomes for children are generally good with above average educational attainment at GCSE level. However, there is a higher than expected level of obesity in children and 13% of children live in low income households.

Amongst the older population the number of hip fractures resulting from falls, is higher than the national average and levels of dementia and demand for mental health services for older people are rising as the population ages.

There is a small but nonetheless significant homeless population in Bath and North East Somerset and a high level of people who misuse drugs.

A higher proportion of people receive services in hospital than generally in England and lengths of stay once in hospital remain higher than the average. There are also a higher than average number of people admitted to long term institutional nursing and residential care although the age at which they are admitted tends to be higher than elsewhere in England.

Unemployment rates are low at 1.9% (compared to 3.8% national average). There is increased competition for staff between public sector employers, coupled with independent health providers within the locality of BANES along with the hospitality, tourism industry and retail. There are also high levels of self employment in the area. Turnover of health staff is 9% and for the Council it is 4% and with the economic downturn a drop in staff turnover is anticipated.

Both the NHS and the Local Authority are regarded as good employers with good terms and conditions and excellent holiday and pension provision but with some of the local and national shortages of nurses, social workers, community support staff and occupational therapists success in recruitment can sometimes be variable. The local environment is also a good pull factor for many who want to work in the area, this again supports recruitment and retention. As with many NHS organisations we do attract

overseas staff wanting to come to the UK to add to their experience and enjoy the UK standards of living.

We are continuing to offer training placements for Social Workers, Occupational Therapists, Physiotherapists, Nurses and Specialist Community Public Health Nurses. This not only helps us support the professions, it is a good source of recruitment once staff qualify.

70% of jobs in the BANES area are taken up by residents; however there is a high proportion of employment in the less well paid service industries with low wage rates, especially when compared with costs of living. Housing costs means Bath is still one of the least affordable housing areas in the country. With the shortage of affordable and key worker housing some staff have to commute to work from outside of the area which can also impact on our ability to attract staff and for them to get to their place of work easily and in good time.

Through this plan, we will develop a workforce which is, at all levels, more highly skilled, more resourceful and more confident in its practice. We will position our registered practitioners in roles in which they are Practitioners, Partners and Leaders with more extensive use made of highly trained Assistant Practitioners and other support workers to deliver hands on care under the direction and supervision of qualified staff. Our workforce will play a even greater role in promoting health and well being and in enabling individuals, families and communities to manage their own health and well being. Through this plan, we will offer exciting and rewarding career opportunities to all our staff and be an employer of choice.

2. VISION AND VALUES

The vision for Bath and North East Somerset Community Health and Social Care Services

To develop new models of community services that will support the growth of the provider arm to secure and sustain the business and to become the provider of choice for community services in B&NES.

Our Community ***** Supporting People to Change Lives for the Better ***** *Our Staff*

Through

Providing excellent, high quality individualised services and care that make a positive difference

By

Focussing consistently and systematically on improving the quality of care across all our services

Ensuring that we do no harm to our service users and provide safe and clean environments and tackling issues such as healthcare-associated infections

Listening to our service users' perspective on the effectiveness of their care

Recognising the importance of the patient experience focussing on dignity, compassion and respect, taking account of the need to ensure equality across all groups of people

We will be accountable to our commissioners and our stakeholders for

Delivering on the objectives and targets agreed as part of our service contracts

Conducting business openly and in line with best governance practice

Managing finances prudently and ensuring that the best use is made of public money

We will support and develop all our staff through

Developing and embedding a new approach to change which will bring together teams of health and social care professionals to shape and implement change across all services

Promoting clinical and professional leadership at every level of the organisation and enabling frontline staff to take key decisions in partnership with their clients

Adopting the best employment practices and support staff to work through and beyond organisational changes

Encouraging professional and personal development through a learning and enabling approach and the provision of training opportunities for all staff

In delivering this service vision we will develop a culture based on the values of:

Openness and honesty in the conduct of our business and in our relationships with the wider public, individuals using our services, staff and partner organisations

Respect for the dignity and rights of all individuals - valuing diversity and the different perspectives people can bring

Listening to the views of the people who use our services, staff and partner organisations and the wider public

Valuing and supporting people that work for and with our services

Integrity, High Performance and Innovation

3. THE PURPOSE OF WORKFORCE PLANNING

Workforce planning can be defined as a systematic process for identifying, implementing and managing the competencies and associated roles required to meet the service users needs and the organisations strategic goals within a set financial framework.

At the point of delivering services to service users, effective workforce planning delivers:

- Better quality of care- right skills, right place, right time
- Reduced risk- ensuring the long term supply of staff

- Greater capacity- through optimum skill mix and productivity

The 'Achieve Breakthrough' organisational change and development programme which has been delivered over the past two years has provided a strong platform on which initiatives around workforce can continue to build. We have concentrated on providing an organisational infrastructure to enable the radical changes that will need to take place over the coming years to be successfully implemented.

Liberating the NHS (DH 2010) highlights the requirement of the NHS to cut bureaucracy and improve efficiency. This means for us that all services both front line and back office must be as productive as they can be, working smarter not harder.

It also clearly states that management costs must be reduced by more than 45% over the next 4 years.

The key strategic objectives for Bath and North East Somerset Health and Social Care Services are aligned to both the NHS and Council objectives and are now also linked to the 8 Quality, Innovation, Productivity and Prevention Programmes (QIPP):

- Optimising Elective Care
- Shifting settings of care and optimising urgent care.
- Best practice care pathways for Long Term Conditions
- Improving prescribing.
- Improving primary and community care
- Improving mental health services.
- Improving learning disability services.
- Improving non clinical productivity.
- Lean systems review of the social care process (Vanguard)

In order to ensure delivery of an appropriate workforce there are three stages:

- Designing the future workforce - this is both understanding and influencing by ensuring that workforce considerations combine with service and financial planning
- Developing the future workforce- this includes commissioning appropriate education, staff development and recruitment and retention processes.
- Delivering the future workforce- this requires management action to ensure plans are delivered, processes are effective, professionals are engaged and best practice is shared.

4. CURRENT WORKFORCE INFORMATION

4.1 Headcount

PCT provider	Council	Total
912	740	1652

4.2 Gender breakdown

PCT provider		Council	
Female	Male	Female	Male
833	79	626	114
91%	9%	84%	16%

4.3 Age profile

PCT provider		Council	
49 years and under	50 and over	49 years and under	50 years and over
614	298	409	331
67%	33%	55%	45%

4.4 Disability

PCT Provider			Council		
Disability	Not disabled	No disability stated	Disability	Not disabled	No disability stated
15	229	668	20	680	40
1.6%	25.1%	73.2%	2.7%	91.8%	5.4%

4.5 Ethnicity

PCT provider			Council		
White British	Other BME group	Not stated	White British	Other BME group	Not stated
802	59	51	670	15	55
87%	6.4%	5.5%	90%	2%	7.4%

4.6 Sexual orientation

PCT Provider			Council		
Heterosexual	Gay, Bi or lesbian	Not stated	Heterosexual	Gay, Bi or lesbian	Not stated
633	8	271	127	12	601
69%	.87%	29.7%	17.1%	1.6%	81.2%

5. IMPLICATIONS FOR B&NES

Taken together, the elements of the strategic context summarised above suggest that providers of community based health and social care will be operating in a world which is significantly different from that to which most of our staff are accustomed.

To enable us to achieve our aspirations:

- We will develop a workforce which is, at all levels, more highly skilled, more knowledgeable and more self-confident in its practice. Specifically, we will need to develop clinical skills which have historically been aligned with hospital based care.

- To develop staff with strong clinical and leadership skills.

- We will offer opportunities for staff currently working in the acute sectors to be redeployed to community practice as the acute workforce reduces in line with the QIPP vision.

- We will develop a workforce which goes beyond providing care and treatment but also sees its role as educating, enabling and empowering individuals and families to take charge of their own health and well-being – they will address health opportunities as well as health needs.

- We will develop a workforce in which practitioners feel confident in working with service users and carers with complex needs which cross over traditional boundaries between mental health and physical health and between health needs and social needs.

- To ensure staff have the relevant skills and expertise to safeguard children and vulnerable adults.

- We will develop a workforce which has a strong customer service ethic – each of our patients, carers or other service users must feel like a valued customer.

- We will find ways of working smarter not harder so that we are able to demonstrate improvements in productivity and value for money.

- We will encourage, support and enable staff to work flexibly across existing and new service areas.

- We will work with our commissioners to develop ways of commissioning services based on the outcomes we deliver and the quality standards we meet as well as on the quantity of inputs we provide.

- We will become a sophisticated and professional business capable of competing successfully against global healthcare organisations.

- We will develop a stable but dynamic workforce to which we attract the brightest and best and in which we retain people who expect to pursue long and varied careers in health and social care.

6. CHALLENGES FOR B&NES

Although we have many pockets of excellence in our services and in our workforce, a track record of innovation and, in particular, of successful partnership and integrated teams, we do face challenges in developing a workforce capable of realising the aspirations of the *Next Stage Review* (Darzi2008) and *Transforming Community Health and Social Care in Bath and North East Somerset – Commissioning Intentions 2010/11 – 2014/15* and of seizing the opportunities which are available as the health and social care system goes through a process of transformation. We do not believe that any of these challenges are unique to B&NES.

The principal challenges which we will address through this workforce plan and are:

- Reduced the number of whole time (PCT provider) equivalent staff by approximately 30 posts by year end. Workforce reductions will be achieved as a result of role redesign, retirements, and improvements in productivity and a greater use of flexible contracts and recruitment reviews (Appendix 1)

- Keeping staff valued, motivated and engaged over the next 3-5 years with the expected reduction in management costs, the separation of the provider organisation and the development of a new organisational form.

- Reducing management costs considerably.

- Attracting people with the skills, knowledge, attitudes and potential which we will need.

- Developing people from novice to expert practitioner particularly as we move to a graduate nursing workforce with registered staff performing as practitioners, partners and leaders. Universities do not produce graduates who are immediately fit to practice, particularly in a community setting; we will need to go considerably beyond preceptorship to help new graduates to become confident and competent practitioners.

- Retaining good people in the organisation by providing interesting and varied careers, ensuring that they are able to practice to a high standard and providing exemplary leadership in health and social care.

- Enabling people to practice efficiently and productively by minimising bureaucracy and providing the infrastructure needed to enable productive practice including consistent and appropriate information technology.

- Introducing new flexible working practices using technology that leads to a more effective use of work based accommodation.

- Extending the scope of practice of professionals in all disciplines to equip them to perform additional roles in any setting, including the community, hospital inpatients, out patients and primary care.

- Further enabling professional leadership roles to influence and support high quality care across the services provided.

- Developing the roles of Assistant Practitioners and other unregistered generic support staff working under the direction and supervision of registered professional practitioners.

- Creating a culture of continuous learning and development so that our workforce is prepared to take advantage of emerging developments in health and social care.

- Ensuring that our professional leads are “business aware” and able to contribute fully to the growth and development of the business enterprise in a competitive market-place. This will include the need to enhance current working partnerships with primary care and with GP’s in particular.

7. LEARNING AND DEVELOPMENT

To achieve B&NES vision it requires a committed and flexible workforce that has the knowledge skills and attitudes to meet the needs of all service users and staff now and in the future.

Effective learning leads to increased capacity, capability and flexibility. These benefits can be maximised where they are focused on relevant areas, occur in a culture that encourages learning, and reflects the context in which practice takes place. The workforce plan aims to build the conditions in which a learning and development culture can flourish.

Ensuring that staff keep abreast of relevant changes in their field is a major challenge and B&NES is committed to annual appraisals and development plans to support on-going learning.

In addition how employees are managed plays a significant part in creating the conditions in which they would say that B&NES is a great place to work. The workforce plan builds on current arrangements to ensure effective management and leadership development is available to all managers across B&NES.

To strengthen learning and development we will:

- Encourage a culture of learning where all staff take responsibility for their own learning and development, through the personal development review process and contribute to the learning and development of others.

- Continue to commission appropriate training and development support and seek out alternative and innovative development solutions ensuring key training interventions are audited to ensure learning outcomes are met and value for money obtained.

- Utilise the skills and expertise of the professional leads within the organization as well as external opportunities to ensure staff are equipped with the right skills to provide clinically effective care at all times.

- Regularly review the organizations training and development programme to ensure all training links to the organizations strategic goals and priorities.

8. LEADERSHIP DEVELOPMENT

Strong leadership, line management capacity and capability are key to our success in the Partnership, as a clear link exists between progressive people management practices and improved productivity and patient outcomes.

We must therefore have the right number of managers and leaders in the right type of jobs, with the requisite skills and knowledge to support, engage, empower, motivate and lead staff. We must also develop managers and leaders with the values, behaviors' and attributes that will help us achieve our strategic objectives, demonstrate our commitment to good employment practice and move B&NES towards embedding and achieving its values.

Management capacity and capability will be maximised, both on an individual level and collectively. Individual capacity and capability will be increased with the help of personal and professional development, through application of the Knowledge and Skills Framework and management competencies.

Organisational capacity and capability can be increased by involving, delegating and empowering staff in the decision making. Also by encouraging managers and teams to build effective relationships both internally and externally and by improving management processes to free up time for managers to manage and lead. We will develop leadership and excellent people management skills at all levels of the organisation. We will develop robust succession planning to ensure that achievements are continued and sustained.

To strengthen our leadership capacity we will:

- Monitor and evaluate leadership programmes making changes as needs are identified.

- Encourage use of mentorship, preceptorship, coaching and learning sets to increase skills in leadership and management.

- Develop policies and procedures that encourage empowerment and support for leaders including the adoption of the Councils Managing Performance Policy across the whole organisation.

- Encourage close working between the human resources team and professional leads in order to deliver 'real life' leadership and management training.

9. TAKING THE STRATEGY FORWARD

This strategy proposes a number of relative high level courses of action to develop a workforce which is capable of leading and delivering the transformational changes which are envisaged in *High quality care for all* (Darzi, 2008), *A framework for action* (Darzi, 2007), *Transforming Community Health and Social Care in Bath and North East Somerset – Commissioning Intentions 2010/11 – 2014/15* and related policy documents and directions.

In taking the plan forward, we now need to:

- Engage with our workforce to discuss the ideas set out in this plan and the thinking behind them. The plan will only be successful if it makes sense to our staff and if they are committed to it.

- Each service/ department/ division/ project to develop detailed workforce action plans linked to the strategic priorities and addressing the issues highlighted in this workforce planning strategy.

- Develop a Talent Management Policy and succession planning system across all Divisions.

- Develop a performance management culture supported by the Managing Performance Policy that will support career development as well as identifying appropriate training, development and competency needs to support role redesign, skill mix, extend roles, flexible employment solutions and different working patterns.

- Require the professional leads to work with the training and development department to develop profession specific development objectives for 2011-2014 that mesh with the QIPP priorities.

- Establish a programme management process to ensure effective implementation, on going monitoring and reviewing to ensure workforce planning is a continuous process and that there is continual organization learning to ensure that it is flexible and adaptable to change.

- To work collaboratively with the Council and other local organizations to develop a consistent approach to identifying the workforce development needs.

Although some parts of the plan can be taken forward relatively quickly, this plan covers a three year time frame and will be refreshed on an annual basis.

Equality impact assessment for financial plans

Financial Plan	Medium Term Service & Resource Plan 2011/12- 2013/14
Name of directorate and service	Adult Social Care & Housing
Name and role of officers completing the EIA	Jane Shayler, Programme Director, Non-Acute Health, Social Care & Housing; Sarah Shatwell, Associate Director, Non-Acute & Social Care; Lesley Hutchinson, Assistant Director, Safeguarding & Personalisation; Corinne Edwards, Associate Director, Unplanned Care & Long Term Conditions; Mike MacCallam, Associate Director, Learning Difficulties & PSI
Date of assessment	1 December 2010

This Equality Impact Assessment (EAI) is used to systematically analyse a financial plan to identify what impact or likely impact it will have on different groups within the community. It should identify any discriminatory or negative consequences for a particular group or sector of the community but will also higlight beneficial impacts.

It is intended that this is used as a working document throughout the EIA process, with a final version including the action plan section being published on the Council's and NHS Bath and North East Somerset's websites.

1.	**Identify the scope of the financial plan**	
	Key questions	**Answers / Notes**
1.1	Briefly describe the aims of the financial plan including • How the financial plan is delivered and by whom • If responsibility for its implementation is shared with other services or organisations • Intended outcomes	Our guidance shows us that the plan is used to: • *To facilitate the delivery of the Services responsibility within the Council's Corporate Plan and Bath & North East Somerset's Community Strategy and to achieve established policy priorities* • *To ensure maximum economy, efficiency and effectiveness in the use of financial resources* • *To ensure the sustainability of the Council's budget in the medium term* • *To facilitate proactive, strategic management of the Council's budget* • *To guarantee responsiveness to an ever-changing and uncertain financial climate*
1.2	Provide brief details of the scope of the financial plan being reviewed, for example: • Is it a new financial or review of an existing one? • Is it a national or legislative requirement? • How much room for review is there?	The Medium Term Service & Resource Plan for 2011/12-2013/14 sets out the key influences affecting adult social care and housing services in the next 3-5 years; the changes that we want to make in order to be able to deliver our vision and priorities, and proposed actions to achieve financial balance in an increasingly challenging local and national context. It is a refresh of the Medium Term Service & Resource Plan 2010/11-2012/13.
1.3	Do the aims of the financial plan conflict with any other financial plan or service activity of the Council or Partnership?	No

2. Consideration of available data, research and information

You need to show that you have made decisions based on evidence. Monitoring data and other information can help you analyse whether you are developing fair financial proposals: a decision which is informed by relevant local and national data about equality is a better quality decision. Please consider the availability of the following as potential evidence:

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

	Key questions	**Data, research and information that you can refer to**
2.1	What is the equality profile of the employees who will be affected by this financial plan?	The equality profile of Community Health & Social Care Services employees is set out on page 6 of the Workforce Planning Strategy (attached).
2.2	What equality training have those who developed the financial plan received?	General equalities awareness training; training on undertaking EIAs; service-specific equalities training; managing equalities; Members of the Health & Wellbeing Partnership Equalities Steering Group.
2.3	What is the equality profile of service users who will be affected by this financial plan?	• The age profile of B&NES is somewhat older than the national average, though we also have more people than expected in their early twenties due to the two universities. In ten years time, we estimate that people over age 85 will number around 6,800 in B&NES compared with 4,300 in 2007 – an increase of about 50%. • As this older age group grows, the younger age group will fall as a percentage of the total population, particularly those in the age range 50 – 64 which has significant implications for the availability of informal and family care. In1950 there was a ratio of 1:2 (one person age 50 – 64 to every two people age 85+), in 2007 this ratio was 1:4, and by 2050 it will have risen to 1:12.

		• The area's ethnic make up is predominantly white: 94.5% British, Irish or other white compared to the English average of 88.7%. • Research suggests that approximately 2% of the population may have learning difficulties – in Bath and North East Somerset this equates to 3504 people (B&NES population 2009 175,180 Office of National Statistics), of these, approximately 876 (5/1000 population) have Moderate to Severe LDs. More detailed information is available in the Commissioning Strategy for People with Learning Difficulties 2006-2010. • See also, Joint Strategic Needs Assessment for Bath and North East Somerset
	Key questions	**Data, research and information that you can refer to**
2.4	What do you know about service users' needs in relation to this service area? (e.g. results of customer satisfaction surveys, results of previous consultations) Are there any particular staffing issues? (e.g. high proportion of female workers etc)	• The Health & Wellbeing Partnership uses a variety of routes to take into account the needs and experiences of local people, service users and carers. Planning is developed in collaboration with local people using stakeholder events for particular service groups; service users and carers are directly involved in pathway development and service improvement programmes; feedback from Patient Advice and Liaison Service (PALS) and complaints services informs our view of services; service users are invited to inform impact assessments of potential changes; and formal consultation exercises are undertaken on areas of major change. • The combined results of the various strands of ongoing engagement has given the Partnership a clear picture of what people see as important: o Convenience of access and less waiting o Better information, involvement and choice o Being treated with dignity and respect o Receiving services in environments that are clean and hygienic o Receiving services that are safe, effective and efficient o Improving health and preventing illness o Increasing the personalisation of social care o Ensuring more services can be delivered in the community o Strengthening services for long term conditions o Improving mental health services o Increasing the provision of affordable housing o Improving access to housing for vulnerable people o Greater assistance for carers

		• Community Health & Social Care Services has 1652 employees comprising 912 people employed by the PCT and 740 employed by the Council. Of these, 91% of PCT employees are female whilst 84% of Council employees are female. More detailed information is available in the CH&SCS Workforce Plan, July 2010.
2.5	Are there any gaps in the data, research or information that is available?	None identified.

3. Assessment of impact

Based upon any data you have analysed, or the results of consultation or research, use the spaces below to list how the financial plan:

- Meets any particular needs of each of the equality groups or helps promote equality in some way.
- Could have a negative or adverse impact for each of the equality groups

	Identify the impact / potential impact of the financial plan on	**Examples of how the financial plan promotes equality**	**Examples of potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender** – women and men	No impact identified	Staff in Community Health & Social Care Services are predominantly women (88%) and any staffing reductions will almost certainly have a greater impact on women than on men. However, this is reflective of the overall gender breakdown of the workforce. As further detail of key proposals (for example, the lean systems thinking review of social care), is worked up, careful consideration will be given to whether the staffing impact of the proposals does fairly reflect the make-up of the workforce.

	Identify the impact / potential impact of the financial plan on	Examples of how the financial plan promotes equality	Examples of potential negative or adverse impact and what steps have been or could be taken to address this
3.2	**Gender identity -** transgender people	No impact identified	
3.3	**Disability** – Disabled people (ensure consideration of a range of impairments including both physical and mental impairments)	• Improved access for people with Learning Difficulties to mainstream services • Improved mental health care pathway, including increased emphasis on independent living and recovery orientated activities	• Reduced capacity in Employment Development Service, which focused on people with Learning Difficulties and Physical & Sensory Impairment. Impact mitigated by refocusing of in-house day services on supporting people into employment.
3.4	**Age** – different age groups	• Greater emphasis on independence, prevention and early intervention for older people, including Older People's independent living service • Implementation of Fairer Contributions for personal social care seeks to address an historic in-balance in the extent to which different service-user groups contributed to their personal social care, with older people making a higher contribution than people with, for example, a learning difficulty.	• Focusing in-house day-services on support for independent living and access to employment potentially reduces access for older people, which will be mitigated through the ability to access other forms of day services/ day time activity through use of a personal budget.
3.5	**Race** – People from black and minority ethnic groups	No impact identified	
3.6	**Sexual orientation -** lesbian, gay, bisexual & heterosexual people	No impact identified	

	Identify the impact / potential impact of the financial plan on	Examples of how the financial plan promotes equality	Examples of potential negative or adverse impact and what steps have been or could be taken to address this
3.7	**Religion / belief** – people of different religious/faith groups and those with no religion or belief	No impact identified	
3.8	**Socio-economically disadvantaged** – people who are disadvantaged due to factors like family background, educational attainment, neighbourhood and employment status	No impact identified	• Reduced levels of funding for the Community Learning Service is likely to result in reduced access to learning and skills development, which may impact adversely on this group. Impact mitigated for homeless people through specifically targeted employment/skills development schemed funded through the Supporting People and Communities funding stream.
3.9	**Rural communities** – people living in rural communities	• The Older People's Independence Living Service is likely to impact positively on access to support for older people living in rural communities.	No impact identified

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

List actions below that you plan to take as a result of this EIA. These actions should be based upon the analysis of data, any gaps in the data you have identified, and any steps you will be taking to address any negative impacts or remove barriers. The actions need to be built into your financial plan and future service planning framework. Actions/targets should be measurable, achievable, realistic and time framed. (Add rows as appropriate)

Issues identified	Actions required	Progress milestones	Officer responsible	By when
Potential impact of Vanguard lean systems thinking review of social care system	Once detailed findings and recommendations of the review are available, specific EIA to be undertaken on proposals.	• Publication of Review Report by 31/1/2011 • EIA undertaken by 28/2/2011	Stella Doble	28/2/2011
Reduced capacity in Employment Development Service for people with Learning Difficulties and Physical and Sensory Impairment.	Greater focus of in-house day services on supporting people into employment.	• Produce strategy for supporting people into employment • Complete reconfiguration of LD Service	Mike MacCallam Jenny Theed	31/7/2011 31/7/2011
Focusing in-house day-services for people with learning difficulties on support for independent living and access to employment potentially reduces access for older people with a learning difficulty	Information and support to enable older people to access other forms of day services/ day time activity through use of a personal budget.	• Identify users of services who are aged 63 and over and complete person centred plans to identify future options • Ensure clear guidance on services that can be funded through use of a personal budget • Continue to provide information and support on personal budgets	Jenny Theed Jane Shayler Jo Gray	31/7/2011 31/01/2010 Ongoing
Reduced levels of funding for Community Learning Service is likely to result in reduced access to learning and skills development for socio-economically disadvantaged people	Commissioning of employment/skills development services for homeless people through Supporting People and Community funding.	• Clear articulation of commissioning intentions • Confirmation of contract/provider	Ann Robins/ Rebecca Potter	Complete 31/3/2011

5. Sign off and publishing

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

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

Date: 29 December 2010

This page is intentionally left blank

Bath & North East Somerset Council	
MEETING:	Healthier Communities and Older People Overview & Scrutiny Panel
MEETING DATE:	18th January 2011
TITLE:	Final Recommendations of the Ear, Nose and Throat and Oral and Maxillofacial Head and Neck Cancers Services Review
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Final Recommendations BANES Substantial Variation Impact Assessment Appendix 1 Letters from Clinicians Appendix 2 Stakeholder Engagement Report Appendix 3 Equality Impact Assessment	

1 THE ISSUE

1.1 The purpose of this paper is to provide BaNES' Healthier Communities and Older People Overview & Scrutiny Panel with sufficient information about the Head and Neck Cancers, Ear, Nose and Throat (ENT) and Oral and Maxillofacial (OMF) Services Review to allow the Panel to decide whether or not to support the proposals to implement the new clinical service model at University Hospitals Bristol NHS Foundation Trust (UH Bristol) in line with the service specification.

2 RECOMMENDATION

The Panel is asked to support the decision of the Professional Executive Committees and Board of NHS BaNES:

2.1 To implement a clinical service model for a centralised hub for all inpatient and day case head and neck cancer, ENT and OMF services with satellite and spokes providing diagnostic, follow up and less complex procedures.

2.2 For the centralised hub to be located at the BRI and hub services to be provided and managed by UH Bristol and for UH Bristol to proceed with implementation planning for May 2012 (in line with the opening of South Bristol Community Hospital).

2.3 For UH Bristol to work with local commissioners and providers from across the network to ensure there is good access to spokes across the network area.

3 FINANCIAL IMPLICATIONS

3.1 100% of the service is in tariff. UH Bristol have committed to paying the costs involved in transferring the elements of the service that will move from NBT. NHS Bristol's Finance Team have made recommendations to the Commissioning Team about how the risks can be mitigated and these will be implemented.

4 THE REPORT

4.1 See attached.

5 RISK MANAGEMENT

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

5.2 The recommendations outlined will move us towards Improving Outcomes Guidance (IOG) compliance. By not implementing these recommendations we risk being unable to meet IOG requirements and therefore Trusts would not be able to meet all peer review measures.

5.3 Financial risks have been mitigated by UH Bristol's confirmation that they can meet the costs of the service transfer and the fact that 100% of activity is in tariff and therefore the cost of this will not change. Further mitigation regarding service growth will be built into the contract.

6 EQUALITIES

6.1 An equality impact assessment has been completed (see appendix 3 of the Final Recommendations Report). UH Bristol was asked to respond to the findings set out in this Assessment and indicates how they would take into account the recommendations in their Provider Response. The Provider Response can be provided on request.

7 CONSULTATION

7.1 *Overview & Scrutiny Panel*

8 ISSUES TO CONSIDER IN REACHING THE DECISION

9 ADVICE SOUGHT

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

Contact person	Ruth Hallett, tel. 07766 291453
Background papers	

Please contact the report author if you need to access this report in an alternative format

This page is intentionally left blank

Advisory Panel Final Recommendations of the Ear, Nose and Throat (ENT), Oral and Maxillofacial (OMF) and Head and Neck Cancer Services Review for Bath & North East Somerset

Document status	Approved by PEC and Board
Document Author	Ruth Hallett
Owner	Head and Neck, Ear, Nose and Throat and Oral and Maxillofacial Services Review Project Board
Date Issued	30 December 2010
Date Approved	

Version	Date	Reviewer	Comment
0.1	14th Oct 2010	Emma Phillips	First draft of sections 1 – 5 (awaiting to agree further headings)
0.2	19th Oct 2010	Emma Phillips	Amended following comments on first 5 sections and additional headings added with draft content
0.3	19th Oct 2010	Ruth Hallett	Amendments
0.4	20th Oct 2010	Emma Phillips	Insertion of diagrams and all sections completed in draft
0.5	25th Oct 2010	Emma Phillips	Added references to Stakeholder Engagement Report and included as append.
0.6	26th Oct 2010	Emma Phillips	Updated to show Yeovil as a spoke not a satellite
0.7	1st Nov 2010	David Tappin	Amendments
0.8	4th Nov 2010	Emma Phillips	Amendments following feedback from SHA
0.9	5th Nov 2010	David Tappin	Further amendments from David Tappin
0.10	5th Nov 2010	Ruth Hallett	Further amendments to include additional supporting evidence
0.11	9th Nov 2010	David Tappin	Amendments
0.12	25th Nov 2010	Ruth Hallett	Amended following further feedback from the SHA
0.13	26th Nov 2010	Ruth Hallett	Included quote from patient representative
0.14	9th Dec 2010	Ruth Hallett	Updated
1.0	30th Dec 2010	Ruth Hallett	Approved by PEC and NHS Board

30th December 2010

30th December 2010

Ruth Hallett, Project Manager

Sponsored by David Tappin, Director of Strategic Development

If you need further copies of this document, or require this document in a different format, please telephone Emma Phillips on 0117 984 1629

Contents

1 Document Purpose

The purpose of this paper is to set out the conclusions of the Ear, Nose and Throat (ENT), Oral and Maxillofacial (OMF) and Head and Neck Cancer Services Review and make recommendations to Professional Executive Committees (PECs), PCT Boards and local scrutiny committees. This Review has been undertaken as part of the Healthy Futures Programme and has had engagement from clinicians and patients across the Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset (BaNES), Wiltshire and Somerset area. The Review has been governed by a Project Board with clinical, patient and NHS organisational representatives.

2 Executive Summary

The Review initially started as a review of Head and Neck Cancer Services in November 2009, but feedback from clinical stakeholders indicated the scope of the review needed to be expanded to cover all ENT and OMF services, benign and malignant. The clinical staff, skills and equipment required to treat benign conditions are the same, in many cases, as those required to treat malignant conditions. Therefore, the clinical service model developed as part of the review process is for all Head and Neck Cancer, benign and malignant ENT and benign and malignant OMF inpatient services.

The clinical service model will bring together the expertise of specialists working in ENT, OMF and Head and Neck Cancer services in a service hub where all surgical procedures will take place. Satellite and spoke sites will enable patients to have diagnostic and follow-up appointments and routine procedures closer to home, with the difference between the satellite site and the spoke sites being the provision of less complex surgery at the satellite whereas spokes will provide consultation and follow up but no surgical procedures. This is described in more detail below.

An independently-chaired Advisory Panel, which first came together in May 2010, undertook a detailed assessment of the location options that could deliver the clinical service model. In May 2010, the Advisory Panel recommended that the Bristol Royal Infirmary site provide the hub services for a number of reasons, including: clinicians' aspirations for a Head and Neck Service and Institute which maximises integrated working and adjacencies; likely developments in cancer treatment in the medium term and it being the location that offered the best opportunity for coordinated service provision for patients. It was agreed that UH Bristol be put through a process of due diligence to test their ability to deliver the clinical service model from the Bristol Royal Infirmary site. On the 4th of November 2010 the Advisory Panel came together again to review evidence submitted by UH Bristol and were assured that they would be able to deliver the model. The Review's Project Board met on the 5th of November 2010 and accepted the Advisory Panel's recommendation.

Our focus now is on discussing the recommendations arising from the Review with organisations' PECs and Boards and local scrutiny committees. Subject to their agreement, a new project will be initiated to add detail to the existing high level implementation plan and ensure the implementation of the Review's recommendations.

We are pleased to have reached this stage of the Review, given that the sort of integration described in the clinical service model has been discussed locally for a number of decades. This is a real credit to the way clinicians, patients and managers have been able to work together to agree the clinical model and have built a strong foundation on which delivery can be assured, if approval is given.

3 Context – Bristol Health Services Plan

Following extensive public engagement and consultation throughout 2004, NHS organisations in Bristol, North Somerset and South Gloucestershire agreed a series of changes to the configuration of local health services as part of the Bristol Health Services Plan in March 2005.

The objectives of these changes were:

- To improve the quality of emergency and specialist services, by concentrating acute hospital services on two hospital sites in Bristol/South Gloucestershire.
- To improve the quality and accessibility of a range of routine services (outpatients, diagnostic services, urgent care, therapies etc).

As part of the planned improvement in acute hospital services a number of specific changes were agreed, including:

- Acute hospital services being concentrated on a redeveloped Southmead Hospital site and the Bristol Royal Infirmary site, with Frenchay becoming a community hospital site.
- The development of a network of local community hospitals and health care centres throughout Bristol, North Somerset and South Gloucestershire.
- Breast services being centralised at St Michael's Hospital.
- Adult Ear, Nose and Throat (ENT) services being centralised at Southmead Hospital.

A number of these changes are in the process of implementation, with construction of the new Southmead Hospital ongoing and a number of new community health care centres and community hospitals completed or being built.

In respect of Breast and Adult ENT services, the plans agreed as part of the Bristol Health Service Plan have been revisited. In the case of the Breast services, a further review concluded in early 2010, following extensive clinical and patient involvement. The conclusion of this review was a proposal for a new service model for breast care services which includes a hub at the new Southmead Hospital, a satellite hub at Weston General Hospital and community spokes at Southmead Hospital, Weston General Hospital, Central Health Clinic and South Bristol Community Hospital. The conclusions of the Breast Services Review were supported by PCT Boards and by the Overview and Scrutiny Committees of North Somerset, Bristol and South Gloucestershire Councils in February and March 2010. The new service model is due to be implemented in 2014, linked to the opening of the new Southmead Hospital.

As part of the Breast Services Review process the Boards of Bristol, North Somerset and South Gloucestershire PCTs revoked their earlier decision, made as part of the Bristol Health Services Plan, to centralise breast services at St Michael's Hospital.

This paper sets out the conclusions of the ENT, OMF and Head and Neck Cancer Services Review. As a result of the reviews conclusions the Boards of Bristol, North Somerset and South Gloucestershire PCTs have been asked to revoke their earlier decision to centralise Adult ENT services at Southmead Hospital.

4 Introduction

In November 2004 the National Institute for Clinical Excellence (NICE) issued 'Guidance on Cancer Services: Improving Outcomes in Head and Neck Cancers' stating that 'head and neck cancers should be managed in services covering a population of one million people treating over 100 cases per year'.

Previous attempts to centralise Head and Neck Cancer services in the Bristol area have failed to reach consensus and a new independently facilitated process was initiated in November 2009 to create a clinically led, patient endorsed model of care with proactive engagement of local clinicians and patients.

A Project Board was established to oversee delivery of the Review and to ensure that the process followed was robust and effective in developing a clinically appropriate solution. Membership of the Project Board has included patient and public representatives, clinicians involved in the delivery of Head and Neck Cancer services, clinicians involved in the delivery ENT and OMF services, representatives of the Avon, Somerset and Wiltshire Cancer Services (ASWCS) Network, local commissioners and provider trusts and Project Team members. The Board has been chaired by Deborah Evans, Chief Executive of NHS Bristol.

At the outset of the review stakeholders were interviewed and there was overwhelming feedback that benign and malignant services should not be separated and therefore the scope of the review was expanded from cancer services to include all ENT and OMF services.

From the outset of the process the clinicians have aspired for the best possible model of care through consensus. There has also been enthusiastic participation from a wide range of patients and other stakeholders. At a stakeholder event on 2nd March clinical representatives presented their proposed new clinical model which was unanimously endorsed by patients, clinicians, PCTs and Trusts.

