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: 19th January 2012
E-mail: Democratic_Services@bathnes.gov.uk

To: All Members of the Wellbeing Policy Development and Scrutiny Panel

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Loraine Morgan-Brinkhurst MBE
Councillor Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor Sharon Ball

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 27th January, 2012

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 27th January, 2012** at **10.00 am** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

   Appendices to reports are available for inspection as follows:-

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

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

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

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

6. **Emergency Evacuation Procedure**

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

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

Wellbeing Policy Development and Scrutiny Panel - Friday, 27th January, 2012

at 10.00 am in the Council Chamber - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

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

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST 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 CHAIRMAN

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

   At the time of publication no notifications had been received.

7. MINUTES 18TH NOVEMBER 2011 (Pages 7 - 26)

   To confirm the minutes of the above meeting as a correct record.

8. MINUTES 29TH NOVEMBER 2011 (Pages 27 - 48)

To confirm the minutes of the above meeting as a correct record.

9. CABINET MEMBER UPDATE (15 MINUTES)

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

10. NHS AND CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Panel will receive an update from the NHS and Clinical Commissioning Group (CCG) on current issues.

11. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES) (Pages 49 - 54)

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

12. UPDATE ON PROPOSED MERGER BETWEEN GWAST AND SWAST (15 MINUTES)

The Panel are asked to consider and comment on the presentation from the Great Western Ambulance Service (GWAS) representatives.

13. SERVICE ACTION PLAN 2012-13 ADULT SOCIAL CARE AND HOUSING (30 MINUTES) (Pages 55 - 94)

Service Action Plans to support the Adult Social Care & Housing Medium Term Service & Resource Plan is 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.

It should be noted that there is a special meeting of the Resources Policy Development & Scrutiny Panel on 6th February, at which time it is intended to take an overview of all of the comments that have been submitted by each of the Policy Development & Scrutiny Panels. This will be the final opportunity for the Resources Policy Development & Scrutiny Panel to highlight issues and options for Cabinet.

Equality Impact Assessments for Financial Plans are available on Council’s website on

the following link
http://www.bathnes.gov.uk/communityandliving/equality/Pages/FinancialPlans.aspx .

14. CHANGES PROPOSALS - CORONER HOSPITAL POST MORTEMS FROM RUH, BATH TO FLAX BURTON PUBLIC MORTUARY (30 MINUTES) (Pages 95 - 104)

The Panel are asked to consider the attached consultation briefing and proposal from the Coroner to:

1) Conduct all Coroner post mortems at Flax Bourton i.e. to cease the current practice of some Coroner post mortems taking place in the Royal United Hospital in Bath (RUH).
2) No longer pay for deceased patient storage at the RUH for 'Coroner Form A' cases (i.e. HM Coroner, after investigation, decides the patient died a natural death and informs the Registrars to proceed with death registration).

These proposals are in line with Coroner provision across the rest of the ex-Avon area.

15. SPECIALIST MENTAL HEALTH SERVICE RE-DESIGN - HIGH DEPENDENCY UNIT (20 MINUTES) (Pages 105 - 128)

This paper describes the results of the impact assessment on the proposal to not re-open the High Dependency Unit beds on Hillview.

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that the provision of mental health acute assessment and treatment services takes place in the acute in-patient ward and Psychiatric Intensive Care Units rather than The Cherries High Dependency Unit and that the six High Dependency unit beds on The Cherries are permanently closed to that function.

16. REPORT FROM THE STRATEGIC TRANSITIONS BOARD (15 MINUTES) (Pages 129 - 144)

This report provides an update on the work and activity of the Strategic Transition Board, noting areas of achievement and highlighting future priorities.

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

- It receives an update report from the Strategic Transition Board on the work of the board and progress toward improving transition planning and outcomes for children with a Statement of Educational Need.
- The summary and conclusions of the report are accepted by the Panel.

17. WORKPLAN (Pages 145 - 150)

This report presents the latest workplan for the Panel.

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

BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 18th November, 2011

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Eleanor Jackson, Anthony Clarke, Kate Simmons, Sharon Ball, Gerry Curran, Brian Simmons and Ben Stevens

34 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

35 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

36 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillors Organ, Bevan and Brinkhurst had sent their apologies to the Panel. Councillors Brian Simmons, Ben Stevens and Gerry Curran were their substitutes respectively.

37 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

Councillor Anthony Clarke declared personal and non-prejudicial interest on the agenda item ‘Referral to treatment times briefing’ as he is member of the RUH Foundation Trust and also member of the Friends of the RUH.

Councillor Katie Hall declared personal and non-prejudicial interest on the agenda item ‘Referral to treatment times briefing’ as she is a member of the RUH Foundation Trust.

Councillor Eleanor Jackson declared personal and non- prejudicial interest on the agenda item ‘Transfer of Community Services to Sirona Care & Health Community Interest Company’ as she is Council’s representative on Sirona Care & Health Community Interest Company.

Councillor Vic Pritchard declared personal and non-prejudicial interest on the agenda item ‘Transfer of Community Services to Sirona Care & Health Community Interest Company’ as he is Council’s representative on Sirona Care & Health Community Interest Company.

Councillor Simon Allen (Cabinet Member for Wellbeing) declared personal non-prejudicial interest on the agenda item 'Cabinet Member update' as he is employed by the National Autistic Society in Bristol.

38 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

39 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 Mr Philip Gait will address the Panel under item 15 on the agenda (Home Improvement Agency Commission update).

40 MINUTES 07/10/2011

The Panel confirmed the minutes of the previous meeting as a true record and they were duly signed by the Chairman subject to the following amendments:

- Minute 23, Page 2, 4th paragraph, last sentence should read 'their services' instead of 'there services'.
- Minute 28, Page 5, 4th paragraph, last sentence should read 'but dissatisfied' instead of 'but not satisfied'.
- Minute 28, Page 6, 6th paragraph, last word should read 'efficiently' instead of 'inefficiently'

41 CABINET MEMBER UPDATE (15 MINUTES)

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

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

Councillor Allen said, related to the Autism Strategy, more information is needed about our population with autism and overall numbers and needs are not known hence why it will be difficult to plan the right services and support for the future.

Councillor Clarke commented maybe the Council should wait with the strategy before they get the right information and numbers.

Councillor Curran commented that our schools provide excellent services for children with autism. Councillor Curran asked when the consultation on Autism Strategy will start/finish.

Councillor Allen said that he will provide more information about the consultation on one of the future meetings. Councillor Allen also said that the strategy will be reviewed nationally in 2013.

Councillor Jackson asked if there were any updates on the Laurels Nursing Home in Timsbury. Councillor Allen replied that he was not aware of any outstanding issues

for that nursing home. Councillor Jackson asked if the update could be provided for the next meeting.

The Chairman thanked Councillor Simon Allen.

The Chairman invited Councillor David Bellotti (Cabinet Member for Resources) to provide an answer to Panel's question from the last meeting. The question for Councillor Bellotti was: What is the intention of £230k allocated the revenue support of hostel facility for homeless?

Councillor David Bellotti answered that there was nothing in the capital programme. Councillor Bellotti also said that the intention of the current administration is to reduce the borrowing. £230k is still there and it could be used within the budget process. It is for the lead Cabinet Member and the relevant Director to decide how the money will be spent. The new medium term plans will be consolidated to form the Council budget which will be considered in February by Council.

The Chairman thanked Councillor Bellotti for providing the answer.

Cabinet Member update

42 NHS UPDATE (15 MINUTES)

The Chairman invited Jeff James (NHS BANES Chief Executive) to give an update to the Panel (attached as Appendix to these minutes).

The Panel noted the update.

NHS update

43 BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES)

The Chairman invited Diana Hall-Hall and Mike Vousden to take the Panel through the update.

The Chairman thanked LINks representatives for an update.

44 MEDIUM TERM SERVICE & RESOURCE PLANNING - 2012/13-2015/16 (20 MINUTES)

The Chairman invited Jane Shayler (Programme Director for Non-Acute Health, Social Care and Housing) to introduce the report.

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

Sirona Care & Health Community Interest Company (CIC) will deliver recurring annual savings of £1.9m for the Council by year five of the contract, total saving for the Council will be £7.4 million over the five year period.

The Panel asked if the most vulnerable users will receive the same level of service considering the proposed reductions to balance budgets.

Jane Shayler said that most vulnerable users will receive the same level of service although it will be a challenge to ensure that the delivery of challenging efficiency savings in the adult social care purchasing budget does not impact on service quality or safety. The Contracting and Commissioning Team will continue to visit residential and nursing care facilities to check that everything is in order in terms of service delivery.

Jane Shayler informed the Panel that draft Equality Impact Assessment (EIA) had been undertaken but it wasn't published yet. No specific issues were identified in terms of adverse impact. Current administration, like the previous one, decided not to reduce the eligibility criteria for adult social services.

The Panel felt that there were no issues requiring further consideration and highlighting as part of the service action plan for January meeting. The Panel also didn't identify any issue in the plan that needs to be referred to the relevant Cabinet Member for further consideration.

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

45 REFERRAL TO TREATMENT TIMES BRIEFING (20 MINUTES)

The Chairman invited Tracey Cox (NHS BANES Programme Director for Commissioning) and Lisa Hunt (RUH Chief Operating Officer) to introduce the report.

Tracey Cox took the Panel through the report. Lisa Hunt added that admitted performance had been sustained, non-admitted performance stayed the same and that the incomplete pathways were not reported accurately by some colleagues. Some patients said that new referral to treatment times are too quick for them (i.e. they might go away on holiday, etc) but those are only small number of patients.

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

The Panel asked if 18 weeks target is still considered to be long time.

Lisa Hunt replied that as far as she is concerned she would like to see patients treated sooner. However, due to financial constraints it is difficult to set waiting time lower than 18 weeks.

The Panel asked to what extent the treatment of patients is affected with the outbreak of viruses, such as Norovirus, where hospital has to close some wards.

Lisa Hunt replied that she built her own winter plan with consideration given to enablement of additional 50 beds if needed although the infection control rate was quite satisfactory.

The Panel asked what percentage of patients missed their appointments.

Tracey Cox and Lisa Hunt replied that the number is not that high and it is variable by department.

It was **RESOLVED** to note the improved local position in terms of performance by the RUH Bath and to note the range of actions being taken to strengthen local performance.

46 VERBAL UPDATE ON CONSULTATION ON THE HIGH DEPENDENCY UNIT BEDS IN HILLVIEW LODGE (10 MINUTES)

The Chairman invited Jane Shayler to give a verbal update on the High Dependency Unit in Hillview Lodge.

Jane Shayler informed the meeting that some Panel Members had a site visit to Hillview Lodge. The AWP and Andrea Morland had staff meeting on 31st October. On the same day there was engagement session with the stakeholders. The session did not make conclusion and commitment was made by providers and commissioners that more information will be provided. A meeting to undertake a formal Impact Assessment will be set in December this year. All stakeholders will be invited to participate in Impact Assessment. The Panel will receive the outcomes of the Impact Assessment in January 2012.

Bath Mind representative said that their main concern is that people who are diagnosed as significantly unwell would not be able to go to Hillview Lodge.

Jane Shayler commented that this issue will be part of the consideration in the Impact Assessment.

The Panel thanked the staff at Hillview Lodge for making them welcome during their site visit.

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

47 UPDATE ON DEMENTIA (15 MINUTES)

The Chairman invited Jane Shayler to introduce the report.

Jane Shayler took the Panel through the report.

It was **RESOLVED** to note the update and to receive a further update on one of the future meetings.

48 HOME IMPROVEMENT AGENCY COMMISSION UPDATE (15 MINUTES)

The Chairman invited Mr Philip Gait to read out his statement.

A full copy of the statement is available on the minute book in Democratic Services.

The Chairman invited Graham Sabourn (Associate Director for Housing Services) to introduce the report.

Graham Sabourn took the Panel through the report and highlighted the following points:

- Increase in demand whilst the budget stayed the same
- All information are available on website
- Extensive consultation had been carried out although the service struggled to engage with clients that are house bound
- Status quo is not an option. The Home Improvement Agency commissioning process aims to achieve better value for money both by undertaking joint procurement with neighbouring local authorities and from the organisation or organisations that are successful in securing the contract.

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

The Panel asked if Mendip Care & Repair had been precluded to make a bid.

Graham Sabourn responded that Mendip Care & Repair were not precluded at all.

The Panel asked how many responses were received from users.

Graham Sabourn responded that in total 65 users responded, mostly from outside the district. The service is now in the process of sending 200 letters to current clients. Graham Sabourn also said that nobody yet knows how many people completed online survey so far.

The Panel asked about the range of services that the provider will be expected to offer to authorities, as described in the bullet point 4.7 of the report, and asked how those services are provided now.

Graham Sabourn responded that that those services are provided by number of organisations now.

The Panel asked if there was a concern that only one organisation would be expected to provide those services in near future.

Graham Sabourn responded that only one bidder had been registered and usually there is no much competition in this field. Users do not have complaints about the locality of the provider. We have to move from status quo. Each Local Authority would present what they want from Home Improvement Agency and we would prepare individual agreement with the provider in order to protect ourselves (i.e. our requirements are different from Bristol requirements).

Graham Sabourn said that Mendip Care & Repair has chance to bid again if they wish. Bristol Care & repair might have the same concerns as others. The Panel of 4 people from each Unitary Authority will decide on the outcome.

Graham Sabourn confirmed that the Home Improvement Agency will provide the same service to service users in all parts of Bath & North East Somerset, including those in more isolated rural areas.

It was **RESOLVED** to note the report and for the officers to take on board comments made in the debate.

49 TRANSFER OF COMMUNITY SERVICES TO SIRONA CARE & HEALTH COMMUNITY INTEREST COMPANY (CIC) (15 MINUTES)

The Chairman invited Jane Shayler to introduce the report. Jane Shayler took the Panel through the report and circulated a photographic record of key events in Sirona's establishment.

Jane Shayler also highlighted that Sirona had cross party support in the Council, clinical support and also the PCT support.

The Chairman said that he and some other Panel Members had a chance to visit some services within Sirona. The Chairman said that services, such as Stroke Service, should promote themselves on how good they are (Stroke Services within top 20 nationally) for the benefit of residents.

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

50 CLINICAL COMMISSIONING PRESENTATION (30 MINUTES)

The Chairman invited Dr Ian Orpen (Member of the Clinical Commissioning Group) to give a presentation.

Dr Ian Orpen highlighted the following points in his presentation named 'B&NES Clinical Commissioning Group':

- Agenda (perspective, timescale, clustering, commissioning support, commissioning intentions)
- The Health White Paper 2010
- B&NES GP response
- Who is in the Clinical Commissioning Group
- The story so far
- Authorisation timeline
- What will Clinical Commissioning Group look like?
- Commissioning Support
- The financial challenge
- Vision
- Achieving the Vision
- What will this mean?
- NAPC Conference 2011 in Birmingham

A full copy of the presentation is available at minute book in Democratic Services.

The Panel **RESOLVED** to note the presentation.

51 WORKPLAN

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

- High Dependency Unit (Hillview Lodge) Impact Assessment – January 2012
- Further update on Dementia – date to be confirmed

The meeting ended at 2.10 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

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

Wellbeing Policy Development & Scrutiny Panel – November 2011

1. PUBLIC ISSUES

Autism Strategy

The Autism Act was passed by Parliament in 2009. The Act puts a legal duty on PCTs and local authorities to provide an appropriate range of services for adults with Autism Spectrum Conditions. Subsequently the Department of Health published in 2010, The National Autism Strategy – and the first year delivery plan. The National Autism Strategy and delivery plan sets the direction for long term change.

In response to this, a Local Autism Partnership Group was formed in B&NES in July 2010. Key aims of the group are the development of an integrated strategy, identifying local commissioning priorities and to provide a more strategic approach to developing better outcomes for people with autism.

In addition to the multi-agency group there is an Autism Providers Group in B&NES. The group membership consists of local service providers and carers who work together to improve the quality and range of local services.

The learning from both groups and the completion of a self-assessment has confirmed that, in line with national findings:

- more information is needed about our population with autism. Overall numbers and needs are not known and therefore it is difficult to plan the right services and support for the future
- the numbers of people with autism who are on the caseload of the specialist mental health teams is known and the associated spend on services is quantifiable – however as the client group is “hidden” in mental health services we do not use this information properly to improve planning.
- some, but not all, people with learning disabilities or mental health conditions, who also have autism, receive a service but those services are sometimes not ideal
- people on the autistic spectrum who do not have a learning disability or a mental health condition are even less well-supported
- assessment and diagnosis services have no clear pathway for referral

- B&NES does not understand the full range of autism/Asperger specific services or non-specific services with the experience and expertise to support people with autism well
- The workforce in both statutory and independent sectors needs further training and support to understand and meet the needs of people with autism
- We need to continue to strive to help people with autism live in appropriate accommodation and to take up employment opportunities.

This information has formed the basis of the strategy development and a 5 year draft strategy has been produced. The key strategy areas have designated lead officers who are responsible for the development and implementation of action plans in line with the commissioning intentions in the strategy. The group are currently planning the consultation process on the draft strategy, which is planned for early 2012.

2. PERFORMANCE

First Annual Adult Social Care Survey & Annual Account

This annual survey is a key element of the government's new Adult Social Care Outcomes Framework (ASCOF). The survey was completed for the first time in Q4 of 2011/12 and preparations for the administration of the second survey in Q4 of 2011/12 are now underway.

The 2011 survey was the first of its kind to cover all service users aged 18+ who receive a social care service, either in a residential/nursing home or as a package of care in the community. The aim was to learn more about whether or not the services help people to live safely and independently in their own home and how they affect their quality of live. The table below provides comparator data for all key outcome measures. Overall the survey results for B&NES are better than the average for England as a whole although they are very slightly below the average for the South West region. In relation to benchmark Local Authorities, B&NES results are slightly better than average.

Key Outcome Measure	B&NES	All England	South West	Benchmark
Social Care Related Quality of Life	18.8%	18.7%	18.9%	18.75%
Proportion of people who use services who have control over their daily lives	77.5%	75%	77.4%	77.9%
Overall satisfaction with care & support services	63.9%	60.9%	62.1%	60.6%
Overall satisfaction with care & support serves (LD specific question)	75.8%	69.4%	71.2%	73.7%
People who use services who find it easy to find information	58.6%	55%	55.2%	55.9%
People who use services who feel safe	64.3%	62.4%	64.2%	62.9%

In addition to the survey each Local Authority must produce an annual 'Local Account' or narrative to describe key areas of good performance as well as areas for improvement. The local account will form the basis of a peer review process which will replace the previous Annual Performance Assessment visits carried out by the CQC. In preparing our first local account in B&NES it will be important to capture all issues across the social care system including equalities, financial, demographic and performance themes. A draft outline local account will be produced by December 2011.

3. SERVICE DEVELOPMENT UPDATES

Care Home with Nursing Local Enhanced Service

A care home local enhanced service has recently been offered to GP practices in B&NES. Practices have been asked to express an interest in providing this service to local care homes with nursing care, by 18th November, with the aim of implementing the service from January 2012. This service seeks to:

- Deliver pro-active health care based on a minimum of weekly routine visits to the care home;
- Provide high quality care in the care home setting, working in partnership with staff in the care home and other health and social care providers to prevent inappropriate admissions to hospital; and
- Enhance the quality of medical cover for the residents of the care home.