5 Current Service Model

Currently, the majority of Head and Neck Cancer services for the populations of Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset are provided in Bristol by UH Bristol and NBT, with a smaller number of patients being treated at the RUH in Bath. Some patients from Somerset and Wiltshire also access services in Bristol either because they are nearer than other local service providers (i.e. Musgrove Park Hospital in Taunton or Yeovil District Hospital) or because their cases are more complex.

Benign and malignant ENT inpatient and day case services are provided by UH Bristol at St Michael's Hospital and the BRI and by NBT at Southmead Hospital.

The RUH also provides ENT inpatient and day case services and NBT also provides daycase ENT services at Weston General Hospital. Benign and malignant ENT outpatient services are provided at Southmead Hospital (by NBT), Weston General Hospital (by NBT), St Michael's Hospital (by UH Bristol), Clevedon Community Hospital (by NBT), Portishead Health Centre (by NBT) and at Nailsea Health Centre (by NBT).

Benign and malignant OMF inpatient and day case services are provided by UH Bristol at the BRI. UH Bristol also provides day case services at Bristol Dental Hospital (BDH). NBT also provides day case services at Frenchay Hospital. Benign and malignant outpatient OMF services are provided at Frenchay Hospital (by NBT), Weston General Hospital (by NBT) and Bristol Dental Hospital (by UH Bristol).

6 Proposed Service Model

The proposed clinical service model is for a hub, satellite and spoke configuration. The difference between the satellite site and the spoke sites is the provision of less complex surgery at the satellite. Spokes will provide consultation and follow up but no surgical procedures. This is described in more detail below.

6.1 Hub

Centralised services will be delivered from a Bristol hub. The hub will provide Multi-Disciplinary Team (MDT) assessment, treatment planning and case management and will have all ENT and OMF inpatient surgery, both benign and malignant, co-located with essential diagnostic services (histopathology, cytology and radiology), specialist cancer nursing services and therapists e.g. speech and language and dietetics.

6.2 Satellite

The RUH and Taunton will be satellite sites.

Satellite services will provide less complex benign and malignant ENT and OMF surgery, diagnostics and oncology services, where these currently exist, plus initial and follow up consultation. This will provide patients from across the region with a choice of treatment sites and reduce the need for travel. Case management will continue through the MDT at the hub.

6.3 Spokes

Spoke services will provide initial consultation and follow up clinics and community based rehabilitation with clinicians travelling from the hub to visit patients rather than vice versa. Southmead Hospital, Weston General Hospital, Yeovil District Hospital, Clevedon Community Hospital, Portishead Health Centre and Nailsea Health Centre will be spokes.

Whilst centralisation takes place there are no plans to change the location of spoke services. Other sites will also be considered as possible future spoke sites and there is a commitment to provide an additional spoke in South Gloucestershire, at Frenchay, Cossham or Thornbury. Any changes in the delivery of outpatient services required in the future will be brought back to PEC, PCT Boards and local Scrutiny Committees for their consideration.

7 Selection of site for Bristol hub

The criteria and process for site selection were produced and agreed by the Project Board. The process agreed involved establishing an independently chaired Advisory Panel to assess the two potential sites for the service hub (Southmead Hospital, part of NBT and the Bristol Royal Infirmary, part of UH Bristol). It was agreed that neither site could deliver all the ideal clinical dependencies. It was therefore a matter of judgement regarding which site could offer the most important dependencies. It was agreed that the Advisory Panel would be the judge of these. Following discussion at the Project Board, Professor Pat Bradley, recently retired Consultant Otolaryngologist / Head and Neck Oncologic Surgeon at Nottingham University Hospitals NHS Trust, was asked to chair the Advisory Panel. Terms of Reference and membership of the Advisory Panel were agreed by the Project Board.

The Advisory Panel met in May 2010 and recommended that the Bristol Royal Infirmary site provide the hub services for a number of reasons, including: clinicians' aspirations for a Head and Neck Service and Institute which maximises integrated working and adjacencies; likely developments in cancer treatment in the medium term and the benefits of being co-located with Bristol Haematology and Oncology Centre and it being the location that offered the best opportunity for coordinated service provision for patients. It was agreed that their recommendation should be tested by a process of due diligence.

The independently chaired Advisory Panel reconvened on the 4th of November 2010 to assess the evidence submitted by UH Bristol as part of the process of due diligence. Commissioners presented to the panel on their expectations, as outlined in the service specification agreed by the Project Board (available on request). UH Bristol presented to demonstrate how they could meet those expectations. NBT provided reassurance that they had been engaged with UH Bristol in developing the response to the service specification. In the light of the evidence presented, the Advisory Panel agreed that UH Bristol would be able to deliver the clinical service model hub in line with the standards outlined in the service specification and provided this reassurance to the Project Board. The Project Board met on the 5th of November and accepted this recommendation.

8 Local Impact for BANES

There is little proposed change for patients from Bath and North East Somerset (BaNES).

For BaNES patients with benign ENT and OMF conditions, services will continue to be provided at the RUH, in its role as a satellite site.

BaNES patients with suspected cancer would have their cases discussed at the central MDT, consisting of a range of clinicians, including specialists from the RUH. If inpatient treatment is required, the MDT will advise on whether or not this could be provided by the RUH. This will depend on the specific details of each case. If it is felt the patient could not be treated at the RUH, they would be referred to UH Bristol for their surgery. If the patient could be treated at the RUH they would be offered the choice of having their surgery at the RUH or at UH Bristol. Patients with suspected cancer are already discussed at the central MDT. The main difference to the service for BaNES patients will be that some patients who

currently access services at Southmead Hospital would now access services at the BRI.

Follow up outpatient appointments will continue to be provided at the RUH as well as at other existing outpatient locations. UH Bristol has also committed to providing an additional spoke in South Gloucestershire at either Cossham, Frenchay or Thornbury Hospitals, subject to further discussion with local commissioners.

The table below shows the number of BaNES patients that were seen in 2009/10 in Bristol and where. Please note, this excludes all those patients treated at the RUH as there is no proposed change in the service for those patients.

Inpatient Activity	NBT ENT			UH Bristol ENT			NBT OMFS			UH Bristol OMFS		
	Day Case	Inpatient	Non Elective	Day Case	Inpatient	Non Elective	Day Case	Inpatient	Non Elective	Day Case	Inpatient	Non Elective
Bath and North East Somerset	12	11	5	27	12	10	27	5	2	4	32	8

Outpatient Activity	NBT ENT			UH Bristol ENT			NBT OMFS			UH Bristol OMFS		
	New	Follow up	TOTAL	New	Follow up	TOTAL	New	Follow up	TOTAL	New	Follow up	TOTAL
Bath and North East Somerset	88	141	229	155	192	347	70	119	189	279	285	564

The table below shows ENT outpatient appointments undertaken by an ENT nurse. These sessions do not require consultant input and therefore are listed separately.

	UH Bristol ENT treatment nurse		
Bath and North East Somerset	5	112	117

In future, all inpatient and day case patients referred to Bristol will be treated at the BRI.

9 Service Reconfiguration Criteria

In May 2010, Sir David Nicholson wrote to all NHS Chief Executives to detail four criteria for service reconfigurations. This section documents how this Review has addressed the requirements set out in this letter.

9.1 Support from GP Commissioners

The role of GP Commissioners has been undergoing a significant change since the start of this Review and, in light of this; the arrangements for GP involvement have also developed.

The review has sought to keep GP Commissioners informed and offer the opportunity to become more engaged in the review. This has been achieved via articles in local GP newsletters and a briefing to GP Consortia. There have been update papers to all PECs and opportunities to comment on the draft service specification. The Review's conclusions will be discussed have been supported by all PECs in the network.

9.2 Patient and Public Engagement

The role of patient, carer and public stakeholders has been to ensure the views of the public, patients and carers are taken into consideration in developing the service model and site criteria.

Existing head and neck cancer patient support groups were visited as part of the project initiation phase of the review. This included two Bristol based groups (the Laryngectomy Support Group and the Bristol Head and Neck Cancer Support Group, also known as the 'collar' group) and a Weston-super-Mare based support group. Established patient support groups do not exist in Bath, Somerset or Wiltshire. An Independent Facilitator also interviewed the chairs of all three support groups to ensure members views could be incorporated into the clinical model.

There has been patient representation on the Project Board via Liz Eley, a Somerset patient. Liz Eley spoke to other patients and worked with the existing patient groups to present patient and carer views to the stakeholder workshop on the 2nd of March. She also presented to the Advisory Panel in May. Liz Eley indicated patients' support for the approach to the review and the proposed clinical model, highlighting the aspects specifically put in at the request of the patients and carers and noting the concerns that remain to be addressed throughout the review. This was reconfirmed to the Advisory Panel on 4th November 2010.

"We were pleased to be included in the Head & Neck/ENT Review for reconfiguring the service as more than just a 'tick-in-the-box' consultation. We have truly been part of the team on this project." – Liz Eley, patient representative.

A User Reference Group was established with 24 patients as members, including head and neck cancer patients, benign ENT and benign OMF patients. In order to facilitate a wider membership, patients are able to send in their comments and feedback in writing, via email and over the phone if they are not able to attend meetings.

All patient representatives who have been engaged in the review receive copies of the newsletter, which is produced at the end of each phase. Six newsletters have been produced as part of the Review so far and a seventh is planned at Project Closure.

There was a patient representative on the Advisory Panel who ensured that the panel kept patient and carer requirements at the forefront of their thinking.

See Stakeholder Engagement Report (appendix 2) for further details of how we have engaged with patients and the public.

9.3 Clinical Evidence Base Underpinning Proposals

Whilst there is no specific clinical evidence regarding centralisation of head and neck cancer in the UK, there is evidence that centralising other services has delivered improved patient outcomes. Clinicians have led the development of the service model and all stakeholders agreed the proposed model at a stakeholder workshop (letters of support form clinicians are included in appendix 1). A Benefits Register has been developed with input from clinicians and patients which documents the expected benefits and how these will be measured (available on request). The first baseline report will be agreed at the Project Board in February 2011 and will be re run a year after the centralised service is operational, to ensure benefits are tracked.

9.4 Develop and Support Patient Choice

Benign and malignant outpatient services will continue be offered the choice of location for outpatient services, including Southmead Hospital, Weston General Hospital, Bristol Dental Hospital, St Michael's Hospital, Clevedon Community Hospital, Portishead Health Centre and in Nailsea Health Centre so patient choice for outpatient services will not be reduced. There will also be a spoke provided in South Gloucestershire at Cossham, Thornbury or Frenchay, subject to further negotiation between the providers and local commissioners.

For inpatient services choice will be reduced from two locations in Bristol, the BRI and Southmead Hospital, to one. The majority of patient and public representatives have indicated their support for the change, recognising benefits to patient care and experience.

The Darzi report called for services to be 'localised where possible, centralised where necessary'.[1] The proposed model illustrates this concept by centralising complex surgery and diagnostics, as recommended by the Improving Outcomes Guidance, whilst providing routine and follow up appointments more locally in the spokes and satellites.

This change should be seen in context of development patient choice for less complex surgery and treatments, with the introduction of the Emerson's Green Independent Treatment Centre and the work underway to develop community services.

10 Recommendations

Project Board recommends that the Overview and Scrutiny Committee:

- Supports the proposed clinical service model for a centralised hub for all inpatient and day case head and neck cancer, ENT and OMF services with satellite and spokes providing diagnostic, follow up and less complex procedures.
- Supports the proposal for the centralised hub to be located at the BRI and hub services to be provided and managed by UH Bristol and for UH Bristol

[1] High Quality Care for All: NHS Next Stage Review Final Report. Professor the Lord Darzi of Denham KBE, 2008.

to proceed with implementation planning for May 2012 (in line with the opening of South Bristol Community Hospital).

- Supports the proposal for UH Bristol to work with local commissioners and providers from across the network to ensure there is good access to spokes across the network area.

All PECs in the network have now supported, NHS BaNES, NHS Bristol, NHS Wiltshire, NHS South Gloucester and NHS Somerset have support the proposals and North Somerset are not due to meet until mid January 2011. With this agreement in place Project Board recommends that these conclusions should be supported by Overview and Scrutiny Committees.

11 Glossary

ASWCS	Avon, Somerset and Wiltshire Cancer Services
BDH	Bristol Dental Hospital
BRI	Bristol Royal Infirmary
ENT	Ear, Nose and Throat
ISTC	Independent Sector Treatment Centre
LINk	Local Involvement Network
MDT	Multi-Disciplinary Team
NBT	North Bristol NHS Trust
OMF	Oral and Maxillofacial
PEC	Professional Executive Committee
RUH	Royal United Hospital Bath NHS Trust
UH Bristol	University Hospitals Bristol NHS Foundation Trust

12 List of Appendices

Appendix 1 Letters from Clinicians

Appendix 2 Stakeholder Engagement Report

Appendix 3 Equality Impact Assessment

This page is intentionally left blank

Bath and North East Somerset Health Scrutiny Select Committee Substantial Variation Impact Assessment

Ear Nose and Throat (ENT), Oral and Maxillofacial (OMF) and Head and Neck Cancer Services Review

Version no.	0.1
Status	Draft
Author	Ruth Hallett
Approver	Janet Rowse
Date for approval/ Date approved	
Agreed circulation of this version	Draft – internal project staff and NHS BaNES Approved – BaNES Health Scrutiny Select Committee

Version	Date	Reviewer	Comment
0.1	30th December 2010	Ruth Hallett	Initial draft

Part One - Description of proposed service changes

1 The current service

Currently, the majority of Head and Neck Cancer services for the populations of Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset are provided in Bristol by University Hospitals Bristol NHS Foundation Trust (UH Bristol) and North Bristol NHS Trust (NBT), with a smaller number of patients being treated at the Royal United Hospital (RUH) in Bath. Some patients from Somerset and Wiltshire also access services in Bristol either because they are nearer than other local service providers (i.e. Musgrove Park Hospital in Taunton or Yeovil District Hospital) or because their cases are more complex.

Benign and malignant ENT inpatient and day case services are provided by UH Bristol at St Michael's Hospital and the BRI and by NBT at Southmead Hospital. The RUH also provides Ear, Nose and Throat (ENT) inpatient and day case services and NBT also provides daycase ENT services at Weston General

Hospital. Benign and malignant ENT outpatient services are provided at Southmead Hospital (by NBT), Weston General Hospital (by NBT), St Michael's Hospital (by UH Bristol), Clevedon Community Hospital (by NBT), Portishead Health Centre (by NBT) and at Nailsea Health Centre (by NBT).

Benign and malignant Oral and Maxillofacial (OMF) inpatient and day case services are provided by UH Bristol at the BRI. UH Bristol also provides day case services at Bristol Dental Hospital (BDH). NBT also provides day case services at Frenchay Hospital. Benign and malignant outpatient OMF services are provided at Frenchay Hospital (by NBT), Weston General Hospital (by NBT) and Bristol Dental Hospital (by UH Bristol).

2 What are the proposed service changes?

The proposed clinical service model is for a hub, satellite and spoke configuration. The difference between the satellite site and the spoke sites is the provision of less complex surgery at the satellite. Spokes will provide consultation and follow up but no surgical procedures. This is described in more detail below.

2.1 Hub

Centralised services will be delivered from a Bristol hub. The hub will provide Multi-Disciplinary Team (MDT) assessment, treatment planning and case management and will have all ENT and OMF inpatient surgery, both benign and malignant, co-located with essential diagnostic services (histopathology, cytology and radiology), specialist cancer nursing services and therapists e.g. speech and language and dietetics.

2.2 Satellite

The RUH in Bath and Musgrove Park in Taunton will be satellite sites.

Satellite services will provide less complex benign and malignant ENT and OMF surgery, diagnostics and oncology services, where these currently exist, plus initial and follow up consultation. This will provide patients from across the region with a choice of treatment sites and reduce the need for travel. Case management will continue through the MDT at the hub.

2.3 Spokes

Spoke services will provide initial consultation and follow up clinics and community based rehabilitation with clinicians travelling from the hub to visit patients rather than vice versa. Southmead Hospital, Weston General Hospital, Yeovil District Hospital, Clevedon Community Hospital, Portishead Health Centre and Nailsea Health Centre will be spokes.

Whilst centralisation takes place there are no plans to change the location of spoke services. Other sites will also be considered as possible future spoke sites and there is a commitment to provide an additional spoke in South Gloucestershire, at Frenchay, Cossham or Thornbury. Any changes in the delivery of outpatient services required in the future will be brought back to PEC, PCT Boards and local Scrutiny Committees for their consideration.

3 Why are these changes being proposed?

This service change is proposed by clinicians supported by patients because it is anticipated to produce the following benefits:-

- Improved patient outcomes in the longer term
  - Less recurrent disease for cancer patients
  - Longer life expectancy
  - Improved clinical competency
  - Further develop specialist skills
  - Attract additional research funding to develop improved treatment
- Improved patient experience
  - Improve patient information to allow patients to make informed choices about their care
  - Reduce patient and carer anxiety for Head and Neck Cancer patients
  - Improve psychological health for Head and Neck Cancer patients
  - Provide convenient local clinics
  - Ward, treatment room, Intensive Treatment Unit and High Dependency Unit all on one site
- Improved effectiveness and productivity
  - Reduce duplication of work
  - Better utilisation of staff
  - Standard policies to ensure consistent use of best practice
  - Increased clinical dialogue
- Improved efficiencies
  - Improved opportunities for training and skills development and career prospects
  - Improved patient rehabilitation for Head and Neck Cancer patients
  - Economies of scale
  - Delivery of Improving Outcomes Guidance (NICE 2004) compliance
  - Delivery of Cancer waiting times standards
  - Delivery of national performance measures (18 week referral to treatment)

Mechanisms are in place to set a baseline in early 2011 (before service change) and then for review annual after service change has occurred.

4 Rationale

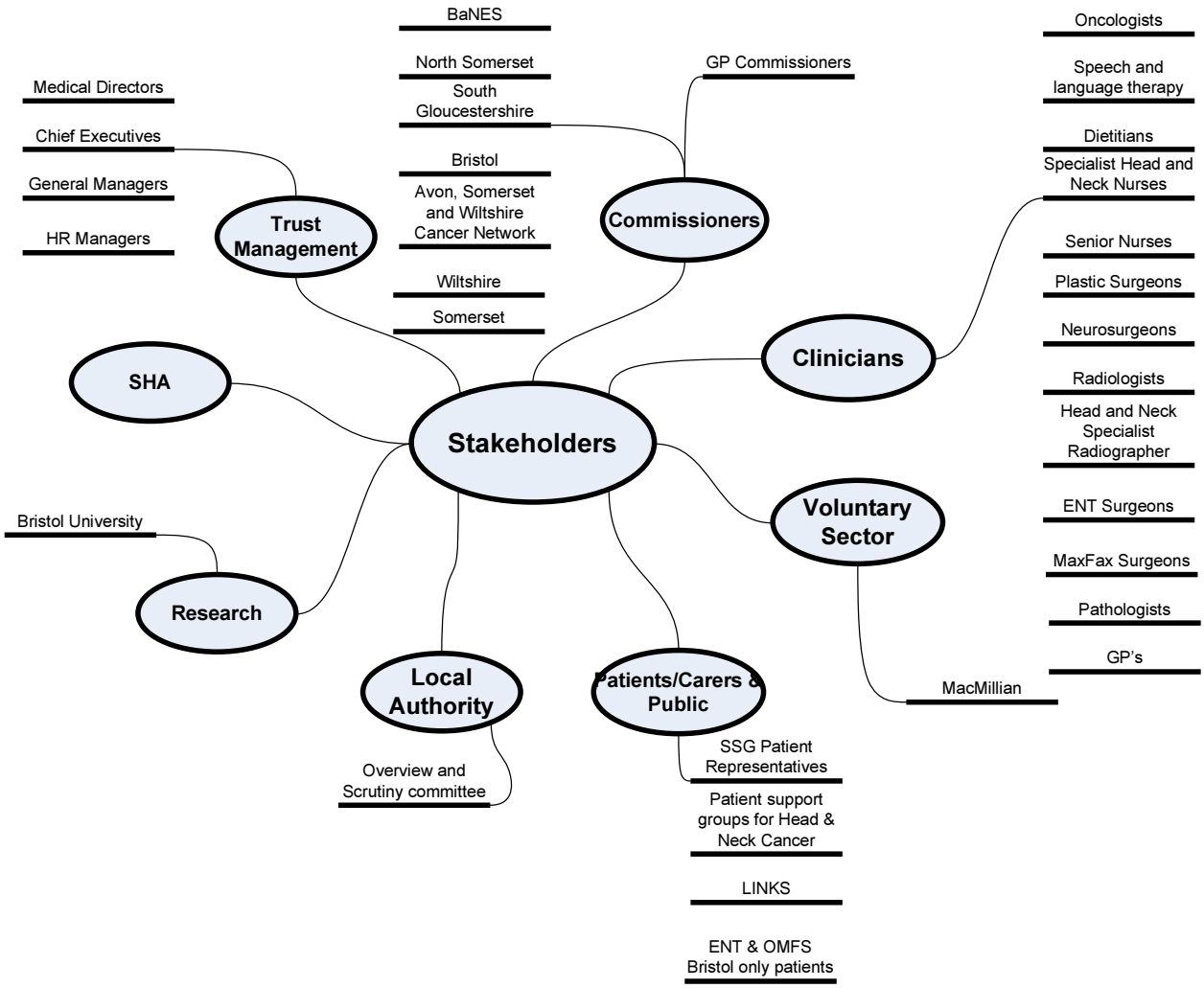
The Review initially started as a review of Head and Neck Cancer Services in November 2009, but feedback from clinical stakeholders indicated the scope of the review needed to be expanded to cover all ENT and OMF services, benign and malignant. The clinical staff, skills and equipment required to treat benign conditions are the same, in many cases, as those required to treat malignant conditions. Therefore, the clinical service model developed as part of the review process is for all Head and Neck Cancer, benign and malignant ENT and benign and malignant OMF inpatient services.

The clinical service model will bring together the expertise of specialists working in ENT, OMF and Head and Neck Cancer services in a service hub where all surgical procedures will take place. Satellite and spoke sites will enable patients to have diagnostic and follow-up appointments and routine procedures closer to home and this is described in more detail below.

An independently-chaired Advisory Panel, which first came together in May 2010, undertook a detailed assessment of the location options that could deliver the clinical service model. In May 2010, the Advisory Panel recommended that the Bristol Royal Infirmary site provide the hub services for a number of reasons, including: clinicians' aspirations for a Head and Neck Service and Institute which maximises integrated working and adjacencies; likely developments in cancer treatment in the medium term and it being the location that offered the best opportunity for coordinated service provision for patients. It was agreed that UH Bristol be put through a process of due diligence to test their ability to deliver the clinical service model from the Bristol Royal Infirmary site. On the 4th of November 2010 the Advisory Panel came together again to review evidence submitted by UH Bristol and were assured that they would be able to deliver the model. The Review's Project Board met on the 5th of November 2010 and accepted the Advisory Panel's recommendation.

5 Summary of involvement process and outcomes

The review has worked hard to ensure all stakeholders have been actively involved in the project. The diagram below provides and overview of all stakeholders who have been involved in the review.



Involvement activities have included:

- A Head and Neck Cancer patients' engagement event
- Case Studies – emails of patient experience
- Interviews with patients and patient relatives
- Interviews with ENT patients at St Michaels Clinic
- Interviews with ENT patients at Southmead Clinic
- ENT patient engagement event

A User Reference Group has been established as part of the review to provide a forum for service users to contribute to the development of key documentation produced as part of the review. Due to the wide geographical area covered and the consequences of some members being current or very recent patients and therefore unable to travel to attend meetings, the group operates in a virtual way as well as through physical meetings. There are 24 patients on the user reference group, including head and neck cancer patients, benign ENT and benign OMF patients.

There has been patient and LINk representation on the Project Board and patient representation on the Project Team and Implementation Group.

The detail of the work undertaken with all these groups can be found within the stakeholder engagement report (see appendix 2).

An equality impact report has also been undertaken (see appendix 3). UH Bristol has detailed how they will take this work forward as part of their response to the advisory panel.

Stakeholders are kept up to date using newsletters, website and workshops.

6 Timescales

The earliest date implementation could happen is May 2012, once bed and theatre capacity is released by the opening of South Bristol Community Hospital. If approval is gained from NHS Boards and Scrutiny Committees, then this will allow a year to implement a smooth transition of services.

7 Does the NHS consider this proposal to be a substantial variation or development?

The NHS considers this to be a substantial variation but one which will have a positive impact for Wiltshire patients.

7.1 Benefits from a clinical perspective:-

Clinicians consider proposals will result in the benefits outlined above in section 3 of this report.

7.2 Benefits from a managerial perspective:-

Managers consider proposals will result in the benefits outlined above in section 3 of this report.

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

The impact assessment process was started at a meeting of the User Reference Group held on the 11th of November 2010. A draft version of this impact assessment was then circulated to all 24 members of the User Reference Group for them to provide written comments. In addition, Joan Bayliss, representative of the six Local Involvement Networks (LINks) on the Project Board, contacted all six LINks inviting them to comment on the draft impact assessment. This impact assessment takes into account all the comments received.

Questions	Responses
1. What are the benefits of the proposed service changes?	There are significant benefits which have been identified by clinicians and patients, these are described in section 3 of this document.
2. What are the dis-benefits? Include how you think these could be managed.	Reduced choice of location for patients for complex surgery. The view of patients is that this is outweighed by the significant benefits to the quality of care and patient experience which will come from centralising the surgical service.
3. Are there any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested?	There will be limited impact for patients, carers and families for patients from BaNES as the planned centralised service is approximately 4 miles from half of the existing service. University Hospitals Bristol is more accessible by public transport and only those patients with complex benign or cancer would be required to travel for inpatient or daycase surgery.
4. How do you think the proposed changes will affect the quality of the service?	The proposals will improve the quality of the service for the reasons described under section 3 above.
5. What do you think the impact of the proposed changes will be on health inequalities?	Equality Impact Assessment undertaken as part of this review concluded the proposals will have a positive impact in health inequalities. See the (appendix 3).
6. Any other comments	
7. If you are a representative of an organisation, such as LINKs, please indicate how you have drawn on the views of others from your group	All six LINks that cover the area of the Review have been invited to comment on the proposed changes. Joan Bayliss, LINk representative for the Review, has conveyed, LINks organisations support for proposals.

Part Three – Impacts at a glance

Impacts	NHS View	Patient/carer/public representatives' view
Impact on patients	+	+
Impact on carers	+	+
Impact on health inequalities	+	+
Impact on local health community	+	+

X = significant negative impact
? = negative impact for some
+ = positive impact

University Hospitals Bristol NHS
NHS Foundation Trust

Department of Oral & Maxillofacial Surgery
Bristol Dental Hospital
Lower Maudlin Street
Bristol BS1 2LY
Switchboard 0117 923 0000
Fax 0117 342 4503
http://www.uhbristol.nhs.uk/dental

P.G. GUEST MBChB BDS FDS RCS FRCS
S.J. THOMAS MB BCh BDS PhD FDS FRCS

C.W. HUGHES BDS,FDSRCS,MBChB,FRCS(OMFS)

Secretary: DEBBIE BOULT
0117 342 4392
Appts: 0117 342 3259

Secretary: NIKKI GOODWAY
0117 342 4392

Our Ref: CWH/KS
Typed: 13th October 2010

David Tappin
Director of Strategic Development
NHS Bristol

Dear David

I am writing to give supporting information for the proposed centralisation of ENT/OMFS/Head and Neck at University Hospitals Bristol.

Within OMFS for the Bristol/Bath region we are a small specialty with 7 Consultants covering a large geographical area with diverse needs covering: facial trauma, treatment of serious orofacial infection, facial deformity, head and neck cancer, oral surgery, cleft surgery etc. We support a centralised service.

There is no doubt that the failure of centralisation on a number of occasions in the past has seriously harmed development of a patient focused service for the region.

At all times during the last 20+ years there has been no doubt that a service which is centralised in its management, strategic planning and delivery would benefit patients, clinicians and the wider healthcare community. From an evidence base this is supported most importantly by common sense (for example using wisdom drawn from any aspect of the commercial sector consolidating its expertise and resource) but is also evidenced by extrapolating published results which apply to other cancer sites and non cancer related surgical experience; such as upper gastrointestinal surgery, gynaecological cancer and vascular surgery (ref 1.2.3.4).

Many of the clinicians who have a stake in the new service have worked in units nationally and internationally. It is clear that given adequate resource and central support 'world class' services will always aim to achieve a critical mass of expertise, resource and research capability at a central site.

The obstacle to this in Bristol has always been achieving consensus opinion when the service was looked at as 'a whole' (meaning that satisfaction of the requirements of every facet of a very diverse service is difficult and that the needs of one group within it may be compromised for some and advantaged for others by a centralisation service). This fact has been taken into account at all stages of the review of the Head and Neck Cancer/ ENT/OMFS review and clinicians have appreciated the transparency and inclusive nature of the process.

We have now achieved a position where consensus is reached. From an Oral and Maxillofacial Surgical viewpoint we all agree that a centralised service will benefit patients, clinicians and the wider health community at all levels of healthcare delivery.

1. The relationship between hospital volume and post-operative mortality rates for upper gastrointestinal cancer resections:Scotland 1982-2003.
   Skipworth RJE et al. European Journal of Surgery 2009.

2. Centralisation of oesophagogastric cancer services: can specialist units deliver?
   Forshaw MJ et al. Ann of Royal College of Surgeons of England 2006.

3. Centralisation of esophageal cancer surgery: does it improve clinical outcome?
   Wouters MWJM et al. Annals of Surgical Oncology. 2009.

4. Meta-Analysis and Systematic Review of the Relationship between Hospital Volume and Outcome following Carotid Endarterectomy.
   Holt PJE et al. European Journal of Endovascular Surgery. 2007.

With kind regards

Mr Ceri Hughes
Lead Clinician for Head & Neck

North Bristol NHS
NHS Trust

Our Ref: PAT/LD/

Department of Otolaryngology
Southmead Hospital
Westbury-on-Trym
Bristol BS10 5NB
(Switchboard: 0117 950 5050)
Direct Line: Tel. 0117 323 6221
Fax. 0117 323 5850
Secretary: *lynsey.dorney@nbt.nhs.uk*

Date: 29th September 2010

Rec'd 13/10/10

Ruth Hallet
Project Manager
Bristol PCT

Dear Ruth

At present Bristol is served with regard to its ENT needs by two departments located in the two trusts providing healthcare in the city. The departments work closely together but are geographically separated and have shown a strong desire to come together for at least 20 years. Clinicians see significant advantages such as increased specialisation and more efficient use of workforce and equipment. At the heart of such a reconfiguration is a desire to improve facilities and services for patients. The two departments have built up regional and national reputations for their service but could be stronger working together.

We recognise that we are dismantling a service that works well and has satisfied peer review to implement a new service model. There are clinical and service delivery risks involved with such a reconfiguration. However it is the consensus view of Clinicians that it is desirable to reconfigure services as there are potential benefits and efficiencies that will arise as a result of this reconfiguration, provided sufficient support with regard to process planning and capacity are put in place. Centralisation of the ENT surgical services will allow the appropriate development of the service in the future to benefit patients.

There is no clinical evidence base to confirm such a movement of services but if one examines other service providers throughout the UK and Europe it is self evident that larger institutions benefit their patients by having better access to new technology, specialist rather than generalist services and development of services arising out of research advances.

Yours sincerely

Paul Tierney MA FRCS (ORL-HNS)
Consultant ENT Surgeon

Avon, Somerset and Wiltshire NHS
Cancer Services

South Plaza
Marlborough Street
Bristol, BS1 3NX

Tel: 0117 976 6600
Fax: 0117 976 6601
Minicom: 0117 900 2675

Mr Geoffrey Pye BSc MSc DM FRCS FRCS(Ed)
Medical Director

geoffpye@nhs.net

4 November 2010

David Tappin
Director of Strategic Development
NHS Bristol
South Plaza
Marlborough Street
Bristol BS1 3NX

Dear David

Local Reconfiguration of Services for Head & Neck Cancer

ASWCS has long supported the review of clinical pathways for Head & Neck cancer on the basis of the clinical evidence of improved outcomes for centralised integrated surgical and oncological services. Evidence of clinical benefit was looked at in great detail in the preparation by NICE of the *Improving Outcomes Guidance* document. This forms the basis of the reconfiguration process.

In addition to the recommendations of the IOG, local clinicians have for many years been looking forward to developing a single site, integrated service that would provide the comprehensive care those patients with this disease require.

The nature of Head & Neck cancer is such that a truly multidisciplinary approach is required and offering this in a single centre of care will really enhance patient's experience of the process of diagnosis and treatment, both surgical and oncological, as well as ensuring optimum outcomes.

Yours sincerely

Ear, Nose and Throat, Oral and Maxillofacial and Head and Neck Cancers Services Review
Stakeholder Engagement Report

Version no.	2.0
Status	Approved
Author	Ruth Hallett
Approver	David Tappin
Date for approval/ Date approved	15th October 2010
Agreed circulation of this version	Draft version – internal review only Approved version – NHS South West and publicly available on website

Version	Date	Reviewer	Comment
0.1	24th Sept 10	Emma Phillips	Initial draft
0.2	30th Sept 10	Emma Phillips	Amends following meeting with Ruth Hallett
0.3	30th Sept 10	Ruth Hallett	Amends
1.0	15th Oct 10	David Tappin	Review and approval
1.1	10th Nov 10	Emma Phillips	Updated following Advisory Panel and to include details of where patients have influenced service spec
1.2	10th Nov 10	Ruth Hallett	Updated to incorporate changes in response to SHA feedback
1.3	11th Nov 10	Emma Phillips	Updated with details of how provider intends to respond to EIA
2.0	26th Nov 10	David Tappin	Review and approval

1 Purpose

This report documents all the stakeholder engagement activities undertaken as part of the Head and Neck Cancers, Ear, Nose and Throat (ENT) and Oral and Maxillofacial (OMF) Services Review since it started in November 2009 to date (November 2010) when the review's conclusions are being discussed with PCT Professional Executive Committees (PECs) and Boards and then with local scrutiny committees.

Stakeholder engagement has been a key component of the review, with three of the review's objectives clearly requiring this (to develop a clinically led, patient endorsed service model; to meet the needs of the local population and improve the patient experience and outcomes and to create a working environment which benefits clinicians and patients).

The Project Initiation Document emphasises the importance of strong stakeholder engagement and set out which stakeholders needed to be communicated with and how this would be done. This report considers the planned engagement with the actual engagement to date (November 2010).

2 Communication and Involvement

Communication and Involvement is one of the review's workstreams and a variety of approaches have been taken to achieve this. This section of the report describes each approach. The different approaches that have been employed reflect the purpose of the communication and involvement required and the stakeholder group being targeted. Section 3 sets out the different stakeholder groups and details the approaches used with them.

2.1 Interviews with Independent Facilitator

An Independent Facilitator was engaged at the beginning of the review to carry out individual interviews with a range of stakeholders. This allowed stakeholders to speak openly and honestly about current services, their views on what should and could change and their perceptions of anything that cause concern as the review progresses. During the interviews, stakeholders received a briefing on how the review would be structured and were invited to comment on and influence this prior to sign-off by the Project Board. The data gathered from the stakeholder interviews was used to help shape the development of the clinical model. See Appendix 1 for the list of stakeholders interviewed.

2.2 Stakeholder events

A number of stakeholder events have taken place throughout the review to present progress so far and enable a wider group of clinical stakeholders to comment. The first stakeholder event took place on the 23rd of November 2009 to establish if there was a drive to carry out the review. A second stakeholder event/ Clinical Reference Group (see section 2.10 below) took place on the 2nd of February 2010. This brought clinicians together specifically to work on the development of the clinical model. A third stakeholder event took place on the 2nd of March 2010 and was attended by 43 stakeholders. This event demonstrated consensus on the reviews approach and the emerging clinical model. See Appendix 2 for the list of attendees at this event.

2.3 Newsletter

A newsletter is produced at key stages in the review and distributed to anyone who has had any engagement in the review. People who receive the newsletter are encouraged to share it with their teams and colleagues. The newsletter reports on the progress of the review and keeps stakeholders informed of the next steps. As of November 2010 we have produced six newsletters. There has been positive feedback on the newsletter and it is considered particularly useful for those stakeholders not closely involved in the review process.

2.4 Website

A website page has been established for the review and contains key documents and details of the review for anyone to access. There are

contact details on the website for people to get in touch if they would like further information.

In addition to the public facing website, there is a restricted access website which all staff involved in the review, including all members of the Project Board, have access to. This is used to share draft documents.

2.5 Update letters

Letters have been produced to formally communicate decisions made by the Project Board to stakeholders as required.

2.6 Project Board

The Project Board is responsible for signing off key documents and making decisions relating to the review. It also has responsibility for agreeing the final set of recommendations.

The membership of the Project Board demonstrates the involvement of all the relevant Primary Care and Acute Trusts at decision-making level, representatives from all involved disciplines, including those involved in treating both benign and malignant ENT and OMF conditions, at decision-making level and representation from patients and Local Involvement Networks (LINks) at decision making level. See Appendix 3 for the full Project Board membership.

2.7 Project Team

The Project Team is responsible for undertaking the work required for the review.

The membership of the Project Team demonstrates involvement of clinicians throughout the development of the review and input from commissioners to ensure that proposals are feasible, will be adopted by commissioners and can be delivered by providers. See Appendix 4 for the full Project Team membership.

2.8 Implementation Group

The Implementation Group's first responsibility was to support the identified preferred provider through the due diligence process designed to test it could robustly deliver the agreed clinical model. Once the Advisory Panel recommended, and the Project Board agreed, that the preferred provider met the requirements of the due diligence process, the role of the group has evolved to oversee implementation.

The membership of the implementation group includes representation from disciplines that will be affected by the proposed changes from managerial and consultant level to staff on the wards. There is also union and HR representation on the Implementation Group. Patient representatives also form part of the Implementation Group to ensure their views remain an integral part of the reconfiguration. See appendix 5 for full membership list.

2.9 User Reference Group

A User Reference Group has been established as part of the review to provide a forum for service users to contribute to the development of key documentation produced as part of the review. Due to the wide

geographical area covered and the consequences of some members being current or very recent patients and therefore unable to travel to attend meetings, the group operates in a virtual way as well as through physical meetings. There are 24 patients on the user reference group, including head and neck cancer patients, benign ENT and benign OMF patients.

The User Reference Group has been meeting at key points during the review to ensure there has been patient, carer and public input throughout. The table in appendix 6 shows User Reference Group meeting dates and the areas they have input to.

2.10 Clinical Reference Group

A Clinical Reference Group has been established as part of the review to provide a forum for clinicians to comment on the review's process and consider how they can begin to work together as a team prior to the physical centralisation. The Clinical Reference Group Appendix 7 shows all the members of the clinical reference group.

In its first iteration, the Clinical Reference Group came together on the 2nd of February 2010 to work through the proposed clinical model (described as a stakeholder event in section 2.2 above).

2.11 Advisory Panel

The Advisory Panel has been established to recommend a location for the proposed centralised head and neck cancers, ENT and OMF service. It has been independently chaired by Professor Patrick Bradley, who has recently retired as Consultant Otolaryngologist / Head and Neck Oncologic Surgeon from Nottingham University Hospitals NHS Trust and has been involved in the Peer Review process. The Panel first convened on the 13th and 14th of May 2010 to make its recommendation and this was tested through a process of due diligence.

The Advisory Panel reconvened on the 4th of November 2010 to review the evidence submitted by the recommended provider as part of the due diligence process to ensure the recommendation was robust. The Panel subsequently recommended to the Project Board that University Hospitals Bristol NHS Foundation Trust (UH Bristol) provides the centralised hub at the Bristol Royal Infirmary (BRI) site.

The membership of the Advisory Panel included representation from public health, primary care and patients from outside of Bristol. See Appendix 8 shows the Advisory Panel membership.

3 Stakeholders

Appendix 9 shows the stakeholders identified at the start of the review. In line with the Project Initiation Document this report will deal with each stakeholder group in turn and set out how they have been engaged in the review.

3.1 Commissioners

The role of commissioners in the project is to provide their understanding of existing services into the service review and information about how any proposed model could be implemented and monitored in practice via commissioning arrangements.

Commissioners from all the Primary Care Trusts (PCTs) involved in the review have been written to throughout the review. This included an introductory letter about the review and outlining the review process. Commissioners were also given an opportunity to comment on the draft service specification prior to Project Board sign off. Louise Rickitt, Associate Director of Acute Commissioning, NHS South Gloucestershire, presented the service specification to the Advisory Panel on the 4th of November 2010.

The Independent Facilitator met with commissioners from the four main PCTs affected by the review – Bristol, North Somerset, South Gloucestershire and Bath and North East Somerset.

All commissioners were invited to the stakeholder event presenting the proposed clinical model on the 2nd of March 2010. Ann Jarvis, Director of Service Development for NHS South Gloucestershire, presented on behalf of all PCTs at this event indicating their support for the review process and the emerging clinical model.

PCT commissioners are represented on the Project Board by Ellen Rule, Programme Director for Planned Care and Cancer, NHS Bristol. Avon, Somerset and Wiltshire Cancer Services (ASWCS) Network is also represented on the Project Board by Tariq White, Nurse Director.

The ASWCS Network Commissioners Group has received three updates on the review to date (November 2010).

Commissioners from all the PCTs involved in the review and ASWCS receive copies of the newsletters.

Commissioners are represented on the Advisory Panel by Ellen Rule, Programme Director for Planned Care and Cancer, NHS Bristol. Ellen shared the draft service specification with commissioner across the network to ensure they all had an opportunity to input into the documents development.

3.2 Clinicians

The role of clinicians in the project is to develop the new service models and present this to the project board with the support of an independent facilitator. They informed the development of the site selection criteria, provided information to support the due diligence process and worked with Trust Management and Commissioners to develop a robust implementation plan.

A wide range of clinicians were interviewed by the Independent Facilitator – 37 spanning all the organisations affected by the review. The Independent Facilitator used the data gathered from the interviews to feed into the development of the clinical model.

The development of the clinical model has been led by three clinical leads: Hoda Booz, Consultant Oncologist; Ceri Hughes, Consultant in Maxillofacial Surgery and Paul Tierney, Consultant ENT Surgeon.

25 clinicians attended the stakeholder event on the 2nd of March 2010 which presented the approach to the review and the emerging clinical model. No concerns on either of these aspects were raised at this event.

There are currently 60 clinicians who are members of the Clinical Reference Group and it is anticipated that this will increase as the review moves towards implementation and clinicians have more questions about the practical implications for them. The feedback from this group has been helpful to the Trust in helping them in putting together the information for the advisory panel.

All clinicians who have engaged with the review at any stage are receive copies of the newsletter and are encouraged to share this with their colleagues.

There is clinical representation on the Project Board for all disciplines involved in the review: ENT consultant surgeons, OMF consultant surgeons, oncologists, radiologists, plastic surgeons, clinical nurse specialists and speech and language therapists.

Clinicians are also involved in the Implementation Group and there have been a number of one to one meetings to ensure their concerns have been listened to. Their feedback has been important in agreeing that there should a single organisation managing the whole service, that cochlear implants should be in the scope of the review and agreeing the planning assumptions for the capacity model (to ensure the right range of beds and theatres available).

3.3 Local Authority

The role of the local authority in the project is to provide public scrutiny of the Head and Neck Cancers Service Review project process and to be aware of how service changes may impact provision of other local authority services.

Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, Somerset and Wiltshire Scrutiny Committees have received two updates on the review via the ASWCS Network update meetings.

Democratic officers receive the newsletter which they are encouraged to share with scrutiny committee members.

The conclusions from the review will be discussed with all six local scrutiny committees at their January 2011 meetings (agenda slots arranged), following approval of recommendations from PCT PECs and Boards.

3.4 Research

The role of researchers in the project has been to inform the service reviews on the impact of any proposed model on the research capability. They have also been asked to participate in the development of the benefits management process.

Research representatives received the project briefing and had interviews with the Independent Facilitator to ensure their views were incorporated into the clinical model. This included Andy Ness, Professor of Epidemiology and Steve Thomas, Consultant Maxillofacial Surgeon and Professor at University of Bristol. Andy Ness also presented the requirements for research to the Advisory Panel on the 13th and 14th of May 2010 and Steve Thomas has also been involved in the development of the benefits register and plan.

There is research representation on the Project Board, provided by Jonathan Sandy.

All researchers who have engaged with the review receive copies of the newsletter and are encouraged to share this with their colleagues.

3.5 Trust Management

The role of trust management is to support the decisions coming out the Service Review, provide information to support the due diligence process and to work with other stakeholders to ensure the development of a robust implementation plan.

David Tappin, the Project Director, has written to all Chief Executives of all the organisations involved in the review informing them of the review and the approach being taken. He also provides regular updates to the Healthy Futures Programme Board which Chief Executives of Bristol, North Somerset and South Gloucestershire Primary Care and Acute Trusts sit on.

The Medical Directors of North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust and the Royal United Hospital Bath NHS Trust are all members of the Project Board. Jonathan Sheffield, Medical Director for UH Bristol presented at the stakeholder event on the 2nd of March on behalf of his fellow medical directors and the Trusts they work for indicating their support for the approach to the review, their endorsement of the proposed clinical model and their commitment to support the implementation of the outcomes of the review irrespective of the site selected to host the centralised hub.

Medical Directors from the two potential 'hub' sites presented evidence to the Advisory Panel when it first met in May 2010. Chris Burton, Medical Director for NBT presented to the reconvened Advisory Panel on the 4th of November to state NBT's commitment to support the implementation of the outcomes of the review by working closely with UH Bristol. Furthermore, NBT have seconded Carly Powell, Assistant General Manager, to UH Bristol half time to as an Operational Manager to consider how the two teams can work together more collaboratively regardless of the outcome of the review.

3.6 Patient, Carer and Public

The role of patient, carer and public stakeholders is to ensure the views of the public, patients and carers are taken into consideration in developing the service model and site criteria.

Existing head and neck cancer patient support groups were visited as part of the project initiation phase of the review. This includes two Bristol based groups (the Laryngectomy Support Group and the Bristol Head and Neck Cancer Support Group (the 'collar' group)) and a Weston-super-Mare based support group. There have been two subsequent visits to the Weston support group to keep them up to date with the reviews progress. Established patient support groups do not exist in Bath, Somerset or Wiltshire. The Independent Facilitator also interviewed the chairs of all three support groups to ensure members views could be incorporated into the clinical model.

There has been patient representation on the Project Board via Liz Eley, a Somerset patient. Liz Eley spoke to other patients and worked with the existing patient groups to present patient and carer views to the stakeholder workshop on the 2nd of March. She indicated their support of the approach to the review and the proposed clinical model, highlighting the aspects specifically put in at the request of the patients and carers and noting the concerns that remain to be addressed throughout the review.

There are 24 patients on the user reference group, including head and neck cancer patients, benign ENT and benign OMF patients. In order to facilitate a wider membership, patients are able to send in their comments and feedback in writing, via email and over the phone if they are not able to attend meetings. Members of the User Reference Group were given opportunities to feed into the development of the service specification and as a result the specification now includes, for example, a stipulation that the provider must outline how they will offer out of hours support, advice and guidance for patients , how they will manage emergency admissions for head and neck cancer patients, the need to provide a designated waiting area for families and carers and a requirement to discuss post-operative communication during pre-treatment stage (further examples can be provided upon request).

"We were pleased to be included in the Head & Neck/ENT Review for reconfiguring the service as more than just a 'tick-in-the-box' consultation. We have truly been part of the team on this project. I represented the patients from both outside Bristol and from Bristol on the Review Group and on the Board and later on the Implementation Group. A fellow patient also attends many meetings on behalf of the Bristol Collar Group. We welcomed the opportunity to make representations to the Advisory Panel, giving the diverse views from patients and are pleased that they recommended BRI site, which was the most convenient to the majority of us. We will offer our patient support at the Overview and Scrutiny committees, as we have a User Group specific to this Review who were involved in the decision, and of course we have consulted with local Groups and patients too. It is great that any patient is welcomed and listened to, but more to the point, action is taken by the hospital, too. We have had a number of our points included in the service specification and will have ongoing involvement and monitoring of this service for the future. It will back up the excellent surgery with an improved overall experience for us patients."

Liz Eley, User Reference Group

Assessment used individual patient interviews and the user reference group to help shape its recommendations. The provider has responded to the points raised, for example the providers has committed to involve patients with learning disabilities in planning the signage for the ward to ensure it is clear and does not cause confusion and to involve the Trust Equality and Diversity Manager in developing partnerships with community groups, health trainers and faith communities to support prevention activities (further examples can be provided upon request).

All patient representatives who have been engaged in the review receive copies of the newsletter.

There is a patient representative on the Advisory Panel to ensure that the panel keep patient and carer requirements at the forefront of their thinking.

3.7 Voluntary Sector

The voluntary sector has a role to play in supporting patients and carers affected by Head and Neck Cancer. We will be ensuring they are kept up to date with the progress of the project.

3.8 Strategic Health Authority

The Strategic Health Autority have oversight of the project progress.

The Strategic Health Authority has received regular updates on the progress of the review.

3.9 GP Commissioners

The role of GP Commissioners is currently undergoing a significant change and in light of this, the importance of engaging with this group to ensure they support the proposals has become evident.

The review has sought to keep GP Commissioners informed and offer the opportunity to become more engaged in the review. This has been achieved via articles in local GP newsletters and a briefing to GP Consortia. There have been update papers to all PECs and opportunities to comment on the draft service specification. The views of the nascent GP Consortia were presented to the Advisory Panel by Will Warin on the 4th on November. Letters from each of the three Bristol localities and emails from South Gloucestershire and Bath and North East Somerset indicate their support for the review. Responses from North Somerset, Wiltshire and Somerset GPs are currently being collated. Their feedback has been important in shaping the advisory panel's recommendation regarding investigating how GP's and patients carers can become more involved in end of life care.

The review's conclusions will be discussed with all PECs.

4 Future Stakeholder Engagement

As the review approaches the implementation phase, it is important to maintain and strengthen stakeholder engagement to ensure this stage is successful and prevent any reduction in service quality during the transition.

As reported above, HR and staff union representatives sit on the implementation group and are developing a plan for staff consultation. Furthermore, informal meetings between UH Bristol and NBT staff, particularly ward staff, are planned.

The merging together of the Clinical and User Reference Groups will enable a wide range of stakeholders to come together to plan and agree the most appropriate way to manage the transition and ensure the recommendations made as part of the review are implemented and a high quality service for patients and carers is maintained throughout this period.

Newsletters will continue to be produced to keep stakeholders updated and the provider has committed to continue this during implementation.

Appendix 1

List of stakeholders interviewed by Independent Facilitator

Name	Job Title/ Remit	Organisation
David Baldwin	Consultant ENT Surgeon	North Bristol NHS Trust
Matthew Beasley	Consultant in Clinical Oncology	University Hospitals Bristol NHS Foundation Trust
Jane Beckinsale	Speech and Language Therapist	University Hospitals Bristol NHS Foundation Trust
Hoda Booz	Consultant in Clinical Oncology	University Hospitals Bristol NHS Foundation Trust
Chris Bryant	Director of Hospital Services	Weston Area Health NHS Trust
Chris Burton	Medical Director	North Bristol NHS Trust
Caroline Calder	Consultant in Histopathology	University Hospitals Bristol NHS Foundation Trust
Diane Cornish	General Manager	North Bristol NHS Trust
Rebecca Davies	Dental Radiologist	University Hospitals Bristol NHS Foundation Trust
Tony Daws	Chairman	Laryngectomy Support Group
Karin Denton	Consultant Cytopathologist	North Bristol NHS Trust
Martin Evans	Consultant Maxillofacial Surgeon	North Bristol NHS Trust
Donna Graham	Clinical Nurse Specialist	University Hospitals Bristol NHS Foundation Trust
Jackie Griffiths	Speech and Language Therapist	University Hospitals Bristol NHS Foundation Trust
Phil Guest	Consultant Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust
Daniel Hajioff	Consultant Otolaryngologist	North Bristol NHS Trust
Hilary Hiscox	Ward nurse	University Hospitals Bristol NHS Foundation Trust
Sarah Hudson	Cancer Services Manager	University Hospitals Bristol NHS Foundation Trust
Ceri Hughes	Consultant in Maxillofacial Surgery	University Hospitals Bristol NHS Foundation

Name	Job Title/ Remit	Organisation
		Trust
Petra Jankowska	Consultant Oncologist	Taunton and Somerset NHS Foundation Trust
Ann Jarvis	Director of Service Development	NHS South Gloucestershire
Claudia Jemmott	Acute Dietetic Team Lead for the BRI and Oncology Dietetians	University Hospitals Bristol NHS Foundation Trust
Cederick Jones	Chairman	Bristol Head and Neck Cancer Support Group
Julian Kabala	Consultant in Clinical Radiology	University Hospitals Bristol NHS Foundation Trust
Alan Lawler	Associate Director of Commissioning	NHS North Somerset
Deborah Lee	Director of Commissioning	NHS Bristol
Teresa Levy	Cancer Services Manager	University Hospitals Bristol NHS Foundation Trust
Helen Lockett	Associate Director of Nursing and Clinical Development	Bristol Community Health
Kathy Lord	Head of Dietetics	North Bristol NHS Trust
Hester McLaine	Commissioning Lead for Cancer	NHS North Somerset
Richard Nelson	Consultant Neurosurgeon & Skull Base Surgeon	North Bristol NHS Trust
Andy Ness	Professor of Epidemiology	University Hospitals Bristol NHS Foundation Trust
Mike Nevin	Head of Division – Surgery, Head and Neck	University Hospitals Bristol NHS Foundation Trust
Desmond Nunez	Consultant Otolaryngologist	North Bristol NHS Trust
Antonio Orlando	Plastic Surgeon	North Bristol NHS Trust
Graham Porter	Consultant in ENT Surgery	University Hospitals Bristol NHS Foundation Trust
Libby Potter	Clinical Nurse Specialist	North Bristol NHS Trust
Miranda Pring	Special Oral Pathologist	University Hospitals Bristol NHS Foundation Trust
Colette Reid	Palliative Care Consultant	University Hospitals Bristol NHS Foundation Trust
Peter Revington	Consultant Maxillofacial Surgeon	North Bristol NHS Trust
Philip Robinson	Consultant Otolaryngologist	North Bristol NHS Trust

Name	Job Title/ Remit	Organisation
Amanda Saunders	Cancer Commissioning Manager	NHS Bristol
Debbie Sharp	Professor of Primary Care Health Care	University of Bristol
Ed Sheffield	Consultant in Histopathology	North Bristol NHS Trust
Jonathan Sheffield	Medical Director	University Hospitals Bristol NHS Foundation Trust
Jacqui Sparkes	Clinical Nurse Specialist	North Bristol NHS Trust
Steve Thomas	Consultant Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust
Claire Thompson	Divisional Manager, Surgery, Head and Neck	University Hospitals Bristol NHS Foundation Trust
Paul Tierney	Consultant ENT Surgeon	North Bristol NHS Trust
John Waldron	Consultant ENT Surgeon	Royal United Hospital Bath NHS Trust
Robert Warr	Consultant Plastic Surgeon	North Bristol NHS Trust
Morwenna White-Thompson	Speech and Language Therapist	North Bristol NHS Trust
Paul Wilson	Orthodontist	University Hospitals Bristol NHS Foundation Trust

Appendix 2

Attendees at the Stakeholder Event on the 2nd of March 2010

Name	Role	Organisation
Professor Debbie Sharpe	Professor of Primary Care Health Care	University of Bristol
Mr Sharpe	Patient	Independent
Amanda Saunders	Cancer Commissioning Manager	NHS Bristol
Ann Jarvis	Director of Service Development	NHS South Gloucestershire
Dany Bell	Cancer Services Manager	North Bristol NHS Trust
Daniel Hajioff	ENT Consultant	North Bristol NHS Trust
Graham Porter	Consultant ENT Surgeon and Clinical Lead	University Hospitals Bristol NHS Foundation Trust
Harry Hayer (in place of Chris Burton)	Director of Organisation, People and Performance	North Bristol NHS Trust
Daphne Havercroft	Lay member	Independent
Prof Jonathan Sandy	Head of Dental School	University of Bristol
Julie Deamer	Modality Lead Nuclear Medicine	North Bristol NHS Trust
John Waldron	Medical Director	Royal United Hospital Bath NHS Trust
Donna Graham	Clinical Nurse Specialist	University Hospitals Bristol NHS Foundation Trust
Caroline Calder	Pathologist	University Hospitals Bristol NHS Foundation Trust
Miranda Pring	Consultant Senior Lecturer Oral & Maxillofacial Pathology	University Hospitals Bristol NHS Foundation Trust
Richard Smale	Programme Director	NHS Bristol
Desmond Nunez	Consultant ENT Surgeon	North Bristol NHS Trust
Tony Jones	PPI Manager	NHS Bristol
Joanna Galpin	Consultant Radiographer & Superintendent of Nuclear Medicine	University Hospitals Bristol NHS Foundation Trust
Claudia Jemmott	Adult Acute Dietetic Manager	University Hospitals Bristol NHS Foundation Trust
Helen Cooper	Sister, Outpatients Services	University Hospitals Bristol NHS Foundation Trust
Claire Greville-Heygate	Speech and Language Therapist	University Hospitals Bristol NHS Foundation Trust
Susan Armstrong	Consultant Radiologist	North Bristol NHS Trust
Suzanne Ford	Chief Dietitian	North Bristol NHS Trust

Teresa Levy	Cancer Manager	University Hospitals Bristol NHS Foundation Trust
Joan Bayliss	LINks Representative	
Michael Norman	Senior Lecturer	University of Bristol
Jackie Sparks	Macmillan Head and Neck Nurse	North Bristol NHS Trust
Claire Thompson	Divisional Manager	University Hospitals Bristol NHS Foundation Trust
Tony Daws	Chair	Larygectomy Support Group
Liz Eley	Patient	
Antonio Orlando	Plastic Surgeon	North Bristol NHS Trust
Hoda Al Booz	Consultant in Clinical Oncology	University Hospitals Bristol NHS Foundation Trust
Tariq White	Nurse Director	Avon, Somerset and Wiltshire Cancer Services Network
David Tappin	Director of Strategic Development	NHS Bristol
Aidan Moran	Dentist	NHS Bristol
Jonathan Sheffield	Medical Director	University Hospitals Bristol NHS Foundation Trust
Ceri Hughes	Consultant Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust
Hilary Hiscox	Sister, ENT Outpatients	University Hospitals Bristol NHS Foundation Trust
Jane Beckinsale	Macmillan Speech and Language Therapist	University Hospitals Bristol NHS Foundation Trust
Tony Brook	Dental Surgeon	University Hospitals Bristol NHS Foundation Trust
Rebecca Davies	Dental Radiologist	University Hospitals Bristol NHS Foundation Trust
Colette Reide	Palliative Care Consultant	University Hospitals Bristol NHS Foundation Trust

Appendix 3

Project Board Membership

Name	Role on Project Board	Job Title	Organisation
Deborah Evans	Project Board Chair	Chief Executive	NHS Bristol
David Tappin	Project Director	Director of Strategic Development	NHS Bristol
Ruth Hallett	Present key project information to the Board	Project Manager	R2H Consulting
Nigel Warmington	Independent assurance of workstream recommendations	Independent Facilitator	BASIS
Richard Smale	Project Assurance	Programme Director	NHS Bristol
Chris Burton	Representing NBT	Medical Director	North Bristol NHS Trust
Jonathan Sheffield	Representing UHB	Medical Director	University Hospitals Bristol NHS Foundation Trust
John Waldron	Representing RUH both management and clinical views	Medical Director	Royal United Hospital Bath NHS Trust
Dr Hoda Booz	Representing views of ASW site specific group and Oncologist	Chair of the ASW site specific group and Oncologist	University Hospitals Bristol NHS Foundation Trust
Paul Tierney	Representing ENT Surgeons	ENT Surgeon	North Bristol NHS Trust
Ceri Hughes	Representing Maxillofacial Surgeons	Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust
Antonia Orlando	Representing Plastics Surgeons	Plastic Surgeon	North Bristol NHS Trust
Dr Julian Kabala	Representing	Radiologist	University

Name	Role on Project Board	Job Title	Organisation
(Sue Armstrong to deputise if required)	Radiologists		Hospitals Bristol NHS Foundation Trust or North Bristol NHS Trust
Karen Denton (Ed Sheffield to deputise if required)	Representing pathologists	Pathologist	North Bristol NHS Trust
Donna Graham (Jacqueline Sparkes to deputise if required)	Representing specialist nurses	Specialist Nurse	North Bristol NHS Trust or University Hospitals Bristol NHS Foundation Trust/
Morwenna White-Thomson (Jane Beckinsale to deputise if required)	Representing Speech and language therapists	Speech and language therapist	North Bristol NHS Trust
Jonathan Sandy	Representing researchers		University Hospitals Bristol NHS Foundation Trust
Liz Eley	Representing the Head and Neck Cancer patient need	Patient Representative	N/A
Joan Bayliss	Ensuring public accountability	Link Representative	N/A
Ellen Rule	Commissioning experience to help inform implementation	Programme Director for Planned Care and Cancer	NHS Bristol
Tariq White	Wider Cancer Network awareness	ASWCS Network Nurse Director	Avon Somerset and Wiltshire Cancer Network
Ardiana Gjini		Public Health Consultant	NHS Bristol
Colette Reid	Representing Palliative Care	Palliative Care Consultant	University Hospitals Bristol NHS Foundation Trust
Desmond Nunez	Representing ENT	ENT Consultant	North Bristol NHS

Name	Role on Project Board	Job Title	Organisation
	clinicians		Trust
Peter Revington	Representing OMF clinicians	Consultant in Oral and Maxillofacial Surgery	University Hospitals Bristol NHS Foundation Trust

Appendix 4

Project Team membership

Name	Role on the Project Team	Title	Organisation
Ruth Hallett	Chair	Project Manager	R2H Consulting
Hoda Booz	Clinical lead	Consultant in Clinical Oncology	University Hospitals Bristol NHS Foundation Trust
Lucy Elliss-Brookes	Data manager	Associate Director, Commissioning and Cancer Intelligence	Avon, Wiltshire and Somerset Cancer Network
Kate Cooke	Equality Impact Assessment lead and clinical adjacencies report	Project Support Officer	NHS Bristol
Diane Cornish/ Dany Bell	Link for North Bristol NHS Trust	General Manager/Cancer Services Manager	North Bristol NHS Trust
Serena Fazal	Finance officer	Senior Contracting Accountant	NHS Bristol
Trevor Foster	Geographical Information Systems (GIS) support	GIS Specialist Team Leader	Avon IM&T Consortium
Ardiana Gjini	To provide Public Health perspective and lead Health Equity Audit	Consultant in Public Health	NHS Bristol
Daphne Havercroft	To champion patient benefits and incorporate learning from the Breast Care Services Review	Project Team Advisor	Independent
Ceri Hughes	Clinical lead	Consultant in Maxillofacial Surgery	University Hospitals Bristol NHS Foundation Trust
Tony Jones	Provide advice on user and carer involvement	PPI Manager	NHS Bristol
Emma Phillips	To support Project Team members and the project	Programme Support Officer	NHS Bristol
Amanda Saunders	To provide commissioning input and lead on the	Cancer Commissioning	NHS Bristol

Name	Role on the Project Team	Title	Organisation
	service specification and satellite and spoke	Manager	
Richard Smale	Feedback on key deliverables, support and advice to Project Team members	Project Assurance	NHS Bristol
Claire Thompson	Link for University Hospitals Bristol NHS Foundation Trust	Divisional Manager	University Hospitals Bristol NHS Foundation Trust
Paul Tierney	Clinical lead	Consultant ENT Surgeon	North Bristol NHS Trust
Tariq White	To ensure review delivers IOG compliance	Nurse Director	Avon, Wiltshire and Somerset Cancer Network

Appendix 5

Implementation Group membership

Name	Title	Organisation	Responsibilities
Claire Thompson	Divisional Manager	University Hospitals Bristol NHS Foundation Trust	Operational impacts management
Carly Powell	Assistant General Manager – Neurosciences	North Bristol NHS Trust	Operational impacts management
Paul Tierney	Consultant Ear, Nose and Throat Surgeon	North Bristol NHS Trust	Chair and Clinical engagement
Ceri Hughes	Consultant Oral and Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust	Chair and Clinical engagement
Hoda Booz	Chair of the ASW site specific group and Oncologist	University Hospitals Bristol NHS Foundation Trust	Representing views of ASW site specific group and Oncologist
Ruth Hallett	Project Manager	R2H Consulting	Project governance
Jeremy Spearing	Finance Manager	University Hospitals Bristol NHS Foundation Trust	Information and finance
Catherine Baldwin	Finance Manager	North Bristol NHS Trust	Information and finance
Katie Murray/ Becky Hocking	HR Manager	University Hospitals Bristol NHS Foundation Trust	Staff communications
Janet Fowler	HR Manager	North Bristol NHS Trust	Staff communications
Carole Tookey/ Donna Graham / Rob Buller	Matron	University Hospitals Bristol NHS Foundation Trust	Nursing representative (Matron / CNS / ward manager)
Sue Parker/ Jacqui Sparkes or Libby Potter / Sylvia Rubino	Matron	North Bristol NHS Trust	Nursing representative (Matron / CNS / ward manager)
Liz Eley	Cancer Patient representative	Independent	Patient representation
Ellen Rule	Programme Director	NHS Bristol	Commissioning Representative

Other people will join the Implementation Group as required. These may include representatives from:

- CNS
- Dieticians
- Speech and Language Therapists
- Pharmacy
- Pathology
- Oncology
- Palliative care
- Clinical psychology
- Estates
- Dental specialists
- Audiologists
- Researchers
- Neurosurgery
- Plastics
- Intensivists
- Radiology
- Anaesthetists

Appendix 6

User Reference Group meetings

Date	Time	Venue	Main purpose
22nd February	2.30pm – 4pm	Deaf Centre, King Square, Bristol, BS2 8EE	Discuss proposed service model
27th April	10.30am – 12.30pm + lunch	Deaf Centre, King Square, Bristol, BS2 8EE	Complete Equality Impact Assessment. Invitation to this meeting will be extended to other appropriate representatives.
3rd June	2pm – 4pm	Deaf Centre, King Square, Bristol, BS2 8EE	Feed into the due diligence process for the site
12th August	10am – 12pm	Deaf Centre, King Square, Bristol, BS2 8EE	Contribute to Provider Response
2nd September	2pm – 4pm	Deaf Centre, King Square, Bristol, BS2 8EE	Contribute to Provider Response

Appendix 7

Clinical Reference Group membership

Name	Job Title/ Remit	Organisation
Sue Armstrong	Radiologist	North Bristol NHS Trust
David Baldwin	Consultant ENT Surgeon	North Bristol NHS Trust
Matthew Beasley	Consultant in Clinical Oncology	University Hospitals Bristol NHS Foundation Trust
Jane Beckinsale	Speech and Language Therapist	University Hospitals Bristol NHS Foundation Trust
Dany Bell	Cancer Services Manager	North Bristol NHS Trust
Wim Blancke	Consultant Anaesthetist	North Bristol NHS Trust
Hoda Booz	Consultant in Clinical Oncology	University Hospitals Bristol NHS Foundation Trust
James Brennan	Clinical Psychologist	University Hospitals Bristol NHS Foundation Trust
Tony Brookes	Dental Surgeon	University Hospitals Bristol NHS Foundation Trust
Rob Buller	Ward Manager	University Hospitals Bristol NHS Foundation Trust
Carol Cook	Clinical Nurse Specialist	Royal United Hospital Bath NHS Trust
Diane Cornish	General Manager	North Bristol NHS Trust
Jacqueline Cornish	Head of Division, Women's and Children's Services	University Hospitals Bristol NHS Foundation Trust
Rachel Craven	Anaesthetist	University Hospitals Bristol NHS Foundation Trust
Susan Douglas	Locum Consultant in ENT	University Hospitals Bristol NHS Foundation Trust
Tony Fielding	GP	NHS Bristol
Peter Goyder	GP	NHS Bristol
Donna Graham	Clinical Nurse Specialist	University Hospitals Bristol NHS Foundation Trust
Jackie Griffiths	Speech and Language Therapist	University Hospitals Bristol NHS Foundation Trust
Phil Guest	Consultant Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust

Name	Job Title/ Remit	Organisation
Daniel Hajioff	Consultant Otolaryngologist	North Bristol NHS Trust
Hilary Hiscox	Ward nurse	University Hospitals Bristol NHS Foundation Trust
Sarah Hudson	Cancer Services Manager	University Hospitals Bristol NHS Foundation Trust
Ceri Hughes	Consultant in Maxillofacial Surgery	University Hospitals Bristol NHS Foundation Trust
Claudia Jemmott	Acute Dietetic Team Lead for the BRI and Oncology Dietetians	University Hospitals Bristol NHS Foundation Trust
Tina Jewell	ENT Nurse Practitioner	North Bristol NHS Trust
Julian Kabala	Consultant in Clinical Radiology	University Hospitals Bristol NHS Foundation Trust
Claire Langton-Hewer	Consultant Otolaryngologist	University Hospitals Bristol NHS Foundation Trust
Teresa Levy	Cancer Services Manager	University Hospitals Bristol NHS Foundation Trust
Kathy Lord	Head of Dietetics	North Bristol NHS Trust
Jane Luker	Radiologist	University Hospitals Bristol NHS Foundation Trust
Fiona MacKay	Clinical Nurse Specialist	Royal United Hospital Bath NHS Foundation Trust
Steve Mather	Consultant in Anaesthesia and Perioperative Medicine	University Hospitals Bristol NHS Foundation Trust
Ed Morris	Anaesthetist	North Bristol NHS Trust
Richard Nelson	Consultant Neurosurgeon & Skull Base Surgeon	North Bristol NHS Trust
Andy Ness	Professor of Epidemiology	University Hospitals Bristol NHS Foundation Trust
Desmond Nunez	Consultant Otolaryngologist	North Bristol NHS Trust
Antonio Orlando	Plastic Surgeon	North Bristol NHS Trust
Kevin Page	Prosthetics	North Bristol NHS Trust
Darren Pinder	ENT Surgeon	Royal United Hospital Bath NHS Foundation Trust
Graham Porter	Consultant in ENT Surgery	University Hospitals Bristol NHS Foundation Trust

Name	Job Title/ Remit	Organisation
Libby Potter	Clinical Nurse Specialist	North Bristol NHS Trust
Carly Powell	Assistant General Manager	North Bristol NHS Trust
Miranda Pring	Special Oral Pathologist	University Hospitals Bristol NHS Foundation Trust
Anne Pullyblank	Surgeon and Lead for Clinical Risk	North Bristol NHS Trust
Colette Reid	Palliative Care Consultant	University Hospitals Bristol NHS Foundation Trust
Peter Revington	Consultant Maxillofacial Surgeon	North Bristol NHS Trust
Philip Robinson	Consultant Otolaryngologist	North Bristol NHS Trust
Sylvia Rubino	Ward Manager	North Bristol NHS Trust
Ellen Rule	Programme Director – Planned Care and Cancer	NHS Bristol
Jonathan Sandy	Head of Dental School	University Hospitals Bristol NHS Foundation Trust
Mike Saunders	Consultant Otolaryngologist	University Hospitals Bristol NHS Foundation Trust
Ahmed Shaaban	Consultant Otolaryngologist	North Bristol NHS Trust
Ed Sheffield	Consultant in Histopathology	North Bristol NHS Trust
Jonathan Sheffield	Medical Director	University Hospitals Bristol NHS Foundation Trust
Catherine Sluman	Speech and Language Therapist	North Bristol NHS Trust
Pat Smith	Audiologist	University Hospitals Bristol NHS Foundation Trust
Jacqui Sparkes	Clinical Nurse Specialist	North Bristol NHS Trust
Steve Thomas	Consultant Maxillofacial Surgeon	University Hospitals Bristol NHS Foundation Trust
Claire Thompson	Divisional Manager, Surgery, Head and Neck	University Hospitals Bristol NHS Foundation Trust
Paul Tierney	Consultant ENT Surgeon	North Bristol NHS Trust
Carole Tookey	Matron	University Hospitals Bristol NHS Foundation Trust
Natty Triskel	Clinical Psychologist	North Bristol NHS Trust
John Waldron	Consultant ENT Surgeon	Royal United Hospital Bath NHS Trust
Robert Warr	Consultant Plastic Surgeon	North Bristol NHS Trust