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Wellbeing Policy Development and Scrutiny Panel
18th November 2011

Key Issues Briefing Note

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1 Management Arrangements
Jeff James resigned as Chief Executive of NHS Bath & North East Somerset and NHS Wiltshire on 20 October 2011. Jeff will remain in post whilst arrangements for covering Chief Executive responsibilities are sought. Further updates will be brought to the panel as appropriate.

2 Cluster Governance
The NHS has received guidance in a letter released by Jim Easton National Director for improvement and efficiency on 29th September 2011 which requires PCT clusters to move towards more aligned governance during the transitionary period up to April 2013 when PCTs will be abolished and Clinical Commissioning Groups will be fully established. The directive calls for single Boards to be created across each cluster. The timescale for making this change was set at December 1st 2011 other than in exceptional circumstances. It is important to note that this development is not a disestablishment of existing PCTs. Bath and North east Somerset PCT would continue to exist as a separate legal entity as would NHS Wiltshire but the Board for both organisations would be led by a single chairman a single set of Non Executive Directors and a single executive team. A single executive is already in place across B&NES and Wiltshire and the panel received information about the strategic director appointments at its last meeting. Since the release of the letter local discussions have been taking place concerning the benefits and risks of such an alignment and the impact of implementing it to the proposed timescale. Bath and North East Somerset Council have made representations to the Strategic Health Authority expressing concerns that the proposals may impact on local partnership arrangements and calling for a delay to the intended implementation date and additional consultation. A contributor session is now being organised to enable the panel to hear the details of the proposals and to consider the issues from the perspective of the key partners concerned. A date for the session has been set at November 29th 2011.

3 NHS Reform The Department of Health has issued further guidance for commissioners: "Developing commissioning support: towards service excellence" which sets out a framework to support the Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board. The Department envisages the establishment of between 25 and 35 commissioning support organisations (CSOs) across England, which will provide a range of support services to be shared by CCGs. The provision would be likely to include infrastructure services such as finance, Information management, business intelligence, pathway design, performance monitoring, communications and engagement and contract management. The NHS Commissioning Board is likely to host NHS CSOs from 2013 until no later than 2016 when CSOs will establish themselves as independent providers. It is understood that the NHS Commissioning Board itself will be represented through 4 regions in England. The

establishment of SHA clusters into 4 regions as reported to the panel at its previous meeting is expected to form the footprint of the commissioning board regions.

4 Establishment of national NHS 111 service

The Secretary of State for Health has made a national commitment for the roll-out of a single NHS telephone number – 111 – which is a free to call number, available 24 hours a day, 365 days a year. NHS 111 is a telephone advice line and signposting service for patients with unscheduled health problems which require assessment but which are not so serious as to require a 999 call.

Overview and Scrutiny Committee Chairs and chief Officers and Local Involvement Network leads have previously received a verbal briefing on these proposals from the Head of Engagement and Stakeholder Relations at the South West Strategic Health Authority. A paper is included as an appendix to this update which sets out information about plans to introduce NHS 111 services across the seven Primary Care Trust clusters in the South West region.

NHS Briefing Note Nov 2011 -Appendix 1

South West Strategic Health Authority

Briefing for Overview and Scrutiny Committees

Introduction of NHS 111 in the South West

1. Purpose of the report

1.1 The aim of this paper is to provide Overview and Scrutiny Committees with information about plans to introduce NHS 111 services across the seven Primary Care Trust clusters within NHS South West.

1.2 Overview and Scrutiny Chairs and chief Officers and Local Involvement Network leads have previously received a verbal briefing on these proposals from the Head of Engagement and Stakeholder Relations at the South West Strategic Health Authority.

2. Decisions/actions requested

2.1 Overview and Scrutiny Committees are asked to receive and note proposals for the introduction of NHS 111 within the South West.

3. Background

3.1 NHS 111 is a new national NHS service. It is a telephone advice line and signposting service for patients with unscheduled health problems which require assessment but which are not so serious as to require a 999 call.

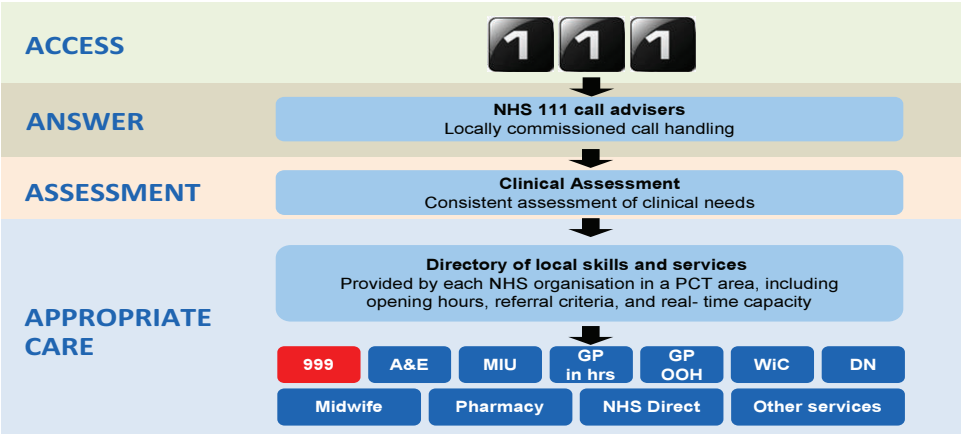
3.2 NHS 111 is a free to call number available 24 hours a day, 365 days a year to respond to people's healthcare needs when:

- they need medical help fast, but do not believe it is a 999 emergency;
- they do not know who to call for medical help, for example they do not have a general practitioner to call or are away from home;
- they think they need to go to Accident and Emergency or another NHS urgent care service;
- they require health information, signposting, or reassurance about what to do next.

3.3 The service is intended to provide consistent clinical assessment at the first point of contact and route customers to the right NHS service first time, without the need for the caller to repeat information. The service provider will have a call handling system with support software, which links automatically into a comprehensive local directory of service.

3.4 A flowchart showing the service model is below in Table 1.

Table 1: NHS 111 – service model



1

3.5 NHS 111 was introduced in four national pilot sites in 2010. These are in County Durham and Darlington, Nottingham City, Lincolnshire and Luton.

3.6 The Department of Health has committed to ensuring that NHS 111 is available in all localities by April 2013. Each Strategic Health Authority, in conjunction with Primary Care Trust Clusters and Clinical Commissioning Groups, has been asked to put plans in place to deliver this.

3.7 National research in 2009 found that 38% of those questioned were not sure of the care options available for non-emergencies outside general practitioner surgery hours.

3.8 The Strategic Framework for Improving Health in the South West similarly identified a need to simplify public access to urgent care, with the current system leaving many people unclear which number to call. NHS 111 is intended to address that need directly.

3.9 NHS 111 will be the gateway to the urgent care system. It will direct people to the most appropriate service for their needs, underpinned by well developed local pathways of care.

4. Current service arrangements – what happens now?

4.1 Currently, people with urgent care needs have a number of choices. They may request an urgent appointment with their general practitioner, ring their out of hours provider, call NHS Direct, attend a minor injury unit, urgent care centre, Accident and Emergency department or other local service.

4.2 In a significant proportion of cases the first destination may not be the most appropriate for that patient, and there is no opportunity for them to be signposted elsewhere early on.

4.3 Callers to current services frequently need to wait to be called back by an advisor, and to repeat their name, details and other information each time they speak to a new advisor.

4.4 There is also potential for both duplication and gaps in current provision of urgent care services.

5. Proposed service development – what will change?

5.1 The seven Primary Care clusters within the South West have been working with Clinical Commissioning Groups and the Strategic Health Authority to develop plans to implement NHS 111 by April 2013.

5.2 The NHS 111 service will provide a single, easy to remember and free to call number for people with any urgent care need. It will route them through to the right service for them, first time.

5.3 The aim of the South West service, in line with the national specification, is to simplify access to the urgent care system by:

- improving public access to urgent healthcare;
- helping people use the right service first time, including self-care;
- providing management information on usage of services to commissioners;
- enabling and supporting quality and productivity plans for urgent care.

5.4 The core principles that the new service will deliver are the ability, 24 hours a day, 365 days a year, to:

- dispatch an ambulance without delay where the call is an emergency;
- complete a clinical assessment on the first call without the need for call back;
- refer calls to other providers without re-triage;
- transfer clinical assessment information to other providers;
- book appointments where appropriate;
- signpost to another service, where outside the scope of 111;
- conform to national quality and clinical governance standards.

5.5 These represent an improvement on the current system and will help people to navigate the urgent care system much more rapidly.

5.6 The new system also involves the development of a comprehensive directory of service. The directory of service lists and defines all local services with daily availability. When people ring NHS 111 the call handlers will have access to the local directory of service and be able to direct the caller to the service most appropriate to their needs.

5.7 Suitable providers for the NHS 111 services in the South West are being sought through a procurement process. There is a single collaborative procurement across the South West with local geographical lots based on the seven Primary Care Trust clusters:

- NHS Bath and North East Somerset and Wiltshire;
- NHS Bristol, North Somerset and South Gloucestershire;
- NHS Cornwall and Isles of Scilly;
- NHS Devon, Plymouth and Torbay;
- NHS Dorset, Bournemouth and Poole;
- NHS Gloucestershire and Swindon;
- NHS Somerset.

5.8 Potential suppliers may bid to provide a service for one or all lots.

5.9 Other services are being developed in parallel with the procurement. Population of a comprehensive Directory of Service is already underway in all cluster areas. This will provide the link between the clinical triage and the most appropriate service available for the caller in their local area.

5.10 The national requirement for NHS 111 is to replace the NHS Direct 0845 4647 service which will cease from April 2013. Primary Care Trust Clusters, with Clinical Commissioning Groups and other local partners, are specifying what should be available within the local NHS 111 service and alongside, to ensure patients can be routed as quickly as possible to the service they need. The range of services under consideration includes out of hours telephony, other local call handling or telephone advice services, and direct booking of slots or visits.

5.11 NHS 111 services will be organised at Primary Care Trust cluster level, with clinical governance arrangements managed locally.

5.12 The NHS 111 service in the South West will conform to a national service specification so that a consistent identity and quality of service is maintained across the country, but delivered locally by the NHS in a way that is most appropriate for each area.

6. Expected benefits from the proposed service development

6.1 The chief benefits anticipated are:

- for the public and patients:

- streamlining access to urgent healthcare;
- avoiding confusion about which service to call or visit;
- speedier route to diagnosis and treatment;

- for the NHS:
  - good information about usage and availability of services leading to improved commissioning and provision of urgent care to meet local needs;
  - increased public satisfaction with NHS services.

7. The engagement process

7.1 This briefing is being shared with all Overview and Scrutiny Committees within NHS South West. Each Primary Care Trust cluster will have an identified lead to link with the Overview and Scrutiny Committee who will be able to respond to questions and share details about local plans and timescales.

7.2 Presentations and discussions are being held with Local Involvement Network leads and groups.

7.3 It is intended that there should be an opportunity for engagement in the development of the NHS 111 service locally.

7.4 A further briefing will be provided following the conclusion of the procurement to update Overview and Scrutiny Committees on the outcome and to outline the next steps.

7.5 Communications to the public about the new service will be very important. There will be a consistent identity and marketing strategy organised nationally for NHS 111. The local NHS is developing its strategy in line with this to ensure awareness and understanding of the new service.

8. Current timescales

8.1 A Pre-Qualification Questionnaire will be published at the beginning of November 2011 inviting suppliers who have expressed an interest in the procurement to submit initial information. The full Invitation to Tender is scheduled to be published in January 2012 and the provider to be selected in June 2012.

8.2 There will be a substantial period for development and mobilisation of the service, to ensure that robust technical, service and clinical governance arrangements are in place. The planned date for the start of the NHS 111 services across the South West is March 2013.

9. Conclusion and Recommendations

9.1 Overview and Scrutiny Committees are asked to:

- receive and note proposals for the introduction of NHS 111 within the South West.

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BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Tuesday, 29th November, 2011

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Eleanor Jackson, Anthony Clarke, Bryan Organ, Kate Simmons and Sharon Ball

52 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

53 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

54 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Loraine Brinkhurst had sent her apology to the Panel.

55 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

There were none.

56 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

There were none.

58 CONTRIBUTOR SESSION ON PROPOSED CLUSTERING ARRANGEMENTS BETWEEN NHS BATH AND NORTH EAST SOMERSET AND NHS WILTSHIRE

The Chairman informed the meeting that the contributors will address the Panel according to the Day Schedule (attached as Appendix 1 to these minutes).

The Chairman invited Jeff James (NHS BANES and NHS Wiltshire Chief Executive) to address the Panel.

Jeff James took the Panel through his summary of the PCT Cluster Implementation Guidance summary, Shared Operating Model for PCT Clusters and the letter from

Jim Easton (National Director for Improvement and Efficiency) issued on 29th September 2011 (all these documents attached as Appendix 2 to these minutes).

Councillor Hall said that Jim Easton said in his letter that 'key principles of model 2 are adopted by all PCT clusters, by December 2011 or, exceptionally, by a date agreed with the SHA' and asked what constitute 'exceptional'.

Jeff James responded that the SHA should give an answer on what constitute 'exceptional'. Jeff James surmise was that the SHA felt there was no particular need to keep the PCTs separate hence why the deadline is moved to December 2011.

Councillor Clarke said that he questions what the SHA is trying to achieve here considering that the relationship between the Council and PCT in BANES is different than the one between Wiltshire Council and their PCT.

Jeff James said that part of the argument for clustering arrangements is to speed up the work between the Councils and Clinical Commissioning Groups and put the PCTs away as they, PCTs, will demise in April 2013.

Councillor Jackson commented that for this area we have a very good model of Council's integration with the PCT. As a result of that the Health Scrutiny worked well with and for both organisations. Councillor Jackson also said that there is a mismatch between BANES and Wiltshire and expressed her concern that the new setup will not have the same standards across (i.e. waiting/referral times difference, etc.).

Jeff James responded that absolutely nothing will stop Health Scrutiny to express their views, or scrutinise, the new setup although Health Scrutiny will not be in the position to contend non-executive appointments on the new board. Jeff James also said that there are differences between BANES and Wiltshire but he will be committed to honour and respect both areas.

Councillor Hall said that her concern was that the Council appeared to have inferior role in these arrangements and not consulted on these issues but expected to act as per requirement.

Councillor Clarke agreed with Councillor Hall and said that he criticise the decision made on the higher level and not on the local level. The Panel has the right to put forward views of the people they represent.
Jeff James responded that clustering will not change legal issues in the Council and Members will still be able to represent their constituents.

The Chairman said that the biggest issue for this authority is that we are merging with another authority that is not quite into the PCT integration like we are.

Jeff James replied that nothing in the letter from Jim Easton says that joint commissioning should end with the PCT clustering.

The Chairman thanked Jeff James for his statement.

The Chairman invited Malcolm Hanney (NHS BANES Chair) to address the Panel.

Malcolm Hanney declared the interest as he is the NHS BANES Chair and also BANES Councillor.

Malcolm Hanney said that the December 2011 deadline is too early and it will be impossible to start with clustering from that date. The issue about model 2 governance option is not about a single chair and single executive team; it is in fact about the proper basis of the partnership. There is also no issue about differences in BANES in Wiltshire but there is an issue about the list of executives operating on cluster level and omission of people, such as Ashley Ayre, who should be the part of the new board. There need to be a lot of understanding and consultation on different issues hence why April 2012 should stay on as the deadline.

From this point Malcolm Hanney read out his statement (attached as Appendix 3 to these minutes).

The Chairman commented that lots of issues would need to be considered in preparation for the new cluster board.

Malcolm Hanney responded that there is a need for a thorough discussion on what will happen until April 2013 and beyond that date (after PCTs demise). There is also a need of the thorough discussion as some people do not understand the scale of the partnership.

The Chairman said that the main complication is that we have integrated services and asked how Wiltshire received that.

Malcolm Hanney confirmed that we have joint staffing (i.e. Ashley Ayre) set under Section 113 Agreement and that makes situation here much more complex.
Malcolm Hanney said that he will meet with the SHA and NHS Wiltshire Chair to discuss these issues further.

Malcolm Hanney said that he will send a copy of the letter, which he will write to the Leader of the Council after the meeting with the Strategic Health Authority on 30th November, to the whole Panel.
Malcolm Hanney concluded by saying that it is important that discussions between BANES and Wiltshire continue in order to understand the guidance on cluster arrangements.

The Chairman thanked Malcolm Hanney for his statement.

The Chairman invited Ashley Ayre (Strategic Director for People and Communities) to address the Panel.

Ashley Ayre said that his starting point is to protect local arrangements and also to provide the best for patients and public. The Council expressed their reservation to the Strategic Health Authority deadlines as it might undermine what we have locally, including what local Clinical Commissioning Group what to do with the Council in near future. In Wiltshire things might be different and they might have different relationships between their Council, PCT and their Clinical Commissioning Group.

Ashley Ayre asked the Panel also to bear in mind policies and financial issues within the Council.

Ashley Ayre said that his role is to develop a new structure and he recognised that the change is inevitable. Mike Bowden (Active Director for Service Development) had been seconded for 18 months by the Council to think about the structure of the new department which would also provide the support to the colleagues in the PCT.

Ashley Ayre also said that there were very good a discussion locally between the Council, PCT and the Clinical Commissioning Group and that there is a good will from all sides to provide the best outcome.

Ashley Ayre informed the Panel that the amount per head that the Clinical Commissioning Group will work with is £25 per head.

Jeff James added that the current PCT costs per head are £37.

The Chairman thanked Ashley Ayre for his statement.

The Chairman invited Jayne Pye (BANES Local Involvement Network) to address the Panel.

Jayne Pye referred to the letter sent by Diana Hall Hall to Sir Ian Carruthers (Chair of NHS South of England) on 3rd November (Appendix 4) and the reply from Charles Howeson (Vice-Chair NHS South of England) on 23rd November this year (Appendix 5).

Jayne Pye said that, as long they get the service, our community do not care who is providing the services to them. Jayne Pye also said that the LINk do not want to lose the good working relationship with the Council and PCT.

The Chairman thanked Jayne Pye for her statement.

The Chairman invited Dr Ian Orpen (Chair of the BANES Clinical Commissioning Group) to address the Panel.

Dr Orpen referred to his briefing (Appendix 6) submitted in advance of the meeting which includes his letter to John Everitt (Council Chief Executive) dated 2nd November.

The Chairman thanked Dr Ian Orpen for his statement.

The Chairman thanked the contributors for their statements and invited the Panel Members to comment.

Councillor Organ said that the Council worked hard for a very long time to be integrated with the PCT and December deadline for cluster arrangements is too short. Councillor Organ asked that the deadline should be April 2012.

Councillor Clarke said that the Panel did not want to undermine on-going process but there are clear differences between BANES and Wiltshire PCTs. Councillor Clarke also did not agree that cluster arrangements should start as of December 2011.

Councillor Jackson agreed with the statements from Councillors Organ and Clarke and added that there is a cross party disapproval of December deadline.

Councillor Hall said that she also did not agree that cluster arrangements should start as of December 2011.

The Chairman concluded that December deadline for cluster arrangements is quite unreasonable and disruptive.

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

The Wellbeing Policy Development and Scrutiny Panel heard from a range of contributors on proposed clustering arrangements between NHS Bath and North East Somerset and NHS Wiltshire at their meeting on Tuesday 29th November 2011.