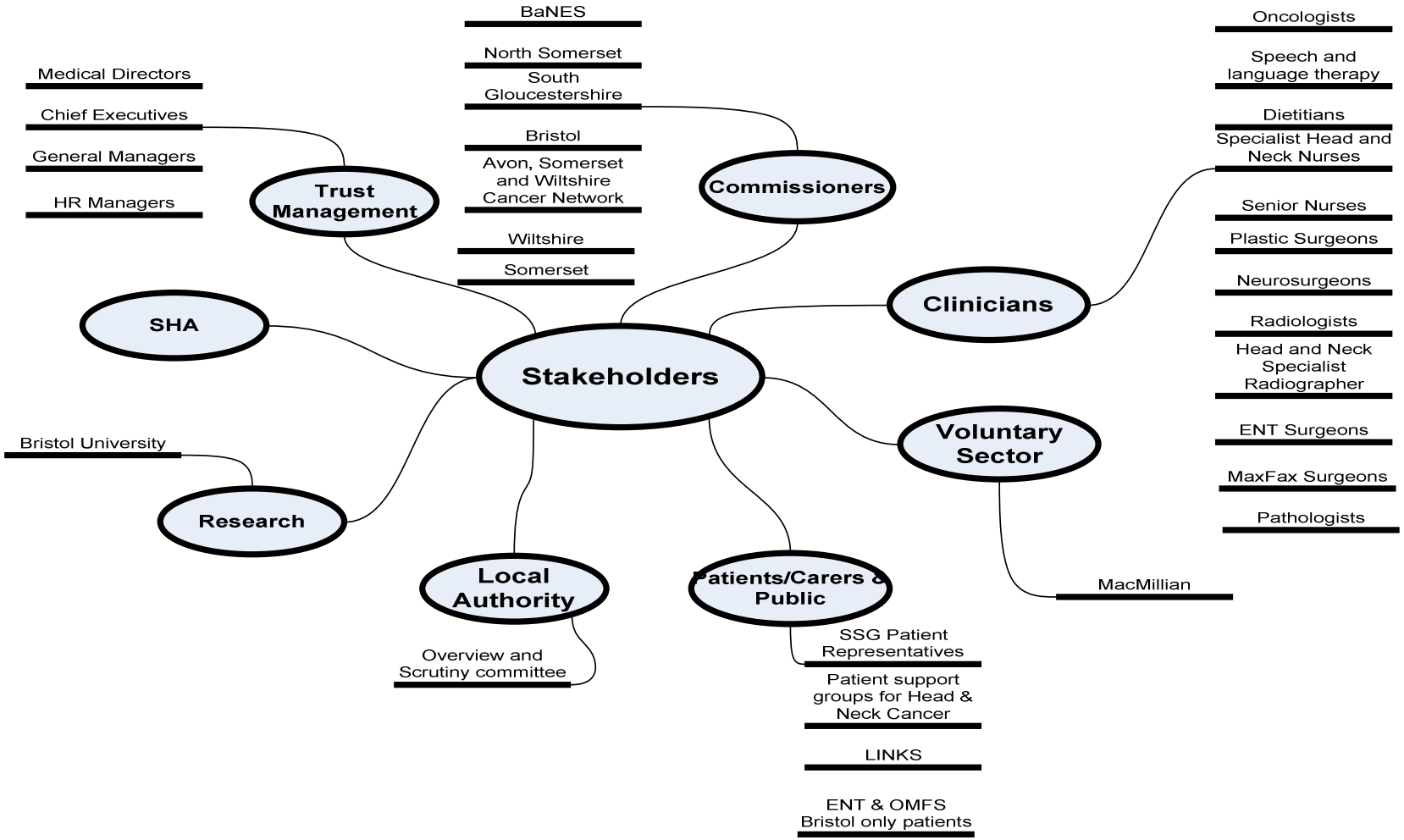
Name	Job Title/ Remit	Organisation
Dawn Webster	Audiologist	North Bristol NHS Trust
Mike Wheeler	Dental School Manager	University Hospitals Bristol NHS Foundation Trust
Morwenna White-Thompson	Speech and Language Therapist	North Bristol NHS Trust
Andrew Wilkinson	Audiologist	North Bristol NHS Trust

Appendix 8

Advisory Panel Membership

Name	Job title	Organisation
David Tappin	Director of Strategic Development	NHS Bristol
Pat Bradley	Independent Chair	
Aidan Moran	Dentist	Redland Park Dental Surgery
Dusty Walker	Non-executive director	NHS Bath and North East Somerset
Maggie Rae	Director of Public Health	NHS Wiltshire
Marilyn Jones	Patient Representative	
Nigel Warmington	Independent Facilitator	Basis
Ellen Rule	Programme Director for Planned Care and Cancer	NHS Bristol
Claire Barber	Head and Neck Specialist Nurse	The Royal Devon and Exeter NHS Foundation Trust

Appendix 9


Stakeholders
Trust Management
Medical Directors
Chief Executives
General Managers
HR Managers
Commissioners
BaNES
North Somerset
South Gloucestershire
Bristol
Avon, Somerset and Wiltshire Cancer Network
Wiltshire
Somerset
Clinicians
Oncologists
Speech and language therapy
Dietitians
Specialist Head and Neck Nurses
Senior Nurses
Plastic Surgeons
Neurosurgeons
Radiologists
Head and Neck Specialist Radiographer
ENT Surgeons
MaxFax Surgeons
Pathologists
SHA
Voluntary Sector
MacMillian
Research
Bristol University
Local Authority
Overview and Scrutiny committee
Patients/Carers & Public
SSG Patient Representatives
Patient support groups for Head & Neck Cancer
LINKS
ENT & OMFS Bristol only patients

This page is intentionally left blank

Equality Impact Assessment

On the

Head and Neck Cancers, Ear, Nose and Throat and Oral and Maxillo Facial Services Review

(Access and use of the service by patients)

Version 1.0

Contents

Equality Impact Assessment Front Sheet

Name of the service being assessed: Head and Neck Cancers Services Review

Directorate: Public Health

Date Impact Assessment completed: 15th June 2010

Is this a new or existing service?	New	N	Existing	Y
Is this a provided or a commissioned service?	Provided	N	Commissioned	Y
Is this EIA part of a service review or a service change?	Review	Y	Change	N

On which equality strands/target groups has this Impact Assessment been carried out?

Race	Y	Religion or Belief	Y	Disability	Y	Gender	Y
Age	Y	Sexual Orientation	Y	Health			

Names and roles of the people carrying out the Impact Assessment (ie the steering group):
This document has been produced as part of the Head and Neck Service Review. The project team meeting for this review has been used to discuss the document and the project board has signed it off. The Project Team comprises of the following members:
Ruth Hallett, Hoda Booz, Lucy Ellis – Brookes, Kate Cooke, Diane Cornish, Dany Bell, Serena Fazel, Trevor Foster, Ardiana Gjini, Daphne Havercroft, Ceri Hughes, Tony Jones, Emma Phillips, Amanda Saunders, Richard Smale, Claire Thompson, Paul Tierney, Tariq White

Service Manager	David Tappin
Signature	
Date	

1. Introduction

This is an equality impact assessment of the plans for a new hub, satellite and spoke configuration of head and neck cancer services across the Avon, Somerset and Wiltshire Cancer network and the centralisation of ear nose and throat services (ENT) and oral maxillo facial services (OMFS) inpatient services for Bristol. Clinicians have clearly stated in the clinical model that the centralisation of surgical head and neck services would require the centralisation of inpatient ENT and OMF services. Whilst ENT and OMFS are two related but distinct specialities, head and neck cancer services are a sub speciality of the two. Head and neck cancer services are delivered by a multi disciplinary team approach provided by both ENT and OMFS and surgeons have a shared case load to diagnose and treat head and neck cancers. It is also worth noting that the scope of the review only covers adult services (age 16+).

This equality impact assessment considers the six highlighted equality strands (race, religion or belief, disability, gender, age and sexual orientation) as well as additional factors around deprivation, risk factors and where people live. These have been included as it is recognised that most head and neck cancers can be attributed to lifestyle choices such as smoking and drinking alcohol and as it has been reported that there is a nine year difference in life expectancy between the most affluent and most deprived wards in Bristol (McMahon, 2008).

In November 2004 the National Institute for Clinical Excellence (NICE) issued 'Guidance on Cancer Services: Improving Outcomes in Head and Neck Cancers' promoting centralisation of services covering a population of one million people treating over 100 cases per year.

The Bristol, North Somerset, South Gloucestershire (BNSSG), Bath and North East Somerset (BaNES) and Wiltshire and Somerset health communities already benefit from high quality head and neck cancer services. Clinicians are keen to build on this to create the "South West Head and Neck Institute" - a regional centre, nationally and internationally renowned for world class patient outcomes and pushing the boundaries of clinical excellence in which a single team will work cohesively with the optimum mix of services co-located where possible.

2. Head and Neck Cancers Overview

There are over 30 specific cancer sites in this group and cancer for each particular site is relatively uncommon. Head and neck cancer as a group of cancers is uncommon and therefore the number of patients accessing the service is few, with only 182 new cases being registered across the Bristol Trusts in 2007.

Treatment of these cancers require similar skills and so services to treat a range of head and neck cancers can usefully be grouped together.

There are some differences between Equalities considerations Thyroid and upper aerodigestive tract cancers. For example there is a strong link between upper aerodigestive tract cancers and Social deprivation, but none has been found for Thyroid cancers (6)

There are also strong links between certain risk factors and some head and neck cancers. Some of these risk factors are widely practiced amongst certain Equalities groups and because of this; there is information under some equalities group section of

risk factors which are particular to this group. This is especially true of the “Race” equalities group where differences in lifestyle mean that there is an increased risk of some head and neck cancers for some groups.

3. Ear, Nose and Throat Services Overview

ENT services specialise in the diagnosis and treatment of ear, nose, throat, and head and neck disorders, including facial plastics and some cosmetic surgery.

Diagnosis and treatment of the ears commonly include hearing loss, ear infections balance disorders and tinnitus. When ear surgery is indicated, it involves microsurgical techniques including reconstruction of the bones of the ear, mastoid surgery and implant insertion.

Diagnosis and treatment of disorders relating to the nose include injuries and deformities of the nose, cosmetic surgery, adenoidectomy, sinus infections, seasonal allergies and tumours of the nose and sinuses. When surgery is indicated it may involve septoplasty, septorhinoplasty surgery or endoscopic sinus surgery utilising minimal access techniques with endoscopes and camera monitoring. Surgical navigation systems may be used for safety. In some circumstances more major nasal resections are necessary.

Inflammations of the throat and tonsillectomies, laryngitis, snoring, voice and swallowing disorders and tumours of the throat and larynx are also treated and diagnosed by ENT services. When indicated, surgery of the pharynx, larynx and upper digestive tract is either external or endoscopic. It may encompass major resections and primary reconstruction.

ENT services also treat and diagnose head and neck disorders including swelling of the neck, cysts and thyroid disorders and benign and malignant tumours of the lymph and salivary glands. A number of cosmetic procedures are also performed by ENT services.

ENT services are accessed from infancy to end of life. Because ENT covers such a wide range of conditions and such a high proportion of patients presenting to GPs have ENT symptoms, the referral rates from General Practice to ENT are very high; ENT consultations accounted for 4.4% of all NHS outpatient attendances in 2008/09 (http//www.hesonline.nhs.uk). Given that only 12% of these consultations result in hospital admissions, the outpatient consultation and its outcome is crucial for good practice in ENT.

For this reason, the diagnostic skills, the doctor patient interaction and often the reassurance given in the outpatient setting have a major bearing on the quality of the service in ENT – the “therapeutic consultation”. The 12% of patients referred to ENT who are admitted for surgery need a wide range of operations and so when surgery is necessary the variety of techniques used is extensive often requiring high technology and expensive equipment.

4. Oral Maxillo Facial Services Overview

Oral and maxillofacial surgery is the surgical specialty concerned with the diagnosis and treatment of diseases affecting the mouth, jaws, face and neck.

The specialty of oral and maxillofacial surgery is unique in requiring a dual qualification in medicine and dentistry and is a recognised international specialty.

The scope of the specialty is extensive and includes the diagnosis and management of facial injuries, head and neck cancers, salivary gland diseases, facial disproportion, facial pain, temporo mandibular joint (TMJ) disorders, impacted teeth, cysts and tumours of the jaws as well as numerous problems affecting the oral mucosa such as mouth ulcers and infections.

Oral & Maxillofacial (OMF) Surgeons are the specific experts on diseases affecting the mouth, face, jaw and neck. As a result of their training, OMF Surgeons diagnose and treat symptoms, pathology, deformity and trauma affecting the mouth, face, jaws and neck.

As a result of treating diseases located in this anatomical region, OMF Surgeons can provide advice on multi-system pathology where this affects the head and neck. Furthermore, advice is provided for specialities such as clinical oncology to minimise and treat complications in the head and neck, following therapies provided by these other speciality groups.

5. Information and Intelligence

List the available data (both quantitative and qualitative) which will support the impact assessment:

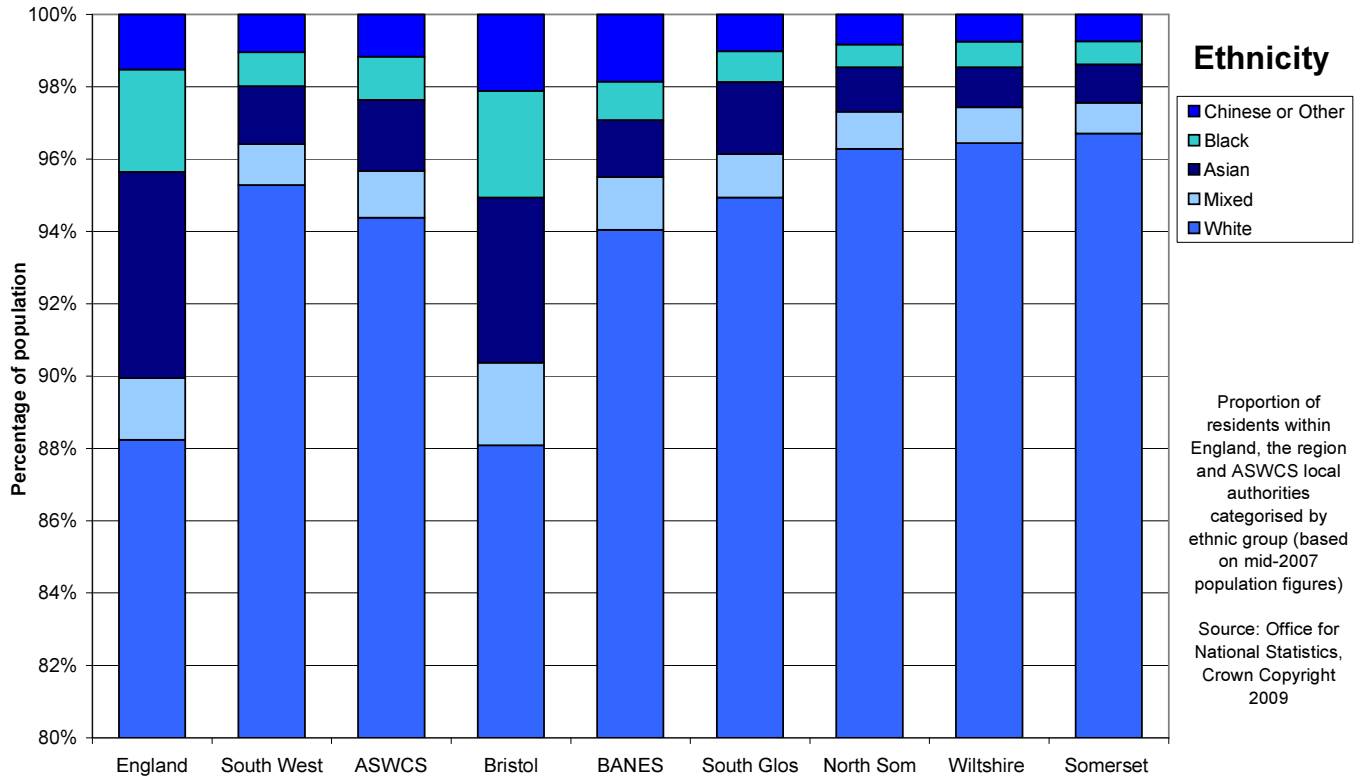
1. Head and Neck Cancers Services Review Health profile presentation
2. Head and Neck cancer patients engagement event on 27th April 2010
3. Department of Health Equalities Impact Assessment on Cancer Reform Strategy
4. Case Studies
5. Data from MDTs for 2009
6. Guidance on cancer services improving outcomes in head and neck cancers (IOG)
7. Lucinda Platt: *Parallel lives? Poverty among ethnic minority groups in Britain*, London 2002
8. Duleep Allirajah, Dr Katia Herbst and Dr Louise Morgan: *Free at the point of delivery: exposing the hidden cost of hospital travel and parking for cancer patients*, London, Macmillan Cancer Relief in association with Dr. Foster, 2005
9. National Audit Office: *Tackling Cancer Improving the Patient Journey*, London, National Audit Office, 2005
10. Census
11. Telephone conversation with Kate Mc Dermott, Health Facilitation Co-ordinator
12. Interviews with patients and patient relatives – names withheld.
13. Interviews with Speech and Language therapists
14. Interviews with ENT patients at St Michaels Clinic 22nd July 2010
15. Interviews with ENT patients at Southmead at clinic 27th July 2010
16. Bristol Joint Strategic Needs Assessment, NHS Bristol and BCC, 2008
17. Gale L, Naqvi H and Russ L (2008) *The Health of People with Learning Difficulties in Bristol*, Bristol Public Health Department
18. Scully C, Bedi R (2000) *Ethnicity and Oral Cancer, Lancet Oncology* Sep; 1(1):37-42

6. Key Findings

- The new service needs to gather, analyse and report equalities data and this requirement should be built into the service specification
- There is an increased risk for certain ethnic groups e.g. South Asians
- There should be partnership work with other agencies and services to raise awareness of Head and Neck cancers and risk
- Some groups may not understand what cancer or ENT and OMFS disorders are and the service should take care when communicating with all patients
- There should be more information about the cancer, treatment, the effect on quality of life and how long a patient has to live
- Recognition that different groups use English in different ways
- “end of life” planning and care is important
- The service must plan communication and feeding for the immediate post operative period needs planning in advance
- The route via a dentist is less accessible for patients with Learning Difficulties
- Transport needs of older and disabled people need to be considered
- To support patient choice, the service should consider giving the option of either savory or sweet Percutaneous endoscopic gastrostomy (PEG) feeds
- There should be more proactive signposting to cancer help for minority ethnic communities
- The service should consider allowing patients to pre order food in advance of their operation with support from a dietician where appropriate
- Patients and family members should be provided with a quiet space as part of the ward/ space design for the newly centralised service
- There needs to be some consideration to allow family members to stay and support patients, when appropriate
- A shuttle service between North Bristol Trust and University Hospital Bristol sites need to be investigated which could be used by both patients and staff
- A leaflet needs to be produced which explains access to the University Hospital Bristol sites including public transport and parking facilities nearby
- There needs to be a follow up of the health check for patients with Learning Difficulties for those who are identified as not being registered with a dentist
- Commissioners should consider giving dentists similar Learning Difficulties training as that offered to General Practitioners
- Providers should ensure that translation and interpretation services are offered to every patients for whom English is not a first language

7. Assessing the Impact – Head and Neck Cancer

7.1 Race

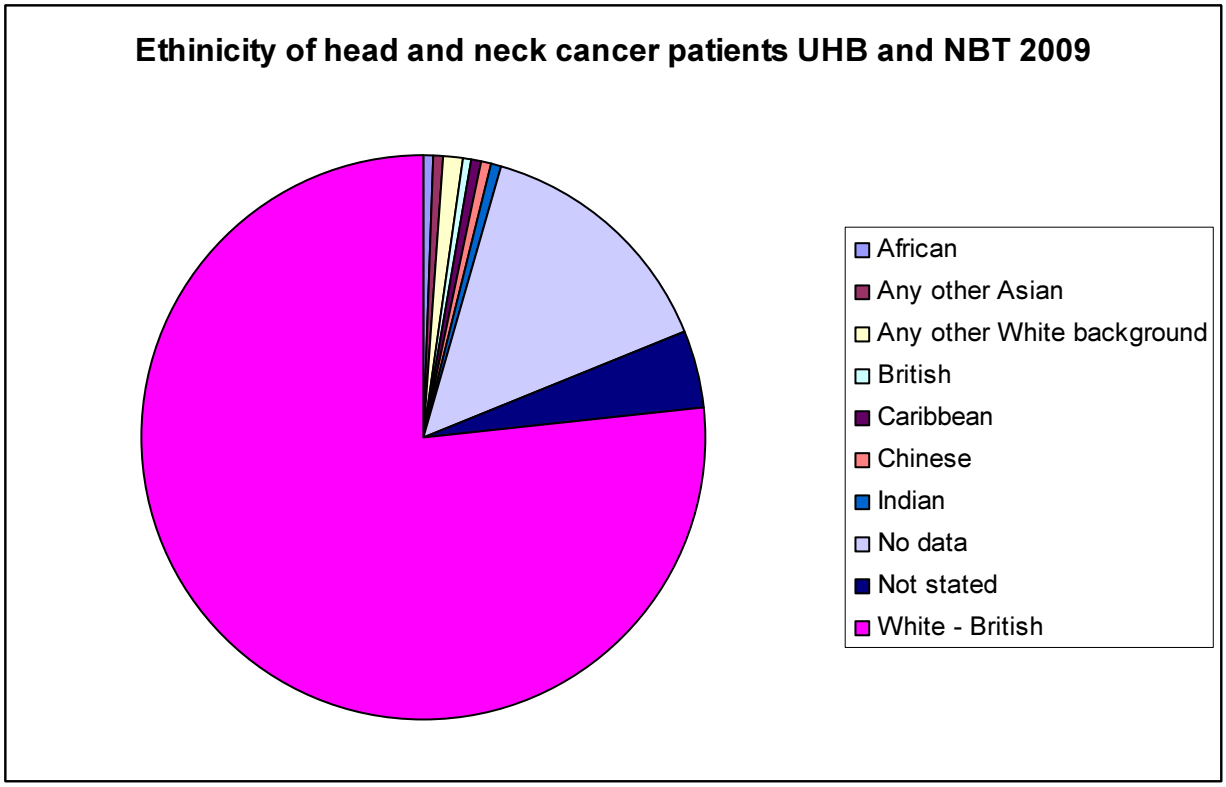


The above graph shows the ethnic profile of the local population (not just patients with cancer).

We can see from the graph that Bristol has a larger Asian and Chinese population than its neighbours within the Avon, Somerset and Wiltshire area.

There are a number of ethnic groups which are recognised as having a higher risk of certain head and neck cancers and these directly relate to lifestyle factors common to these groups.

It is vital that race is monitored, recorded and reported on in the new service to ensure that people from higher risk groups are engaging with the service.



The above graph show that the majority of patients who have come through head and neck cancer services have classed themselves as White – British. It also shows that there is a considerable number of patients (15%) for whom there is no data.

The development of a centre of excellence should be seen as an opportunity to develop innovative partnerships. The centre should aim to work with local community groups, health trainers, faith communities, to improve awareness of risk factors.

Rates of Oral cancer are higher among people from a South Asian background and the risk of dying from cancer of the pharynx is five times higher for immigrants from the Indian sub continent than for British natives.

Betel quid chewing is a strong independent risk factor for pharyngeal cancer (cancer of the back of the throat). A World Health Organization study has found that chewing betel nuts can cause oral cancer and that the rate of these malignant mouth tumours was highest in Asia where the betel nut is a widely used stimulant. Betel nut, which contains an addictive stimulant similar to nicotine, is widely used in parts of Southeast Asia, India, Pakistan and the South Pacific as a breath freshener, a hunger antidote, a substitute for cigarettes.

The use of chewing tobacco was most prevalent among the Bangladeshi BME group. (3)

There is an NHS Asian tobacco helpline, website and leaflets which are available in Urdu, Punjabi, Hindi, Gujarati and Bengali. The helpline is available every Tuesday 1-9pm and the same spoken languages are available. The leaflets and website both mention the link between chewing tobacco in paan and oral cancer:

“People chewing tobacco in paan are over 5 times more likely to be at risk of oral cancer”

There are a number of issues around race which are highlighted well by the story of one patient relative who told the story of her mother who was first diagnosed with mouth cancer when she was 78 and died when she was 80. In this case, the patient was of Indian origin and had been born in India. The patient relative told us that she has chewed betel nut back in India but that there was some mystery surrounding her childhood and youth. The patient was deaf and had speech, but did not speak English. All communication with medical professionals was via family members. She was treated in Bristol at St Michael's hospital.

7.2 Communication

When first told about the cancer diagnosis, the relatives did not understand what cancer meant. It seemed as though this was something that could be fixed by surgery.

"When we went to the dental hospital and they saw it there, straight away, they said it was cancer. I didn't know what cancer was. No one in my family had cancer."

"I didn't have the true picture of the cancer. It's Important to tell us "we do not know the state of the cancer on your mothers tongue". "

"I think the first things we need to do is for there to be someone to talk to and take care of us and give information – I didn't have that."

During the time immediately after the operation, the patient used a pen and paper to communicate. This communication was in Kachi which only one member of the family could read. Relatives stayed with the patient all the time that she was in hospital and the fact that they were able to do this was valued greatly.

During the patient's final stay in hospital, the relative strongly feels that the medical professionals knew that her mother was going to die soon but this was not communicated to relatives. Ideally they would have liked for the patient to be allowed to die at home, but if this was not possible, to be told clearly how long the patient has to live so that the relatives can gather together to say goodbye.
In this case, a new baby had recently arrived in the family. As this happened in the same hospital, the patient was taken to visit the baby and was able to hold her.
But the rituals for this family (who are Muslim) around the birth of a new baby also took up their time.

"So then when we talked about how to take my mum home again, they said they didn't think she would make it.
It didn't strike me what she was really telling me. And they had taken the oxygen out because they knew she was only going to be there for a couple of hours or so."

The storyteller had gone home to wait in for a sling for her mum to pull herself up on at home and during this time, her mum died.

There is a tendency in some English cultures to skirt around issues such as death but this story highlights how there is a need for families to be told in a straightforward way when a patient is expected to die.

There is support available for patients from BME communities with Cancer from “Cancer Help for Minority Ethnic Communities” hosted by Bristol Community Health. This family did make contact with them, but this was only after they had seen the information in the Oncology waiting room. This support was not mentioned to them by the medical professionals treating the patient.

As with all services, the communication needs of people whose understanding of English is limited needs to be considered. Information on how best to communicate with the patient also needs to be passed over to the service from the referrer to ensure the first contact with the services is as productive as possible. E.g. if the patient requires an interpreter, this needs to be arranged in advance.

Communication needs were raised by patients an involvement event and a specific case mentioned was that during the post operative period when communication is already difficult, when patients and staff use English in a different way, this may form an additional barrier at a time when it is important for the patient to be able to communicate medical needs.

The following is from a patient interview which highlights how we may use English in different ways. This patient is White British and female.

“So there was one nurse who had English as an additional language and her English was too perfect and one time she asked about some medication and she said she could give me a suppository and I asked what it was for and she assumed I didn’t know what a suppository was so she said “it’s for your bottom” so I thought that was to help me go to the toilet and I said I didn’t need that. She looked a bit surprised but she didn’t say anything. So I was having chronic diarrhoea and I can laugh about it now but obviously at the time it wasn’t funny. Then the night nurse came on and asked if I wanted some pain relief I had a choice of it going through my nose tube or in my bottom and I was so sick then of things going down the tube that I asked for it in my bottom. So I turned over expecting to have an injection in my bottom and she actually gave me a suppository! But I didn’t realise that you could have pain relief as a suppository and that’s what the previous nurse had been talking about.
I turned down a painkiller but stayed on a laxative via the nasal tube, which I didn’t realise they were giving me.
She was black (the nurse) and I think she got upset because I’d mentioned the situation to another nurse and I think she told her and she thought I didn’t like her but she was a lovely nurse and I was happy with her nursing. I wish I could have explained to her afterwards when I could talk properly. She was so upset. I think the other nurse told her in an insensitive way. Once I could talk it would have been fine. “

This highlights that we all speak English in different ways and this may apply to people of different races and have English as an additional language or people who have English as a first language. We use language differently around the country and around the world and medical professionals may use terminology that is not familiar to the patient. When communication is more difficult – for example when someone cannot talk, it can make the situation even more difficult.
It is important that the staff in the service do not make assumptions about what a patient or relative can or cannot understand.

“Because they’re good at their job and they know, its second nature to them so they forgot to say things sometimes and unfortunately when you get to the 20th patient and

you've had to say it 20 times you might forget to say something. For every single patient its new so they still need to know."

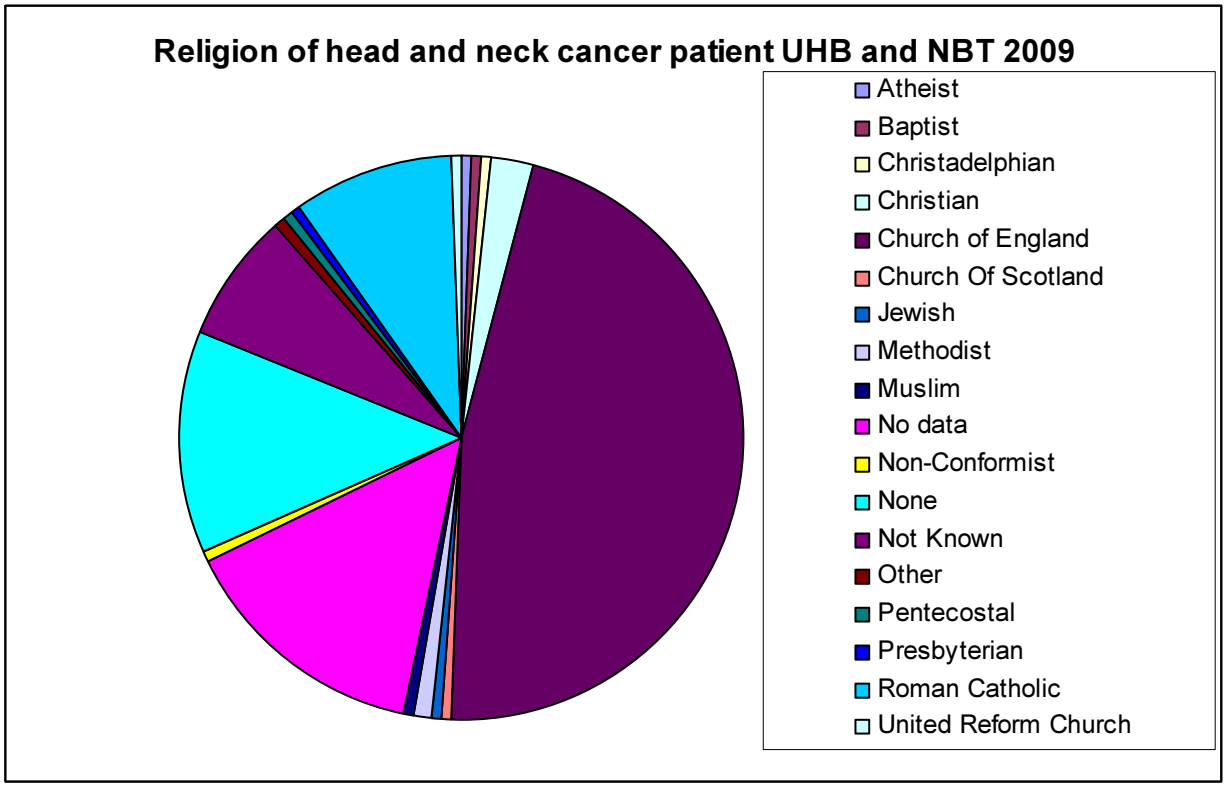
From other documents

Race has historically been poorly recorded in the NHS limiting the quality of available data. It is difficult in some cases to differentiate between the influence of race and that of deprivation. (3)

The lower than average socioeconomic position of some Black and Minority Ethnic groups is the main reason behind their worse health outcomes. Most Black and Minority Ethnic groups have higher rates of poverty (lower income, less benefits, more unemployment, fewer necessities and more deprivation).(7)

When receiving treatment and care Black and Minority Ethnic patients, particularly those outside large urban conurbations, can have problems with communication of cancer diagnosis and information, particularly when the first language is not English. (9)

7.4 Religion or Belief



A quiet space to grieve, pray or for quiet contemplation was needed for people of all or no religion It was raised in discussion at an involvement event that is lacking in the newly built Bristol Heart Institute, and it was felt a lesson should be learnt from this. It was felt that as over half of all head and neck cancer patients die a space for either patients or family members is an important consideration when designing the space for the centralised service.

The chaplains are available as a point of contact for all faiths at the hospital. Patients and relatives should be made aware that they are available and can contact officials or representatives from other faiths on the family's behalf.

Religion should not be assumed based on race, for example Indian census data shows that 2.33% of the population are Christians which is higher than the 2% figures for Sikhism.

End of life care is particularly relevant for this patient group as there is a high mortality rate for head and neck cancers of over 50%. Where patients are not well enough to go home to die, a flexible environment which can be adapted for different patients and families from different religions and beliefs is needed. For example, comfortable chairs and pull out beds so that families can stay with a patient while they are dying. As previously mentioned under Race, it is important that relatives are clearly communicated with if medical professionals know that the patient is dying. This will allow them time to gather together to say goodbye and perform whatever cultural or religious practices are appropriate.

Food was mentioned as an issue particularly that supplied in the immediate post op period. This is detailed further under the “Disability” section. Consideration of different religion and beliefs will need to be considered as part of menu planning. For example some people do not eat meat either for religious or other reasons and there needs to be food choices available which take this into account.

7.5 Disability

We have not been able to access a breakdown by disability of either those patients who access the service or those who work in the service. The standard equalities issues around accessing a service such as physical building access, leaflets available in accessible formats, longer appointments for patients with learning difficulties, all apply.

Additionally, there are some issues which apply specifically to head and neck cancer treatment and some disabilities which are caused by the cancer and/or the treatment.

There are a number of issues around communication which are particularly relevant to this group.

Firstly, communication between professionals. When a General Practitioner or Dentist refers a patient over to head and neck services, there needs to be a way to communicate any particular needs that the patient may have in addition to details on the medical condition they are being referred to. For example a patient with Learning Difficulties (LD) may need a longer appointment; a Deaf patient may need a British Sign Language interpreter. Ensuring these needs are communicated will mean that the patient's first appointment with the service can be as productive as possible.

Communicating with the patient also needs consideration as people with Learning difficulties may need extra time to explain information to them and leaflets and other information in an accessible format. People with sensory impairments also have specific communication needs and this need to be taken into consideration. Head and neck cancer and the associated treatments can be complex and this needs to be fully communicated.

The following is from a patient who was treated 15 years ago at Southmead Hospital. She had a laryngectomy operation.

Diet

"I believe it was a Sunday. I had been informed that my solid diet would commence that day. Breakfast I was offered 3 choices. Bread and jam, bran flakes or ready brek. I chose the latter as the easier option. I could not eat it because it was lumpy and the flakes and lumps were spilled over the sides of the dish, it looked awful so I sent it back.

Dinner I was given roast beef potatoes and veg. I tried but could not swallow the bit of veg. The nurse commented that I had not eaten breakfast nor dinner and this was "worrying", I asked if there were any soup or ice cream but she could only offer me a crumble for desert which I could not eat. This went on for five days.

The speech therapist came to see me and asked me to take a drink of water. I could not swallow in one gulp because the liquid would sit for a few seconds in my throat and it took a couple of swallows before it went down. She said this combined with my inability to eat was concerning. I asked for a soft food diet and she said that some of the food I had received was soft such as mashed potato.

Eventually a dietician came to me. She was very cross. She told me that she should have visited me the day before my solid diet commenced, but she had not been informed

and they had only contacted her because I was not eating. She said that everything would change now and she was in charge of my diet; she said that she would send up double of everything and she did. I had yogurts, ice cream and soups, jelly and rice, ready brek which was very well mixed and creamy. This was wonderful and gradually by the time I left the hospital I was able to eat rice with sauce and pasta etc. I had no further trouble and found within a short time that there is no foods that I could eat but it takes time and to expect a patient, who has undergone the kind of surgery that I had, to eat a normal diet is ridiculous. It needs a common sense attitude. I do hope other patients are not having to endure the same treatment but I imagine that attitudes have changed; at least I hope they have."

Language and Communication

The following is from another patient who was treated at both Royal United Hospital and St Michaels.

"They said I wouldn't be able to talk and they said it was alright because we're very good at understanding what you want and there was actually one nurse who was very good but of course she wasn't on all the time. She was good at anticipating. The others were good once I could start writing stuff. I hadn't realised how much you do rely on talking. When you've got a traci when you've first had the operation you can't talk. One of the nurses was really good at lip reading so that was good. I used a notepad to write things down and then I got my daughter to bring in one of those children's drawing boards – you know that you can wipe off and that was good because if you didn't have the energy to lift up your arm properly you could scratch on it with a nail or something.

When I was going up in ambulance in St Michaels from intensive care at UHB and I couldn't talk. I was put on one of those slide under, lift off things. I was strapped down and my elbow kept on bashing against the side and my elbows were bare because I just had a nightgown on but I couldn't say anything because I couldn't talk at that time. I couldn't say it was hurting and I couldn't move my arms because I was strapped in. From their point of view I was safe because I was strapped in but I don't think they realised how scary it was for me to be bounced about in an ambulance and not be able to say anything – it was traumatic. The ward is actually on site now (at UHB) so they're fixing that. You want to be able to say ouch, ouch but you can't!

At the BRI I mean I knew it's a few years on but they have a specialist ward and that's what they do all the time so they were really skilled at cleaning out the traci and knowing what to do and also they took my off it really quickly. So my partner left on the Friday night I couldn't talk and he had to go away for the weekend. So the next day I was talking with the finger on and then I had it removed so by Sunday night when he came to see me, I was talking normally and he couldn't believe it was like a miracle! The first time I didn't speak for a long time. It was two different situations so it's difficult to know if the technology has moved on or if it's because of the specialist nurses. "

For patients undergoing surgery, there needs to be a plan in place in advance which details their food and communication needs during a time of temporary disability when needs may be different. This point was highlighted during an interview with one cancer patient who had also had surgery on his leg:

"After the operation the nurse who looked after me didn't have very good English, I couldn't understand her and I couldn't make her understand me. I kept sliding down the bed on to my bad leg and I couldn't communicate this or reach the buzzer so I had to keep setting the alarm off to get attention. I had pain from trapped wind because of the anaesthetic and I couldn't explain to anyone and no body told me about this before the operation"

The planning for this period should include the speech and language therapist (SLT) and the dietician. Communication methods need to take into account the needs of both the patient and the members of staff who each may each use English and/ or other languages in different ways. Sensory impairments and other disabilities also need to be considered e.g someone with a learning disability may need to use pictures rather than writing words down. A number of communication tools can be explored before surgery so that the patients and SLT are confident that the patient will be able to communicate their needs during this period if they are not able to speak in the way they are used to. It is especially important that they are able to communicate any acute medical needs at this time.

One idea talked about with patients was to have a picture board which was introduced before surgery:

"The picture boards would be great for non English speakers and Special needs so that would suit a lot of people. You'd need a symbol for pain and things like that and feeling sick."

However, the use of communication boards should take into consideration the individual patient needs. One patient criticise explained they were given a writing board during their inpatient say at UHBristol "but I couldn't hold a pen".

Such communication tools may already be used by speech and language therapists (SLTs) in other work.

For food and nutrition needs, patients may have difficulty either chewing or swallowing solid foods directly after their operation. At this point they may also have difficulty communicating. It would be possible for a dietician to work with on site staff to develop a menu which took in to account patients nutritional needs, their possible limitations in chewing or swallowing and gave choices to take in to account their beliefs and preferences around food. The patient could then choose from this menu before their operation.

Some patients may need to use Percutaneous endoscopic gastrostomy (PEG) feeding as a primary or additional feeding method following surgery, usually on a temporary basis. On patient commented that he wanted a savoury feed for his feeding via Percutaneous endoscopic gastrostomy (PEG) but was told that only there was only sweet available. He disliked the sweet versions and has since found out that savoury versions are available but were not offered while in hospital.

Both head and neck cancers and their treatment can have an effect on long term eating, speaking and breathing abilities and can leave patients with a long term disability.

Learning Difficulties (LD) – from telephone conversation with Kate Mc Dermott, Health Facilitation Co-ordinator

There are Community Learning Difficulties Teams (CLDT) in each area covered. These teams include Speech and Language therapist and would be able to help with pre appointment planning before the first appointment with the service.

Once a patient is at United Hospital Bristol Trust, support is available from the Learning Difficulties liaison nurses who can communicate with the community team and support the patient.

The recent Direct Enhanced Service (DES) has seen more people with Learning Difficulties register with General Practitioners. In Bristol, 48 General Practitioners have received training to raise awareness of Learning Difficulty issues. This has not been checked across other areas. An annual health check will be conducted for patients with Learning Difficulties and one of the questions will ask whether they are registered with a dentist. However, currently there is no system whereby registration with a dentist is then followed up. People with Learning Difficulties are less likely to be registered with a dentist and those who have come from institutions where health care is provided are especially unlikely to be registered as they have been used to dentistry being organised for them.

So currently a General Practitioner is more likely to be aware of the Community Learning Difficulties Team and can refer to them as part of the referral to the service.

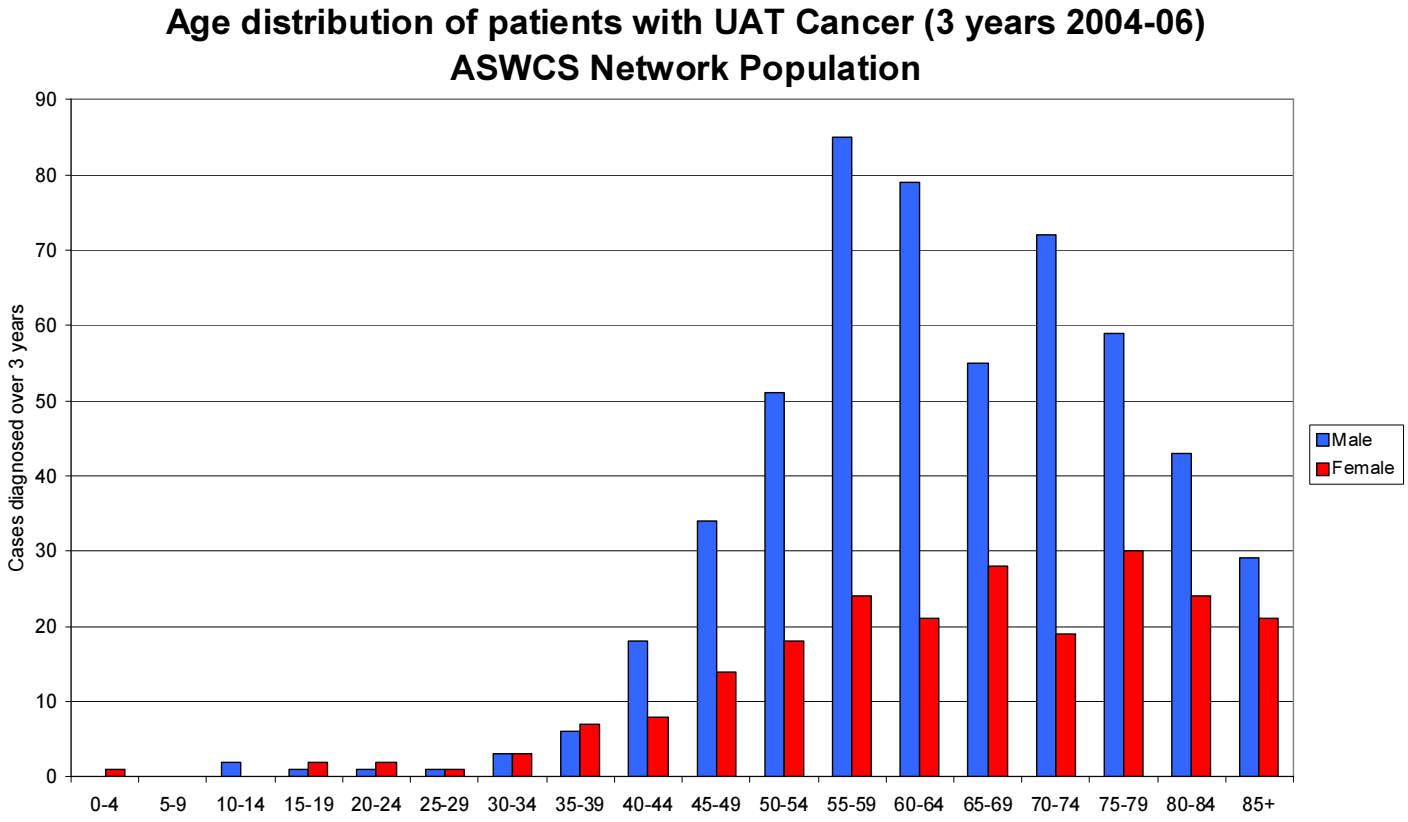
The route via a dentist is less accessible for patients with Learning Difficulties at the moment. This firstly because they are less likely to be registered with a dentist and therefore less likely to be referred in to the service by them and secondly, the dentist is less likely to be aware of the support offered by the Community Learning Difficulties Team because they haven't received training in the way that many General Practitioners have.

To help rectify this, there needs to be some follow up of the annual health check questions whereby patients who are identified as not being registered with a dentist are followed up.

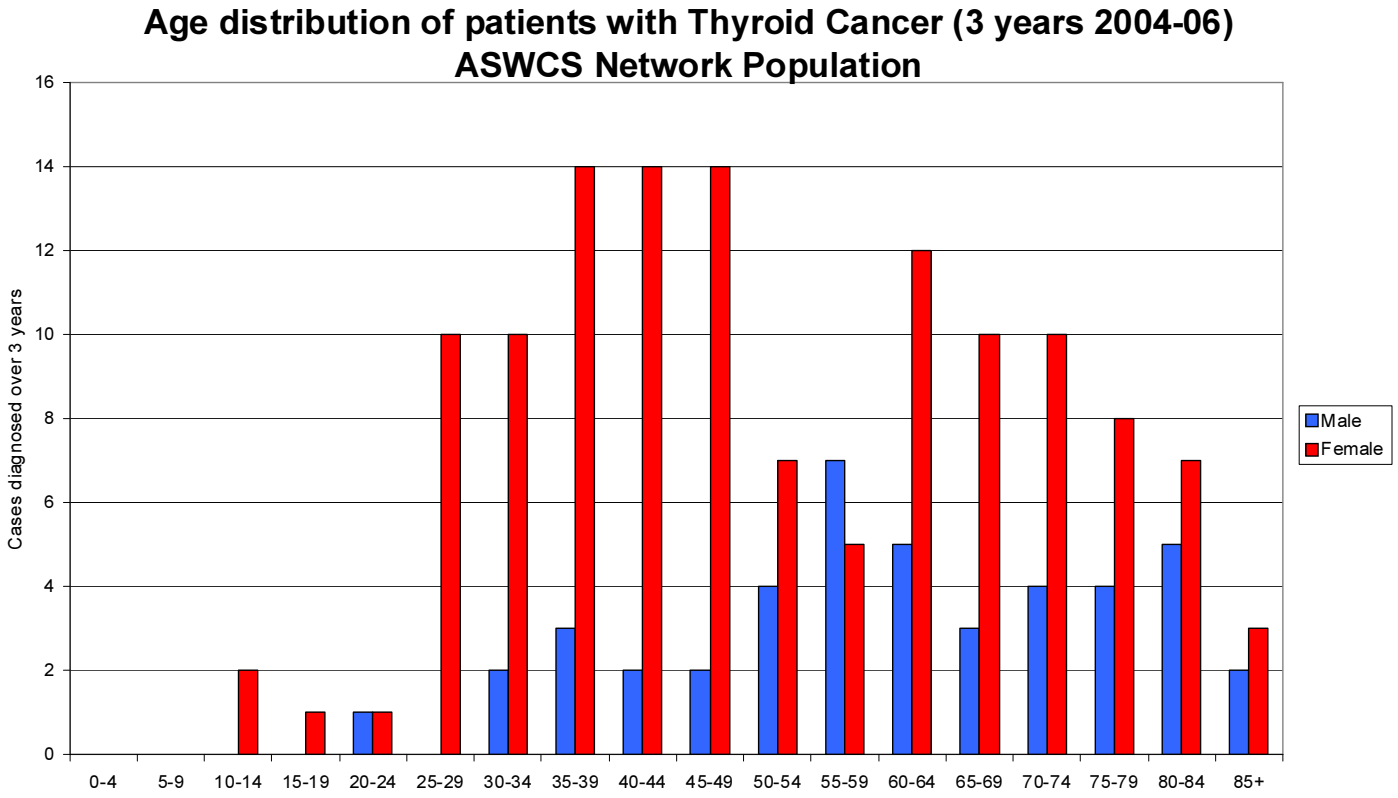
Assuming this leads to more people with Learning Difficulties registering with dentists, better links are then needed between the Community Learning DifficultiesTeam and dentists.

7.6 Gender and Age

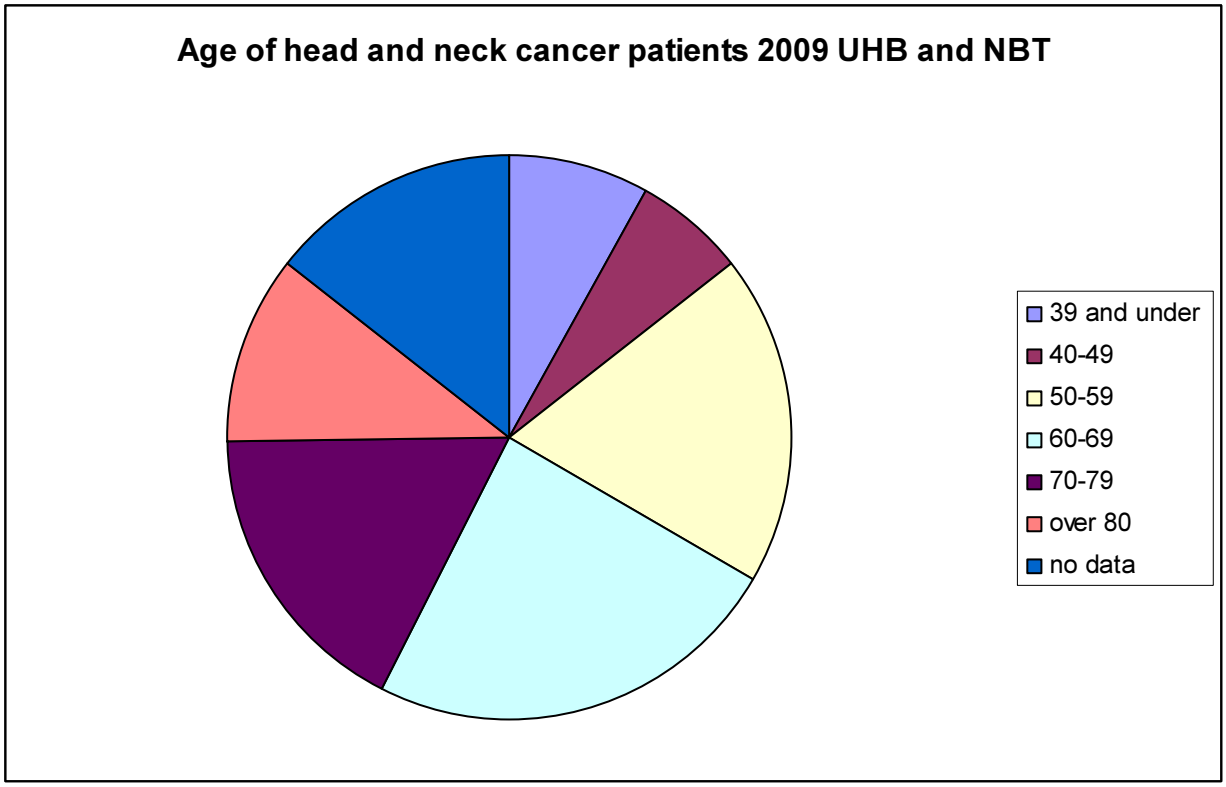
The graph below show the age distribution for those patients with Upper Aerodigestive Tract Cancers throughout the Avon, Somerset and Wiltshire Cancer Network Area. As you can see these cancers are more common amongst men and is more likely to affect those who are over the age of 44.



The graph below show that Thyriod cancer is more common in women than in men and the risk is more evenly spread throughout the age range. However, the number of overall cases is lower than for UAT cancers.



The graph below show that in 2009 that the majority of patients discussed at the multi-disciplinary team meeting were over the age of 49. However, there were still a number of patient who did not accurately have their age recorded.



We didn't have any specific issues raised about gender either by the user reference group or individual patient interviews, apart from that there should be separate female and male wards. However, it should be noted that the majority of patients involved in both the user reference group and the all individuals patients and relatives interviewed, were women.

Thyroid cancer is more common in women, among whom new cases peak between the ages of 30 and 54. Other head and neck cancers are more common in men.

Head and Neck Cancer treatment can significantly affect the way a person looks and one patient commented that younger people may be more worried about how they look after surgery.

"If I was younger and I had small children I might be more worried. [about my appearance] It's quite an important part of your rehabilitation. So I've been waiting quite a while [to have new teeth put in].

Patients relatives were mentioned a number of times in interviews. Because head and neck cancers tend to affect older people more, relatives are also likely to be older and this needs to be considered. Small things can make an important difference.

"Jeremy [the surgeon] said to the nurse you couldn't get her a cup of tea could you? And mum always remembers that."

Looking after relatives at a time when the patient is unable to consider them themselves is seen as important by patients.

It is planned that inpatient services will be centralised whilst diagnostic, follow-up and rehabilitation services should be provided closer to home. Travel arrangements therefore are an important consideration due to wide geographical coverage of this

service. It important the service develops a clear supportive approach to ensuring patients understand the various ways they can access the service. Free bus passes are available for people over 60 and public transport links to the hubs are important. However, the service should be public transport may not be suitable for everyone and some treatments are likely to leave people feeling unwell, so parking options also need to be communicated effectively to patients and relatives.

The speech and language therapists expressed concerns for their older patients which patients had raised with them. One solution discussed was a shuttle bus that went between North Bristol Trust and University Hospital Bristol sites:

“Access is a concern. This is a real worry for both us and patients. I would need to be able to drive to University Hospital Bristol and know that I will have a space. And my patients need to know that too. So a really clear leaflet about where they can park is needed. They need to feel confident that they will be able to park when they get there. For vulnerable patients with head and neck cancers, standing around on a bus stop is really difficult.

It may be that patients could actually choose to park at Southmead and then take a shuttle down to University Hospital Bristol.

They are worried about getting there and then having to walk from where they’ve parked their car, especially patients with respiratory problems. So if it was reliable and door to door that would work well for everyone and we would prefer to use that. Because then you don’t need to worry about parking when you get there and it would be better for the environment too.”

There are two suggestions from this:-

1. One is that a shuttle service between North Bristol Trust and University Hospital Bristol sites is investigated. This could be used by both patients and staff.

2. A leaflet is produced which explains access to University Hospital Bristol sites including public transport and parking facilities nearby.

Neither of these ideas is specific for head and neck cancer services and would need wider input and possibly partnership work with Bristol City Council and First Bus.

During patient interviews the relative of a head and neck cancer patient also expressed her concern for older patients accessing services particularly around having to ‘chase’ appointments;

“The system is not sensitive to the needs of anyone on their own or who may be old and vulnerable. I am concerned about people who can’t chase things themselves or use the internet to find things out”. I feel sorry for any one older, or who is on their own, it would be hard for anyone to ask for what they need”

The patient himself also expressed concern:

“There was a communication breakdown along the way, if I hadn’t chased it I don’t know what state I would be in now that is what worries me, especially about people who can’t chase things up”

7.7 Sexual orientation

We do not have a breakdown of patients by sexual orientation.

The issue of assumed gender of significant other came up when we were discussing this with the user reference group. Staff should be trained to use language which doesn't assume the gender of the for example the person they may want with them when talking about their condition or treatment.

8. Assessing the Impact – Ear Nose and Throat Services and Oral Maxillo Facial Services

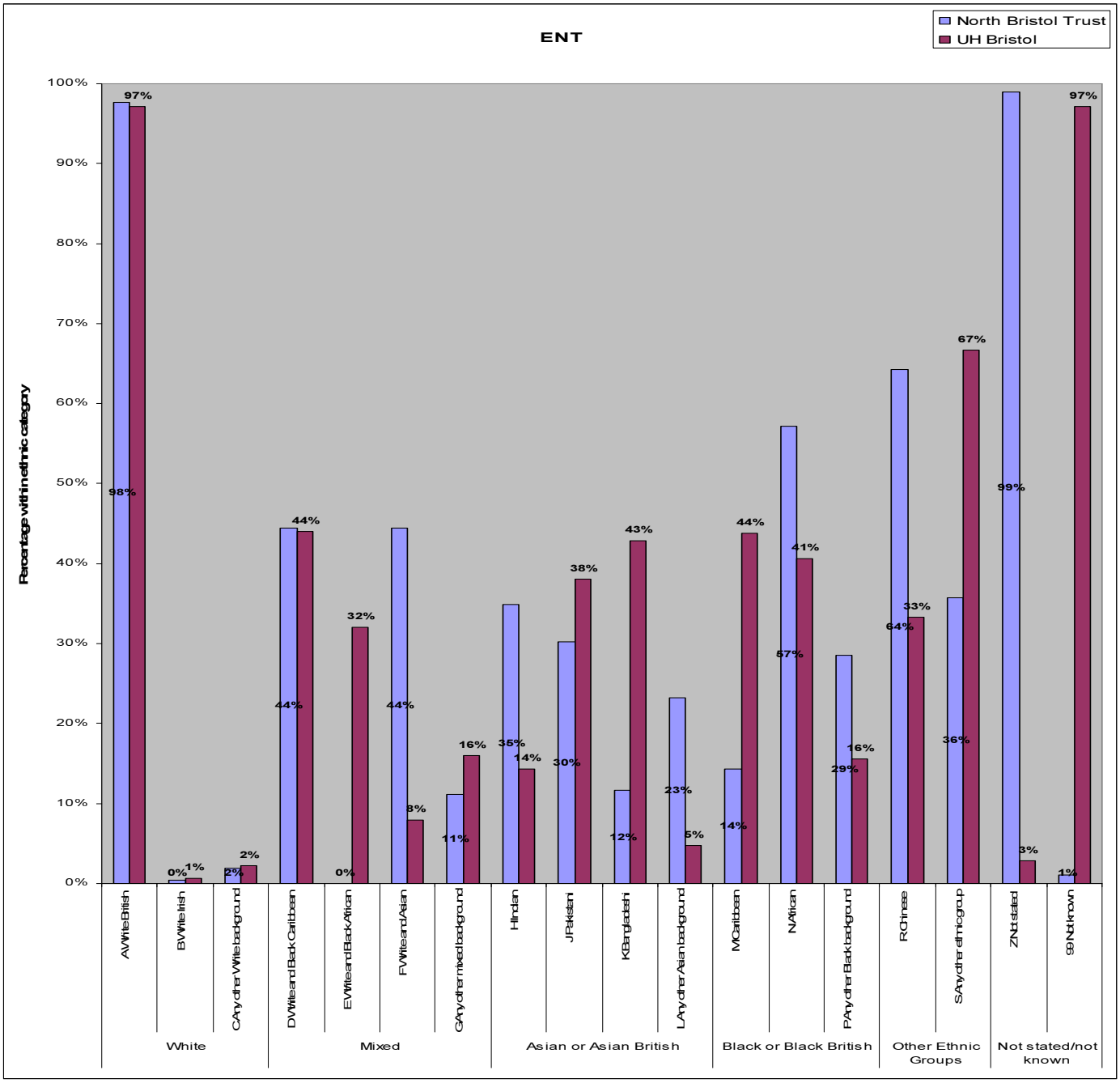
Many of the issues identified through engaging with patients accessing Head and Neck Cancer Services will be common to patients accessing both ENT and OMFS services. The following information is in addition to the issues already identified in the Head and Neck section of this Equality Impact Assessment. The review covers those patients who are accessing ENT and OMF services currently delivered by NBT or UHB. For those patients who live in the Avon, Somerset and Wiltshire Cancer network but who are accessing services outside of Bristol there will be no change in the existing service delivery and therefore this section of the document primarily focuses on Bristol.

8.1 Race

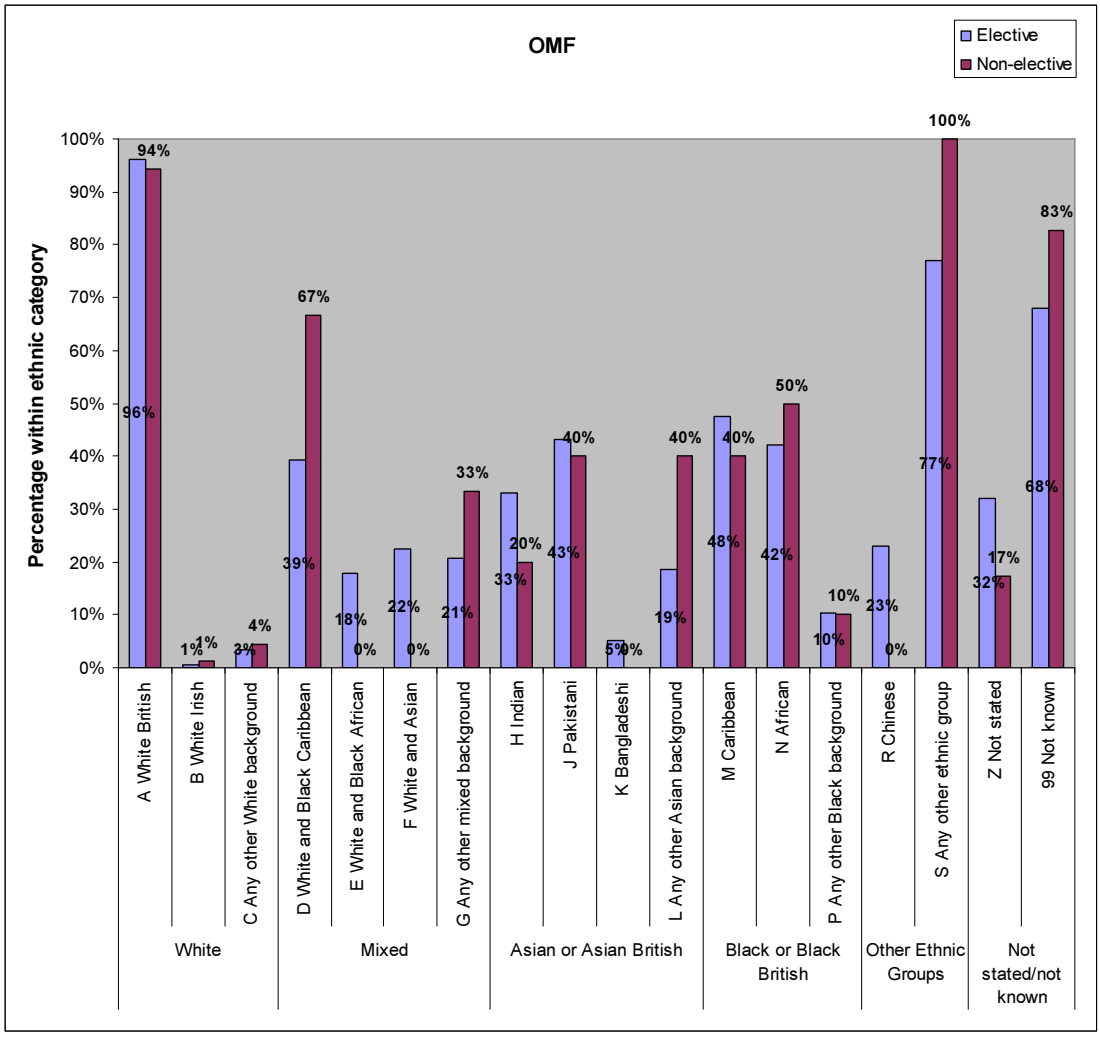
As the chart below shows, Bristol is an area of increasing ethnic diversity. There are more people from Asian, Chinese and mixed ethnicities living within Bristol compared to the South West and the neighbouring areas. South Gloucestershire also has a larger population of people of Asian ethnicities. In line with population projections the numbers of people from non White British ethnic backgrounds will increase. Therefore consideration needs to be given in the planning of services to ensure that any new services are accessible to all ethnic groups.

The Joint Strategic Needs Assessment identified that there are a number of information gaps, particularly around carers and people with learning difficulties, physical impairments, mental health and ethnicity recording. This will need to be improved in order to properly consider the needs of people from different ethnic groups and vulnerable groups and who as a result may be suffering health inequalities.

In ENT services there are a higher number of cases where ethnicity is not recorded at UHBristol, therefore there may be even higher numbers of patients from non white backgrounds presenting at UHBristol. Across both trusts there is a much higher proportion of unknown ethnicity in non elective cases than in elective cases. This highlights the need to improve ethnic monitoring at both trusts.



There is greater ethnic diversity within the patient population presenting at UHBristol than at NBT, with a higher proportion of mixed race and black patients and a smaller proportion of white patients. There is no significant variation in ethnicities between elective and non elective patients.



For patients accessing OMFS services there is a much higher proportion of unknown ethnicity in elective patients compared to non-elective patients and there are no significant differences between the ethnicity profile of elective and non-elective patients.

There is however greater ethnic diversity amongst OMFS patients at UHBristol compared to NBT and a higher proportion of all non-white groups.

The proportion of unknown ethnicity is twice as high in OMF as in ENT (20% compared with 10%); this is particularly noticeable at NBT (22% compared with 4%).
There are a higher proportion of non-whites accessing OMF services than ENT (10% compared with 6%) and this is spread across all of the non-white ethnic groups. However there is no specific evidence that indicates ethnic minority Maxillo Facial patients are at any greater risk.

As previously discussed, certain ethnic groups have been identified as having higher risk of oral cavity cancers. There is growing evidence of intracountry ethnic differences, mostly reported in the UK and USA.

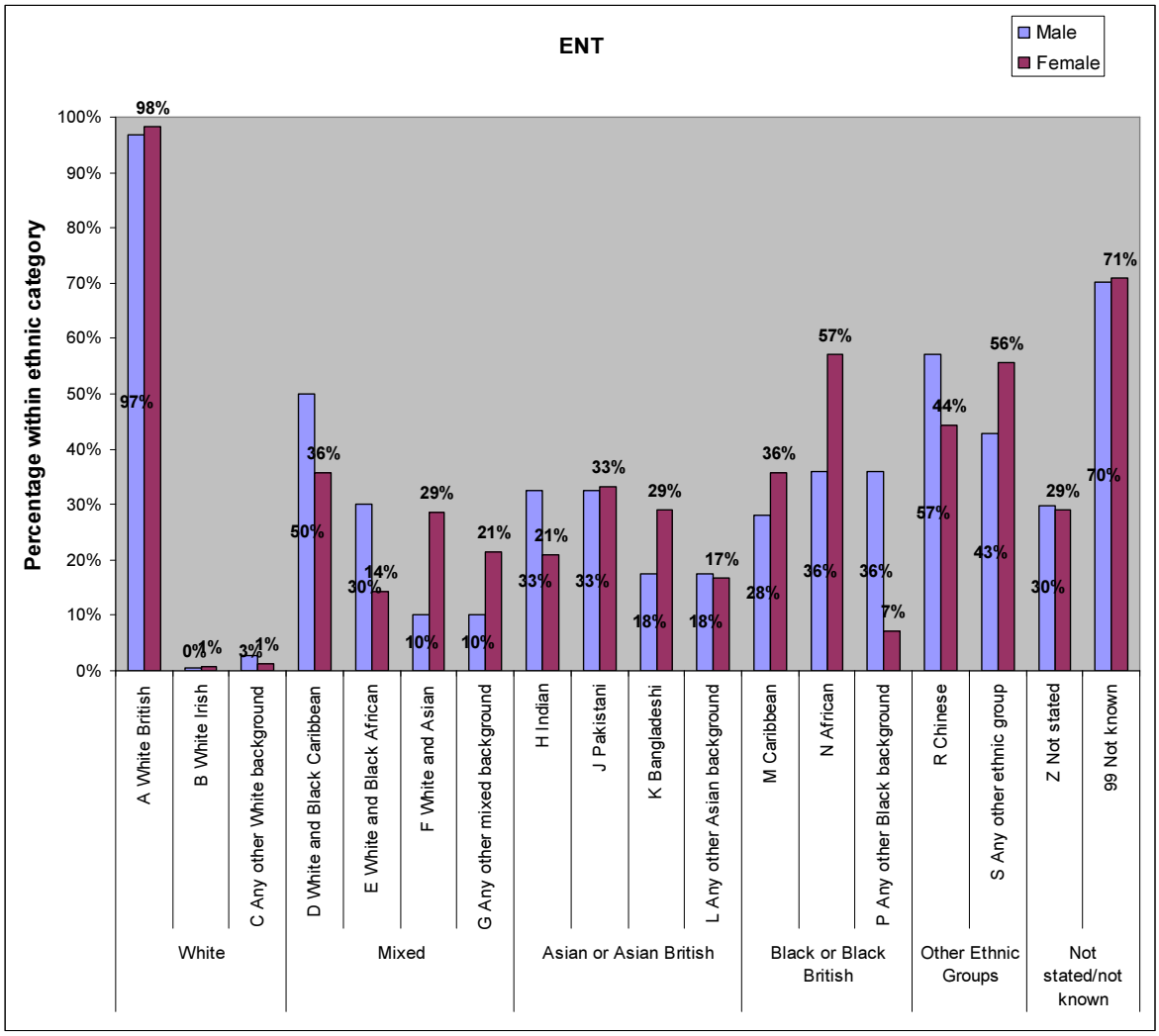
These variations among ethnic groups have been attributed mainly to specific risk factors, such as alcohol and tobacco (smoking and smokeless), but dietary factors and the existence of genetic predispositions may also play a part. Variations in access to care services are also an apparent factor (Scully C, Bedi R (2000) Ethnicity and Oral Cancer, Lancet Oncology Sep; 1(1):37-42)

No specific equality issues were highlighted during patient interviews concerning access or quality of service. Issues relating to communication were highlighted by head and neck cancer patients especially concerning verbal impairment due to a procedure or condition and these principles should extend to ENT or OMFS patients with similar communication difficulties either due to deficiency in English language skills or impairment due to a condition or disorder. One ENT outpatient who described himself as Indian commented on a “communication break down” in explaining to him his condition, treatment and outcomes post operatively. The patient was given the opportunity to speak with a clinician who could converse in Hindi and the patient highlighted the ease in further understanding his condition in a language he was more skilled in.

However both trusts have access to translation and interpretation services for speakers of other languages both face to face and via a telephone interpretation service. All patients must be given the opportunity to access this service and this would be facilitated by the collection of data around language spoken and read but also the asking of the question would you like to use translation and interpretation services.