The Panel made the following **RECOMMENDATIONS**:

1. The Panel did not support the conclusion of the NHS Management Board that the key principles of model 2 PCT cluster governance must be adopted by December 2011. The Panel did not agree with the 'top down' approach from the NHS Management Board when a local decision of April 2012 had been mutually agreed between both NHS Bath and North East Somerset and NHS Wiltshire.
2. The Panel felt that the deep integration between the Council and NHS Bath and North East Somerset and the Clinical Commissioning Group's commitment to continuing these partnership arrangements in the future qualified as exceptional circumstances to allow deferral until April 2011 to allow the complexities of future working arrangements to be properly established.
3. The Panel asked Malcolm Hanney to send a copy of the letter, which he will write to the Leader of the Council after the meeting with the Strategic Health Authority on 30th November, to the whole Panel.

Appendix 1

Appendix 2

Appendix 3

Appendix 4

Appendix 5

Appendix 6

The meeting ended at 7.50 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

Wellbeing Policy Development and Scrutiny Panel
29th November 2011at 5.30pm
Brunswick Room

Contributors Session –

To consider the context for the proposed clustering arrangements of NHS Bath & North East Somerset and NHS Wiltshire and the related implications for:

- **Our current arrangements in the form of Bath and North East Somerset's Health and Wellbeing Partnership and joint commissioning arrangements**
- **Future organisational arrangements with the Clinical Commissioning Group and proposed Commissioning Support Units**

Meeting structure and timings

Time	***Item***
5.30	• Welcome & Introductions by the Chairman, Councillor Vic Pritchard • Standard agenda items
5.35	• Presentation from Jeff James (BANES and Wiltshire NHS Chief Executive) • Q&A with the Panel
6.35	• Statement from Malcolm Hanney (NHS BANES Chair) • Q&A with the Panel
6.50	• Presentation from Ashley Ayre (Strategic Director for People and Communities) • Q&A with the Panel
7.50	• Statements/briefing from Diana Hall Hall (BANES Local Involvement Network) and Dr Ian Orphen (Clinical Commissioning Group) • Q&A with the Panel
8.20	• Members of the public and Councillors. Panel can ask factual questions.
8.35	• Conclusion. Panel to make recommendations/resolution/proposal (if any) in public.
8.45	Meeting ends.

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Department of Health Policy and Practice guidance on PCT Clusters

PCT Cluster Implementation Guidance
Gateway Reference 15520
Issued 31 January 2011

Context

2. The creation of clusters is intended to:
   - Sustain management capacity, and a clear line of accountability, providing greater security for the delivery of current PCT functions in terms of statutory duties, quality, finance, performance, QIPP and NHS Constitution requirements through to March 2013;
   - Provide space for developing GP Commissioning Consortia to operate effectively;
   - Provide a basis for the development of commissioning support arrangements, allowing current commissioners and new entrants to develop a range of commissioning support solutions from which consortia and the NHS Commissioning Board can secure expert support;
   - Similarly, provide space for new arrangements with Local Authorities, and particularly Health and Wellbeing Boards to develop;
   - Provide a mechanism to enable high quality NHS staff to move to new roles in consortia, commissioning support arrangements and the NHS Commissioning Board, including minimising unnecessary redundancy costs;
   - Support the provider reform element of the transition particularly in terms of ensuring progress with the FT pipeline through commissioning plans.

Establishment of Clusters

6. Each SHA has therefore been asked to take the necessary steps to ensure that, as at June 2011, sensible clusters of PCTs exist which have the following features:
   - A single Chief Executive, accountable for quality, finance, performance, QIPP and the development of commissioning functions across the whole of the cluster area;
   - Supported by a single executive team for the cluster. This must include a Director of Finance to ensure effective financial management, a director with responsibility for the full range of commissioning development and medical and nurse directors to ensure clinical engagement and leadership. From these and any other cluster director posts, there should be clarity about personal leadership for in year performance and medium term QIPP delivery, service quality and safety, communications, and informatics. Local Directors of Public Health will not be consolidated at cluster level, in order to support the transfer of this function to upper tier local authorities. Further detail of the transitional processes associated with creating the new Public Health landscape will be published separately;
   - Be sustainable until the proposed abolition of PCTs at the end of March 2013;

7. We expect that the geography of clusters, where not already clearly established is likely to be based on existing sub-regional arrangements, although SHAs have indicated that there may be some exceptions to this to reflect specific local circumstances or patient flows. The formation of clusters is designed to give space to emerging consortia to take on responsibility for commissioning so, clusters must not be on the same footprint as GP commissioning consortia, so where very large consortia are proposed this may affect cluster geography. Cluster configuration will be signed off by the NHS Chief Executive.
8. For new clusters, SHAs will ensure that key partners, and particularly GP commissioning consortia, local authorities and NHS providers have been engaged in discussion on the nature of cluster development in their area, in terms of geography, functions and how they will support the development of more local commissioning and partnership arrangements through GP commissioning consortia and Health and Wellbeing Boards. Current information received from SHAs suggests there will be around 50 clusters nationally.

Accountability Arrangements

15. Following appointment, the cluster Chief Executive will be confirmed as the Accountable Officer for each of the constituent PCTs by the Boards concerned. He or she will be expected to exercise the full range of responsibilities associated with being the Accountable Officer.
16. Whilst allocations, and accounts will remain at PCT level, with critical roles for the individual PCT Boards, the managerial processes for monitoring and holding to account will be exercised through the cluster Chief Executive.
17. Boards will retain their full range of statutory accountabilities and will have a clear agreement, adopted by the Board, of which of those are being exercised through the cluster arrangements, and which are being retained at PCT level.

HR Issues

31. The appointment of cluster Chief Executives needs particularly careful handling where jointly appointed PCT Chief Executives/Local Authority Directors exist. Again we do not intend that either the appointment or non-appointment of such a person to a cluster Chief Executive position should automatically lead to the dismantling of effective joint PCT/LA appointments prior to 2013. The SHA, cluster, PCT and Local Authority should work together to identify how best to sustain joint working arrangements, and the development of new joint working structures, including, as appropriate, the retention of such jointly appointed posts. Equivalent considerations should be given to joint appointments at PCT Director Level.

Board Issues

41. We have been working with the Appointments Commission to identify good practice and implementation options which strike this balance, and their guidance is attached in Appendix A. It sets out:
a. Key design principles for board arrangements in support of clusters;
b. A number of suggested options for the operation of board arrangements;

c. Identifies how, in the context of these approaches, a range of practical issues can be tackled, including appointments and terminations, schemes of delegation and appropriate use of the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Amendment Regulations 2010 which removes the disqualification contained in the Primary Care Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 which prevented an individual serving as a Chair or non-executive of one PCT from being appointed and serving as the Chair or a non-executive of another PCT at the same time.

Appendix A Advice on Non Executive Issues

3.3 Governance principles

Comply with statute –PCTs will continue as separate statutory entities with no statutory mergers of PCTs. As a result, the governance arrangements for PCT clusters must enable PCT boards to continue to comply with their statutory requirements. In line with regulations for PCT board membership[3], each board must continue to have in post a non-executive Chair and a minimum of five and not more than seven non-executives. Following an amendment to the regulations, Chairs and non-executive directors can now be shared across PCT boards. Each PCT board will also need to continue to include members with a suitable range of experience and skills for that PCT, as would usually be the case. PCT boards will need to continue to publish a separate annual report and set of accounts.

Operational context - Whatever governance structure PCT clusters put in place, it is critical that it enables the effective and efficient discharge of the specific functions and responsibilities of both the cluster board and of the individual PCTs (including their legal requirements) that are set out in the PCT Cluster Implementation Guidance, withoutplacing disproportionate demands on the single executive team. Governance arrangements will also need to be appropriately aligned with the requirements set out in the HR Framework for managing the transition.

Supports the executive team - Consideration should be given to the potential impact that the governance arrangements being considered will have on the single executive team that will be required to manage the arrangements, particularly around the demands they will place on the executive team in terms of the complexity of the management task and the workload that will be involved.

3.4 Design principles

Effective – the arrangements should demonstrate that boards can continue to provide effective strategic leadership, independent scrutiny, constructive challenge and transparency in decision-making. The constituent PCT boards will remain as statutory bodies and appropriate consideration will need to be

given and arrangements made to enable them to continue to exercise these and the specific responsibilities set out in the PCT Cluster Implementation Guidance, either through the cluster board or by meeting separately.
Proportional and cost-effective – the approach should be simple, avoid unnecessary bureaucracy and support the Department of Health's target to reduce management expenditure, while at the same time ensuring that it provides the necessary stability and resilience needed to sustain the arrangements effectively until April 2013.

Locally determined – the design of the governance arrangements should meet the local need and situation and have the support of stakeholders, such as GP consortia and local authorities.

PCT Cluster Governance Options

Model 1
PCT cluster board is populated with a Chair from one of the constituent boards and 'cluster' non-executive director(s) nominated by each PCT. Each PCT would delegate relevant functions to the cluster board. The number of cluster non-executives from each PCT can vary according to local circumstances.

Model 2
A single Chair and set of non-executives meet with the single executive team on the cluster board to discharge the respective statutory functions of the constituent PCT boards. All of the PCT boards involved in the cluster would have an identical Chair and non-executive team, with the same individuals being appointed to all of the PCT boards.

Model 3
A single individual chairs the cluster board and is appointed to all the constituent PCT boards, but the non-executive team is comprised both of a person or persons appointed to all constituent PCT boards, described in the diagram below as 'shared NEDs' and a person or persons appointed specifically to an individual PCT ('locality NEDs'). The number of shared and locality non-executives can vary according to local circumstances, but the requirements for a minimum of five and maximum of seven non-executives to be appointed to each PCT board must be met.

Model 4
PCT boards form into a cluster arrangement but continue to operate with their own Chair and non-executive team, but share a single executive team. Individual PCT boards would work together to identify and agree the common issues for all boards within the cluster and what are individual PCT issues. Each constituent PCT board holds the single executive team to account for its individual as well as the cluster issues.

Shared Operating Model for PCT Clusters
Gateway Reference16436
Issued 28 July 2011

10. As set out in the PCT Cluster Implementation Guidance, published in January 2011, governance arrangements for Clusters should comply with statute, fit the operational context and be locally determined. However, in ensuring that these arrangements fit the operational context Clusters will need to pay particular attention to **ensuring that governance arrangements are effective, but do not place disproportionate demands on the single executive team**. We are aware that some models currently in use are placing significant demands on executive teams and this is an issue that will require further consideration.

12. We also expect **Clusters to continue to maintain and build strong working relationships with local government**. This includes, where possible respecting pre-existing local joint working or joint appointments, and appropriately involving local government in developments or refinements of Cluster arrangements. It includes supporting CCGs to develop their own joint working arrangements with local government and to engage in the development of health and wellbeing boards. It also includes working with local government to implement the new arrangements for public health.

PCT Cluster Governance
Letter from Jim Easton National director for Improvement and Efficiency
Gateway reference 16713
Issued 29 September 2011

I am writing to set out the conclusions of the NHS Management Board following our recent discussions on the governance arrangements of PCT Clusters. Many of you have contributed to those discussions and I am grateful for those contributions.

The Management Board was guided by two objectives:

i) supporting the direction of travel for reform, in particular whilst allowing for effective management of the transition, providing space and support for CCGs and Local Authorities to begin establishing the local relationships that will, subject to legislation, be the bedrock of the new NHS commissioning system;

ii) having governance arrangements with absolute clarity about responsibility and accountability and which are efficient and effective.

On this basis we have concluded that, of the four governance models that were originally described for PCT clusters, model 2 is the most effective model. Many PCT clusters have already adopted or are adopting this model and we strongly welcome this. Indeed, it is the model which has been adopted by the SHA clusters. A number of other clusters have effective governance arrangements which incorporate the key features of model 2.

SHAs have been asked to ensure the following key principles of model 2 are adopted by all PCT clusters, by December 2011 or, exceptionally, by a date agreed with the SHA:

- a single board meeting transacting, as far as is practicable, the board business of all of the constituent PCTs;
-a single executive team with single chief executive;
-a single individual as chair of the cluster, therefore excluding shared or rotating arrangements.

SHAs will be working with you and the Appointments Commission to establish the implications of this for your organisation and any necessary further action.

Wellbeing Policy Development and Scrutiny - 29 November 2011

In July 2005 Bath & NE Somerset Council and NHS Bath & NE Somerset agreed to proceed with an integration project which now covers Children's Services; Adult Social Services, Health and Housing; and Public Health. Integration has been supported on a cross party basis within the Council and by key stakeholders including LiNK and local clinicians. Over the period since July 2005, B&NES has been at the forefront of partnership working with consequential benefits to the residents we serve.

Earlier this year the Joint Provider Social Enterprise (Sirona) was established and transfers of businesses and 1,700 staff were effected by 1 October 2011. It is one of the few joint Social Enterprise providers, one of the very few that includes children's services (community paediatrics and Lifetime) and the only one in the South West that includes public health. The Council and PCT worked very hard to meet challenging Department of Health (DH) timelines while ensuring, as best we were able, the involvement and support of our staff groups, GPs and other professionals and the local community.

In 2006 there was serious concern that the important link of coterminosity may be severed by combining NHS B&NES within a larger Greater Wiltshire (that was the term actually used in the Council report of 30 March 2006) or Avon PCT. In the end the Government recognised the importance of coterminous working between PCTs and local unitary authorities and NHS B&NES continued as an independent entity. It is unlikely that integration would have progressed in the way it has if NHS B&NES had been part of a larger PCT and it is noted that Council / PCT relationships are much weaker in neighbouring areas including Wiltshire.

The NHS is currently the subject of major transition. This can be seen locally with the establishment of Sirona, the development of Clinical Commissioning Groups (CCGs), PCT Clustering, the development of Commissioning Support Organisations (CSOs) with geography and activity still to be determined, the transfer of public health to local authorities (although it is already part of the partnership and under the Health & Wellbeing Partnership Board) and with heavy financial pressure on the PCT (and the Council) and on related management capacity.

On 29 September 2011, the DH issued a letter to PCT Cluster Executives indicating that (unless exceptionally agreed by the Strategic Health Authority) each cluster should have, by 1 December 2011, a single executive team, a single board meeting transacting as far as is practicable the Board business of constituent PCTs, and a single Chair of the Cluster.

NHS B&NES and NHS Wiltshire had already reached agreement to have a common Chair and Non-executive Directors by 1 April 2012 and in order to assist in a managed transition I had indicated that I would stand down as Chair on that date. However, over the period to 1 April 2012, critical decisions need to be made including on the balance of what is done locally and what is done at a cluster or CSO level and what that will mean for the Partnership, our joint staff and our community. The personal and organisational relationships will be critical during this period as Council, CCG, PCT, Cluster and the local community explore and determine the best way forward.

Following discussions with and representations by the Council, the CCG and LiNK and, following a two week local 'pause' agreed by the SHA to consider how best to progress, I wrote to the SHA on 4 November 2011 requesting that NHS B&NES be an exception to the

DH 'guidance' and enclosed copies of letters from the Leader of the Council and from the CCG and LiNK. My cover letter and an enclosed governance paper I had also prepared were used to support the case for a deferral until 1 April 2012. (There are a number of governance issues affecting the ability to create a single executive given current PCT Regulations and related Directions) irrespective of the criticality of having regard to the Partnership arrangements. I await a formal response from the SHA and will be meeting with them tomorrow. After that I will be able to respond more fully to the letter I have received from the Council and / or determine if further representations may be appropriate.

The PCT recognises that it is in a partnership with the local authority which the CCG wishes to continue through to 2013 and beyond, that there are business and employment issues that need to be discussed and resolved in terms of any proposals for, and prior to any implementation of, a single executive and a single board meeting at Cluster level. The clustering arrangements must reflect the local situation and agreements and recognise the significant involvement of senior Council executives in the management of the joint businesses including through the Health & Wellbeing Partnership Board (which has overall responsibility for the monitoring and implementation of the Partnership's businesses). We believe that the nature and extent of the Partnership is such that an exception should be considered by the SHA to give sufficient time to work through the matters of principle the Council and others have raised and determine the practical mechanisms to manage the joint businesses going forward recognising the strength and value of the Partnership.

I shall be pleased to answer any questions.

Malcolm Hanney

Malcolm Hanney
Chairman
NHS Bath & NE Somerset
29 November 2011

Bath and North East Somerset
Local Involvement Network

30 St John's Road
Bathwick
Bath
BA2 6PX
Tel. 01225 445538
contact@baneslink.co.uk
www.baneslink.co.uk

Sir Ian Carruthers
NHS South of England
South West House
Blackbrook Park Avenue
Taunton
Somerset
TA1 2PX

3 November 2011

Dear Sir Ian

B&NES and Wiltshire PCT Cluster - Joint Commissioning

The Bath & North East Somerset Local Involvement Network has now been working with NHS B&NES and B&NES Council for over three years, and has during this time been impressed by the commitment of these bodies to the implementation of Joint Commissioning arrangements across the health and social care sectors. We are convinced that this very close partnership is of great benefit to service-users and carers in both sectors, and that it must not be lost as a result of NHS reorganisation.

We have been concerned already at the possible threat to these joint arrangements that may arise from the removal of community services in B&NES to a new Social Enterprise. We are even more concerned at the threat that may come from the clustering of the B&NES and Wiltshire PCT's. It seems to us that the latter is very far behind B&NES in the practical implementation of and the very strong commitment to joint commissioning, and we fear that a new PCT Cluster will have to compromise between the positions of the current PCT's, leading to a dilution of commitment to joint commissioning in our area. We are, of course, also aware of the recent resignation of the Chief Executive of NHS B&NES, which could lessen the impact of the PCT's legacy in this important area.

The LINk would be grateful for any comments the SHA can make on this, and for some reassurance that the valuable work done and structures evolved in B&NES for Joint Commissioning will not be lost as clustering arrangements are implemented.

Yours sincerely,

Diana Hall Hall
Chair, Bath & North East Somerset LINk

cc. Dr Ian Orpen, Chair,B&NES CCG
Cllr Vic Pritchard, Chair, B&NES Wellbeing Policy Development & Scrutiny Panel
Cllr. Malcolm Hanney, Chair, NHS B&NES

NHS
South of England

23 November 2011

Diana Hall Hall
Chair
Bath and North East Somerset Local
Involvement Network
30 St John's Road
Bathwick
Bath
BA2 6PX

South West House
Blackbrook Park Avenue
Taunton
Somerset
TA1 2PX

Tel: 01823 361000
www.southwest.nhs.uk

Dear Ms Hall Hall,

Thank you for your correspondence setting out your views on the Board governance arrangements for the NHS Bath and North East Somerset and NHS Wiltshire Cluster. Your views are very helpful.

We are disappointed that both organisations could not reach a joint view on the best way to meet the governance arrangements set out by the Department of Health.

Given the majority of Primary Care Trust clusters now have the right arrangements in place, it is vital we meet with both organisations to agree a way forward on how they will meet national NHS policy.

Once we have met with the organisations, we will ensure that you are kept up to date with progress.

Once again, thank you for sharing your views.

Yours sincerely

Charles Howeson
Vice-Chair
NHS South of England

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B&NES Wellbeing Policy Development and Scrutiny Panel
Contributors Session
29th November 2011

B&NES Clinical Commissioning Group Briefing

The B&NES Clinical Commissioning Group (CCG) made clear its views that the very short time scale for board merger by 1st December represented an unwanted distraction as we considered how best to configure the CCG to face the huge challenges ahead. It was obvious to us that the local arrangements of partnership with the council gave us different options and opportunities to other emerging CCGs given the degree of existing integration and collaboration. It was our belief to take full advantage of this required sufficient time to avoid the risk of unwittingly undermining existing arrangements that might be otherwise in the interests of the council, public and the CCG.