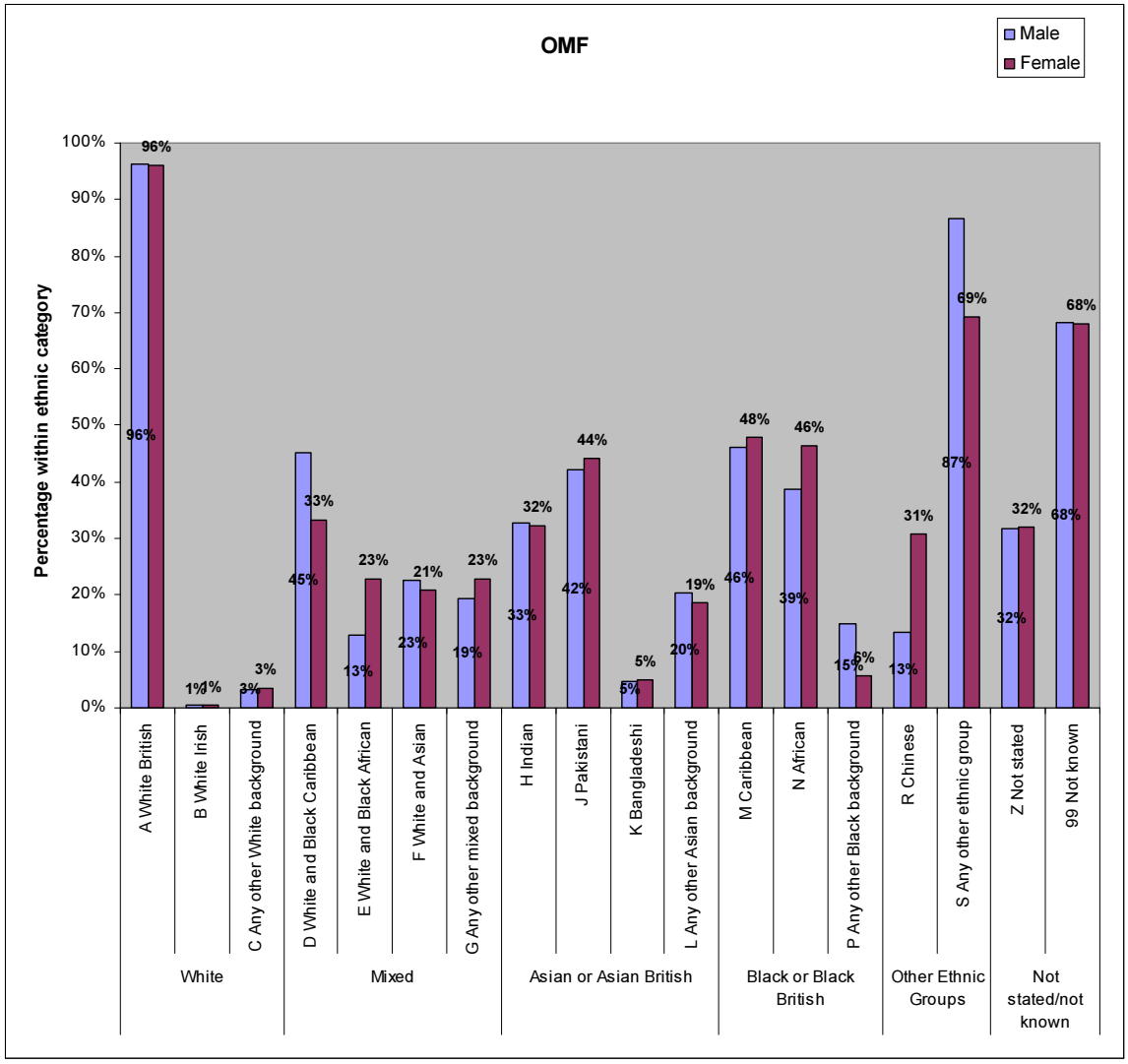
As with all NHS services, Oral & Maxillofacial Surgery Services and ENT services are to be designed around core standards of care and delivery and apply to all patients irrespective of ethnic backgrounds or other personal criteria.

8.1 Gender



The numbers of males and females accessing ENT from the White British population are almost equal. Within other populations there are variances between males and females accessing ENT services. Within the patients recorded as North African there is a greater percentage of females in ENT services. There is no known evidence to suggest that females of Black African descent are at a higher risk of ENT conditions.

There are a higher number of males of any other black background, accessing ENT services. This may be a result of the monitoring process with males identifying themselves as any other black background. This also highlights the need for the quality of ethnic monitoring to be improved.



For OMFS service patients from a white British background the gender split is equal. Similarly to ENT services a higher number of women from the Black African population are accessing OMF service compared to males of the same ethnicity but this difference is less than for ENT services. Males from any other ethnic groups are the second largest population accessing OMFS services.

No issues were raised during consultation with ENT and OMFS patients around access to or the appropriateness of service in relation to gender.

8.2 Religion and Belief

There is no available data on the self reported belief or religion of patients accessing ENT or OMFS services. During patient interviews no issues were raised regarding access to or the appropriateness of the service for patients with beliefs or who practised a religion. The issues raised during interviews with Head and Neck Cancer patients are also applicable to all patients accessing services.

8.3 Disability

There is no statistical evidence on the disabilities of people accessing ENT or OMFS services within Bristol. However certain disabilities will require treatment and diagnosis by ENT and OMFS. It can be assumed that a proportion of patients currently accessing ENT and OMFS services are being treated for an ENT or OMFS disorder relating directly to a disability. Two patients interviewed described themselves as disabled due to the conditions they were being treated for by ENT services.

There is evidence that disorders of the ear, nose and throat are high within people with Down syndrome and it is predicted that ENT specialists may treat these disorders in people with Down syndrome with increasing frequency as life expectancy for this population increases.

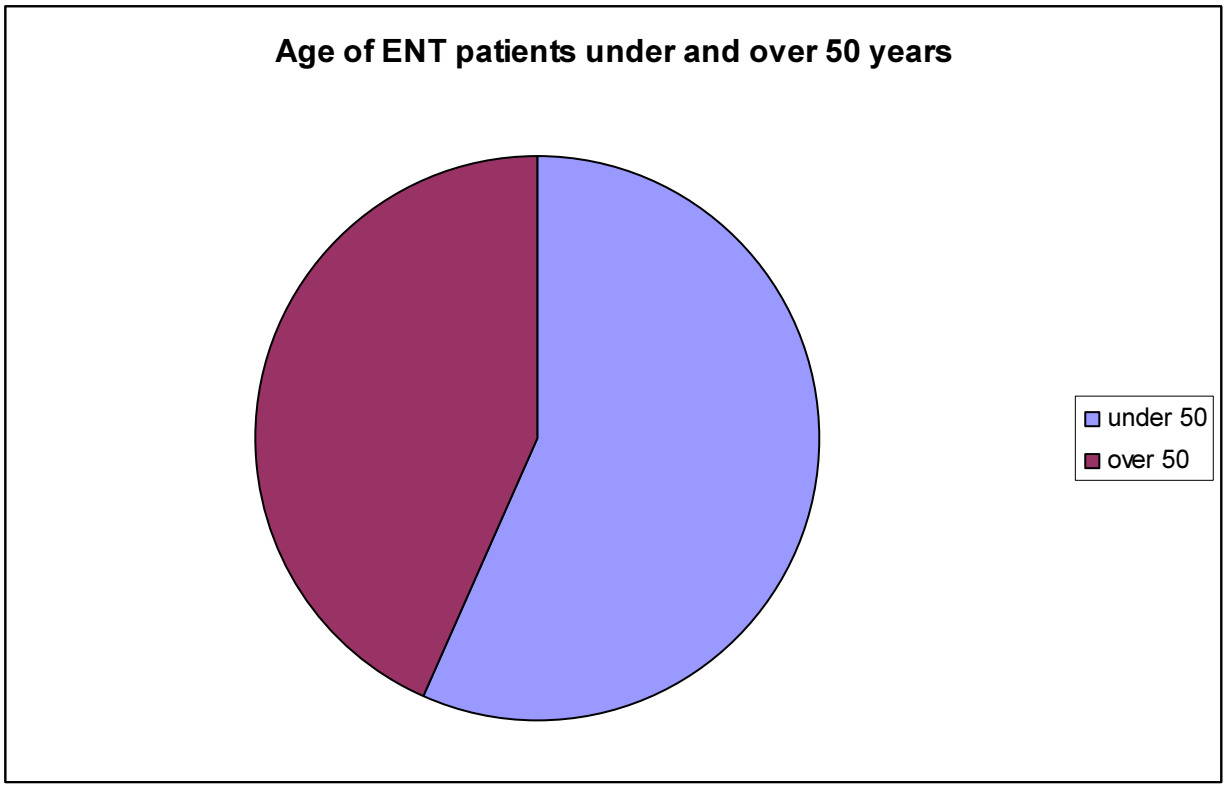
No issues relating to disability were raised during ENT and OMFS patient interviews. However as previously mentioned the standard equalities issues around accessing a service such as physical building access, leaflets available in accessible formats, longer appointments for patients with learning difficulties need to be considered when providing all services.

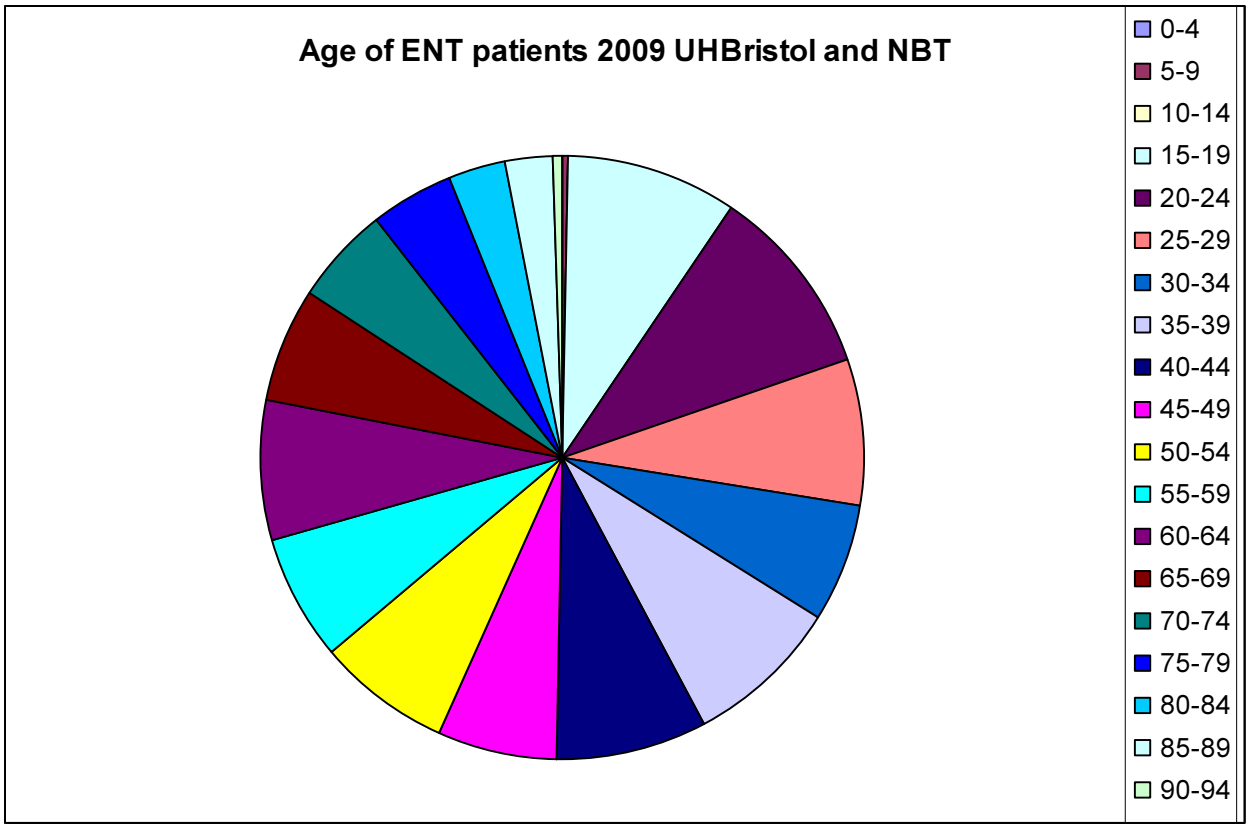
The communication needs of people accessing these services will need to be considered. A large proportion of patients accessing ENT and OMFS are likely to have hearing and/or speech impairments.

In 2008 a survey was carried out with 28 GP practices in Bristol looking at the health of people with learning difficulties in Bristol. Information was received concerning 1098 patients with LD. 11.7% of people with learning difficulties were identified as being hearing impaired. In addition, communication difficulties were present in 139 of the 1001 patients for whom information was available.

All health services should ensure that they are able to provide appropriate methods of communication for people with learning difficulties and to provide where possible extended appointments when needed. Literature should be made accessible and produced in large font with pictures to accompany text.

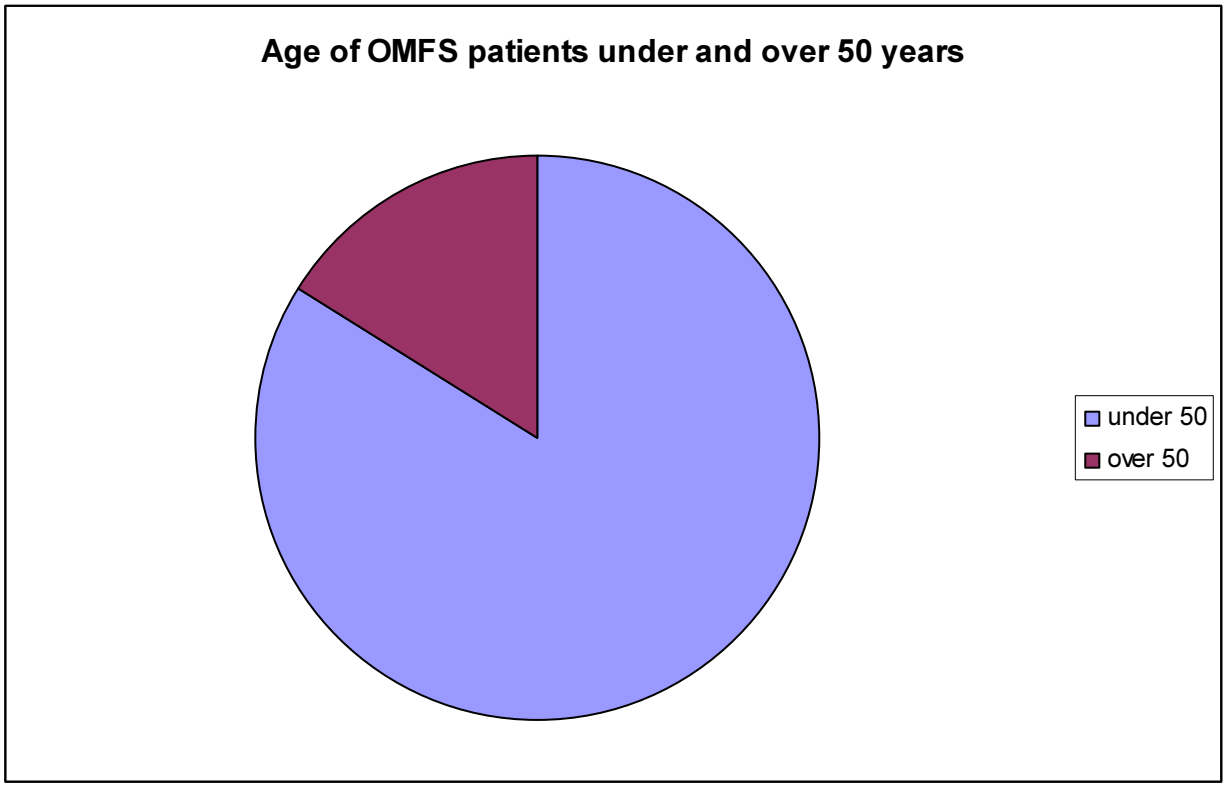
8.4 Age

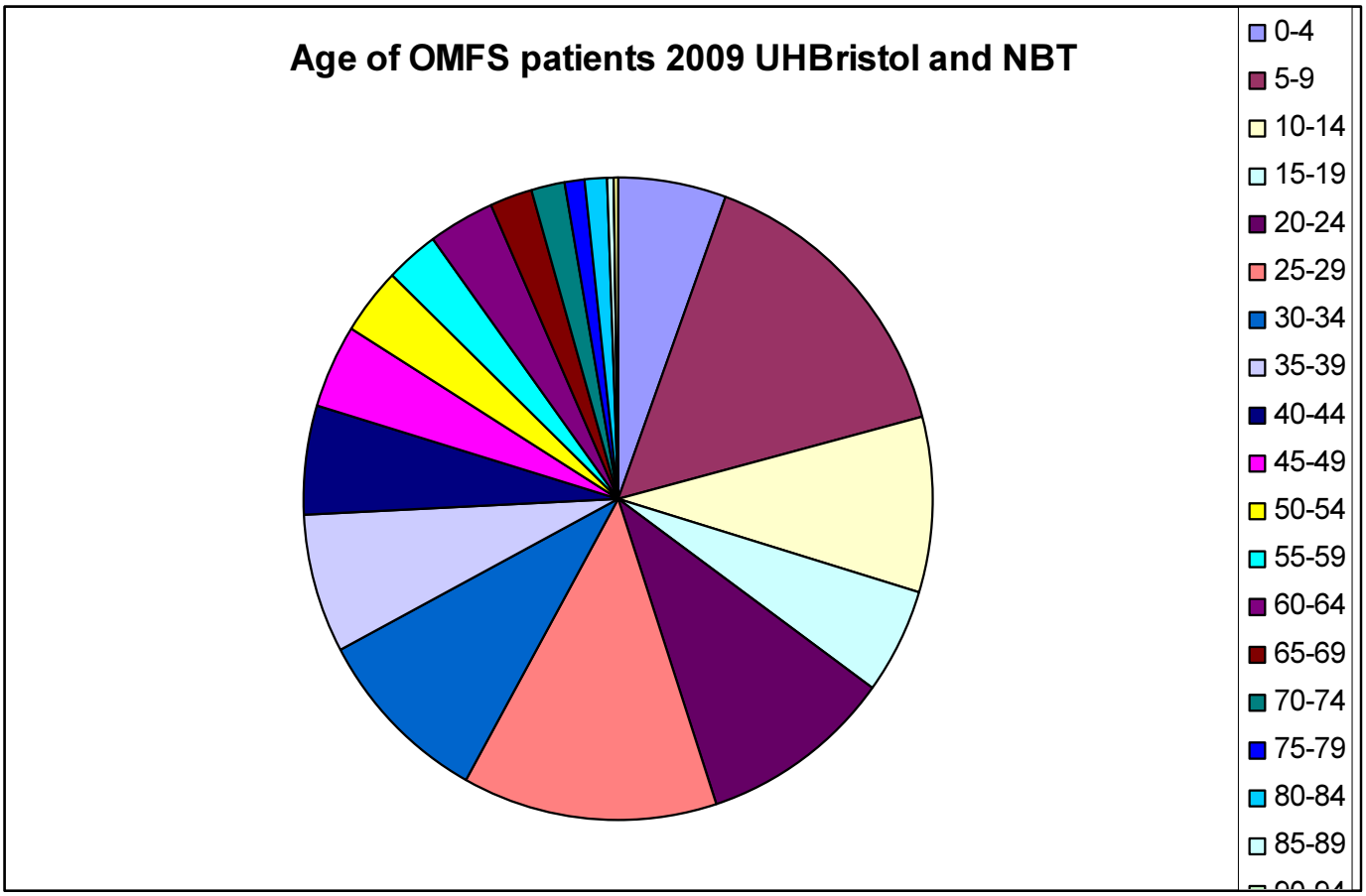




ENT services are accessed across the lifespan but there appears to be a greater proportion of both elective and non elective cases under the age of 50. The most frequently seen age group at both NBT and UHBristol is the 20 – 24 year old age group.

This is very different picture to the cancer patients and services should be sensitive to ensuring the information provided in appealing this wide demographic.





No issues were raised during patient consultations regarding appropriateness or access to ENT and OMFS patients regarding age. It is worth noting that considerably more elective and non elective OMFS cases are aged under than fifty years of age.

8.5 Sexual Orientation

There is no recorded information on the sexual orientation of patients accessing ENT or OMF services. However all services should comply with equality policies and deliver services to the same quality irrespective of sexual orientation. It would be valuable for monitoring purposes for sexual orientation to be captured.

Action Plan

Recommendation	Key activity	Progress milestones	Officer Responsible	Progress made
It is vital that race, sexual orientation and language spoken and read is monitored, recorded and reported on in the new service to ensure that people from higher risk groups are engaging with the service.	This requirement should be built into the service specification and monitored via performance management		Ellen Rule	
The provider should consider as part of their response to the service specification how they support prevention activities and they develop partnerships with community groups, health trainers, faith communities etc,	Provider response template completed considering this action		Claire Thompson	
The provider should ensure that there is a clear link between the service and “Cancer Help for Minority Ethnic Communities” hosted by Bristol Community Health.	Provider response template completed considering this action		Claire Thompson	

The provider should ensure there is a link between the service and the hospital chaplains	Provider response template completed considering this action		Claire Thompson	
For patients undergoing surgery, there needs to be a plan in place in advance which details their food choices for their time of temporary disability. A choice of food for oral or PEG feeding should be available for patients to choose from while in hospital	The service specification should detail the need for food choices to be made available in advance. The provider response template should consider the recommendation regarding patient choice for both oral and PEG feeding.		Ellen Rule Claire Thompson	
For patients undergoing surgery, there needs to be a plan in place in advance which details their communication needs during a time of temporary disability. Different communication methods should be offered for patients to choose from.	The service specification should detail the need for communication tools to be discussed during the preoperative stage. The provider response should consider how to make this available in practice.		Ellen Rule Claire Thompson	

Follow up of the annual Learning Difficulties health check questions whereby patients who are identified as not being registered with a dentist are followed up.	Project Manager to inform Lesley Russ of this specific requirement		Ruth Hallett	
Ensure there are links between the Community Learning Disabilities Team and Dentists and GPs.	Project Manager to inform Lesley Russ of this specific requirement		Ruth Hallett	
A shuttle bus service using an accessible vehicle to be used between NBT and UHB sites is investigated.	This should be referred to the Healthy Futures Programme Board for consideration, as part of wider service planning		David Tappin	
A leaflet is produced which explains access to UHB sites including public transport and parking facilities nearby.	The provider should consider this as part of their response		Claire Thompson	
There needs to be communication and information about cancer and cancer treatments, ENT and OMFS procedures in an easy to understand format appropriate to the patient and family e.g. in a different language or accessible to people with Learning Difficulties	The service specification should detail this requirement. The provider should consider as part of the their response how they could enable this to happen		Claire Thompson	
A quiet place to be provided for patient and family	The provider should consider as part of the their response how they could enable this to happen		Claire Thompson	

Provision is made for family members to stay with the patient	The provider should consider as part of the their response how they could enable this to happen		Claire Thompson	
Providers should ensure that translation and interpretation services are offered to every patients for whom English is not a first language	The provider should consider as part of the their response how they could enable this to happen		Claire Thompson	

Bath & North East Somerset Council		
MEETING:	Healthier Communities & Older People Overview & Scrutiny Panel Meeting	
MEETING DATE:	18 January 2011	
TITLE:	Shaping Up, A healthy weight Strategy for B&NES	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Shaping Up, A healthy weight Strategy for B&NES Adult Pathways Children Pathway		

1 THE ISSUE

1.1 Obesity is a major health problem for people in Bath and North East Somerset. It is a major contributing factor for type II diabetes, cardiovascular disease, a contributory factor in hip and knee replacements as well as many other health problems. The rates are rising for both children and adults. There are a range of contributing factors in the rise in obesity and this strategy aims to address these where we can locally through preventing more people becoming overweight and obese and through the provision of treatment to those who are an unhealthy weight.

2 RECOMMENDATION

The Healthier Communities & Older People Overview & Scrutiny Panel is asked to agree that:

2.1 The strategy is approved for publication and implementation.

3 FINANCIAL IMPLICATIONS

3.1 There are no new financial implications of this strategy. Funds are already committed to pay for treatment and prevention programmes. However, there is a substantial cost if we fail to address obesity, with more ill-health and the costs that will bring to health and social care budgets in the medium to long term.

4 THE REPORT

4.1 Obesity in both children and adults is a public health risk. This has been acknowledged in the Government's white paper on public health, Healthy Lives, Healthy People.

4.2 Obesity in children is a major predictor for obesity in adults. Through the national child measurement programme we have reliable data collected every year so we can accurately report how many children aged 5 and 10 are overweight and obese. According to the 2009/10 data, 15.8% of reception year children (age 4/5) were overweight and 8.4% were obese. Amongst year 6 children (age 10/11)13.1% were overweight and 16.7% were obese.

4.3 Obesity in adults is implicated in a range of health problems including cardiovascular disease, musculoskeletal problems and some cancers. In addition, obesity is interconnected with anxiety and depression, being both a cause and symptom. The cost of obesity is growing with the cost to the health service of treating conditions such as type II diabetes and hip and knee operations. There is a wider cost from obesity and it impacts on social care, welfare benefits, and carers to name a few. The impact is felt on business too, as days are lost to preventable conditions.

4.4 In line with guidance from NICE there are several areas for actions. We have identified we must tackle the global determinates of health and illness through working towards access to cheap healthy food for all, spaces to exercise in, active travel, and that children in particular have access to opportunities for a healthy lifestyle.

4.5 We also recognise that people must be encouraged to recognise the problem and ensure that they do what they can to look after their health and achieve and maintain a healthy weight. This is done through ensuring there is good, consistent information, that health professionals are able to screen and offer good, consistent advice and that people become equipped with the tools to make good choices.

4.6 However, for those whose weight is already causing problems we need to ensure that there are effective weight management programmes based on evidence and good practice. It is cost effective to invest in helping people lose weight than to treat the ill health caused by it. A small number of people will be eligible for intensive support and surgical intervention.

4.7 This strategy sets out our intentions of how to meet the needs of the population. We shall ensure that there is good governance through the development of a commissioning and strategy group and stakeholder events. We intend to ensure that we halt the rise in childhood obesity and help adults in B&NES become healthier individuals.

4.8 The governance of the strategy requires the formation of a strategy and commissioning group who will develop the strategy and will formulate a plan to implement the strategy through the next 3 years.

5 RISK MANAGEMENT

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

6 EQUALITIES

6.1 There has been an equality impact assessment undertaken.

7 CONSULTATION

7.1 We have consulted with representatives of the following groups:

Other B&NES Services; Stakeholders/Partners; Other Public Sector Bodies;

7.2 Consultation has been carried out in 2 ways. Firstly, throughout the writing of the strategy, individual people were consulted for their experience, knowledge and ideas. Secondly, there was a formal consultation period followed by a meeting of stakeholders. The strategy has also been to the PEC at the PCT.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Sustainability; Young People;

9 ADVICE SOUGHT

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

Contact person	Helen Erswell 01225 831452
Background papers	Shaping Up 2011 Pathways – adult and children
Please contact the report author if you need to access this report in an alternative format	

This page is intentionally left blank

Shaping Up!

A Strategy to support residents of Bath and North East Somerset to achieve a Healthy Weight.

2010 – 2013

Acknowledgements

Thanks to Derek Thorne and the original strategy group for the original shaping up strategy on which this refresh is very much based. Thanks to Sarah Whittle Williams for her work on the strategy. Thanks also go to Cheryl Richards form the Dietetics service, Cleo Newcombe-Jones from the Planning Policy department, Lynda Deane and Marc Higgins from the sport and active leisure team for their valuable insights.

Introduction

A strategy was initially developed in B&NES in 2005 and refreshed in 2007. Since then, obesity has climbed the national public health agenda. In 2008 the Department of Health produced "Healthy Weight, Healthy Lives: A Cross-Government Strategy for England".[1] This document outlines the problem facing England in relation to obesity and sets out what the government intends to do. This version of the Shaping Up renews our commitment in Bath and North East Somerset to tackling the causes and effects of obesity and uses current and recent guidance to inform our work.

Obesity is a major public health concern. In England currently nearly a quarter of adults and one fifth of children in England are obese. Rates of obesity are increasing and The Foresight report[2] predicts that nearly 60% of men, 50% of women and 25% of all children could be obese by 2050 if we continue on the current trajectory. The associated costs to society and business could reach £45.5 billion per year by 2050, with a 7 fold increase in NHS costs alone.

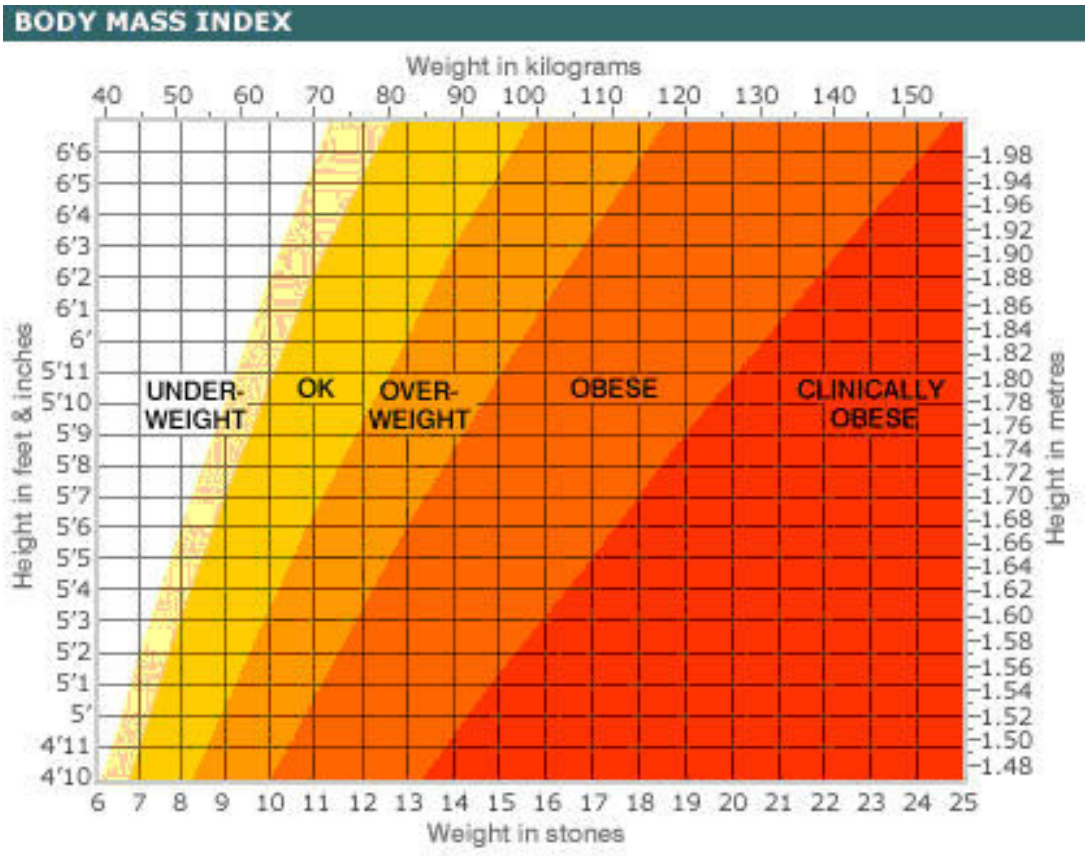
Obesity is defined as a significant excess of body fat which occurs when energy intake exceeds expenditure over a long period of time. Obesity is known to increase the risk of a range of health problems particularly type 2 diabetes, stroke and coronary heart disease, cancer and arthritis. It is also important to note the immense impact of overweight and obesity on emotional health and quality of life.

Body Mass Index (BMI), a measure of weight in relation to height, is used to identify levels of obesity within a population. Crude BMI is less accurate for children, as they are still growing so the measurement is adjusted to allow for age, gender and height. BMI is an indicator of health and should be used with

[1] Healthy Weight, Healthy Lives: a Cross-Government Strategy for England Department of Health (DH) (2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082378

[2] Tackling Obesities: Future Choices www.foresight.gov.uk (2007)

caution when exercised when used for individuals. Clinical judgement is necessary to assess individual's weight where there is concern.



The causes of obesity are complex; factors include biology, behaviour, culture, environment and socio-economics. Personal responsibility is a factor in weight management and focus on behaviour change can have an impact. We must also acknowledge the role of environment in the increase of obesity. We live in an obesogenic environment whereby more people work in offices whilst fewer people have a physically active job. We benefit from labour saving devices in the home and rely heavily on cars to get around. Our physical environment has increasingly led to our dependence on cars to get to out of town shopping centres and supermarkets. In addition, there is more pressure on our green spaces, a culture wary of letting children walk or cycle to school and less opportunity to incorporate physical activity into our everyday life.

Our eating habits have also changed enormously. Fewer people cook meals from scratch, relying on high sugar, high fat foods. We eat out more and portion sizes have increased. Alcohol has become a normal part of many people's everyday live all of which contribute to more calories consumed. For many people in areas of socioeconomic deprivation, it is difficult to access good quality, fresh food and for some the basic skills of vegetable preparation are unfamiliar. People rely on cheap, energy-dense food to feed their families and convenience stores are the places people shop for their families. It is increasingly difficult for people to remain a healthy weight and where people who are economically deprived live, the task is even harder.

With this in mind, the Foresight report demonstrates that policies and small scale interventions aimed at individuals are inadequate in themselves at reversing the current trend. In order to make an impact on obesity rates, a bold, whole system, population based and sustained approach is required.

The scale of the problem in B&NES

The scale of the problem in B&NES broadly reflects the national picture. 21.5% of adults are considered to be obese, slightly less then the average in England of 24.2%.[3] The same health profile reports that only 12.5% of adults are physically active (that is active for 30 minutes 5 times a week). Only 21.2% of B&NES residents, compared to 11.6% nationally, are active at least 3 times a week for 30 minutes according to the active people survey from Sport England in 2008/9.[4] This is a significant decline from 23.8% of people recorded in 2005-2006.

In B&NES it is estimated that £45.8 million will be spent by the NHS in 2010 on disease related to overweight and obesity, set to rise to £49 million in 2015.

In B&NES in 2008/9 the National Child Measurement Programme (NCMP) showed 7.9% of reception and 13.4% of year 6 children were obese. However, whilst we compare favourably to the national obesity rates of 9.6% in reception and 18.3% in year 6 and the regional rates of 8.9% in reception and 16% in year 6. Significantly, the rates of children who are overweight in reception is 16.5%, higher then the regional rate of 14% and the national rate of 13.2%. This could either be a sign of a reducing obesity rate *or* a worrying indicator of future problems. Combining these figures shows that 24.4% of children at reception are either overweight or obese, that is the equivalent to 1 in 4. We must not be complacent as this is too many overweight and obese children, whose health will be affected as they grow into adults.

[3] Health Profiles 2010 www.healthprofiles.info
[4] www.sportengland.org

Aim

The aim of the partnership in Bath and North East Somerset is:

To improve the health of local people through a reduction in obesity and in the promotion of healthy lifestyle behaviours which achieve and sustain a healthy weight.

The aim will be supported through the development of 5 themes.

- Promoting and providing a healthy environment, making healthy choices easier
- Promote Self Care, prevention and early intervention
- Provide treatment for adults and children who are overweight and obese.

In order to achieve this we need to ensure we have a solid infrastructure. In order achieve this we will

- Develop and use the intelligence and data.
- Build an effective workforce.

Population Priorities

Obesity is an issue which can cross social boundaries. The population of B&NES is relatively affluent and yet, has high and growing rates of overweight and obesity. We need to ensure that we address the needs of all people and work across the PCT, local authority, private and voluntary sector to ensure the needs of all residents of B&NES is addressed. However, rates of inactivity and obesity are higher amongst people who are economically disadvantaged.

The strategy for addressing obesity must take all of these factors into consideration when determining priorities for action.

The whole population will be prioritised through universal prevention (see appendices). The universal approach will involve tackling the wider determinants of health and illness and require the cooperation of partners from a wide range of sectors.

We also need to ensure that we target our prevention at people who are at most risk of becoming overweight and obese. We must help the inactive become more active, we must target people at the time when they are most at risk of weight gain and help prevent the overweight going on to become obese.

Therefore, targeted preventative activity will be centred on specific points in the life cycle:

- **New and expectant mothers**, who at this time in their lives are most at risk of gaining weight, as well as their decisions affecting the health and weight of their unborn children and infants, and often their partners as well. Breastfeeding protects the child against obesity in later life, and helps mothers reduce their weight postnatally.

- **Early Years and School aged Children**, in order to affect children we need to support the entire family to make lifestyle changes that will be long term and will set behaviour patterns that will stay with the children as they grow into adults and become parents themselves.

- **Middle aged adults** who are perhaps beginning to accept weight gain as an inevitable part of ageing, and who can make real changes on their immediate health outcomes by making changes to their lifestyle now.

Targeted prevention activities must always prioritise those from lower socioeconomic groups. This is because they are more likely to be overweight or obese and physically inactive. They will also have less access to gyms, healthy food outlets, bicycles, are least likely to breastfeed and may well have high levels of stress and low levels of self efficacy.

We must provide weight management services for all who are overweight and obese and need help in reducing their weight. These services must be accessible and patient centred. They need to focus on behaviour change; practical skills to help maintain any weight loss and be a combination of healthy eating and physical activity.

Finally, we will provide specialist clinical services for those who have not lost weight through conventional dieting and exercise. We will ensure that the psychological factors are also addressed and that people receive the help and support they need to achieve weight loss and maintenance.

Promoting and providing a healthy environment, making healthy choices easier

We need our environment to support us to be healthy. We need healthier choices to be the easier choice to make. This involves all partners in Bath and North East Somerset, alongside colleagues in National, regional and sub-regional organisations working together. This will extend to partners outside of the public sector such as developers, retailers and employers this work strand will involve work between a number of agencies in B&NES.

- We will advocate for the needs of the residents of B&NES to ensure that health and specifically healthy weight, is full considered in policies and plans for B&NES
- We will promote active travel, increasing the numbers of journeys walked and cycled.
- We will improve access to sport and leisure facilities, particularly amongst people in our priority groups.
- We will improve access to healthy food for everyone in the community
- We will support and promote healthy schools
- We will support breastfeeding and challenge the culture to ensure women who want to can breastfeed for longer.

Promote self care, prevention and early intervention.

For both staff and the public, discussing the sensitive issue of weight can be difficult. Many frontline staff are unclear of what they can do to help and which services are available for those that need it. Both staff and the public are confused by BMI measurements (especially for children) and what being overweight or obese means in terms of their health. Parents often underestimate their own children's weight; particularly those parents who are overweight

themselves. Most people over estimate how much physical activity they do and under estimate how many calories they consume.

Increasingly people's family and friends are overweight whilst simultaneously being surrounded by unobtainable images in the media of extreme slenderness and often underweight people, particularly women.

There needs to be an objective measure for people to understand what a healthy weight is and how to achieve it. We need to ensure advice on weight is consistent and supportive. People need to be able to identify for themselves when weight is an issue.

Losing weight can be extremely difficult and people may find themselves locked into a cycle of endless dieting and weight regain. Preventing weight gain is a sensible precaution for most people and they need to know what a healthy weight is and how to maintain it for themselves, without endless interventions from professionals.

- We will continue with the National Child Measurement Programme and follow up letters to all parents so that any issues with children are identified early.
- We will implement the health checks programme for those over 40, ensuring that accurate information is available for people to take action as required.
- We will promote self care, encouraging people to regularly weigh themselves and take steps to address any weight issues early on.
- We will encourage health professionals to talk to patients about their or their children's' weight.

Provide Treatment for those who are overweight or obese.

For people who are already overweight or obese, there needs to be provision for them to help them lose weight. For some, this will be education, lifestyle adjustment and self care. Other people may have longer term needs or underlying psychological or physical health problems that need to be addressed. Children too may be at different points in the spectrum and need to have their needs addressed in a sensitive manner.

Services need to be rooted in the social and cultural norms of people and communities, reflecting achievable aims, appropriate person-centred levels of support and long term behaviour change.

- We will review service provision, providing evidence based services for adults and children
- We will ensure that services are a range of interventions across the tiers (see appendix 2)
- We will ensure there is a pathway on which sits services at different levels of intensity, which makes clear when there is need for action and is simple for a range of clinicians to use.
- We will ensure all services are non-judgemental, person-centred accessible and based upon NICE guidelines
- Services will be monitored by commissioners to ensure they are effective and value for money.

Developing the intelligence and data

We need to ensure we have up to date information from our service providers, GPs and other partners. We need to collect the right data and use it to inform commissioning and performance management, to deliver better and more appropriate services and to be able to demonstrate how effective our programmes are and indeed, if they are effective at all. We also need to make use of existing data and market segmentation information to inform our programmes and work areas.

- We will continue to collect, analyse and disseminate data from the breastfeeding initiation, health visitor first visit and 6-8 week check, school meals uptake and NCMP to inform our work and target services
- We will collect data from service providers enabling effective monitoring of services as well as contributing to our understanding of the situation in B&NES
- We will use the Healthy Foundations market segmentation principles to inform the work how we target people and communities.
- We will ensure that monitor performance of service providers in order to ensure we reduce rates of obesity in B&NES

Building an Effective Workforce

A range of agencies work to reduce overweight and obesity in the population. We need to identify the key partners and ensure they are included in any stakeholder group. We also need to identify who else can contribute and ensure their skills are developed in order to give clear and consistent advice to people. We need to ensure that there is an active network of people, with good communication between them who can deliver the work. We will ensure they are supported to do this through good quality information, training and resources.

- We will establish a commissioning group to ensure that people who commission relevant services are communicating effectively
- We will establish a stakeholder group to ensure that different service providers, clinicians and the wider public health workforce are communicating with commissioners and each other
- We will publicise the care pathways so all potential referrers are clear about service provision in B&NES and use feedback from stakeholders to continuously improve the pathways.

- We will ensure that training is available so that the workforce is competent to deliver the work
- We will ensure that all information we produce is clear, concise and consistent

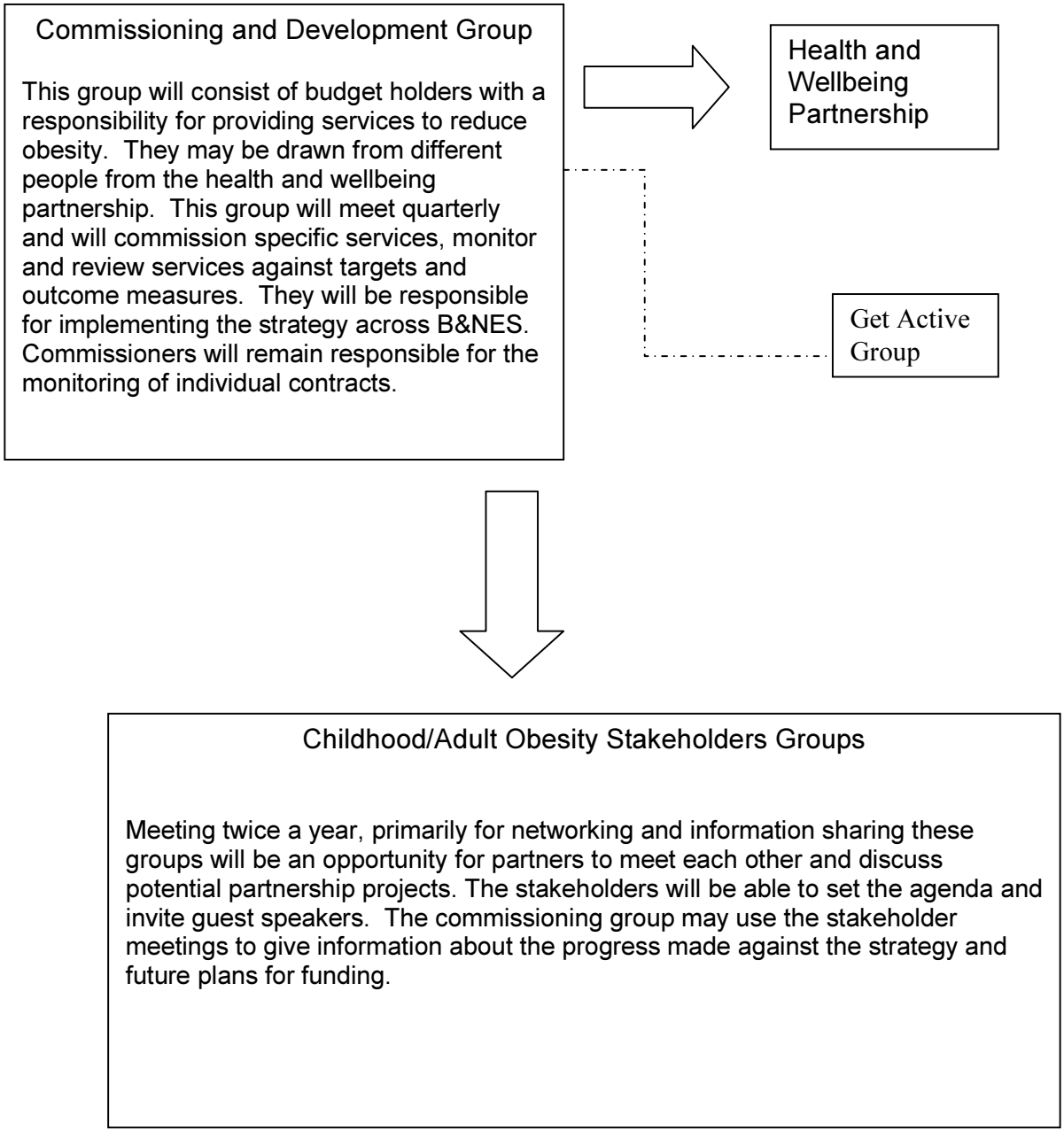
Principles

The strategy will be progressed with consideration to the following key principles:

- The Health and Wellbeing Partnership will lead the healthy weight strategy.
- The strategy will generate specific actions for implementation which will be refreshed annually.
- Actions will be developed, prioritised and agreed through a multi-agency partnership.
- Agreed actions will be based on reliable up-to-date evidence and guidelines.
- Monitoring and evaluation is an integral part of all work.
- Key links to other strategies will be identified and actively pursued.
- Key staff groups and influential partners will be involved in the further development and implementation of the strategy.
- Successes of the partnership will be publicised and celebrated

Governance

This strategy sits within the framework of the health and wellbeing board. The governance structure will ensure that there is accountability in the delivery of the strategy with people contributing in the most effective forum. There are links and crossovers with the Get Active strategy and governance structure with many issues being pertinent to both groups. In order to avoid duplication of work and recognising that many participants from the Get Active commissioning and developing group will also sit on the obesity strategy group, the physical activity work is delegated to the get active group with public health commissioners providing the link between them. There will be a report presented to the obesity group from the get active group.



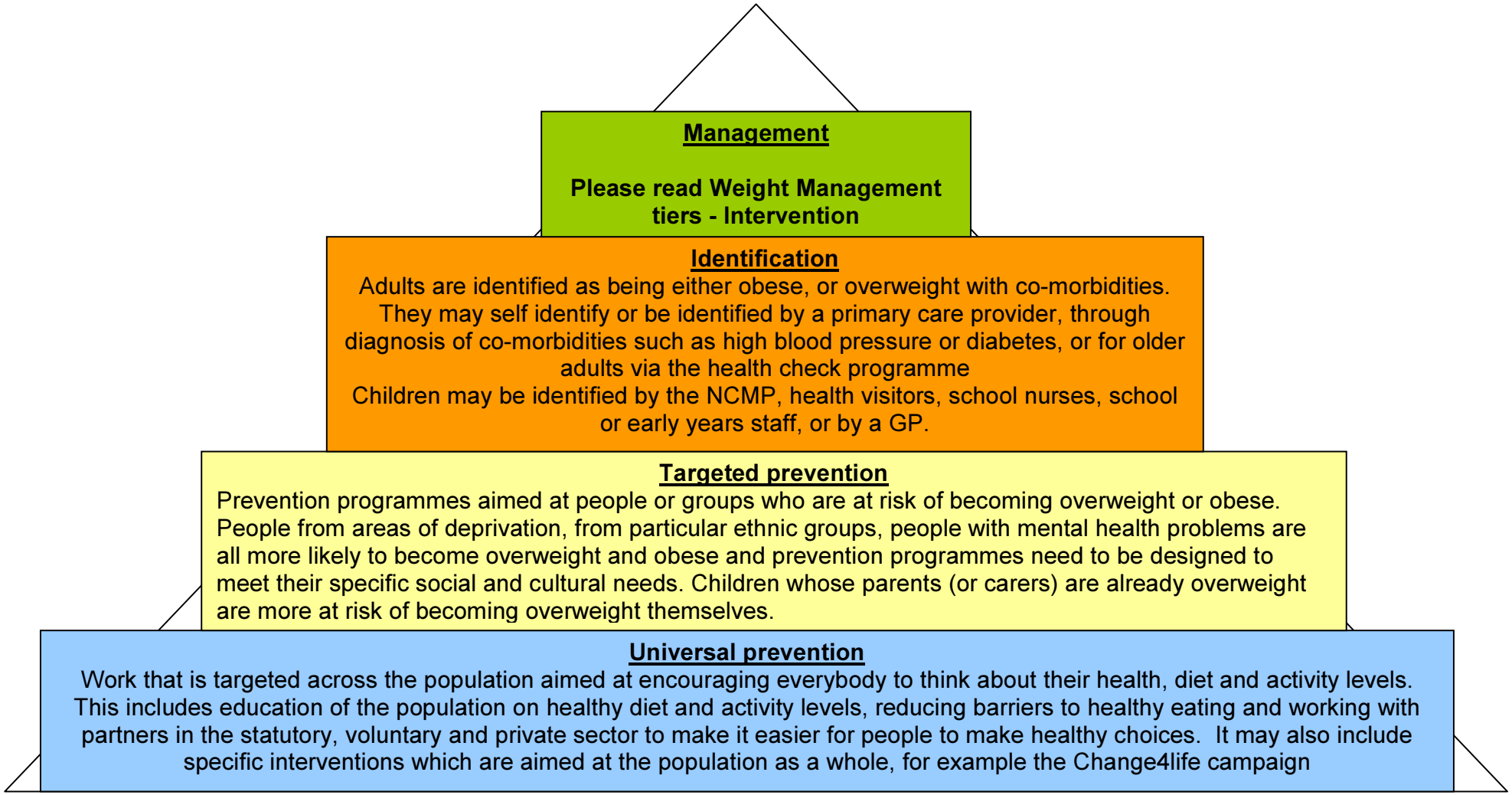
Targets and performance monitoring

The table below shows the different targets to which the healthy weight strategy contributes to, reflecting the whole systems approach required to address the obesity problem. This section of the strategy is particularly vulnerable to change and will be refreshed annually to reflect new targets.

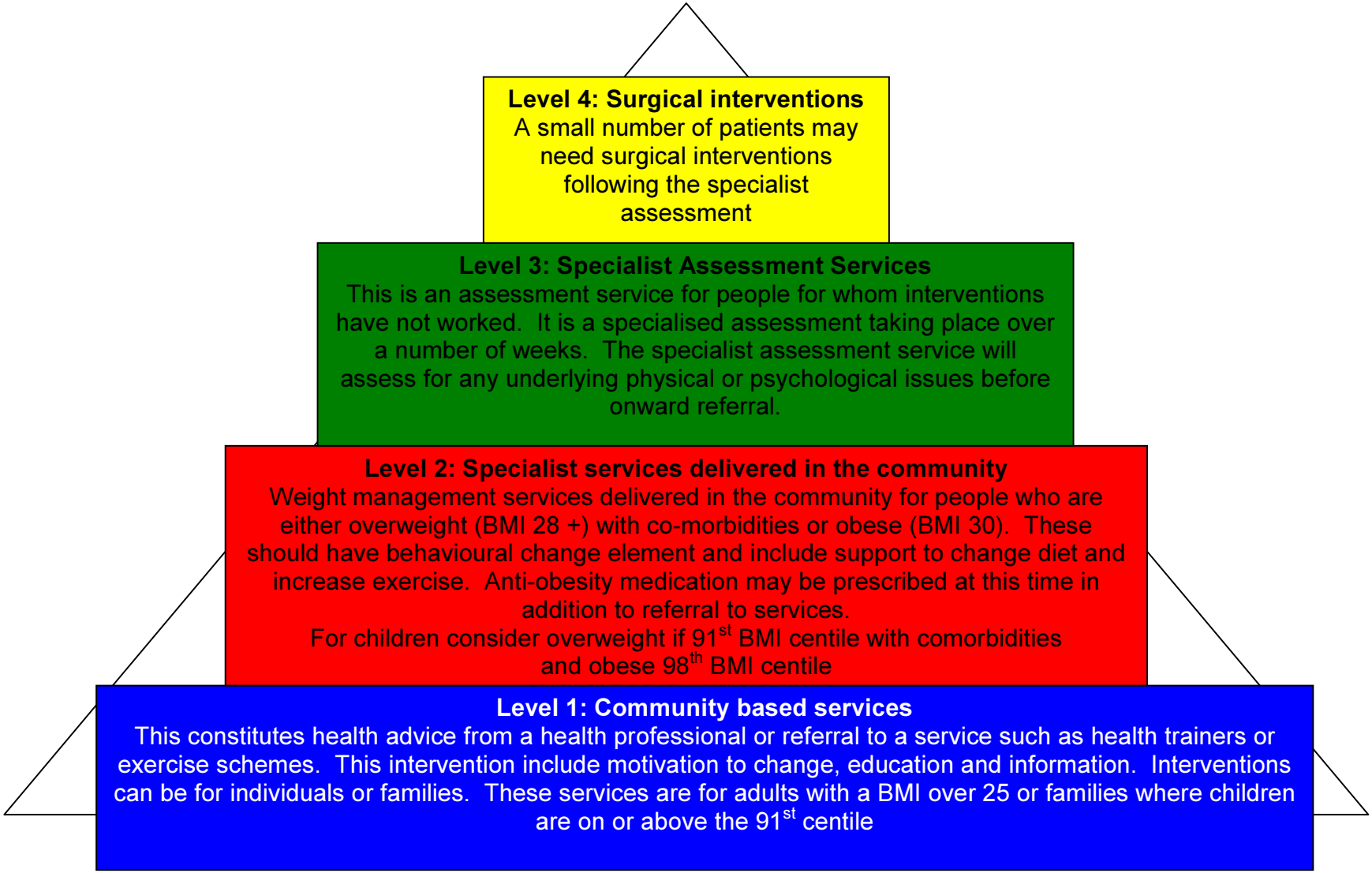
Responsibility for the targets will continue to sit with current owners but those owners will be encouraged to fully engage with the strategy and stakeholder groups in order to work across the partnership to achieve those targets and work towards improving the health of people in B&NES.

Stronger Communities	NI 8 Adult participation in sport
Children and Young People	NI 53 Prevalence of breastfeeding at 6 – 8 weeks from birth (NHS Vital Sign) NI 55 Obesity among primary school age children in Reception Year (NHS Vital Sign) NI 56 Obesity among primary school age children in Year 6 (NHS Vital Sign) NI 57 Children and young people's participation in high-quality PE and sport PSA 12 Improve the health and wellbeing of children and young people NI 52 Uptake of school meals
Adult Health and Wellbeing	NI 119 Self-reported measure of people's overall health and wellbeing NI 120 All-age all cause mortality rate NI 121 Mortality rate from all circulatory diseases at ages under 75 NI 122 Mortality from all cancers at ages under 75 NI 124 People with a long-term condition supported to be independent and in control of their condition NI 137 Healthy life expectancy at age 65
Local economy	NI 175 Access to services and facilities by public transport, walking and cycling NI 176 Working age people with access to employment by public transport (and other specified modes) NI 177 Local bus passenger journeys originating in the authority area
Environmental Sustainability	NI 198 Children traveling to school – mode of travel usually used

Appendix 1: Healthy Weight Tiers – Prevention

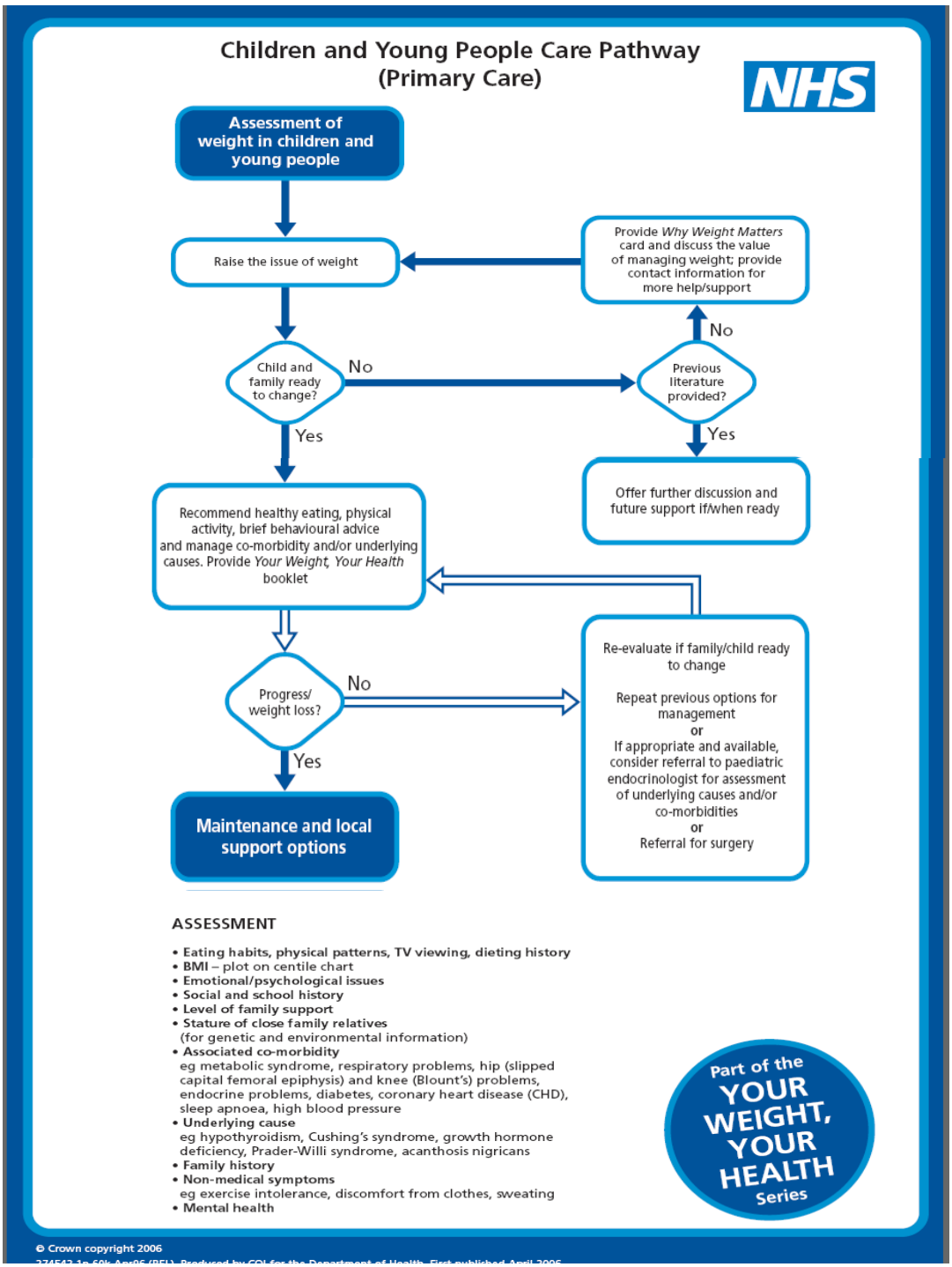


Appendix 2: Healthy Weight tiers – Intervention



Appendix 3: Children and Young People's Care Pathway

This is the pathway from healthy weight, healthy lives. A local children's pathway is in development.



Appendix 4: Linked Strategies

Within Bath and North East Somerset there is a wide range of activity taking place to effect change in the areas with the highest rates of obesity. To this end there are a number of important strategies which link to this document. The following list is not exhaustive but highlights the key strategies in B&NES which play a crucial part in combating the rising rates of obesity.

Regional Spatial Strategy
Core Strategy (currently at options stage)
Green Space Strategy
Green Infrastructure Strategy
Infrastructure Delivery Plan
Joint rights of way improvement plan 2007 - 2011
Local Food Production Strategy
Planning Obligations Supplementary Planning Document
B&NES Sustainable Community Strategy
B&NES Get Active Strategy
B&NES Play strategy
B&NES Breastfeeding Strategy (under development)
Wiltshire Maternity Services Strategy & Action Plan
B&NES Cultural Strategy
Children's and Young People's Plan
Healthy Child Programme
B&NES Sustainable Modes of Travel to School Strategy (SMoTSS)

This page is intentionally left blank

Public Health Map

NHS: Community Services and secondary care

- Promote activities that fit easily into everyday lives, e.g. walking.
- Use multi-component interventions such as dietary assessment and targeted advice, family involvement and goal setting.
- Offer tailored advice based on individual preferences and needs.
- Provide ongoing support – in person or by telephone, post or internet.
- Include promotional, awareness-raising activities as part of long-term interventions, not as one-off activities.
- Address concerns about: the availability of services; the cost of changing behaviour; the taste of healthier foods; the safety of walking and cycling.

NHS: Primary Care

- Discuss weight, diet and activity at times when weight gain is more likely, for example: during and after pregnancy; the menopause; stopping smoking.
- Tell people who are stopping smoking where they can get advice on weight management; and encourage physical activity.

Local authorities and partners

- Identify and address environmental barriers to physical activity and healthy eating.
- Address concerns about safety, crime and inclusion.
- Encourage active travel through cycle lanes and bike stands, walking routes, including area maps and pedestrian crossings; traffic calming measures; improved street lighting.
- Ensure building designs encourage the use of stairs and walkways.
- Encourage local shops and caterers to promote healthy food and drink choices via the healthy options scheme

Workplaces

- Address weight in any health checks.
- Implement tailored physical activity programmes and cross organisational policies which promote and facilitate physical activity.
- Improve food provision – actively promote healthier choices in line with existing guidance and educational and promotional activities.
- Any incentive schemes to be long term and part of a wider programme to manage weight, diet and activity.

Self-help, commercial and community weight-loss programmes

- Follow best practice standards.
- Local authorities and PCT to only endorse or recommend programmes if they meet best practice standards

The Public

- Reduce sedentary time and increase activity. Try to build in 30 minutes of moderate activity at least 5 days a week.
- Eat five portions of fruit and vegetables a day.
- Keep a check on your weight, be conscious of clothes feeling tighter and act sooner rather than later.
- Seek advice from a health professional if concerned.

Care Pathway for Weight Management

Assessment of weight/body fat
Body Mass Index (use with caution),
Waist circumference (as appropriate for people with BMI <35)

Individual ready to address weight problems

Level 1 – Weight maintenance & self directed early intervention.	Target Group
• Provide healthy eating information • Provide information about local physical activity programmes such as walking and cycling schemes • Encourage self care and regular monitoring	• BMI of 18.5 – 25 (weight maintenance) • BMI of 25 -35 with no co-morbidities

Level 2 – Primary Care Services	Target Group
• Consider referral *(if meeting criteria)* to: ○ Healthy Lifestyles Service ○ Slimming on Referral ○ Counter weight ○ Passport to Health • Consider prescription of obesity medication • Minimum regular monitoring 3/12 • Consider referral to dietetics service if meeting their criteria	• People should be referred to level 2 services if they have not lost and maintained 5 – 10 % at level 1. • People should enter the pathway here if they are BMI 25 + with co-morbidities *or* BMI 30 + without co-morbidities. • An assessment of each individual should be carried out to determine the most appropriate service for the individual.

Level 3 – Secondary Care Services	Target Group
• Assessment of co-morbidities • Referral to intensive Multi-disciplinary assessment service	• People who meet the NICE criteria for Bariatirc surgery

Level 4 – Specialist Secondary Care Services	Target Group
• Bariatirc surgery is for people who have been through the assessment service and referral is via this service only.	• People who meet NICE criteria for surgery and have been through multi-disciplinary assessment service

Settings

Primary Care & Community

Primary Care

Secondary Care

Secondary Care

Public Health Map adapted from National Institute of Health and Clinical Excellence

This page is intentionally left blank

Healthy Weight in Early Years (0-4) Pathway

Relevant Professionals

Midwife	GP
Health Visitor	Dietician
Nursery Nurse	Practice Nurse / Registered General Nurse
Children's Centre Staff	Pre-school staff
Childminder	Breastfeeding counsellor
Parent Support Advisor	Lifestyle Services

Identification

- Take every opportunity to raise the issue of weight, provide verbal and written information to encourage appropriate feeding practices/ healthy eating, increased physical activity and reduced sedentary activities.
- Encourage the parents to ***contact health visitor, or midwife*** if the family are motivated to make a change, or contact them directly if there is a child protection concern.
- If appropriate, use **Healthy Weight for Children Behaviour Change Brief intervention** to support family to make a change.

Assessment

- Use clinical judgement to decide when to measure height and weight
- Measure height and weight (using accurate measurement tools)
- Assess parents / child for co-morbidities or complex needs and family history.
- Use WHO centile charts to plot infant /child's weight
- Discuss with parents their judgement of their child's weight. Assess their feelings and the family's readiness, motivation and barriers to change

Intervention

- Offer Behaviour Change Brief Intervention
- Provide Start4life and Change4life materials and encourage families to seek support from a health professional when ready
- Record height and weight and any action taken on child's health record (red book), inform referrer if appropriate
- Use clinical judgement to decide if any action needs to be taken
- Where parents are overweight link into adult healthy weight pathway
- Adhere to relevant NICE guidelines
- Consider a CAF, or refer to Children's Social care for an Initial Assessment if the child is considered to be in need or in need of protection

Healthy Weight in Children (5-16) Pathway

Relevant Professionals

Teacher	GP / Dietician
Health Visitor	SENCO
School Nurse	Practice Nurse
Pastoral support staff	Parent support advisor
Childminders	Play worker
Youth Worker	Extended Services

Identification

- Take every opportunity to raise the issue of weight, provide verbal and written information to encourage appropriate feeding practices/ healthy eating, increased physical activity and reduced sedentary activities.
- Encourage the parents to ***contact school nurse,*** if family are motivated to make a change, or contact them directly if there is a child protection concern.

Assessment

- Use clinical judgement to decide when to measure height and weight
- Measure height and weight using accurate measurement tools.
- Assess child for co-morbidities / complex needs and family history.
- Use 1990 BMI Growth reference chart to plot child's weight and facilitate discussion around the family's feelings and to assess family's readiness, motivation and barriers to change

Intervention

- Offer Behaviour Change Brief Intervention
- Provide Change4life materials and encourage families to seek support from a health professional when ready
- Record height and weight and any action taken on child's health record (file), inform referrer if appropriate
- Use clinical judgement to decide if any action needs to be taken
- Where parents are overweight link into adult healthy weight pathway
- Adhere to relevant NICE guidelines
- Adhere to locally established child protection guidelines and protocols.
- Consider a CAF, or refer to Children's Social care for an Initial Assessment if the child is considered to be in need or in need of protection

Bath & North East Somerset Council	
MEETING:	Healthier Communities and Older People Overview & Scrutiny Panel
MEETING DATE:	18 January 2011
TITLE:	Progress on tackling winter health
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: B&NES Affordable Warmth Draft Action Plan January 2011	

1 THE ISSUE

The latest publication in 2010 of the Local Authority Health Profiles identified B&NES as an outlier with a high proportion of the total number of deaths taking place during the winter months. This paper updates the Committee on the actions being taken to tackle this and bring about improvement.

2 RECOMMENDATION

The Healthier Communities and Older People Overview & Scrutiny Panel is asked to agree that:

2.1 The Action Plan of the B&NES Affordable Warmth Action Group is proportionate and comprehensive

3 FINANCIAL IMPLICATIONS

3.1 The Keep Warm Keep Well booklet is provided free nationally. Local Warm Streets project administration and marketing is paid for by the sponsors Scottish and Southern Energy so covering the costs of the Warm Streets leaflet. The other actions proposed are about how we prioritise the use of current staff time. Although there is uncertainty about national budget allocations that impact on affordable warmth services.

3.2 Housing Services contribute staff resources to the help oversee the Warm Streets partnership arrangements and raise awareness of the service amongst B&NES residents and Council frontline staff. The Council currently provides some grant funding towards loft and cavity wall insulation for vulnerable residents.

4 THE REPORT

4.1 The conditions which cause the majority of excess winter deaths are cardiovascular and respiratory diseases. The effect of low temperature is to reduce the effectiveness of the immune system, cause thicker mucus, and encourage mould growth so making a person more susceptible to infections such as respiratory ones. Low temperature also raises the blood pressure and thus makes people more susceptible to strokes and heart disease. The cold also causes hypothermia, falls and other injuries, and poor mental and social health and an increase in hospital admissions.

4.2 We need to ensure that all front-line staff going into people's homes are aware of our poor excess winter deaths position and can identify cold houses and give occupant(s) the contact details to access remediable support services. We need to improve the systems and ways of working between the health, statutory, private and voluntary sectors and housing services tackling fuel poverty and affordable warmth in B&NES. We need to give the work of the Affordable Warmth Group more prominence.

4.3 The numbers of excess winter deaths in England and Wales reduced markedly in 2009-2010 with a decrease of 30 per cent compared with figures for 2008/09. Unfortunately because of the need to produce comparative national information the Health Profiles indicator where we were the worst in England covers 2005-08. Over these three years there were 130 excess winter deaths yearly in B&NES. In 2008-09 according to local data there were 139 excess winter deaths but the comparative position will not become available until June 2011 and in 2009-10 there were only 73 excess winter deaths. Our local calculation of the Excess Winter Mortality Index for B&NES also shows that this reduced markedly from 28.3% in 2008-09 to 14.0% in 2009-10, a figure similar to the one 5 years ago when we ranked in the middle of other local authorities. This lower figure will not inform the national Health Profile 3 year moving average indicator until the 2012 one is published.

4.4 An important related issue is the withdrawal of the national Warm Front scheme which provides grant funded heating and insulation measures for low income

vulnerable households. The government funding for this scheme is being reduced significantly over the next two years before it is expected to be replaced by part of the Green Deal arrangements currently being worked on by the Government. However, there are currently no specific arrangements for a similar grant funded scheme at this point in time. The Council's local Warm Streets Partnership Scheme is expected to continue to provide loft and cavity wall insulation for low income vulnerable households, energy efficiency advice and benefit check

4.5 Assistance for heating improvements is currently available for vulnerable owner occupiers through the Council's Home Improvement Assistance Scheme. Following the removal of the Private Sector Renewal Capital allocation by Government, Housing Services are considering options to mitigate the loss funding for this scheme. Subject to funding being available, options for assistance may include small grants for works such as repairs to heating systems for vulnerable low income households.

4.6 The actions to promote affordable warmth in B&NES have been developed by the B&NES Affordable Warmth Action Group. This group includes members from the Council, Public Health, Somer and other agencies working with groups vulberable to cold. These actions are aimed to:

- improve the energy efficiency of all housing in Bath and North East Somerset.
- maximise income for vulnerable households
- reduce household expenditure on fuel
- develop partnership working with all appropriate organisations and agencies in order to effectively

A full list of the actions being undertaken and being considered is shown in the Appendix.

5 RISK MANAGEMENT

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

6 EQUALITIES

6.1 Excess winter mortality in B&NES affects the elderly disproportionately and women more than men. There is marked local geographical variation by electoral ward and by general practice. People in the least deprived areas and those in the next to most deprived ones have had the worst experience with excess winter mortality in recent years. We have no local information on the impact of sexual orientation, religion, ethnicity, and disability although it is very likely that those in poor health are adversely affected by cold weather. A formal proportionate equalities impact assessment has not yet been carried out.

7 CONSULTATION

7.1 We will consult on the Affordable Warmth Action Plan with Ward Councillors, Cabinet Members, Parish Councils, Town Councils, Overview & Scrutiny Panel, Other B&NES Services, Service Users, Local Residents, Community Interest Groups, and Other Public Sector Bodies.

7.2 We will send hard copies and electronic ones to stakeholders as appropriate for a two month consultation period.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Property; Human Rights.