The CCG had been consulted about, and were happy with, the1st April date for a board merger agreed between NHS Wiltshire and NHS B&NES.

So I wrote the following letter (dated 2nd November) to John Everitt as part of a wider submission to the Strategic Health Authority from the B&NES Council, NHS B&NES and LiNK. This summarises effectively the views of the CCG.

Dear John

You have asked for confirmation of the views of the Clinical Commissioning Group with regard to the DH proposals for a single board and single executive for NHS B&NES and NHS Wiltshire by 1 December 2011. These comments are provided in the context of our plans for maintaining and developing the close partnership with the Council and as members (2) of the Health & Wellbeing Partnership Board which we have been pleased to have joined and been warmly welcomed by our Council colleagues.

It is very apposite to consider the reasons why an early board merger is not appropriate for B&NES as I leave the National Association of Primary Care (NAPC) conference in Birmingham. We have heard from a wide range of speakers including:

- *Sir David Nicholson*
- *Andrew Lansley*
- *Dr David Colin-Thome OBE, recently retired National Director for Primary Care at the DH*
- *Professor Steve Field, Chair of the NHS Future Forum*
- *Sophia Christie Chief Executive Birmingham East on secondment to DH as Director of Alignment and Coordination*

There was a very strong theme running through the meeting regarding the imperative of good, close and supportive relations with your local authority. Andrew Lansley noted that a year ago Health and Wellbeing Boards had been only a concept, but there were now 132 across the country. He also stressed the role of the new tariff structure due to be announced shortly to facilitate integrated commissioning of services.

Nigel Edwards, senior fellow at the Kings Fund and former Policy Director of the NHS Confederation, said that the reforms will deliver a strong National Commissioning Board and potentially strong localities. The latter though, is not a given and will require CCGs to make it happen: fundamental to this will be the relationship with the council as well as the public, through the Health and Wellbeing Boards.

Both Steve Field and David Colin-Thome confirmed the view of the vital importance of HWB in personal conversations we had with them. The latter has firsthand experience of what the Partnership has delivered locally from his attendance at the Sirona Workshop day last week.

It has been our experience that the joint approach has delivered key benefits to us locally and this is noticeable not only in Sirona's existence as joint provider of Health and Social Care, but by what it

help deliver even before it became a Social Enterprise. The DTOCs (Delayed Transfers of Care) in B&NES are less than 1% as opposed to over 5% in Wiltshire in the most recent figures from the RUH monthly quality scorecard. DTOCs rates have been consistently low for BANES over the last 12months, and this is in no short measure due to the integrated approach we have taken with our Local Authority and community provider and the effective partnership working that has been developed. This joined up approach is one the key ways of delivering the enormous challenges we have ahead of us and reflects our almost unique position with the existing Partnership and HWB. We are aware that neighbouring local authorities look to BANES as a good example of partnership working and are keen to learn from our experience and success in achieving what we have.

It also needs to be acknowledged that there are already established formal contractual arrangements of senior managers between the LA and NHS BANES and the current timetable of clustering does not take adequate account of the need for consultation with regard to the changes.

There was a lot of discussion about the role of clusters being customer focused and responsive to the requirements and requests of CCGs as they start to develop into intelligent clients for commissioning support. To that extent, one might reasonably argue that clusters have a responsibility to respond to what their constituent CCGs views are on an issue such as this. It is clear that at no point were we directly asked for our views about the proposed merger date (by the cluster executive).

Also, much was made of the choices that CCGs need to consider about what support they wish to obtain and where from. Local authorities were noted to be an obvious and significant potential alternative to clusters for obtaining support.

Given the additional general agreement from Andrew Lansley down, stressing the practical importance of integrated commissioning and delivery to reshape radically the models of care and the importance of the HWB and CCG relationship, it is crucial that we allow sufficient time to explore how this will impact on the CCG's plans for its commissioning support and where it chooses to get it from. We are also concerned that the other part of the cluster has yet to establish a close relationship and we would be concerned at the potential for major distraction for us a CCG and wider community, including the Council, over the coming vital 5 months, should an early merger take place. This period is likely to be pivotal as we flesh out the details regarding our commissioning structure and requirements.

For all these reasons outlined above, it remains the firm view of the CCG that a there is an overwhelming argument for a delay in board merger to April 2012 to take into account the peculiar local factors in play.

Best wishes

Ian

Dr Ian Orpen
Chair
BANES Clinical Commissioning Group
www.suliscom.co.uk
Ian.orpen@nhs.net
07900055930

Bath and North East Somerset

Local Involvement Network

Report to B&NES Wellbeing Policy Development & Scrutiny Panel, 27 January 2012

1. Hillview Lodge -AWP High Dependency Unit

The Impact Assessment for the proposed changes at the HDU has now taken place, and the LINk's Deputy Chair, Jill Tompkins, will contribute to the later agenda item on this.

2. HealthWatch

As the Panel will probably be aware, the start-date for Local HealthWatch has now been delayed again until April 2013. This will bring their start into line with that of the new Health & Wellbeing Boards. It was announced at the same time that additional money would be made available to Local Authorities for the establishment of Local HealthWatch and for the setting-up of Local HealthWatch Pathfinders,

The Health & Social Care Bill completed its Lords' Committee stage just before Christmas, and the date is awaited for commencement of the Lords' Report stage. A number of amendments pertinent to HealthWatch are being pursued by the Lords, the two main ones relating to the independence of HealthWatch: firstly, the inappropriateness of HealthWatch England being established as a committee of the Care Quality Commission, and secondly the threat to the local independence of Local HealthWatch from their funding by and contractual relationship with Local Authorities.

3. PCT Clustering and Joint Commissioning

At the Panel's last meeting on 18 November, we reported on the letter that the LINk had sent to Ian Carruthers, Chief Executive of the Strategic Health Authority, outlining its serious concerns over the future of the strong joint commissioning arrangements in B&NES when the B&NES and Wiltshire PCT's were joined together in a single PCT Cluster. We have now received a reply from Charles Howeson, Vice-Chair of the SHA, and this is attached for the Panel's information, together with our original letter.

4. LINK's Visits to Care Homes

The LINk has decided to make a small series of familiarisation visits to care homes in B&NES. It will start these with a visit to Heather House care home in Batheaston on 1 February.

Diana Hall Hall

Chair, B&NES Local Involvement Network

16 January 2012

Bath and North East Somerset
Local Involvement Network

30 St John's Road
Bathwick
Bath
BA2 6PX
Tel. 01225 445538
contact@baneslink.co.uk
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cc. Dr Ian Orpen, Chair,B&NES CCG
Cllr Vic Pritchard, Chair, B&NES Wellbeing Policy Development & Scrutiny Panel
Cllr. Malcolm Hanney, Chair, NHS B&NES

23 November 2011

NHS
South of England

Diana Hall Hall
Chair
Bath and North East Somerset Local
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Bath
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Given the majority of Primary Care Trust clusters now have the right arrangements in place, it is vital we meet with both organisations to agree a way forward on how they will meet national NHS policy.

Once we have met with the organisations, we will ensure that you are kept up to date with progress.

Once again, thank you for sharing your views.

Yours sincerely

Charles Howeson
Vice-Chair
NHS South of England

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development & Scrutiny Panel	
MEETING DATE:	27 January 2012	**AGENDA ITEM NUMBER**
TITLE:	Service Action Plan 2012-13 Adult Social Care & Housing	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Service Action Plans 2012-13 Adult Social Care & Housing		

1 THE ISSUE

1.1 Service Action Plans to support the Adult Social Care & Housing Medium Term Service & Resource Plan is 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 ResourcesPolicy Development & Scrutiny Panel on 6th February, at which time it is intended to take an overview of all of the comments that have been submitted by each of the Policy Development & Scrutiny Panels. This will be the final opportunity for the ResourcesPolicy Development & 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 An issue of increasing profile is that of equality impact assessments. It is essential that equities issues are properly considered as part of the decision making process and the Panel is encouraged to review this aspect of the proposed budget and service changes.

2 RECOMMENDATION

The Panelis recommended to:

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

2.2 Identify any issues requiring further consideration at the special meeting of the ResourcesPolicy Development & Scrutiny Panelon 6th February and subsequently by Cabinet in February as part of the annual Service Action Planning and Budget process.

2.3 Identify any issues arising from the draft Service Action Planit 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 Medium Term Plan reports to the November meetings of Policy Development & Scrutiny Panels. The draft Service Action Plans are in line with the Medium Term Plans and the budget limits used to compile those plans. There has been a move away from simply using departmental cash limits so that special factors, such as the transition within the local education authority role, demands on social care, the Change Programme etc, could be properly taken into account.

3.2 The financial climate for Local Government and the public sector has deteriorated rapidly as a result of the recession and its impact on Government debt. The Chancellor's Autumn Statement made it clear that the cuts will continue for the foreseeable future and beyond the existing comprehensive spending review period. 2012/13 is the second year in a two year national settlement for Local Government. 2013/14 will see a new financial regime and some return of Business Rates for local use.

3.3 The Local Government grant figures for the 2012/13 settlement have since been confirmed, albeit in draft. The consultation about changes in funding for academies (to so called 'top slice' from local authorities) has been put back, as has the implementation of recovery of land use planning costs. Council Tax grant will be payable to local authorities with a Council Tax increase of 0% to cover the equivalent of a 2.5% increase. Those that increase Council Tax above 3.5% will be subject to a local referendum. Government has advocated pay constraint in the public sector and their restrictions are in line with assumptions already made in the Council's Medium Term Plan. The various proposed changes to pensions have no impact in the short term. Other adjustments will be set out in the annual budget report but these are not expected to affect the interim conclusions in the various Medium Term Plans.

3.4 Business Rates will increase by 5.6% but the Council simply collects this on behalf of central Government and even when the new system comes in during 2013/14 the rate will be set nationally.

4 THE REPORT

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

- Policy Development & Scrutiny meetings - review of Service Action Plans at all January meetings.
- ResourcesPolicy Development & Scrutiny Paneltakes overview of PDS comments – 6th February 2012
- Cabinet recommendations to Council to enable budget setting - 8th February 2012 cabinet meeting
- Council approval of budget - 14th 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 14th February. The reserve date is 23rd 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
- New Vision and Values for the Council to be incorporated into a revised Corporate Plan in spring 2012.

The Medium Term Service & Resource Plans and annual Service Action Plans will be important background documents as will the various equalities impact assessments

4.4 Each Service Action Plan contains commitments for the year ahead. Those commitments support the Medium Term Plans which aim to cover the next three years, albeit that the uncertainty about the funding of years 2 & 3 has meant that only a direction of travel could be indicated for future years.

4.5 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 Policy Development & Scrutiny Panelsto consider matters that need highlighting and to raise such matters with portfolio holders in advance of the February Cabinet meeting.

4.6 Issues highlighted by Policy Development & Scrutiny Panelswill be collated and summarised for the ResourcesPolicy Development & Scrutiny Panelmeeting on 6th February. 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. An important consideration for the Panel is whether those Service Action Plans contain the right actions to help mitigate equalities issues arising from those plans.

6.2 The associated equalities impact assessments are published on the Council website and a link will be provided for Panel members. To be lawful the decision making process needs to take into account equalities issues.

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 taken place as part of the previous Corporate Plan and Sustainable Community Strategy processes. Members of the Council are being consulted about the emerging new Vision and Values.

7.3 A Budget Fair was run in October 2011to receive comments on the emerging budget plans. Separate consultation is also being arranged for the local business community.

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 (Divisional Director - Finance) have had the opportunity to input to this report.

Contact person	*Jane Shayler, Tel: 01225 396120*
Background papers	*Draft Medium Term Service and Resource Plan 2012/13-2014-15 Adult Social Care & Housing,* as submitted to Wellbeing Policy Development & Scrutiny Panel, 18th November 2011.
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council

Adult Social Care & Housing

Service Action Plan

2012/13

This plan is an active document that will be reported against every six months via the Service Delivery Programme performance report. All staff that are part of the Service should have an opportunity to contribute to its creation and any new staff joining the Service should be made aware of this document as part of their induction.

Introduction	
Programme Director, Non-Acute Health, Social Care & Housing	Jane Shayler
Lead Portfolio Holder	Simon Allen; Tim Ball
Staffing Establishment (2012/13)	80, including delivery of Housing Services, integrated Commissioning of Non-Acute Health, Social Care & Housing, Adult Safeguarding and Quality Assurance.

Scope of Service (size, proportions and activities)

Primarily a commissioning role in respected of integrated commissioning of adult social care, housing and health services. Also includes delivery of housing services.

- Learning difficulties
- Physical & Sensory Impairment
- Mental Health
- Substance Misuse
- Adult Social care commissioning
- Supporting People & Communities
- Unplanned care
- People with Long Term Conditions
- Housing

Management Structure of Service

Structure attached as Appendix 2

Non-Acute Health, Social Care & Housing Management "Portfolios" attached as Appendix 3

Customer Profile

Outline who your main customers are, e.g., service users, residents, other council services, officers, members, partners etc

Following the transfer of community health and social care services, the Non-Acute Health, Social Care & Housing predominantly commissions (plans and purchases) services for adults and older people in Bath & North East Somerset, including:

- Learning difficulties
- Physical & Sensory Impairment
- Mental Health
- Substance Misuse
- Adult Social care commissioning
- Supporting People & Communities
- Unplanned care
- People with Long Term Conditions
- Housing

For further detail see Appendix 2, which details each commissioning manager's "portfolio" or area of commissioning.

On 1st October 2011 700 social care staff and 1000 health staff providing integrated Community Health & Social Care Services transferred to the newly established Sirona Care & Health CIC (Community Interest Company)www.sirona-cic.org.uk. Sirona provides a wide range of social care and community health services including:

- Community Alarm and Equipment Services
- Community Hospital in-patient and out-patient services
- Community Locality Teams, which includes social workers, nurses, therapist and integrated reablement services
- Community Resource Centres – providing residential & day care for people with dementia and those with more general need for care and support
- Employment Inclusion Service – supporting adults with a mental health problem or learning disability into paid employment
- Extra Care – providing 24-hour care and support to older people and those with a disability living in extra care housing
- Health Improvement Service – promoting healthy lifestyles through specific programmes eg food in schools, food worker programme, health trainers, stop smoking service
- Health Visitors
- Hospital Social Work Team

- Integrated Access Team – providing triage, referral and signposting service
- Learning Difficulties Locality Service including day services, Social Work, supported living services, learning difficulty nursing and services that support people access facilities in their local communities
- Mental Health Support &Reablement services – to support people with a range of musculoskeletal needs
- Minor Injuries Unit, Paulton Hospital
- Psychological Therapies Service
- Speech and Language Therapy – adults and children

The Community Mental Health Service, including Approved Mental Health Practitioners, is managed, on behalf of the Council, by Avon & Wiltshire Mental Health NHS Partnership Trust ('AWP'). AWP also provides specialist mental health services.

The delivery of Housing Services has been retained within the Council and includes the following services for people in need of housing advice and assistance, including those who are homeless, owner-occupiers, private tenants and landlords and tenants of housing associations/social housing :

- Housing Improvement Team - we can help to provide financial help to adapt or make essential repairs to your home; for example, if you have difficulty climbing the stairs or your roof is leaking. We can also offer help if you are finding it difficult to stay warm and heat your home.
- Housing Standards Team - we work with tenants and landlords to improve the housing conditions in rented properties. If your landlord is not carrying out repairs in your home we can help in getting them done.
- Homesearch Team - we administer the housing register for social housing. You can contact us if you would like to join the register for social housing or if you are interested in sheltered housing.
- Housing Options and Homelessness Team - we can give advice on a range of housing options available to you, including moving to a more suitable home or help if you are having problems with your landlord.
- Supported Lodgings Team - we can arrange lodgings in private homes for young people to help them in their transition to independent living.
- Strategic Housing Development Team - we work with Housing Associations and builders to enable them to provide new affordable homes.

Are there any specific customer needs that require your service to change?

Transitions from Children's Services to Adult Social Care

Each year Adult Social Care & Housing accepts responsibility for the commissioning of social care services for a number of young people with learning difficulties as they reach 18, who, having received an assessment, are identified to have eligible needs as an adult, primarily for residential accommodation and/or personal care. A total of 87 new services, or placements, have been commissioned from 2006/07 to the present day. Of the 87 placements – 84 (96%) have been due to commissioning new services for young people moving into adulthood. The remaining 3 placements have been for older people moving into the area and becoming ordinarily resident in B&NES.

Information held by the Council indicates that there are approximately 80-90 children who will reach 18 in the next five years who are likely to have eligible needs for social care as an adult. There is a particular 'spike' in current year 11 – (aged 15-16) where there is a significantly large number of children with a diagnosis of Autism, which suggests that there will be an even greater demand on social care and the purchasing budgets in 2014/15. There will be a year on year requirement to commission services for young people with learning difficulties reaching adulthood for approximately 15-20 people a year

There are an increasing number of young people with multiple and complex needs living into adulthood as improvements in healthcare continue, who will require individually tailored packages of care and support. Some will be eligible for funding from Continuing Healthcare, however many will not and will require social care commissioned services. These are potentially high cost services due to the level of complexity of need that the young person will have.

There will be an increase in the number of young people and families using personal budgets to fund a wider range of support than has traditionally been provided from social services.

Personal Budgets (particularly for People with Physical Disabilities)

In line with the Council's strategy all adults with a physical disability receiving a social service have been provided with, or are moving on to a personal budget. Within the population of 289 people there are currently a total of 183 (63%) people receiving a personal budget. This is an increase from 139 (42%) in November 2010.A 'commissioned' personal budget is one that is arranged on behalf of the service user by a Social Worker/Care Manager or other key worker whilst a 'direct payment' personal budget is passed to the service user, who then purchases a bespoke package of care and support. For people with complex needs this may include employing a Personal Assistant.

There has been an overall shift in the proportion of people receiving community based packages as opposed to residential care. At the same time there has been a shift of service users with more complex needs from more traditional models of community-based care such as Home Care and Supported Living to more diverse, bespoke packages of care purchased through a Personal Budget.People with more complex/multiple needs are being supported to live in the community and whilst this is in line with the Council's strategy to promote independence and in line with both national and local policy to give people greater choice and control, it is the case that bespoke community based packages are a more expensive way of meeting need. This is exacerbated by the loss of economies of scale associated with a block-contracting approach to commissioning more standardised services.

The budget pressures being seen in Personal Budgets across all client groups but, in particular for people with physical disability highlight the importance of having a clear policy framework for both Personal Budgets and that clearly sets out the level of choice and control over both care setting and service provider(s) that individual service users are able to exercise. Over the coming year, a review of the policy framework will be undertaken and, it is possible, that this review will lead to a revision of the policy.

Demographic Pressures

In addition to the need to respond to changing expectations, including for greater levels of personal choice and control over both the form of services provided and the provider of those services, adult social services need to be planned in the context of projections of the impacts of demographic growth. The impacts set out in Table 1 below are based on ONS (Office of National Statistics) projections for Bath & North East Somerset, based on the actual B&NES resident population as at April 2010 of 186,927.