9 ADVICE SOUGHT

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

Contact person	Philip Milner 01225 831451
Background papers	Partnership Board for Health and Wellbeing Report Date: 15 September 2010 Report Title: Winter Health in Bath and North East Somerset
Please contact the report author if you need to access this report in an alternative format	

Appendix: B&NES Affordable Warmth Draft Action Plan January 2011

Key Objective	Task	Housing Sector	Timescale	Partners involved	Resource implications
1. To improve the energy efficiency of all housing in Bath and North East Somerset.	Review energy efficiency measures for grant funding in the private sector.	Private	ongoing	Housing Services /CSE	existing resources
	Continue the promotion of Warm Streets to private sector residents including the marketing benefits of Heat Seekers	Private	ongoing	Housing Services/CSE/ Heat Seekers	existing resources
	Liaise with EAGA and other appropriate partners to maximise the uptake of Warm Front assistance for heating and insulation subject to availability. Identify any suitable alternative assistance for heating and insulation measures for vulnerable households which is currently in place or under development at a national or local level to replace the Warm Front scheme. National level arrangements include those likely to be proposed as part of the Governements Green Deal initiative. As an alternative, a low interest loan is currently available for eligible households to remedy category 1 rated excess cold and other Housing Health and Safetey Hazards.	Private	ongoing	Housing Services/EAGA/CSE/relevant partners	existing resources
	Incentivise private sector landlords to install energy efficiency measures through the Landlord Accreditation Scheme-eg Warmer Lets (Insulation)	Private Rented	ongoing	Housing Services/ Climate Energy	existing resources
	Work with Planning Department to ensure that best practice energy efficiency is encouraged in new housing in Bath and North East Somerset.	Private	ongoing	Housing Services/ Planning Dept/ Corporate Sustainability Team	existing resources
	Expand Eco-schools work to link with Warm Streets and promotion of behavioural change at home.	Cross Tenure	ongoing	Housing Services/ Corporate Sustainability Team	low
	Produce information material for householders promoting the investment potential and environmental benefits of adopting energy efficiency measures.	Private	short-term - to be done	Housing Services/CSE/ EST/Corporate Sustainability Team	low
	To improve the energy efficiency of homes for vulnerable people when discharged from hospital (review service) working with Intermediate Care Team	Private	ongoing	Housing Services/ Care& Repair/ EAGA	existing resources
	Provision of an authority wide scheme to ensure that all households in Bath and North East Somerset can benefit from basic energy efficiency measures at a subsidised rate = Warm Streets	Private	ongoing	Housing Services/CSE	existing resources

Key Objective	Task	Housing Sector	Timescale	Partners involved	Resource implications
	Provision of a targeted area-based scheme to deliver energy improvements to households in areas of the authority with a high incidence of Fuel Poverty = Warm Streets	Private	ongoing	Housing Services/CSE	existing resources
	Continue to use low cost loans to facilitate energy efficiency improvements in Private Sector housing and explore potential to extend this to hard to treat homes	Private	ongoing	Housing Services/Wessex Reinvestment Trust	existing resources
2. To maximise income for vulnerable households.	Ensure that Bath and North East Somerset residents have access to the Benefits Health check services offered by Warm Streets and further develop referral mechanism. Warm Streets Benefits health checks have generated £85,000 of payments for claimants, apparently equivalent to around £1,000,000 cumulative income over 5 years.	Cross Tenure	ongoing	Housing Services/CSE	existing resources
	Continue to make referrals to Bristol Debt Advice Centre (BDAC) to provide fuel debt and money advice and assistance to B&NES residents	Cross Tenure	ongoing	Housing Services/BDAC	existing resources
3. To reduce household expenditure on fuel.	Conduct study of the costs and benefits of fuel switching in public and private sector housing.	Cross Tenure	medium term - to be done	Housing Services /Corporate Sustainability Team/CSE	low
	Provide fueling switching information and link to an approved internet price comparison site on B&NES website	Cross Tenure	medium term - to be done	Housing Services	low
	Ensure that all energy advice staff are fully trained on Affordable Warmth issues and help available	Cross Tenure	ongoing	Housing Services/CSE	existing resources
	Provision of energy meters through loan system to affect behavioural change	Cross Tenure	ongoing	Housing Services/Corporate Sustainability Team	existing resources
	Develop package of energy saving/awareness raising products to link with insulation programmes	Private	about to start - short term	Housing Services/Utility Supplier	existing resources
4. To develop partnership working with all appropriate organisations and agencies in order to effectively deliver Affordable Warmth in Bath and North East Somerset.	Work with CSE to promote Affordable Warmth in the BME community	Cross Tenure	ongoing	Housing Services	existing resources
	Improve links with RSLs to share knowledge /best practice in addressing Fuel Poverty	RSL	ongoing	Housing Services/RSLs	existing resources
	Encourage /facilitate liaison between advice services to ensure good signposting between organisations.	Cross Tenure	improved & ongoing	Housing Services/CSE/various advice agencies	existing resources
	Raise awareness and provide training to Social Services and other frontline council staff and establish clear referral mechanisms to help and advice services to advance Affordable Warmth in B&NES	Cross Tenure	ongoing	Housing Services/Social Services/CSE	existing resources

Key Objective	Task	Housing Sector	Timescale	Partners involved	Resource implications
	Provide training to PCT frontline staff and establish clear referral mechanisms to help and advice services to advance Affordable Warmth in B&NES	Cross Tenure	ongoing	Housing Services/B&NES PCT/ CSE	existing resources
	Provide training to Housing Services frontline staff and establish clear referral mechanisms to help and advice services to advance Affordable Warmth in B&NES	Cross Tenure	ongoing	Housing Services/CSE	existing resources
	Run a poster/leaflet campaign at PCT service points (health centres/dentist surgeries etc)	Cross Tenure	ongoing	Housing Services/B&NES PCT/CSE	existing resources
	Set up Affordable Warmth Action Group in B&NES	Cross Tenure	ongoing	Housing Services/various	existing resources
	Improve links and partnership working with B&NES PCT	Cross Tenure	ongoing	Housing Services/B&NES PCT	existing resources
	Fire Service visits to households to consider winter warmth and advise appropriately	Cross Tenure	short term to be started	Housing Services/ Fire Service	existing resources
	Pilot and roll out referral scheme to housing services from general practice	Cross Tenure	ongoing	Housing Services/B&NES PCT	existing resources
	Work with local voluntary organisations such as Age Concern and Transition Bath to raise awareness in the community of Affordable Warmth and services available	Cross Tenure	ongoing	Housing Services/ B&NES PCT/voluntary agencies	existing resources
	Consider expanding housing services referral scheme with private sector agencies	Cross Tenure	ongoing	Housing Services/ B&NES PCT/private agencies	existing resources
	Run campaign in community pharmacies about winter warmth yearly	Cross Tenure	ongoing	Housing Services/ B&NES PCT	existing resources
	Develop Big Society working with Age UK/Age Concern Winter Warmth and church groups	Cross Tenure	short term to be started	Housing Services/ B&NES PCT/voluntary agencies/churches	existing resources
	Understand why Weston GP practice has a high excess winter mortality index and Weston ward has a low one	Cross Tenure	ongoing	B&NES PCT	existing resources
	Check with energy companies who has unexpected low energy use in winter	Cross Tenure	short term to be started	Housing Services/ B&NES PCT	existing resources
	Find out who has not received their seasonal influenza vaccination and target them with services	Cross Tenure	short term to be started	B&NES PCT	existing resources
	Do regular stories for the media and use digital media for raising awareness about winter warmth and services available	Cross Tenure	ongoing	Housing Services/ B&NES PCT	existing resources

Key Objective	Task	Housing Sector	Timescale	Partners involved	Resource implications
	Consider using Genesis Trust, Neighbourhood Watch, Energy Champions, Meals-on-Wheels, and Crisis at Xmas to raise awareness in the community of Affordable Warmth and services available	Cross Tenure	short term to be started	Housing Services/ B&NES PCT	existing resources

low	costs below £5,000
ongoing	activity currently underway
short-term	commencement within 6 months
medium term	commencement within 12 months

Bath & North East Somerset Council	
MEETING:	Healthier Communities & Older People Overview & Scrutiny Panel
MEETING DATE:	18 January 2011
TITLE:	Gynaecology Cancer Services Review
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: • Main Report :- Gynaecology Cancer Services Review – Next Steps	

1 THE ISSUE

1.1 A comprehensive review of gynaecological cancer services commenced in September 2008 and came to a close in September 2009. At the conclusion of the review the 6 Primary Care Trusts (PCTs) in the Avon & Wiltshire & Somerset Cancer Network made a recommendation that complex gynaecology cancers from the RUH should be transferred to UHB in the future in order to deliver a service that was compliant with the NICE Improving Outcome Guidance (IOG).

1.2 A Joint Overview and Scrutiny Committee was due to be held in June 2010 but following the general election these plans were postponed as the Secretary of State for Health set out new policy commitments on service reconfiguration. These are a set of 4 measures against which proposed service re-configurations should be tested and referred to as the "the four tests".

1.3 The attached paper informs the Healthier Communities & Older People Overview & Scrutiny Panel Committee of the outcome of a local assessment of the gynaecological cancer services review against the "four tests". It also informs the panel based on this assessment of the proposed next steps for a revised local solution to providing gynaecology cancer services.

2 RECOMMENDATION

The Healthier Communities & Older People Overview & Scrutiny Panel is recommended to:

2.1 Note the local assessment against "the four tests" and the proposed set of conditions to work towards delivering local services that are IOG compliant.

2.2 Consider what further briefings or updates the panel requires.

3 FINANCIAL IMPLICATIONS

3.1 There are no financial implications associated with these proposals.

4 THE REPORT

4.1 The attached paper describes the PCT's assessment of the gynaecology review against the "four tests". Based on this review a series of measures have been identified that will strengthen the delivery of local services but seek to retain the surgical treatment of complex gynaecology cancer services on the RUH site.

5 RISK MANAGEMENT

5.1 The review has fully assessed risk and has drawn conclusions based on a risk assessment. The conclusions have been supported by independent bodies.

6 EQUALITIES

6.1 An Equalities Impact Assessment of Gynaecology cancer services was completed by the B&NES commissioning team in 2009 as part of the review and fed into the process. It is proposed that both providers are requested to complete a further equalities impact assessment within 6 months to identify any potential issues.

7 CONSULTATION

7.1 As part of the original review process the PCT carried out a series of engagement activities with members of the general public. Subsequent to the conclusion of the review additional involvement has been sought from UHB and RUH clinicians, the B&NES GP consortia and the National Cancer Action Team.

7.2 Individual patient and public representatives who participated in the review have been written to advise them of the proposed next steps.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 All the following issues are relevant to Gynaecology Cancer Services: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Human Rights; Health & Safety and Impact on Staff.*

9 ADVICE SOUGHT

9.1 The PCT's Professional Executive Committee (including GP representatives), Board and the Avon and Wiltshire and Somerset Cancer Board have considered the issue prior to its presentation to the Healthier Communities & Older People Overview & Scrutiny Panel.

Contact person	Tracey Cox, Tel 01225 831736
Background papers	HCOP O&S meeting on 19th December 2009 - *The future of specialist care for patients with gynaecological cancer*

Please contact the report author if you need to access this report in an alternative format

NHS
Bath and
North East Somerset

Title: Re-configuration of Gynaecology Cancer Services

Purpose

1. To inform the Healthier Communities & Older People Overview & Scrutiny Panel of:-

- NHS B&NES' local assessment of the Gynaecology Cancer Services Review against "the four tests"
- The proposed set of service improvement measures that will be put in place to work towards delivering local services that are IOG compliant.

Background

2. In response to requests made by B&NES Healthier Communities and Older People Overview and Scrutiny Panel following an earlier review process, a comprehensive review of gynaecological cancer services commenced in September 2008 and came to a close in September 2009.

3. At the conclusion of the review the 6 Primary Care Trusts (PCTs) in the Avon & Wiltshire & Somerset Cancer Network made a recommendation that complex gynaecology cancers from the RUH should be transferred to UHB in the future in order to deliver a service that was compliant with the NICE Improving Outcome Guidance (IOG).

4. The RUH service operates with a catchment population of less than half a million. The IOG recommended catchment population is 1 million. It also operated without the two gynae-oncology sub specialists recommended in a regular peer review by ASW Cancer Services Network. It is led by a single sub specialist consultant gynae-oncological surgeon.

5. The UHB service operates with a catchment population slightly below the 1 million recommended by the IOG and employs three sub specialist consultant gynae-oncological surgeons and a specialist trainee.

6. The impact of the proposed changes was that approximately 100 patients per year (35 of which would be BANES patients) would receive their surgical treatment at UHB whilst all diagnostic, outpatient and follow-up care would continue to be provided at the RUH. The recommendation was subject to review by all six Overview & Scrutiny Committees, 3 of which considered that the service changes were a substantial variation and/ or requested further information about the proposed changes including information on the evidence base for the proposed changes.

7. A Joint Overview and Scrutiny Committee was due to be held in June 2010.

Following the general election these plans were postponed as the Secretary of State set out new policy commitments on service reconfiguration. These policy commitments were outlined in a letter by David Nicholson on the 20 May and were included in the Revision to the Operating Framework for the NHS in England 2010/11, published on the 21 June 2010. Further guidance on service reconfiguration was outlined in the David Nicholson letter of the 29 July 2010.

8. The Secretary of State identified four key tests for service change, which are designed to build confidence within the service, with patients and communities. The tests require existing and future reconfiguration proposals to demonstrate;

    - Support from GP commissioners
    - Strengthened public and patient engagement
    - Clarity on the clinical evidence base; and
    - Consistency with current and prospective patient choice

9. In the light of these announcements the proposal to transfer specialist gynaecological surgical treatment was deferred to enable a full assessment of the new policy requirements to be undertaken.

10. This paper sets out the results of the ASWCS Network and NHS B&NES' assessment of the application of the 4 tests to the proposed re-configuration of gynaecology cancer services and on the basis of this assessment and following dialogue with the SHA sets out a proposed way forward.

Applying the reconfiguration tests

11. The guidance circulated on the 29 July outlines two processes, one for schemes underway and a second process for new schemes.

12. As the reconfiguration of gynaecological cancers in ASWCS had been through a lengthy and thorough process up to consultation with the Overview and Scrutiny Committees the assessment has been undertaken in respect of the guidance for schemes that are underway.

13. Local commissioners must demonstrate to the SHA that the tests have been applied and met. Where the four tests have not been met the SHA should consider halting the proposal and/or seek advice from the Independent Reconfiguration Panel (IRP) or the National Clinical Advisory Board (NCAT). A review and assessment against the 4 tests is detailed below.

Supports from GP Commissioners

14. Engagement with GP commissioners in the Network at the time of the second review (launched in September 2008) was via PCTs respective Professional Executive Committees and Boards. The B&NES PEC Chair a BANES GP, was involved in the process including the Gynaecology Project Steering Group which oversaw the review process. However, there was no separate GP engagement process at that stage.

15. B&NES PCT coordinated the review on behalf of the six PCTs in the Network including Bristol and South Gloucestershire. This was a comprehensive review and consultation programme that aimed to identify the best configuration for specialist gynaecological cancer centre services. The review set out to define excellence,

identify options to achieve this and recommend a preferred option for the future. This was followed by impact assessments carried out by the PCTs and a public consultation process, in line with the Health Overview and Scrutiny Committee recommendations.

16. Recommendations for the preferred option were made to the Avon, Somerset, and Wiltshire Cancer Network Board, and the six Network PCT Boards. The Cancer Network Board and all six PCT Boards accepted the recommendations made and forwarded them to each of the six Network Health Overview and Scrutiny Committees (HOSCs) for their approval. Three of the HOSCs considered that the proposals did *not* constitute a major service change; three considered that it did and were seeking further information. Further consultation with the three HOSCs seeking further information was halted prior to the general election and the subsequent moratorium.

17. At the time of the review the main process for seeking GP support on these proposals was through engagement with GP representatives on the Professional Executive Committees and PCTs Boards; these GPs were supportive of the proposal to transfer complex gynaecology cancers to UHB.

18. Subsequently the views of GPs on the PCT's Professional Executive Committee and the B&NES GP Consortia have been sought on the current position and a potential way forward. There is consensus amongst GPs that a local approach for delivering an IOG compliant service is preferable given the current position.

19. **Assessment:** - **GP involvement at the time of the review was via PCT's Professional Executive and Boards. Engagement processes with GPs are changing with emerging GP Consortia. The PCT has received confirmation that the local GP Consortia and Professional Executive Committee are supportive of the revised proposal set out within Section 39-45 below.**

Strengthened public and patient engagement

20. There is already statutory provision for the engagement of local communities and Local Authority Health Overview and Scrutiny Committees. Section 242 of the National Health Service Act 2006 requires that local health organisations make arrangements in respect of health services to ensure that users of those services such as the public, patients and staff are involved in the planning, development, consultation and decision making in respect of the proposals. Section 244 of the Act places obligations on a PCT to consult with Overview and Scrutiny Committees on issues that may be determined as a substantial change.

21. The Bath and North East Somerset HOSC in their meeting in August 2007 raised objections to the proposal to reconfigure gynaecological cancer services from the Royal United Hospital Bath to the United Hospital Bristol, as they considered this a substantial change. A joint meeting of the six HOSC's in the Network was established in January 2008 and now meets annually to be briefed on current and any subsequent service change in cancer services. The HOSC's were all briefed throughout the review launched in 2008 by members of the Cancer Network and the PCTs involved.

22. A substantial programme of public engagement was undertaken during the review including the establishment of a service user group which included the participation of patients. Members of the public and Local Involvement Network members had participating places on the decision-making steering group. Outside of the business of these groups additional engagement activities were undertaken at

various stages including communications, briefings, other media and opportunities for patients and the wider public to comment. All materials from the review were published openly on the NHS B&NES Website.

23. The Network User Involvement Group has been kept informed of the progress of the gynaecological review and users have been an important element in influencing the progress of the review and participated on the Network Board.

24. Objections and further considerations raised by the users and general public on the proposed service changes have been dealt with carefully and appropriately by NHS B&NES as the leading PCT and the Network and all organisations kept informed and updated. During the review a number of the HOSCs raised concerns about the national policy to centralise and the role of the Cancer Action Team, the body setting the guidance for centralisation.

25. A joint scrutiny review meeting was planned on the 21 June 2010 to liaise with the three HOSCs in the Network who were seeking further information about the proposals and to answer fully questions and objections raised regarding the proposed service changes. Members of the National Cancer Action Team had prepared a response and were planning to come to the Network to discuss concerns with the HOSC representatives; this was postponed because of the moratorium.

26. An external assessment and legal opinion of the efficacy of the approaches taken to satisfy patient and public involvement was completed. This independent report confirmed that the activity undertaken had been adequate to meet the statutory obligations under section 242 and 244.

27. **Assessment**: - **It could be reasonably judged that the review process would satisfy the requirements on Strengthened public and patient engagement, although further work would need to take place with HOSCs and patient groups if the review were to proceed.**

Clarity on the clinical evidence base

28. The Improving Outcomes Guidance (IOGs) was started by the Department of Health in 1996 with Guidance first produced on Breast Cancer and lastly Gynaecological Cancers in 1999. This process was then handed over to the National Institute of Clinical Excellence (NICE) in 2000. The Cancer Action Team has clarified the following;

29. - The IOGs are guidance with an expectation from the centre that the guidance will be followed unless there is a good reason not to. This expectation has been set out in various documents and supporting processes that have been put in place to monitor the delivery of the IOGs.

30. - The 'Improving Outcomes Guidance' set out recommendations for future service delivery of gynaecological malignancies. The Guidance recognised that the most critical aspects of clinical decision making and service delivery require sufficient caseload to justify bringing together the scarce specialist skills and facilities necessary to permit effective multi-professional and multidisciplinary care. This requirement is balanced against the need to provide services as close to the patient's home as possible, but ensuring the patient receives high quality, safe and effective care.

31. The Improving Outcomes in Gynaecological Cancers 1999 was accompanied by Guidance on the research evidence which was designed to be read alongside The

Improving Outcomes in Gynaecological Services –The Manual. There were four questions posed as the basis for the research outlined in the research evidence IOG document:

1. Is there evidence that specialist surgeons or centres, or expert multiprofessional teams, deliver more appropriate treatment and improved survival?

2. Is there evidence that clinical nurse specialists can achieve improved quality of life for women with gynaecological cancers?

3. How important is expert pathology?

4. How effective are specialist palliative care teams for enhancing quality of life in cancer patients and improving communication between health care sectors?

32. Members from the British Gynaecological Cancer Society (BGCS), the Gynae NSSG Leads Group and the BGCS/NSSG Leads Guidelines Group met in 2007 at A Cancer Reform Strategy Gynaecological Cancers Workshop to inform the vision for gynaecological cancer services in 2012. In their resulting paper they confirmed that the configuration of existing gynaecological cancer services is based on the IOG published in 1999 and this would remain the basic structure for services in 2012. However, they felt that new research evidence/accepted clinical guidelines will render aspects of the IOG obsolete and these should be identified by the profession.

33. As part of the review process the evidence base for the IOG was shared with stakeholders. However, it is fair to state that the strength of the evidence base remained a point of contention and debate and was one of the key issues the Cancer Action Team had been asked to address at the cancelled 21 June HOSC event. There is a clinical perspective that supports the concept of a multi-disciplinary team (MDT) arrangement (as highlighted in paragraphs 40-42 as being a clinically effective mode of delivery.

34. **Assessment:** - **Current IOG guidance remains in place and evidence suggests that there remain benefits to service delivery by bringing together specialist skills and facilities. However, locally within the ASWCS network there is insufficient confidence on the current evidence base as part of the gynaecology IOG to enable commissioners to put forward a sufficiently strong case to support the service re-configuration which would receive the support of all stakeholders.**

Consistency with current and prospective patient choice

35. The quality of services at the recommended centre for centralised gynae cancer services was a key theme at the beginning of the review process led by Bath and North East Somerset PCT. Support for the proposed centre was backed up with caveats on improvements that had to be made in United Hospital's Bristol's service. The pathway for patients from Bath and Wiltshire recognised the need for them to receive high quality services as close to home as possible with specialised services provided in a specialised centre where necessary. Although patient choice of provider is for elective services and specifically excludes malignancy, the aim was to localise where possible and centralise only where evidence recommended it would improve outcomes. On this basis, the proposal was that initial diagnosis and some parts of treatment such as oncology and follow-up services could still be provided nearer to the patient's home with complex surgery carried out in the specialist centre.

36. **Assessment: - The re-configuration proposals are consistent with national policy on the patient choice and its application to cancer services.**

Summary

37. In reviewing the process of Gynaecological cancer services reconfiguration started in September 2008 by NHS B&NES the following conclusions against the four key tests have been drawn:

    1. Support from GP Commissioners was not sought comprehensively in practices whose patients will be significantly affected by the case for change; however GP's had been consulted as part of the review. The current perspective of local GP's is that they are supportive of a locally based solution to current service arrangements.

    2. Strengthened public and patient engagement was a key element of the review process from September 2008 with the public and users being involved in planning, development, consultation and decision making. The views of public and patients were mixed with some supporting the proposals and others contesting them. However there was no consensus reached and whilst the independent assessment indicates that the PCT met its statutory obligations, further work would be required to satisfy 3 of the 6 HOSCs.

    3. Clarity of the clinical evidence has been contested, though there remains support for the centralisation of specialist skills as outlined in the 1999 Improving Outcomes Guidance. Locally, there is not currently support amongst local clinicians to the model set out in the IOG which is centralisation at one site. The current and new arrangements in place described below which have a joint multi-disciplinary team and centralised decision-making, leave and sickness cover and audit arrangements meet most of the requirements of the IOG but without fully centralising surgical services.

    4. Consistency with current and prospective patient choice has been upheld as the reconfiguration recommendations support services locally where possible across the patient pathway and centralised where necessary, predominantly for surgery.

38. From the Network's and PCTs assessment of the position against the 4 tests, it is concluded that it will be extremely difficult to engage stakeholders with progressing the review recommendations as set out in September 2009.

Adopting a local solution

39. In recognition of the position described above it is recommended that the reconfiguration proposal set out in September 2009 should *not* be progressed. A local solution should be adopted and further steps taken to strengthen local service arrangements in line with the principles of national guidelines. Commissioners in B&NES have asked the RUH to put in place arrangements to ensure all patient care is overseen by the central specialist MDT and to ensure joint cover and audit arrangements are in place. These arrangements will bring patients many of the benefits of centralisation, without physically moving the location of services.

40. Since the review a robust joint MDT has been established and is now in operation

across the 4 Trusts. UHB is recognised as the centre with joint working taking place between providers and robust prospective audit arrangements in place. These developments represent a change in the service configuration under review, are a significant move forward and are expected to strengthen patient care and patient outcomes.

41. In adopting a local solution it is recognised that there should be a risk assessment of current service arrangements to ensure that patients can be assured that services continue to be provided safely and effectively and where possible service outcomes can be improved. This assessment has been considered and it is proposed that the following measures be put in place to ensure the arrangements fully satisfy clinical standards and give confidence in respect of any perceived risk:

- confirmation of a single specialist multi-disciplinary team for gynaecological cancer hosted by University Hospitals Bristol NHS Foundation Trust;
- confirmation that surgery taking place at the two sites will be to a single tumour site specific operational protocol;
- ensuring proper cover for the surgical team at Bath including arrangements for leave and sickness cover;
- the development of joint job plans, for example honorary contracts in the non-home trust;
- commitment to regular audit that the treatment decisions made at the specialist multi-disciplinary team are carried out, across both sites;

42. The National Cancer Action Team has been consulted on the proposed service enhancements and has confirmed that with these measures in place they would support the revised approach and approve the local solution. The position will be kept under clinical review as part of the Peer Review process.

43. The RUH and UHB have been formally written to request a joint action plan that demonstrates how these conditions will be met with the plan signed off by both Chief Executive Officers.

44. However, there is already evidence of progress against these measures:-

- A single MDT is in place but further work is required to provide teleconferencing to improve communications across the sites to include professionals who are unable to attend
- Cancer managers at both Trusts are in the process of drafting a single tumour site specific protocol
- The site specific group is working on the audit structure now and is expected to agree a position by January 2011

45. The B&NES Professional Executive Committee considered the revised proposal at its meeting on November 25th and supported the measures described. (The meeting included 3 representatives of the new GP Consortia and 3 existing GP PEC members).The proposals were subsequently considered and supported by

the PCT Board at its December meeting.

Recommendations

46. The Healthier Communities & Older People Overview & Scrutiny Panel is recommended to:

- Note the local assessment against “the four tests” and the proposed set of conditions to work towards delivering local services that are IOG compliant.
- Consider what further briefings or updates the panel requires.

Bath & North East Somerset Council	
MEETING:	Healthier Communities and Older People Overview & Scrutiny Panel
MEETING DATE:	18th January 2011
TITLE:	Young People's Substance Misuse Services Briefing
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: None	

1 THE ISSUE

1.1 This is a briefing on young people's substance misuse issues in B&NES, including ketamine use.

2 RECOMMENDATION

The Healthier Communities and Older People Overview & Scrutiny Panel is asked to note the report.

3 FINANCIAL IMPLICATIONS

3.1 None.

4 THE REPORT

THE PREVALENCE OF SUBSTANCE MISUSE AMONG YOUNG PEOPLE

4.1 It is difficult to quantify the extent to which local young people misuse drugs and alcohol.

4.2 In a recent survey, 12.9% of B&NES pupils in years 6, 8 and 10 reported frequent use of drugs and / or alcohol (Tell Us 4, 2009-10). Frequent use is defined as being drunk and / or having taken illegal drugs or volatile substances twice or more in the last 4 weeks. This result was not significantly different from the previous year's result of 10.8% and in line with national Tell Us results (9.8%) and the average for similar authorities.

4.3 11% of pupils in the survey responded "Yes" to the question "Have you ever taken drugs?", 86% responded "No" and 3% did not want to say.

4.4 Research published in 2010 by the NHS Information Centre indicates that smoking, drinking and drug use among school children is generally on the decline (Fuller and Sanchez 2010, link below).

http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-urveys/smoking-drinking-and-drug-use-among-young-people-in-england/smoking-drinking-and-drug-use-among-young-people-in-england-in-2009
This report details findings from an annual survey which took place across 247 English secondary schools in 2009 and surveyed nearly 7,700 pupils aged 11-15, representing an estimated population of around 3.1 million pupils

It found:

- The percentage of 11 to 15 year-olds who had ever taken drugs stood at 22% in 2009, compared to 29% in 2001 (the first year in which the current method of measuring drug use was used).

- The percentage who had tried smoking at least once was 29% – the lowest figure since the survey began in 1982 when it was 53%, and

- The percentage who had ever drunk alcohol was 51% in 2009 compared to 61% in 2003 from when the current downward trend in alcohol use began.

- While, overall, smoking, drinking and drug use has been declining among this age group, the report showed usage becomes more common as children get older.

4.5 As to the question of Ketamine, there is no hard data available on the extent of use by young people in B&NES. However, in the study mentioned above 0.6% of young people reported having tried Ketamine.

4.6 Since Project 28 opened in February 2005, 26 young people have been referred for specialist treatment because of ketamine use, 10 in the last year.

PROJECT 28

4.7 In-volve is commissioned to deliver a range of targeted and specialist substance misuse services to young people in B&NES from Project 28, its base in Bath.

4.8 Since opening in February 2005, 588 young people have accessed specialist treatment at Project 28 for drug and / or alcohol problems. Outcomes for this particular cohort are closely monitored through the National Drug Treatment Monitoring System and there is evidence that Project 28 gets good results. In 2009/10, 50 out of 57 young people completed their treatment successfully (as defined by National Treatment Agency) i.e. left drug free or as an occasional user.

4.9 Project 28 also delivers a range of other preventative services. See figures for the period February 2005 to July 2010 below

Service Provided	young people helped
Brief interventions	664
Outreach	8,427
Harm reduction information/advice	4,781

Professionals attending 2 day training	288
Workshops in Schools, Colleges & Youth Clubs	176
Open access drop in	12,935
Music Programme	950
Information & advice for families	322

4.10 Project 28 is innovative in its approach. For example, it successfully applied to the Alcohol Education Research Council for funding to pilot a positive psychology group work programme for young people with outstanding results (see appended report: Project 28 - Five Years On). This programme has now been mainstreamed as part of the commission. More recently, the Project was also awarded Department of Health Innovations Funding to develop an alcohol brief intervention tool for young people. This is currently being rolled out, in particular to professionals working with young people in vulnerable groups.

4.11 Project 28 has a good track record of working with Commissioners to respond to identified local needs. For example, in 2010, in response to soft intelligence that young people were using ketamine in the Norton Radstock area, a satellite base was set up in the local college, thus making information, advice and referral into specialist treatment more accessible to young people living in the area.

4.12 There is a very clear framework for assessment, planning and performance management in relation to the needs of young people who require specialist treatment. The Children's Service brings together a multi-agency group to complete the annual Young People's Substance Misuse Needs Assessment, which in turn informs the annual Substance Misuse Treatment Plan. Both are submitted to and signed off by the National Treatment Agency (NTA) and are also used to inform the B&NES Children and Young People's Plan.

4.13 In-volve's current contract to deliver young people's substance misuse services ends 31st March 2011. Project 28 is a valued and well respected service and the intention is to extend this contract for a further year to March 2012 and then, to review the commission in preparation for a competitive tendering process for the 3 year period 1st April 2012 – 31st March 2015. At the time of writing this report the exact value of this contract has still to be determined. The budget comprises of numerous funding streams (see below) and not all settlements have been announced

4.14 **2010/11 Young People's Substance Misuse Budget**

Sources of funds	
HO YOT Substance Misuse through YJB	25809
NTA Treatment Plan	46902
HO Annual Contribution through Area Based Grant	30589
DCSF Annual Contribution through Area Based Grant	23884
Adult DAT Pooled Budget Contribution	43012

Community Safety (Incl. Reducing the Fear of Crime)	79000
PCT - Contribution Dr Pointing Clinic	12205
	261401
Expenditure	
Payments to Involve	241344
Children Looked After Prevention Target	3508
YOT Psychiatric Nurse & Resources	13290
PSHE Drugs Education	2000
	260142

WORK IN SCHOOLS AND COLLEGES

4.15 LEA maintained schools in B&NES are well supported to address substance misuse issues. There is a full-time PSHE & Drug Education Consultant based within the School Improvement Team who provides consultation, training and support to schools and colleges. She also carries out direct work with young people when required.

4.16 The school nurse team is skilled at delivering substance misuse interventions, working directly with young people in schools and colleges.

4.17 Project 28 has a presence on Tuesdays at the Link (a special school for young people with emotional and behavioural difficulties) – seeing 4 -5 pupils a week. Also, a satellite base at Norton Radstock College on Wednesdays.

4.18 There is a good range of drug and alcohol education being delivered to young people in LEA Maintained Secondary Schools and FE colleges across the area. The programmes are outlined below:

- The PSHE & Drug Education Consultant and the Youth Strategy Officer (Avon and Somerset Police) deliver a drugs awareness training programme to pupils in year 10. In 09/10, 10 out of 13 LEA maintained secondary schools participated.

- The Alcohol Harm Reduction Project Officer in Environmental Services delivers alcohol awareness sessions in the City of Bath College and attends Freshers' Week at both local FE colleges and Universities to give out harm reduction information and advice. She has also developed an Interactive Alcohol Harm Reduction Drama Project which will be delivered to all LEA maintained secondary schools in B&NES (February 2011).

- The Youth Strategy Officer (Avon and Somerset Police) is developing a new alcohol awareness programme 'Under the Influence' which will be delivered in secondary schools in the new year.

- In 2009-10, 7 Secondary School were recruited to the ASSIST smoking prevention programme and the plan is to roll this programme out further in 2010-11

4.19 Preventative work is coordinated through the Young People's Substance Misuse Group and members of this group are currently actively involved in the refresh of the B&NES Alcohol Harm Reduction Strategy.

5 RISK MANAGEMENT

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

6 EQUALITIES

In 2010, an Equality Impact Assessment and action plan was completed on all substance misuse services for adults and young people in B&NES.

7 CONSULTATION

7.1 This report has been sent to the Section 151 Finance Officer and Monitoring Officer for their consideration

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Young People; Human Rights;

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Council Solicitor), Section 151 Officer (Divisional Director - Finance) and Divisional Director Health Commissioning & Strategic Planning had the opportunity to input to this report and have cleared it for publication.

Contact person	**Rosie Dill** **01225 477820**
Background papers	
Please contact the report author if you need to access this report in an alternative format	

This page is intentionally left blank

Bath & North East Somerset Council
MEETING: **HEALTHIER COMMUNITIES & OLDER PEOPLE OVERVIEW & SCRUTINY PANEL** MEETING DATE: **18th January 2011**
TITLE: **PANEL'S WORKPLAN FOR 2011**
WARD: All
AN OPEN PUBLIC ITEM
List of attachments to this report: Appendix 1 – Panel Workplan

1 THE ISSUE

1.1 This report presents the latest Workplan for the Panel (Appendix 1).

1.2 The Panel is asked to review and note its future work programme.

2 RECOMMENDATION

2.1 The Panel is recommended to:

a) Note its latest Overview & Scrutiny workplan for 2011 at Appendix 1

b) Consider workplan items scheduled for forthcoming meetings and, in discussion with the relevant officers, determine how best to undertake overview & scrutiny of them. This should involve consideration of the management of meetings – identifying key issues to be addressed will partially determine the timetabling and format of the meetings, and whether, for example, any contributors or additional information is required.

3 BACKGROUND

3.1 The purpose of the workplan is to ensure that the work of the Council's Overview & Scrutiny (O&S) bodies is properly focused on its agreed key areas. It is designed therefore to assist the public in identifying issues to be considered by O&S bodies, and to assist Councillors and officers to plan ahead and to ensure that the work priorities agreed by the Council are properly resourced and considered. The workplan is not intended as a rigid document and will be flexible to respond to changing circumstances (e.g. changes in the Cabinet Forward Plan).

Contact person	Jack Latkovic, Senior Democratic Services Officer (01225 394452)
Background papers	None

This page is intentionally left blank

Last updated 7th January 2011

Healthier Communities and Older People OS Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
18th Jan 2011						
	Cabinet Member update		Cllr Vic Pritchard			
	NHS update					
	LINks update					
	Service Action Plans		Jane Shayler			
	Final Recommendations of the Ear, Nose and Throat and Oral and Maxillofacial Head and Neck Cancers Services Review		Tracy Cox, Liz Eley and John Waldron			
	Shaping Up, A healthy weight Strategy for Bath and North East Somerset		Helen Erswell (NHS BANES)			
	Progress on tackling winter health		Dr Pamela Akerman and Philip Milner (NHS BANEs0			
	Gynaecology Cancer Services Review		Tracey Cox			
	Young People's Substance Misuse Services Briefing		Rosie Dill			

Last updated 7th January 2011

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
15th Mar 2011						
	Cabinet Member update		Cllr Vic Pritchard			
	NHS update					
	LINks update					
	Update from Somer Housing		tbc			
	AWP Service Redesign - tbc		AWP			
	Public Health White Paper		Dr Pamela Akerman and Dr Ian Orpen (Chair, GP Consortium Board)			
	GPs to be invited to talk about their plans for Health Organisational chart					JR suggestion
	Care Review update report		tbc			
Future items						
	Wheelchair Review		NHS BANES			Summer 2011