Table 1

	2012	**2013**	**2014**
Adults 20-65	109,400	109,700	110,200
% growth	0.5%	0.3%	0.5%
Smoothed average	**0.4%**	**0.4%**	**0.4%**
Over 65s	32,900	33,700	34,300
% growth	2.5%	2.4%	1.8%
Smoothed average	**2.3%**	**2.3%**	**2.3%**
Over 85s	5,200	5,400	5,500
% growth	2.0%	3.8%	1.9%
Smoothed average	**2.6%**	**2.6%**	**2.6%**

Service Delivery

Planned improvements to service delivery in 2012/13

Following the transfer of community health & social care services to Sirona Care & Health CIC on 1st October 2011, which marked a significant milestone in the transformation of community services no further substantial changes to services are planned during 2012/13.

Areas of the Service that are to be stopped or reduced in 2012/13 (due to budget pressures / change in focus etc)

None anticipated.

External influences / pressures that could impact on service delivery during 2012/13 (excluding budget pressures)

New Adult Social Care Outcomes Framework (ASCOF) – The ASCOF places much greater emphasis on the delivery of outcomes, personalisation and the promotion of choice and control and on the adult social care system being more comprehensively informed and directed by the views of service users and carers. The ASCOF contains four broad *outcome domains,* all of which contain an element of feedback gleaned from user and carer surveys:

- Enhancing quality of life for people with care & support needs
- Delaying & reducing the need for care & support
- Ensuring that people have a positive experience of care & support
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

The framework also relies much more heavily on Local Authorities 'telling their own story' i.e. facilitating a process through which the issues that matter to social care users and their carers locally are captured, reported on and communicated to central Government.

Law Commission Review of Adult Social Care Legislation - The report of the Review was published in June 2010 and the Government has indicated in its response that new legislation will be introduced in 2012 that picks up key recommendations from the Review. Proposals, which are likely to be adopted, include a broader definition of carers who are entitlement to an assessment of their needs and may be eligible for services and the removal of the current restriction on use of direct payments/personal budgets to fund residential care. Both of these proposals are likely to have budgetary implications.

Service Costs

Explanation of Service costs (including areas of high spend and growth / investment)

Adult Social Care & Housing purchasing budgets (funding a wide range of commissioned independent and third sector services, including nursing, residential and home care as well as Personal Budgets) represent approximately 90% of the spend covered by this plan with the remaining 10% funding delivery of housing services and the commissioning team, including adult safeguarding and quality assurance. Table 2 provides a breakdown of spend as at October 2011.

Table 2

	Gross £'000	Net £'000
Mental Health Commissioning – Adults of Working Age and Older People	10,388	7,784
Older People Commissioning	35,253	18,243
Physical Disability & Sensory Impairment Commissioning	3,377	3,090
Learning Difficulties Commissioning	23,181	17,093
Supporting People & Communities Commissioning	6,413	6,074
Adult Care Commissioning – Other	6,540	2,155
Adult Substance Misuse (DAT)	2,923	598
Housing Services	3,020	2,255
Total 2011/12 budget at October 2011	**91,095**	**57,292**

Value for Money improvements - planned efficiencies / savings to be made during 2012/13

Cashable Efficiencies

In developing the proposals to move towards sustainable financial balance we have prioritised those areas where either our knowledge of the market and/or benchmarking of our performance and/or spend indicates that there are still efficiency gains to be made through: effective procurement and contract negotiation; and streamlining or tightening systems and processes. This approach resulted in a three-year programme aimed at bringing the unit cost of placements and packages in line with the South-West average and also to reduce the number of residential and nursing care placements made in line with the overall service strategy, which is to sustain greater numbers of people in community settings. 2012/13 represents the third and final year of this programme. The Placements & Packages Steering Group has been in place for two years now and has overseen an ambitious work programme designed to deliver a reduction in both the unit cost of residential and nursing care placements and a reduction in the number of placements being made in residential and nursing care. Key elements of the work programme are summarised below:

- **Single Panel** – has been in place since March 2011, replacing client-group specific panels for agreeing placement/package funding. The change is designed to ensure consistency, equity and value-for-money for all individual placements and packages of care and also to identify pricing differentials between different providers for comparable placements and packages.
- **Placements & Packages Policy** – sets out for health and social care managers and other case managers the overall approach and policy framework for setting up placements and packages of care and support in B&NES, including guidelines on resource allocation and specific areas of practice. Was formally adopted, following consultation, in April 2011.
- **Investment in community-based options** - including re-ablement, rehabilitation, prevention and early intervention where the evidence supports these approaches as sustaining people in their own homes;
- **Market Shaping** - greater focus to procurement; contract negotiation and management. A framework contract for Continuing Health Care has been put in place and savings of circa £1.2 million delivered to bring in line with benchmark; targeted negotiations with providers informed by benchmarking and pricing structure breakdown are being undertaken and delivered up to 10% efficiency savings in-year with a full-year effect in 2011/12. Focused re-commissioning of some learning difficulties and mental health services to deliver improvements in quality and value-for-money.

Additional Income

Increased income from personal contributions for social care –2012/13 represents the full-year effect of implementing the *Fairer Contributions* Policy for existing service users following agreement of the revised policy in May 2010. The Policy does not apply to registered residential or nursing care, which is subject to a national charging policy.The*Fairer Contributions* Policy was introduced in May 2010 for all new service users entering the social care system and for existing service users in April 2011. Financial modelling set out in the November 2009 report to Healthier Communities & Older People Overview & Scrutiny Panel showed that approximately 72% of non-residential social care service users would see an increase in their contribution whilst around 11% would see a decrease and a further 17% would experience no change. Prior to implementation of the new policy, Bath & North East Somerset generated the lowest level of income from contributions (6.98% of costs) when compared with all other South West local authorities (average 11.77% of costs).

Home Adaptations & Aids - Delivery of a reduction in expenditure on mandatory Disabled Facilities Grants through agreeing with Somer Housing Group that Somer will fund an increased share of DFGs for Somer tenants. Spend in 2010/11 on adaptations to the homes of disabled tenants of Registered Providers (social housing providers) was approximately £600,000, the majority of which were in Somer Housing Group properties. The new agreement will see Somer& the Council sharing the cost of the majority of their adaptations. It is estimate that this will save the Council at least £100,000 with no impact on the rights of disabled people to access aids and adaptations.

Summary from Medium Term Service & Resource Plan(add hyperlink to relevant web page for more detailed information)				
MTS&RP Items	**2011/12 (for comparison) £'000**	**2012/13 £'000**	**2013/14 £'000**	**2014/15 £'000**
Opening Budget	52808	57473	53682	54038
Removal of one-offs	0	-4371	0	0
Savings	-3228	-3588	-2112	-2847
Settlement grant	1600	1300	200	0
Growth	2018	2868	2268	2268
Proposed Base Budget	53198	53682	54038	53459
Target Budget	53198	53682	54038	53459
Deficit / (Surplus)	0	0	0	0
Additional Stretch Reductions	0	0	0	0
In Year Adjustments (including £3.14m of s256 in 11/12)	4275			
Proposed Overall Budget (November 11 rollover)	**57473**	**53682**	**54038**	**53459**
s256 from PCT	0	2796	2436	2132
Total net directorate budget including s256	**57473**	**56478**	**56474**	**55591**
Net movement of Council funding		580	356	-579
Please note that the savings for years 2013/14 and 2014/15 are indicative at this stage and need further development				

Workforce Planning

It is important that the Council continues to maintain and develop the workforce necessary to meet its future needs both in terms of the numbers employed and skills & competency required of those employees. To inform the forward Organisational Development and Workforce Planning Strategy, please complete the section below with details of actions you have taken or plan to address your service needs. The list of questions is neither exclusive or exhaustive but intended to assist you in considering the broader issues which may relate to either your service or Change Programme Workstreams.
Please also outline any identified needs that you cannot address/think will be more difficult to address.

Alternatively, if your service has developed a specific workforce plan, attach it as an appendix to this Service Plan.

Organisational Development: Implementation of 'future organisational model': • *How are you developing new workforce structures/ways of working to support the 'future council' organisational model?* • *What alternative service delivery arrangements are planned/anticipated?* *Are you considering job redesign? If so how/what*	The transfer of establishment of Sirona Care & Health CIC represents the implementation of a key element of the strategy for transforming community services and of the Council's Change Programme. Sirona have workforce development plans in place, which will be revised and further refined in light of the organisation's business plan.
Leadership and Management Development: • *What plans do you have for developing leaders in the new context?* • *Do you have a programme to assess and develop manager competency and meet gaps?* *Have you identified new manager skills that will be necessary in the 'future council'*	A management development programme to support the establishment of the new structure for the People and Communities Department is being developed as we go through the options appraisal and consultation. The skills & competencies set out in the section below are those identified at this stage.
Skills & Competencies • *Have you identified new skills/competencies that will be necessary for success in the new working environment/context?* • *Do you think you have a significant skills gap, if so what and how might it be addressed?* • *Have you identified that these skills might be missing/in short supply in the workforce as a whole?*	Indications of the kind of skills People and Communities will need to strengthen in future are: • Procurement, commercial management and market place facilitation (to support the Commissioning Leads) • Data/Intelligence/Best Practice/Survey results assimilation (to support role of strategic planning and commissioning) • Communication: development of strategy, partnership development, community development, engagement,

	consultation and information giving. In particular developing an awareness of knowledge sharing (knowledge platform) • Bid writing and presentation to reflect the current position of the requirement to bid for funding • Negotiation skills with partners and other agencies to take forward the increased need for alignment and pooling of resources • Political awareness and ability to negotiate through complex political processes
Recruitment & Retention • *Do you anticipate any recruitment difficulties in the current financial climate?* • *Are you undertaking any activity with partner organisations etc to address current/future skills shortages* *Is removal of the default retirement age likely to impact on your workforce?*	No specific recruitment difficulties are anticipated in the current financial climate. Commissioners will continue to work with partner/provider organisations to inform their workforce development plans. No specific impacts are anticipated as a result of the removal of the default retirement age.
Identified needs that cannot be addressed at service level/may be more difficult to address at this level	

Equalities
We are committed to the Council's core value of ensuring there is equality of opportunity through employment and service delivery. We are committed to promoting equality and eliminating discrimination on the grounds of age, disability, faith/religion or belief, gender including transgender, marital / civil partnership status, race, colour, ethnic or national origin and sexual orientation. Equality Impact Assessments (EIA) are carried out on all service changes and actions to mitigate impacts. **Please follow the link to the appropriateEIA .equality impact assessment: financial plan**

Key Service Priorities 2012/13

It is important to show how each service priority links to the new Corporate Plan, in particular the four strategic objectives & high level outcomes set out in the table below. At the end of each priority, services **must** indicate whether it will contribute to an objective & add the reference letter for each outcome it will help to deliver.

Objectives	Outcomes	Ref
1. Promoting independence and positive lives for everyone	Children and young people enjoy their childhood and are prepared for adult life.	**A**
	Schools develop and extend their role in the local community	**B**
	Youth Service works with the community to provide opportunities to support and develop young people	**C**
	Older people are supported to live independently.	**D**
	The people most in need are supported to live full active lives.	**E**
2. Creating neighbourhoods where people are proud to live	Where people feel safe	**A**
	There are decent affordable homes in private and social sector	**B**
	Clean streets and open spaces	**C**
	Where people are able to travel easily with reduced traffic congestion and pollution	**D**
	Where local people actively lead the delivery of improvements in their community	**E**
	Where there are opportunities to participate in sports, leisure and cultural activities	**F**
3. Building a stronger economy	With a broad range of job and employment opportunities	**A**
	With a strong local business sector, tourism, and local shopping	**B**
	Key development sites are delivered to increase the number of local businesses.	**C**
	A diverse economy with growth in the low carbon, knowledge creative, and ICT industries	**D**
4. Developing resilient communities	Where local people have developed their skills and use them to improve their community	**A**
	Where decisions are made as locally as possible	**B**
	Where there is easy access to public services and local amenities.	**C**
	Communities have adapted to changes in our climate and are not dependent on high carbon energy	**D**
	Recycling and reduction in waste continues to be extended	**E**

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Priority 1:			
Details of Service Priority	Ensure effective multi-agency planning to support young people with disabilities into adulthood.		
Impact on local community	Young adults with disabilities are supported to be active members of their community.		
Groups of service users affected	Young people with physical disabilities, sensory impairment, learning difficulties, autism spectrum disorders and mental health needs.		
Key Activities (add more lines as appropriate)		**Timescales**	**Performance Measures**
Implement revised transition plan process with targeted schools, based in National best practice – Getting A Life		September 2012 for pilot schools March 2013 for all schools	Number of young people using revised transition plan – target 100% of SEN students by March 2013 Number of schools/academies using revised process – target 100% Reduction in out of area residential/college placements and increase in local provision
Develop improved transition website to provide better information for young people and families		September 2012	Service User feedback Number of 'hits' on website
Establish user engagement forum in partnership with Off the Record		May 2012	Number of participants – target 20 young people User feedback
Roll out of training strategy for person centred approaches to transition planning across different agencies		Ongoing	Number of staff attending training
Run minimum three seminars in 3 Ways and Fossewayschool for family carers to cover: housing options; education and employment; use of personal budgets		June 2012; October 2012; March 2013	Number of families attending – target 50% of families of SEN children in school leaving year

Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:		
Strategic Objective	**Contributes – Y/N?**	**Relevant Outcomes**
1. Promoting independence and positive lives for everyone	**Y**	**A,B,E**
2. Creating neighbourhoods where people are proud to live	**N**	
3. Building a stronger economy	**Y**	**A**
4. Developing resilient communities	**Y**	**A, C**

Priority 2:			
Details of Service Priority	Put in place plans to improve facilities for Gypsies & Traveller facilities.		
Impact on local community	Unlikely to impact during 2012/13 due to the timescales associated with delivery of the outcomes of this project.		
Groups of service users affected	Gypsies and Travellers.		
Key Activities		**Timescales**	**Performance Measures**
Host Workshop Organise & host an initial ½ day workshop to develop a draft site delivery plan. This will be referred to Housing & Major Projects Panel prior to going to Cabinet for agreement as detailed below. Workshop to include representatives of the travelling community. This initial workshop is likely to be the first of a wider programme of engagement with key stakeholders including representatives of the travelling community that seeks to identify and develop plans to address the accommodation and other specific needs of the travelling community.		**Spring 2012**	Workshop taken place & outcomes report completed.
Update Gypsy &Traveller Accommodation Assessment (GTAA) Agree at B&NES and West of England level the approach to updating the GTAA. If GTAA update agreed then seek to commission.		**Spring 2012**	Corporate agreement on way forward & update commissioned.
Cabinet Agreement Agree corporate approach in relation to site delivery, that is, what type of sites e.g. transit, residential, how many sites & pitches, financing arrangements, project management etc.		**Spring/Summer 2012**	Site provision strategy agreed.
Site Investigation Following on from Planning's development work on the G&T DPD, begin to identify suitable sites.		**Summer/Autumn 2012**	Short list of sites identified.
Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:			

Strategic Objective	Contributes – Y/N?	Relevant Outcomes
1. Promoting independence and positive lives for everyone	Y	A, E
2. Creating neighbourhoods where people are proud to live	Y	A, B, C, E
3. Building a stronger economy	Y	C
4. Developing resilient communities	Y	E

Priority 3:			
Details of Service Priority	Further development of re-ablement& rehabilitation services to prevent admission to hospital and nursing care, facilitate early discharge from hospital and support the independence of older people.		
Impact on local community	Older People and people with disabilities are able to remain in or return to their local community.		
Groups of service users affected	Older People and people with disabilities		
Key Activities		**Timescales**	**Performance Measures**
Complete Re-ablement& Post Discharge Support Extended Research Pilots with partner providers.		Most pilots to be completed by January 2013 although some may extend to July 2013	Detailed performance measures have been developed for each individual specification. High level measures include: NI125 - % of people still at home 90 days post discharge. Rate of residential admission per 10,000 population.
Evaluate findings of ERPs and develop commissioning strategy		January to March 2013	Re-ablement Strategy
Support Sirona to finalise integration of Intermediate Care & Home Care Re-enablement, including service structure, operation and performance management/measurement		August 2012	Single performance measure developed& implemented

Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:		
Strategic Objective	**Contributes – Y/N?**	**Relevant Outcomes**
1. Promoting independence and positive lives for everyone	**Y**	**D, E**
2. Creating neighbourhoods where people are proud to live	**N**	
3. Building a stronger economy	**N**	

4. Developing resilient communities	**N**	

Priority 4:	
Details of Service Priority	Review and revise, as appropriate, the Personal Budgets policy framework.
Impact on local community	People who require support from social services are treated fairly through the appropriate distribution of resources.
Groups of service users affected	Older people, people with physical and learning disabilities, people with sensory impairment, people with mental health problems and others with long-term or life limiting illnesses/conditions

Key Activities	Timescales	Performance Measures
Analysis of current distribution and spend in relation to PBs to inform equalities impact assessment and policy revisions	April 2012	Analysis completed
Analysis of current application of FACs criteria to inform equalities impact assessment and development of clearer guidance for Sirona staff	April 2012	Analysis completed
Revise Resource Allocation System to support improved practice and address equalities issues	April 2012	RAS published
Training for Sirona and AWP managed staff on revised policy, FACs guidance and resource allocation system	May to July 2012	100% of relevant staff trained
Review service users against revised policy, FACs guidance and resource allocation system	August to December 2012	100% reviews completed

Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:

Strategic Objective	Contributes – Y/N?	Relevant Outcomes
1. Promoting independence and positive lives for everyone	**Y**	**E**
2. Creating neighbourhoods where people are proud to live	**N**	
3. Building a stronger economy	**N**	
4. Developing resilient communities	**Y**	**A, B, C**

Priority 5:			
Details of Service Priority	Develop and implement local Autism Strategy and related work.		
Impact on local community	People with Autism are supported to be active members of their community.		
Groups of service users affected	Adults with an Autistic Spectrum Disorder.		
Key Activities		**Timescales**	**Performance Measures**
Review the existing assessment and care management capacity and capability with Sirona with regard to meeting the needs of people with Autism, and ensure that during this period we develop a specific assessment and care management skill base.		Complete review by June 2012 Revised service specification in place by September 2012	Number of adults identified as having diagnosis of ASC % of adults with ASC who have been assessed or reviewed by ASC specific care manager
Spot purchase from AWP a diagnosis and treatment service for people with an Autistic Spectrum Condition		Ongoing	Number of adults accessing the service – target 10 adults per year
Commission Autism awareness training available to all		Develop specification – May 2012 Secure training provider – July 2012 Rollout of training programme – September 2012	Number of staff accessing training Range of agencies accessing training Participant feedback
Focus on young people with Autism who will need new services as they move into adulthood		Identify SEN students with ASC – April 2012 Programme for completing revised	Number of SEN ASC students with revised transition plan – target 100% of current year 12 and Year 11 to have revised plan

	transition plan in place by July 2012	
Establish user forum for with service users and family carers of people with Autism	Ongoing	Number of participants Service User feedback
Create a purchasing budget specifically for meeting the needs of people with ASC	By September 2012	Purchasing budget in place

Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:

Strategic Objective	Contributes – Y/N?	Relevant Outcomes
1. Promoting independence and positive lives for everyone	**Y**	**A,B,E**
2. Creating neighbourhoods where people are proud to live	**Y**	**A**
3. Building a stronger economy	**Y**	**A**
4. Developing resilient communities	**Y**	**A,B,C**

Priority 6:	
Details of Service Priority	Implementation of the National Dementia Strategy.
Impact on local community	People with dementia and their carers should live well in their communities, accessing care and support that they would benefit from.
Groups of service users affected	People with dementia and their carers.

Key Activities	Timescales	Performance Measures
Implementation of local action plan which is available on the PCT's website	As per the action plan	NICE Dementia Quality Standards, CQUINs, Adult Social Care Framework & NHS Outcomes Framework
Maintain and develop key stakeholder relationships through the dementia care pathway group	On-going	Attendance at pathway group meetings and action plan delivery
Commission memory services support from the transfer of health funding to the local authority as per NHS guidance under a section 256	May 2012	Service user and carer feedback

Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:

Strategic Objective	Contributes – Y/N?	Relevant Outcomes
1. Promoting independence and positive lives for everyone	**Y**	**D, E**
2. Creating neighbourhoods where people are proud to live	**N**	
3. Building a stronger economy	**N**	
4. Developing resilient communities	**N**	

Priority 7:	
Details of Service Priority	Review and refresh the Safeguarding Adults Strategy.
Impact on local community	Awareness raising, ensures safeguarding is everybody's business, robust safeguarding adults multi-agency arrangements.
Groups of service users affected	All "vulnerable" adults

Key Activities	Timescales	Performance Measures
Agree safeguarding adults strategy review and identify gaps with Local Safeguarding Adults Board (LSAB).	September 2011	Convene and facilitate specific LSAB meeting.
Draft Safeguarding Adults Strategy	February 2012	Draft strategy in place.
Consult on draft Safeguarding Adults Strategy	Feb-April 2012	Report to LSAB in March 2012 followed by consultation event
Launch Safeguarding Adults Strategy	May 2012	Launch event(s) have taken place.

Contribution to Strategic Objectives – please indicate which of the Corporate Plan objectives and outcomes this priority will contribute to:

Strategic Objective	Contributes – Y/N?	Relevant Outcomes
1. Promoting independence and positive lives for everyone	**Y**	**E**
2. Creating neighbourhoods where people are proud to live	**Y**	**A**
3. Building a stronger economy	**N**	
4. Developing resilient communities	**N**	

Appendix 1 – Key Performance Measures and Targets 2012/13

Draft Key Performance Indicators

Performance Indicator	2011/12 Forecast Performance	2012/13 Target
Emergency admissions for people aged 65 & over		To be agreed
Emergency bed days for people aged 65 & over		To be agreed
Admissions to residential & nursing care (rate, all ages)	105/10,000	82/10,000
Admissions to residential & nursing care direct from hospital (actual monthly, all ages)	8	<10
Numbers of people dying at home		To be agreed
Proportion of people still at home 91 days post discharge	96%	95%
Social care related quality of life	18.8	18.9
Proportion of people who use services who have control over their daily life	77.5%	80%
People who receive self-directed support & direct payments	70%	100% (by year end)
Overall satisfaction of people who use services with their care & support	69.7%	72%
People who use services & their carers who find it easy to find information	58.6%	62%
Number of adults with Learning Difficulties in settled accommodation	65%	70%
Number of adults with LD in paid employment	8%	9%
Number of eligible adults with LD in receipt of a personal budget	80%	100%
% of adults with Autistic Spectrum Condition (ASC) who have been assessed or reviewed by ASC specific care manager	n/a	50%
Average time for major adaptations to be completed from initial enquiry to B&NES Access Team (weeks) (M)	44	46
Households in temporary accommodation (M)	30	37
Homefinder tenancies that are successfully* sustained % (Q) (*Successful = in place for 1 year or more)	85%	60%
NI 155 - Affordable homes delivered against the 4 year cumulative target % (Q)	35%	25%

Performance Indicator	2011/12 Forecast Performance	2012/13 Target
Empty properties brought back into use *Cumulative over financial year (No.) (Q)	6	25
Number of adults with Mental Health needs in settled accommodation	75%	75%
Number of adults with Mental Health needs in paid employment	18%	18%
% of decisions made in 2 working days from the time of referral	95%	95%
% of strategy meetings/discussions held within 5 working days from date of referral	90%	90%
% of strategy meetings/discussions held with 8 working days from date of referral	100%	100%
% of overall safeguarding activities / events to timescale	90%	90%
The proportion of people who use services who feel safe	60%	60%

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People and Communities Department

Interim Structure

Ashley Ayre
Strategic Director

Mike MacCallam
Associate Director, Learning Difficulties and PSI

Andrea Morland
Associate Director, MH & Substance Misuse

Sarah Shatwell
Associate Director, Non-Acute & Social Care

Corinne Edwards
Associate Director, Unplanned Care &LTC

Graham Sabourn
Associate Director, Housing

Jane Shayler
Programme Director – Non-Acute Health, Social Care & Housing

Robin Cowan
LSAB Independent Chair

Mike Bowden (Acting)
Divisional Director- Service Development

Jeremy Smalley
Divisional Director- Skills & Employment

Charlie Moat
Service Manager- Social Care

Trina Shane
Service Manager- Social Care

Sara Willis
Service Manager- Int. Services 0-11

Maurice Lindsay
Divisional Director - Safeguarding, Social Care & Family Service

Nikki Bennett
Int. Safeguarding Officer

Lesley Hutchinson
Asst. Director – Safeguarding& Personalisation

Mary Kearney-Knowles
Quality Assurance & Improvement Manager

Jo Gray
Divisional Director- Adult Safeguarding, Children's Quality Assurance Personalisation& Practise Development

Strategic Finance

Liz Price (Acting)
Divisional Director- Health, Commissioning & Planning

Tony Parker
Divisional Director - Learning and Inclusion

Mike Gorman
Head Teacher – VirtualSchool

Dawn Harris
Specialist Behaviour Support Service

Paula Bromley
Youth Service

Nigel Harrisson
Inclusion Support

Sally Churchyard
Youth Offending Team

Wendy Hiscock
School Imp. & Achievement

Human Resources Strategy

Richard Morgan (Acting)
Finance & Resources Manager

Jim Gould
LSCB Independent Chair

Jayne Fitton
Human Resources Operation

Phillip Frankland
E.Y Strategic Planning

Chris Kavanagh
Capital and Schools Organisation

Kevin Amos
Admissions & Transport

Steve Taylor
Schools I.C.T.

Lynn Attwood
Parent Partnership

John Barnes (Acting)
Strategic Planning Manager

Jane Egre
One System Team Manager

Margaret Fairbairn& Catherine Phillips
Health Commissioner & Project Manager

Ian Tomlinson
Commissioning &Contracting (child care placements)

Joe Duncan
Data and Performance

Amber Gillani
Contracts & Commissioning

Mary Kearney-Knowles
Policy & Strategy Manager

Pamela Akerman
Joint Director of Public Health (Acting)

Paul Scott
Assistant Director – Public Health

Denice Burton
Assistant Director – Health Improvement

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Sarah Shatwell Associate Director, Non-Acute and Social Care	**Lesley Hutchinson** Assistant Director, Safeguarding & Personalisation	**Mike MacCallam** Associate Director, Learning Difficulties &Physical Disability	**Andrea Morland** Associate Director, Mental Health & Substance Misuse	**Corinne Edwards** Associate Director, Unplanned Care & Long Term Conditions	**Graham Sabourn** Associate Director, Housing
Commissioning Portfolio: • Supported Living • Early Intervention & Prevention • Advice, Information & Advocacy • Support for Carers • Registered Residential & Nursing Care • Domiciliary Care • Re-ablement (joint with CE) • Voluntary & Community Sector • Social Care Transformation & Strategic Planning **Specific Accountability:** • Supporting People & Communities Programme • Adult Social Services Charging & Eligibility Policies • Provider Accreditation • Sirona Social Care Services (social work, alarms/equipment, CRCs) • Unplanned & Social Care & Long Term Conditions (joint with CE)	**Service Portfolio:** • Personalisation • Social work practice development • Safeguarding non delegated responsibilities - Operational Lead • AMHP Service supervisor **Commissioning Portfolio:** • Safeguarding adults including: - Multi agency LSAB work - Multi agency P&Ps - SCRs lessons learned - Performance management AWP andSirona for safeguarding case coordination - Cross boundary working • Performance management safeguarding and MCA for ALL health and social care contracts • DOLS applications processing and decision making PCT and LA • Adult care FOI requests	**Commissioning Portfolio:** • LD Adult social care commissioning including placements and packages; employment development; personalisation & roll out of personal budgets • PSI social care commissioning including placements and packages; employment development; personalisation and roll out of personal budgets • LD and PSI health – Primary Care; Secondary Care; Specialist (secure) LD services; Mental Health; Community LD health and social services • Health and Social Care commissioning for adults with Autism (shared with Andrea) • Service user and carer engagement/involvement for LD/PSI/Autism, including access to advocacy	**Commissioning Portfolio:** • Acute Specialist Mental Health commissioning including in-patients, early intervention, recovery, crisis intervention, eating disorders etc. • Development of local PbR system • Primary Care mental health services – IAPT and counselling • Specialist (secure) mental health services • Mental health social care and community support service development – including e.g employment, placements & packages • Adult substance misuse commissioning – joint DAAT services i.e. all tier drug and alcohol services **Specific Accountability:** • Acute Mental Health Services contract with AWP	**Commissioning Portfolio:** • Acute and community commissioning for unplanned care and long term conditions for example COPD, dementia, stroke, CHD, diabetes, EoLC • Lead service/pathway redesign to support the delivery of the whole of the QIPP programme **Specific Accountability:** • Community services contract with Sirona Care & Health C.I.C • Delivery of QIPP • Performance management of specific targets/indicators via Intervening for Success in conjunction with Sarah	**Commissioning Portfolio:** • Develop the Council's strategic housing role & supporting strategies. • Range of commissions to support strategic role inc. HIA; HDP; BCU. **Service Portfolio:** • Housing advice; homelessness & temporary accommodation • Housing allocations • Housing standards • Housing improvements & disabled adaptations • Housing enabling & scheme development • Fuel poverty & domestic energy efficiency **Specific Accountability:** • Management of service capital budgets. • Lead service input into West of England/LEP boards.

• Older People's Agenda (joint with CE)	• Caldicott Guardian for LA • Non delegated responsibilities for CCA assessment, reviews, support plans **Specific Accountability:** • As above with the exception of Practice development all statutory requirements • Whole system development and accountability through PBH&WB, PCT Board and Council Corporate Performance	• Lead on multi agency working to improve transition planning for young people across health, social care, education. • Provider engagement **Specific Accountability:** • LD Pooled budget – spend & placements • CHC spend on LD and PSI (18-64) • Adult care lead – transitions • Performance Management of Sirona Contract for LD and Hearing and Vision specs. • Delivery of QIPP workstream – LD • Delivery of MTFP • Safeguarding practice post Winterbourne View – including commissioner assurance	• Specialist mental health (secure) service spend and placements • Joint Mental Health and Social Care and Community Commissioning Strategy		• Lead service input into corporate "Places" agenda inc. Gateway Group; Housing Delivery Panel; BWR board. • Lead service input into LSP Energy Efficiency work stream
Team/Staff Management: • Commissioning & Contracts Officers • Supporting People & Communities Team • Information Officer • Carers Breaks Project Officers	**Team/Staff Management:** • Safeguarding and Practice Development Team • AMHP Team Leads	**Team/Staff Management:** • Project Officer • Commissioning and Contract Officer (shared) – LD and PSI • Admin.	**Team/Staff Management:** • MH AOWA Review Officer (LA) • Mental Health Social Work Lead Professional (LA) • Substance Misuse Commissioning Manager/admin (LA)	**Team/Staff Management:** • Project Manager	**Team/Staff Management:** • Full range of strategic housing staff inc. surveyors; EHOs; data analyst; admin; enabling officers; social worker; housing advisors etc. • 40+ FTE

Associate Directors Purpose & Principal Accountabilities

Purpose	
• Lead the commissioning of services within the portfolio, including achievement of specific local and national targets, delivery of savings programmes & implementation of agreed developments.	• Provide leadership & direction to the system design. • Support Programme Directors in developing longer-term strategic plans. • Work with providers to promote effective working relationships across the system of care
Working with community partners, public & service users	
• Initiate means of assuring involvement & engagement and act as lead • Develop local partnerships bringing people together to work collaboratively and provide context for working together	• Take decisions on highly complex individual cases involving application of priority criteria, matters of PCT/Council policy, statutory requirements & high risk
Working with clinicians & practitioners	
• Lead engagement with clinicians/practitioners to inform strategy & drive quality, service design & resource utilisation • Manage interfaces with range of partners to promote collaboration & adoption of integrated pathways	• Build & manage relationships and handle potential conflict arising when initiating & managing change • Oversee Project Management of change programmes
Managing knowledge & assessing needs	
• Analyse information to understand service provision, identify areas opportunity or concern & articulate to others to promote understanding and action • Develop hypotheses to improve service provision & lead their testing and refinement	• Share knowledge of all service areas & contribute to needs assessment and identify opportunities to work across traditional service boundaries
Financial Stewardship	
• Monitor financial performance of contracts, holding providers to account • Identify & report any areas of risk & initiate corrective actions – escalate concerns where appropriate • Work closely with Finance team to ensure adequate financial modelling of service options	• Lead formation of robust business cases • Lead contract negotiations • Prioritise investment in accordance with strategy • Provide assurance regarding plans to achieve targeted savings
Market Management	
• Establish and develop formal & informal relationships with existing and potential providers • Provide guidance to relevant market sectors, promoting awareness of required direction and encourage innovation	• Maintain an in-depth appreciation of the market place, including cost & best practice comparisons • Lead & co-ordinate cross- service initiatives and produce proposals which maximise the opportunities arising from integration
Performance Management	
• Identify the measures that matter & ensure their inclusion in service agreements and contract terms. • Monitor provider performance and provide assurance on delivery and attainment of financial and other targets	• Provide/co-ordinate production of reports. • Maintain an in depth appreciation of all key performance; adjusting service provision and measures to suit.

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Consultation Briefing – December 2011 and January 2012
Flax Bourton Public Mortuary to undertake all Coronial post mortems at Flax Bourton

Timescale

Formal consultation commences 23rd December 2011. Responses by 31st January 2012.

Response to

Zillah Morris, Statutory Services Manager, Bristol City Council
Zillah.morris@bristol.gov.uk

Proposal

The Coroner is proposing to:

1) Conduct all Coroner post mortems at Flax Bourton i.e. to cease the current practice of some Coroner post mortems taking place in the Royal United Hospital in Bath (RUH).
2) No longer pay for deceased patient storage at the RUH for 'Coroner Form A' cases (i.e. HM Coroner, after investigation, decides the patient died a natural death and informs the Registrars to proceed with death registration).

These proposals are in line with Coroner provision across the rest of the 'Avon' area.

Background

HM Coroner Service

HM Coroner for Avon investigates any sudden or unexplained death in the jurisdiction of Avon. Coroners are required to act in accordance with laid down rules and procedures.

A death is reported to HM Coroner for the following reasons:

- A doctor has not treated the deceased during their illness;
- The doctor attending the deceased did not see them within 14 days before they died or after death;
- The death occurred during an operation or before recovery from the effect of an anaesthetic;
- The death was sudden and unexplained or by suspicious circumstances;
- The death may be due to an industrial injury or disease, or to accident, violence, neglect or abortion, or to any kind of poisoning;
- The death occurred in police custody or in prison.

The HM Coroner for Avon is an independent judicial officer responsible only to the Crown for the proper fulfilment of their judicial duties. Neither the local authority nor anyone else may legitimately dictate to the Coroner how they shall carry out their judicial functions (including whether to hold a post mortem or inquest), or seek to exercise any control over them in that respect.

In order to maintain their independence, the HM Coroner for Avon is the sole decision maker in relation to judicial decisions including commissioning the following services in the course of carrying out their investigations:

- Post mortems
- Histology reports
- Inquests.

The Coroner has the power to send the deceased to any mortuary in any part of the country.

Funding of and support for the Avon Coroner Service

Local authorities are obligated to support the provision of Coroner's Services. They must ensure that the Coroner is free to carry out the coronial business through having:

- Adequate accommodation for the coroner, administrators, courts and mortuary;
- Coroner staff administering the coronial workload. These staff are Bristol City Council employees;
- An adequate budget to undertake the service, which is administered according to the Council's financial regulations.

HM Coroner for Avon, the Coroner court for inquests and administrative support, as well as Flax Bourton Public Mortuary are funded by a partnership of four local authorities:

- Bath and North East Somerset Council
- Bristol City Council
- North Somerset Council
- South Gloucestershire Council

Bristol City Council acts as the 'lead' authority. Bristol City Council pays the Coroner and Deputies, employs the staff, and manages the budget, the office, and the court premises, as well as running the Flax Bourton public mortuary.

Flax Bourton Public Mortuary
Flax Bourton Public Mortuary opened in 2009, funded by the 4 local authorities, to undertake routine and forensic post mortems on behalf of the Avon Coroner. It is one centralised and specialist unit providing the highest standard of mortuary facilities.

Deaths are categorised into 'community' deaths (including deaths in custody) and 'hospital' deaths. Coroner 'Form A ' cases are when the deceased does not require a post mortem and is available for immediate release to the family, generally in the care of a funeral director, from the hospital. The current charge to the local authorities for a short period of deceased patient storage is unique to RUH in the Avon area. There isn't a 'service' provided, as the deceased are still patients of the hospital.

Table 1: Work undertaken by Flax Bourton mortuary on behalf of the Avon Coroner:

Category of death	Local authority area			
	B&NES	North Somerset	South Gloucestershire	Bristol City
Community	Yes	Yes	Yes	Yes
Hospital	No	Yes	Yes	Yes

However, the Coroner currently also carries out Coroner post mortems at the Royal United Hospital in Bath.

Volumes of deaths in Avon Coronial District
The number of deaths reported to HM Coroner for Avon has been between 4,600 and 5,000 per year in the last few years.

Inquests opened as a percentage of deaths are between 15-17% each year.

The percentage of post mortems has slowly decreased from just over 50% a few years ago to the national average of 44% last year.

Local authority budget cuts
There is an overall cut to local authority expenditure across the country of approximately 27% of income from central government revenue grant. Cuts are being made across all four local authorities funding the partnership. The local authority partners are looking to Bristol City Council to also cut the budget of the Avon Coroner Service.

Bristol City Council has a corporate financial target - the projected savings requirement to balance budgets over the next three years – of £42m.

All local authorities have an obligation to identify and highlight potential efficiencies in public services. Bristol City Council has reviewed their services and operations and look to remove duplication wherever possible, with the aim of a reduction of expenditure.

Budget

Sub Unit	Budget £'000	FTE	Notes
Coroner	1,400	*4.6	*not including HM Coroner and Assistant Deputy Coroners
Mortuary	525	7	

£80,000 of the expenditure for the Coroner (post mortem volume dependent) is a payment to the Royal United Hospital in Bath (RUH) to carry out post mortems on behalf of the Avon Coroner. The current charge to the local authorities is £210 per post mortem.

Bringing all the Bath hospital Coroner post mortems in-house to Flax Bourton would realise a cost for transport of the deceased to Flax Bourton (approximately £60.00), but at very little additional service expenditure, the unit would absorb this workload (based on 2011-2012 figures this would not be greater than approximately £18 per body).

The combined savings of proposals 1 and 2 would see local public funds in the region of £40,000 per annum (volume dependent) remaining with the local councils and saved rather than expenditure to the NHS.

Other savings (not subject to this particular consultation) include:

- To review the histology services currently provided by a number of Trusts across the Avon area to look for possible efficiencies and expenditure reductions. Link with the planned Bristol Pathology Service and review respective transport charges. This work to be delivered in approximately 2014/15.
- Review the current structure of the mortuary staffing to achieve optimal capacity of the Flax Bourton Mortuary, which will improve efficiency and reduce employee costs. This work to be delivered in 2012/13.

Benefits of the proposal

Carrying out all post mortems at Flax Bourton will minimise expenditure, as the existing service unit is optimised and realises better value for money across Avon.

Not paying for 'Form A' deceased patients will bring the RUH in line with hospitals in Bristol, North Somerset and South Gloucestershire.

Consultation

PHASE 1

i. 24th November 2011 -Bristol City Council: Budget conversation launched.
ii. 24th November 2011 – details of proposals sent from Strategic Director Corporate Resources, Bristol City Council to Chief Executives of RUH and B&NES.
iii. 19th December initial response received from B&NES Council CEO Mr Everitt with a request for wider consultation and a helpful list of relevant parties for consultation supplied.
iv. 7th December. Request from RUH Trust representative Dr Meehan for costs of post mortems at Flax Bourton.

PHASE 2

i. 23rd December 2011 – this consultation paper circulated.
ii. Responses by 31st January 2012
iii. Early February 2012: Four authority finance meeting with Avon Coroner to review feedback from all four authorities and consider responses from other properly interested persons and make a final recommendation.
iv. 8th February 2012 Final recommendations circulated to all respondees
v. 13th February 2012 Coroner Decision
vi. 24th February 2012 Bristol City Council –Full Council documentation will contain decision and savings proposals

Impact assessments –

Equalities – See Appendix B

Environmental – 18 miles between Bath and Flax Bourton, 15 miles between Weston and Flax Bourton, 11 miles between Frenchay and Flax Bourton, 10 miles between Southmead and Flax Bourton.

Locality - RUH would still be in a position (and encouraged) to offer viewings for families prior to transport to Flax Bourton, as happens now with deceased patients from other NHS Trusts. Equally Flax Bourton Public Mortuary has the facility to offer viewings once the deceased is in their care; there have not been any reported issues with this arrangement from the Coroners Officers from other areas for the last two and a half years operations. It is impracticable to have a specialist facility in each location; the public are aware and informed of this situation for a number of services.

Resilience – RUH is currently one of the Resilience Partner Mortuaries used in the event that operations are disrupted at Flax Bourton Public Mortuary (i.e.

for building work, equipment / building failure, etc.). Following the history of successful partnership working in this area, and the recognised need (by HM Coroner, Local Authorities, and the NHS) to provide a suitable and appropriate service to the residents of the Avon jurisdiction, it is hoped that this arrangement can continue.

Flax Bourton Public Mortuary clearly requires resilience capacity going forward and, as such, is currently negotiating further resilience agreements with other Local Authorities and NHS Trusts to mitigate any potential impact on resilience following this review.

Security of case notes – there will be a requirement to transport hospital case notes with each deceased patient originating from RUH. Such case notes must be securely transported and traceable, whilst maintaining patient confidentiality. See Appendix C to achieve this.

Continuity of care – A copy of the post mortem reoprt is always sent to the GP and hospital clinician of all deceased patients who undergo post mortem at Flax Bourton, whether Avon or non-Avon. In addition, the hospital clinicians involved in the patient's care are always very welcome to discuss the case by telephone, or attend the examination if they so wish, as is the case with clinicians from other, local NHS Trusts – no issues have been reported with this system so far.

Duty of Care: As part of the consultation process, respondees, by appointment, are offered the opportunity to view facilities and review first hand the experience for families from beginning to end of the Coronial process in Avon. A chance to meet the team and people involved, and to see that there is good work across agencies to provide the best of services and support to those bereaved. HM Coroner is also currently setting up a voluntary service called Coroners Court Support Service to aid the journey for persons who come into contact with the service across Avon.

Appendix A

Details of Flax Bourton Public Mortuary

Flax Bourton Public Mortuary opened in April 2009 as a purpose built ex-Avon wide facility. The unit currently undertakes routine and forensic post mortems of the deceased referred to the Avon Coroner for all local authorities with the exception of hospital deaths from the Royal United Hospital.
Clinical, consented PMs are also undertaken on behalf of several local NHS Trusts.

Flax Bourton Public Mortuary has:

- 135 body storage spaces, including secure forensic, bariatric, and freezer spaces;
- 7 post mortem tables;
- A full forensic / infectious isolation suite with digital fluoroscopy;
- A training facility with video-link PM viewing system;
- A dedicated viewing / formal ID suite;
- A full Human Tissue Authority (HTA) licence;
- An up to date Quality Management System that, along with comprehensive Standard Operating Procedures, follows the principles of ISO9001: 2008.

The unit also undertakes additional, specialist post mortems (i.e. chemical contaminated, forensic, infectious, DVI [Disaster Victim Identification]) for other Coronial jurisdictions outside of Avon.

The staff team at the mortuary consists of:

- Visiting specialist doctors (Consultant Histopathologists)
- Bristol City Council employed Anatomical Pathology Technologists

Appendix B

Bristol City Council Equality Impact Assessment Form
CS 35 Mortuary Business case for all post mortems for Avon at Flax Bourton
Directorate and Service: Corporate services
Lead officer Yvonne Dawes
Additional people completing the form Anne James (Principal Equalities officer)

Start date for EqIA: 10 Nov 2011 **Step 1 – Use the following checklist to consider whether the proposal requires an EqIA**

1. What is the purpose of the proposal?

All Avon Coroner post mortems to be carried out at the centralised unit at Flax Bourton Public Mortuary.

Currently all Coroner post mortems apart from RUH, Bath hospital post mortems are carried out across Avon at Flax Bourton.

This proposal will ensure consistency in approach, reduce expenditure leaving the organisation and assist in providing best value for money for the purpose built unit to service the whole of the Avon area.

High	**Medium**	**Low**

2. Could this be relevant to our public sector equality duty to:	
a) Promote equality of opportunity	L
b) Eliminate discrimination	L
c) Promote good relations between different equalities communities?	L

RUH would be encouraged, as other hospitals in Avon, to allow families to view deceased patients prior to transfer to Flax Bourton. The viewing facilities at Flax Bourton are of a high quality if families wished to view whilst in the care of the Coroner at this site.

3. Could the proposal have a positive effect on equalities communities?

There should be little change. It works well across three other areas in Avon and for the community deaths in the Bath area. The site is accessible 24/7. Most communities are aware that services per location is not viable, but that every effort is made to ensure the whole end to end Coronial experience for users is as satisfactory as possible.

Appendix C

Security of Case Notes

To achieve this, Hospital Envopaks Medical Records Carriers (http://www.itw-envopak.com/Envopak/Hospital-Envopaks/9177-/Medical-Records-Carrier) will be procured to securely contain the notes during transit (these must be tagged shut once full). A small form will be stapled to the front of each set of case notes (see example below), which will be signed by each person involved in the process accepting custody of the notes (as with a Police evidence continuity label). This will ensure that an audit trail of the notes' movements can be maintained.

Description	Location	Date	Time	Name	Signature
Handed to T.Davis FD	RUH Mortuary	01/01/12	11:45	A.N. APT	
Accepted by T.Davis FD	RUH Mortuary	01/01/12	11:46	A.N. Undertaker	
Handed to APT	Flax Bourton	01/01/12	12:48	A.N. Undertaker	
Accepted by APT	Flax Bourton	01/01/12	12:49	A.N. APT	
Handed to T.Davis FD	Flax Bourton	04/01/12	13:14	A.N. APT	
Accepted by T.Davis FD	Flax Bourton	04/01/12	13:15	A.N. Undertaker	
Handed to APT	RUH Mortuary	04/01/12	14:17	A.N. Undertaker	
Accepted by APT	RUH Mortuary	04/01/12	14:18	A.N. APT	

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	January 27th 2011	**AGENDA ITEM NUMBER**
TITLE:	**Specialist Mental Health Service re-design – High Dependency Unit**	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1a – Impact Assessment form Appendix 2 – Report on HDU closure for stakeholders		

1 THE ISSUE

1.1 This paper describes the results of the impact assessment on the proposal to not re-open the High Dependency Unit beds on Hillview.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

2.1 The provision of mental health acute assessment and treatment services takes place in the acute in-patient ward and Psychiatric Intensive Care Units rather than The Cherries High Dependency Unit and that the six High Dependency unit beds on The Cherries are permanently closed to that function.

3. FINANCIAL IMPLICATIONS

3.1 The savings and reinvestments from the entire AWP Mental Health Re-design schemes were described and accepted in the previous Mental Health Redesign paper. The savings that will be realised from this change are related to the reduced use of agency staff.

4. THE REPORT

To meet our strategic aim of delivering high quality, community services supported by in-patient beds that are delivered to national standards and benchmarks, an impact assessment has been completed on re-provision of the High Dependency Unit beds into the acute ward and Psychiatric Intensive Care beds and the impact of not using the beds for this purpose.

It takes place in the context of:

- the type of care being delivered in the HDU beds not being compliant with national models or standards,

- the unit being unable to be used for at least 9 months due to significant structural damage,

- no change in access to services and no experience of service users receiving Psychiatric Intensive Care services from other organisations.

- improved efficiency and throughput on the main ward aided by increased staffing and skill set and a more fully developed crisis and home treatment team in the community enabling people to remain in their homes wherever possible.

- Further enhancement of community services during 2012-13

5. THE IMPACT ASSESSMENT

The impact assessment and its results are attached at Appendix 1.

No negative impacts were assessed against this change.

Clear mitigating actions have been agreed in order to manage any possible effects for some clients (amber scores) – see paper.

6. RISK MANAGEMENT

A risk assessment related to the issue has taken place within the impact assessment and mitigating action identified.

7. EQUALITIES

As part of the NHS engagement and impact assessment processes for the closure of the HDU beds the equalities impact was assessed by both staff and stakeholder groups. There were no adverse impacts identified. There are potential positive improvements relating to gender and disability for people needing Psychiatric Intensive Care.

The current layout of Sycamore does not lend itself to always being able to de-escalate a situation quickly by removing someone to another area to calm down. This can be problematic and frightening for some older adults who are the ward at the time.

As described in Appendix 1, this will be mitigated by:

- AWP developing a de-escalation suite on Hillview – the process has begun for establishing this facility.

8. CONSULTATION

Trades Unions; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Stakeholders/Partners; Section 151 Finance Officer; Chief Executive; Monitoring Officer

There has been engagement with AWP staff over the last 6 months through newsletters and meetings this includes engagement with the integrated team. In

addition the ward holds monthly Acute Care Forum meetings to which stakeholders as well as staff are invited and where issues of concern and improvement can be discussed.

9. ISSUES TO CONSIDER IN REACHING THE DECISION

Social Inclusion; Customer Focus; Sustainability; Human Resources; Health & Safety; Impact on Staff

10. ADVICE SOUGHT

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

Contact person	Andrea Morland, Associate Director Mental Health and Substance Misuse Commissioning 01225 831513
Background papers	*Equity & Excellence: Liberating the NHS (DH 2010)*, sets out ambitions to make primary care the nexus of health care planning, commissioning and delivery, with acute/secondary care services restricted for those with the most severe conditions. *The Transforming Community Services (DH 2010)* program states that Community services are changing to provide better health outcomes for patients, families and communities and to become more efficient; by providing modern, personalised, and responsive care of a consistently high quality that is accessible to all. *No Health without Mental Health (Royal College of Psychiatrists & Academy of Medical Royal Colleges 2009)* The report recommends that Primary Care Practitioners become more skilled in the identification of symptoms, especially depression, anxiety and cognitive impairment in people with chronic physical illnesses; adding that Primary Care Developments need to include the timely availability of specialist mental health advice & support. *Age Consultation 2011 (Equality Act 2010:* Ending age discrimination in services, public functions and associations).This means that any age-based practices by the NHS and social care would need to be objectively justified, if challenged. *Bath and North East Somerset Joint Mental Health Commissioning Strategy 2008-2012*
Please contact the report author if you need to access this report in an alternative format	

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REPORT TO THE WELLBEING POLICY DEVELOPMENT AND SCRUTINY COMMITTEE AT Bath and North East Somerset COUNCIL

PROPOSED CHANGES TO: Cherries HDU , Hillview Lodge

Prepared by:

- Andrea Morland, Associate Director Mental Health and Substance Misuse, B&NES Joint Commissioning Team
- Nicky Bennett.,Nurse Consultant , Avon and Wiltshire Mental Health Partnership Trust
- Alison Griffin, Head of Engagement and Responsiveness, Avon and Wiltshire Mental Health Partnership Trust

Date: January 27th 2012

DECISIONS REQUESTED

The PDS is requested to determine whether the proposed service change outlined in this paper constitutes a substantial variation or development. **(N.B. a substantial variation is a proposed major change in healthcare provision.)**

PART ONE – Description of proposed service changes

The current adult of working age services:

- 1 Crisis and home treatment service
- 1 Assertive Outreach Service
- 1 Early intervention service
- 2 CMHTs
- Hospital liaison at RUH
- 23 acute mental health beds (Sycamore) including 3 for Later Life
- 6 high dependency beds (Cherries), temporarily closed
- 1.6 Psychiatric Intensive Care Unit beds (PICU) based in our
- specialist units - Callington Road, Brislington is the main site for B&NES clients.
- 5 Rehab beds at Whittucks Road, Hanham.

2 . What are the proposed service changes

The proposed service change is to permanently close the 6 bed HDU provision at Hillview Lodge. This change will affect Bath and North East Somerset.

3. Why are these changes being proposed?

The B&NES Commissioning Strategy for Mental Health, in line with modern mental health care practice, is based on the premise that care for serious mental illness is best delivered to people in their own homes, with medical and other care staff working in multidisciplinary teams in community settings. Admission to hospital is a part of the system of care, rather than its core.

The HDU AT Hillview Lodge was set up as a small unit with a high staffing level aimed at rapid turnover of patients too unwell to be easily managed on an open acute ward but not fully meeting the criteria for a psychiatric intensive care unit (PICU).

However, in practice, most of the HDUs, including The Cherries, have been used as PICUs, providing care in a locked facility for periods of time without the environmental (floor space of unit etc) or therapeutic standards being applied to the facilities. The therapeutic environment is often poor due to the limited size of the units (this has been the case at Hillview Lodge) and individual therapy input is also compromised due to the needs of the general ward as a priority. Additionally economies of scale indicate that the small size of the units do not offer a value for money service.

In addition The Cherries has been temporarily closed for a period of time following it becoming unsuitable through physical damage.

4. Rationale

We considered we had three options open to us:

- **Option 1**
  Maintain the Cherries at 6 beds – however due to considerable physical damage to the unit there would need to be a significant investment in refurbishing the unit. This would also keep money tied up in a bed base which is currently demonstrated as not adhering to a national governance provision of care as well as not being required.

- **Option 2**
  Permanently close the Cherries and use the savings to purchase more PICU beds. There is no indication in activity figures that more PICU provision is currently required

- **Option 3**
  Permanently close The Cherries for it's current purpose and use the money released from the beds to invest in the acute in-patient service, community services to help people stay at home and mental health service redesign as well as contribute to the NHS Quality, Innovation, Productivity and Prevention (QIPP) savings programme.

In the above context we would like to take advantage of improved bed management/efficiency opportunities and enable care to be delivered in more appropriate, (and in the case of PICU, compliant to national standards) locations i.e. home, acute in-patient unit and PICU. Services to people who

may previously have received a service in an HDU will be provided either on an acute ward or a PICU ward according to clinical need.

We would therefore wish to do Option 3 and it was this we completed an impact assessment on.

5. Summary of involvement outcomes

In addition to the monthly Acute Care Forum that takes place at Hillview Lodge, which staff and voluntary sector partners attend to discuss issues relating to Hillview Lodge (including The Cherries), AWP and NHS B&NES held two engagement sessions with local stakeholders. The first one focused on a presentation and evolved into a frank and open information sharing and feedback session. The second one was arranged to complete an impact assessment. In between these two meetings further information was provided to stakeholders, answering questions that had been raised – paper attached.

In addition, an impact assessment session was held with the staff from the unit including the psychiatrist which helped inform the NHS view.

The outcome of the involvement sessions revealed that there was broad agreement that the proposals would not have a negative impact upon the majority of the client base, would affect some people negatively in some aspects (HDU admissions 14% of total in 2010-11) and would offer no change or an improvement in service for many. One stakeholder believed that the bed closures represented a significant negative impact on three areas of consideration – see below – but this view was not shared by staff or other stakeholders.

There were clear mitigating actions that needed to be implemented in order to assure ongoing quality of services:

a) **Re-furbish part of the Cherries to provide a de-escalation area** for service users who become very distressed and agitated so that they can be managed safely on the unit. This is especially pertinent for the older adult clients who need to feel secure if the younger clients become disturbed (Raised by staff, see amber on health inequalities on NHS impact assessment). ***This is in progress and is seen as urgent.***

b) Ensure access to the approved PICU beds is maintained across the Trust and that the risks of out-of area PICU placements for B&NES clients are minimised. (B&NES have used minimal PICU beds in 2010-11 and has not used out of area provision to date in 2011-12.) Active performance management by senior AWP staff and commissioner. ***In place and ongoing.***

c) **Continue the enhanced acute care provision in Hillview**. This includes a programme of development/training and supervision (already underway) to enhance the staff skill-set to manage risk and high expressed emotion in a proactive manner using highly developed engagement skills. Due to

critical damage being caused to B&NES HDU this is ***already in place on the acute in-patient unit.***

d) **Continued provision of an upgraded inpatient unit model** to include more integration with other aspects of the service and with enhanced therapeutic delivery as part of the service redesign. This will improve the quality of the in-patient episode. ***Already started and will continue.***

e) **Ensure active risk and quality management and monitoring** to understand and act on service user experience and outcomes as well as be assured that all aspects of medical, nursing and therapeutic care delivery (including the use of medication) are robustly monitored and measured. ***In place and ongoing locally and via the NHS contract.***

6. Timescales

Once agreement has been reached regarding the closure of Cherries HDU, the team will plan the permanent closure. As there are no service users currently using the service there will be no impact upon existing service users or their families.

7. Additional information

In the current financial year there has been no external (external to AWP) usage of PICU beds despite the temporary non availability of the Cherries. There is provision for Banes of 1.6 PICU beds for both males and females and this has been accessed according to need.

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

No. There is no reduction in service in relation to the bed base but rather improved efficiency and a releasing of monies for reinvestment into service development that meets both strategic, patient and operational aspirations.

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

Patients, carers and public representatives are asked to comment on the following areas, in relation to the proposed service changes detailed in Section 2:

Benefits of the proposed service changes	• Increase in staff numbers +20% on Sycamore • More interaction with staff • Increase in opportunities for service users to engage • More Occupational Therapists staff available / no split of provision • PICU has its own dedicated

	therapists • Increased training for staff with associated supervision – supervision rates improving – with associated improvement in skill set of staff on sycamore • Increase in local community services – crisis services and early intervention + more planned primary care liaison • The needs of each individual will be better addressed using a recovery focused approach.
Any disbenefits, including how you think these could be managed	• Wider range of acuity – *national trend.* This can be challenging for staff – training being implemented and individual staff needs will be supported. • Potentially more people will go to a PICU and this will be outside of B&NES. *Monitor numbers and assess if HDU would have been used.* • Some people liked the small environment of PICU especially when they were agitated. *Therefore essential to progress de-escalation unit.*
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	• No change in location of PICU or acute beds suggested so access to services unchanged. • It was acknowledged that for some people based in Bath the main PICU being in Brislington can cause travelling problems. More so if in Salisbury • In general information needs to be good for families about the process.
How do you think the proposed changes will affect the quality of the service	• Carer feedback via carers lead was that the HDU was oppressive (so change may improve experience). • Improvement in skill set of staff on sycamore • Increased number of staff +20% • Developments with some psychiatry (medics + drugs) will

	support improvement – • More use of drugs? • Evidence that there is no escalation in violence and aggression so not impacting on negatively • It was mixed sex and small environment – PICU is neither of these. • Quality has increased immensely over the past few years
Impact of the proposed changes on health inequalities	This was felt to be generally positive or no effect. It was noted that there is 20% less bed capacity overall. • More access to care in the community. • PICU have better facilities/ environment • Pregnant women go to Elizabeth Casson House which is a specialist female PICU. • Rates of admission for young people are very low for 16 to 18 year olds. Discuss with oxford healthcare (for younger people). • Faiths individually focused so no effect. • Gender- it will improve situation for people needing PICU because its single sex accommodation - HDU was mixed. • Staff considered that the de-escalation area was very important because without this some older adults could become frightened when younger adults were very agitated. Therefore they, as group, rated health inequalities as amber. Mitigating action prioritised.
Any other comments	
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	LINKs were involved in both the first stakeholder engagement session in October and the impact assessment meeting. LINKs have fed back that they felt the impact assessment had been very successful and the information

	provided was clear and helpful.

PART THREE – Impacts at a glance

Impacts	NHS Staff View	Patient/carer/public representatives' view
Impact on patients		I x red; 3xorange; 3x green
Impact on carers		1xred; 3x amber; 3x green
Impact on health inequalities		3x amber; 4x green
Impact on local health community		1x red; 2 x amber; 4 x green


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

GLOSSARY

- list definitions of any technical terms, acronyms etc

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Cherries High Dependency Unit Closure		
Report Summary		
Purpose of this Report: As part of the redesign of the acute care pathway all elements of inpatient services have been scrutinised and considered within the context of the overall in-patient service and its safe delivery. As part of this process it is proposed that AWP will close the Cherries High Dependency Unit providing any intensive care needs within the identified Psychiatric Intensive Care Unit (PICU) capacity for BANES, ensuring that this type of care is always provided within a nationally determined and governanced framework of care delivery.		

1. Purpose of the Report

The purpose of the report is to inform stakeholders of the background to the proposed changes, how the proposal was arrived at and to identify the significant changes, benefits and risks.

This paper is in addition to that presented at the Wellbeing Policy Development and Scrutiny panel and follows a first engagement meeting with a stakeholder group to discuss the HDU beds. This paper, and the presentation at the first engagement meeting, will be part of the information used to inform an impact assessment process to be held on xxxxxx.

2. Background

In summary (see appendix 1) a national development of Psychiatric Intensive Care Unit (PICU) provision was undertaken in the mid 1970s in response to the need to manage individuals with challenging behaviours in a more secure environment.

This development of PICUs has resulted in robust assurance frameworks for their use and has standardised the development of the clinical specialty nationally. The UK is at the forefront of the developing PICU services.

In contrast, there is no national background or standards for the development of High Dependency Units in acute care. The implementation of the High Dependency Unit provision within AWP was predicated on a particular clinician's desire for these services to be developed .This saw the last High Dependency Unit being set up in 2005/6 as part of the Callington Road development.

In most cases the term High Dependency Unit is attached to specialist hospitals who may provide a high dependency unit within their own service, acting as an area for the management of individuals who are experiencing a relapse in active psychiatric symptoms (i.e. usually within forensic services). Services which utilised a High Dependency Unit in the past, such as London and Westminster, no longer use this model of care delivery and, to the best of AWP's knowledge, there are currently no other Mental Health Trusts delivering this service either currently or within the last 5 years.

Therefore, in line with our (and commissioner's) aspirations to deliver modern mental health care based on nationally recognised models, AWP considered that the use of the High Dependency Units was not an evidenced way to deliver a governanced and frame-worked model of intensive care delivery.

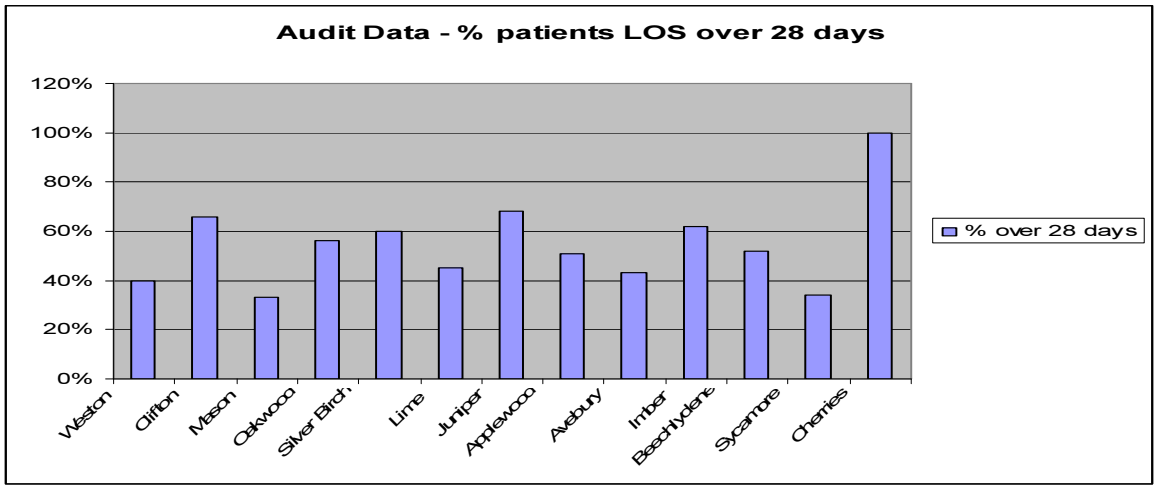
3. Local History and challenges

Within AWP, since the 1990s, High Dependency Units were usually attached to adult acute wards. Their development initially centred on Bristol but expanded across some

other AWP areas. In B&NES this resulted in the Cherries being developed, staffed on a rotational basis with Sycamore.

Whilst the evidence base to support such developments is not apparent it appeared to be a method of increasing the ability of staff to manage service users who presented as requiring increased levels of observation and clinical management for a short period of time. The HDU initiative was intended, therefore, to provide a higher level of intervention than general adult acute inpatient wards could provide, but *not* to provide PICU care which was considered to be of longer duration and for individuals whose risk profile was more severe.

In practice, however, the High Dependency Units have been used as de facto PICUs: providing care in a locked facility for extensive periods of time, in some cases up to a year, without the implementation of a robust evidence base of standards of care provision. An audit completed in 2010 demonstrated that all of the clients in the Cherries had been there for longer than 28 days - the longest length of stay in comparison to acute units and other High Dependency Units – as well as being too long for the intended purpose of the unit.



The HDU environments are also not considered to be inherently therapeutic due to their limited size. This is because the High Dependency Unit provision within AWP was not been designed using the standards of the Implementation Guide for PICU (2002) and

as such did/does not adhere to any nationally set guidance or criteria. In addition, individual therapy input can also be compromised due to the needs of the general ward being prioritised.

There has also been increasing evidence that the use of High Dependency Units has led to a reduction in adult acute psychiatric wards' abilities to manage risk in a pro active and engaged way and has led to an over reliance on using locked environments as a method of containment, thereby contradicting the aim of providing care in the least restrictive setting.

These challenges have been supported by research findings from Australia where the High Dependency Model or acute psychiatric close-observation area has been popular. They too have struggled to develop a therapeutic environment and have experienced difficulties with:

"design and environment, lack of activity and structured time, and nursing care"

(Brien and Cole 2004 International Journal of Mental Health Nursing)

.

Ward staff and medical staff have worked hard to provide high quality care in these environments, at times relying on very junior staff to manage the unit, and have tried to provide a PICU experience for service users. Whilst staffing provision has been equal to that of PICU, due to the small size of the units, it has not provided value for money in comparison to PICU wards due to economies of scale and without the investment or expertise required AWP were running the risk of expanding the PICU bed population of the Trust in an uncoordinated, ungoverned and cost inefficient way.

3.1 Audits of HDU 2010

Two audits took place on HDU usage in 2010 as part of an inpatient audit of clinical placements. In May 2010 none of the individuals that were in the Cherries environment

required PICU and could have been cared for within an acute care ward with appropriately skilled staff and resources .

In November 2010, of the 5 patients on the High Dependency Unit , 2 service users were assessed as requiring PICU care with the remaining 3 service users being able to be cared for elsewhere either on an acute ward or in the community. The 2 service users requiring PICU were female. (AWP had already understood the need to provide more flexible PICU provision for women and had agreed with Commissioners and local authorities to move the PICU provision for women - Elizabeth Casson House – from Blackberry Hill Hospital to Callington Road, where an increase in provision can be achieved. This brought facilities closer to B&NES.)

3.2 Activity information

Attached are the numbers of B&NES occupied PICU bed days from 2008 until the present day.

Year	2008/09	2009/10	2010/11	2011/12 (year to date October 2011)
AWP bed usage	920	479	695	685
External to AWP bed usage	232	127	34	0
Total	1152	607	729	0

From the above table we can see that B&NES clients have been using the PICU provision throughout the times we have had the HDU in place. A problem we faced with

PICU provision was that we were using it so much in 2008/09 we had to use "out-of-AWP" provision for 232 bed days and internal PICU usage was very high. This has slowly decreased and this year we have used no out of area PICU provision. Whilst our number of PICU bed days is high at the moment (685 up to October) this is because we have had 2 clients in PICU on a long term basis because we cannot secure long term placements for them – i.e. they would not be using a HDU bed.

3.3 Admissions

1st December 2009 – 30th November 2010 (Cherries open)	**34 admissions to PICU**
December 1st 2010 – 22nd November 2011	**39 admissions to PICU**

The table above demonstrates the amount of admissions to a PICU bed during the 12 month period prior to Cherries high dependency unit being temporarily closed and the following twelve months. As can be seen there is a slight increase of 5 admissions for a comparable period. This is something that we might expect to see as an annual variation.

4. Description of the main changes and implications

The main changes are: closure of the Cherries High Dependency Unit with an associated increase in senior staff input on the main ward and, as part of work taking place across the Trust, a review of the input of Occupational Therapy (recognised as already good on Hillview). In addition, we will develop an extra care/de-escalation area and investigate different use of the Hillview estate with commissioners.

4. Implications

4.1. Access

Service users will be admitted into ward and service environments which meet predetermined and national criteria. Access to high care at a time when a service user requires complex and intensive support will occur within specifically designed

environments with appropriately trained staff and access to equitable services - PICU. In line with our practice to date this will not be in the immediate local area but will be as close to the service users home as possible in either Bristol (Callington Road) or Salisbury. Please note that Callington Road is the PICU of choice for B&NES.

This will necessitate service users and carers travelling, as it has done over the years - however, specialist care is provided out of the immediate area in many instances within other health care settings and it is envisaged that service users and carers will be assisted to manage these upheavals in the same way that they have done to date.

We will also work with commissioners to understand how to manage an all age unit as we recognise that on some occasions for some older adults Sycamore is not always appropriate. This is a key area of work for 2011-13.

4.2 Staff

Staff have been redistributed into Sycamore. There is no current risk of redundancies to the staff group. Staff also expressed concerns regarding providing care for individuals with challenging behaviour or who are experiencing high levels of distress within adult acute wards. The redesign process has sought to increase each inpatient wards skill set and capacity. Staff will continue to be trained in the skills of therapeutic engagement and the therapeutic environment on the unit will be enriched. Research has shown that developing these skills leads to a reduction in aggression and provides a better experience for the service users.

4.3. Estate - Cherries, Hillview Lodge.

It is proposed that AWP develops a de-escalation area for service users who experience high levels of distress to enable the safe and therapeutic management of individuals using some of the estate of the Cherries. A scoping exercise has been undertaken and the project is being taken forward.

Further use of the estate is also under review with commissioners and may be used in the future as additional capacity for the local and cross-AWP services.

4.4. Information Systems and Technology

There is no known impact.

4.5. Finance

There are minimal savings in estate costs. There are cost savings related to the use of agency and bank over the unit. A total of 8073 shifts were used by High Dependency Units over the last financial year which equates to 17% of the Trust's total. In terms of cost this is £939,213. The overall cost to the Trust in the last financial year for bank and agency was £4,866,214. As can be seen the spend is significant and we would hope to reduce this.

5. Relationship to National Targets and Trust Objectives

5.1 Care Quality Commission (Standard for Better Health)

Patients receive effective treatment and care that:
a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;

5.2. Trust Objectives

To continue the development of our services, providing modern, recovery-focussed services that:

- Are personalised
- Enhance choice
- Change Lives
- Provide a modernised, timely and effective acute care pathway – from CRHT, through Acute and into PICU

Appendix One

The Butler Report (Home Office, Department of Health and Social Security 1975), and its interim version of 1974, advocated the development of forensic psychiatric services in the NHS and suggested a figure of 2000 secure beds. It was proposed that regional secure units (RSUs) would be crucial in supporting the general psychiatric hospital as well as relieving overcrowding in Special Hospitals and providing a service to courts and prisons.

The RSUs were to be 50 - to 150 bedded units closer to major centres of population than the Special Hospitals. The Department of Health and Social Security very quickly made money available for 1000 beds to be provided in RSUs and in Interim Secure Units (ISUs) whilst the former were being built. These ISUs were usually converted psychiatric wards; most had a double door 'airlock' system to enter the unit and secure external exercise areas, as well as unbreakable glass and alarm systems.

Bluglass (1976) proposed that the admission criteria should include any acutely ill patient whose illness was accompanied by difficult and dangerous behaviour but should exclude wandering demented patients, the severely learning disabled and the difficult acute patients.

Thus, historically, the RSU network has been centrally planned and funded whereas locked beds for acutely ill, non-offender patients , PICU have not.

In the UK, PICUs have developed independently of the RSU network, and have provided a range of services in line with local circumstances and needs. This development is wholly appropriate. Units may variably describe themselves as PICUs, extra care wards, intensive care, high dependency, special care, challenging behaviour, locked wards or low secure units. None of these terms initially had a universally agreed definition.

The Glancy report (DHSS, 1974) called for facilities to be set up for psychiatric patients who were violent or unmanageable in open wards. As a result, a number of existing open units upgraded to locked status and some new units were opened. These were called Psychiatric Intensive Care, special care, extra care or high dependency units

(Beer et al., 2001).

The first publications which described locked PICUs came from the USA. Rachlin (1973) stated that 'an open-door policy cannot provide adequately for the treatment needs of all psychiatric patients'. He described the establishment of a 'locked intensive care unit' serving the Bronx area of New York, 'to treat several types of patients who did not respond on open wards'. Half were referred because they were absconders. Crain and Jordan (1979) also reported on a PICU in the Bronx which admitted mainly violent patients, 'who simply cannot be treated with an acceptable level of safety on a regular ward'.

In England the first designated PICU was opened in St James's Hospital, Portsmouth; Mounsey (1979) described the setting up of a twelve-bedded PICU in Salisbury. This was a lockable converted ward for disturbed patients referred from the rest of the psychiatric hospital.

Psychiatric intensive care units (PICUs) have become an integral part of inpatient services. Developments in research and evidence have led to a national recognition of PICU as a standardised service which delivers specific care services defined as follows,

"Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self control, with a corresponding increase in risk, which does not enable their safe, therapeutic management and treatment in a general open acute ward."

Care and treatment offered must be patient-centred, multidisciplinary, intensive, comprehensive, collaborative and have an immediacy of response to critical situations. Length of stay must be appropriate to clinical need and assessment of risk but would ordinarily not exceed eight weeks.

(NAPICU national minimum standards for general adult services in PICU and low secure environments, DOH , April 2002)

To monitor the development of implementation of the National Minimum Standards, a National PICU Governance Network was created in 2004 as a joint venture of the National Institute of Mental Health in England (NIMHE), North East London Mental Health Trust (NELMHT) and NAPICU (Pereira *et al*. 2006.)

Today, the psychiatric intensive care 'movement' in the UK is much further ahead than in any other country including the US. In no other country are there National Minimum Standards for PICUs (developed by a multidisciplinary team including service users) or a textbook dedicated to psychiatric intensive care.

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy and Development Scrutiny Panel
MEETING DATE:	27 January 2012
TITLE:	**Report from the Strategic Transitions Board**
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Main Report and supporting Appendices.	

1 THE ISSUE

1.1 This report provides an update on the work and activity of the Strategic Transition Board, noting areas of achievement and highlighting future priorities.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to agree that:

2.1 It receive an update report from the Strategic Transition Board on the work of the board and progress toward improving transition planning and outcomes for children with a Statement of Educational Need.

2.2 The summary and conclusions of the report are accepted by the panel

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications of this report. However, the work of the Strategic Transition Board as highlighted in the report will have an impact on the Council's medium term service and resource planning. Developing person centred approaches to improving transition planning for young people is expected to enable people to maximise their independence as they move into adulthood,

4 THE REPORT

4.1 The Strategic Transition Board was originally established in 2007 following a review commissioned from an independent organisation – Lifestyles – to review transition processes for the transfer of young adults (all client groups) from Children's to Adult services.

In summary the report found a number of barriers to effective service delivery including:

lack of strong leadership and commitment to transition planning processes,

no strategic overview

Mixed criteria for accessing services

Lack of understanding of roles and responsibilities of the different sectors and agencies involved in the transition

Lack of resources and clear, collated and easily accessible information and communication systems.

Lack of person centred planning and user involvement

4.2 The board's original remit was to implement the recommendations from the Lifestyles review and a workplan was put in place to address the issues above.

In 2008/09 a three year National Transition Support programme was launched, which aimed to raise the standards of transition support and provision in all local areas. Support was provided to all local authority areas to meet their statutory requirements and minimum standards in transition and go on to develop good practice, as one of the 5 work streams that made up the DCSF/DH Aiming High for Disabled children agenda to transform disabled children's services.

4.3 Over the course of the three year programme Bath and North East Somerset moved from Band 3 (the lowest rating, noting need for high support) through to Band 1(the highest rating), as the improvements being driven by the Strategic Transition Board were recognised by the National Transition Support team. During this period the workplan of the Strategic Transition Board was regularly amended to reflect the emerging recommendations from the National Transition Programme and the yearly self assessments. The workplan has been continued and is overseen by the Board. Responsibility for implementing the plan sits with a 'core group' of the

board which is currently chaired by the Associate Director for adults with learning disabilities and PSI.

4.4 Further detail is contained within the main report attached as Appendix 1 and supporting appendices.

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 An Equalities Impact Assessment was initially completed when the Board was established. It is recognised that this needs to be refreshed as the workplan of the board has changed significantly and this will be completed as a matter of priority.

7 CONSULTATION

7.1 *Overview & Scrutiny Panel*

7.2 Consultation with the Wellbeing Policy and Development Scrutiny Panel carried out as a result of receiving this report.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Young People; Human Rights; Corporate; Impact on Staff; Other Legal Considerations

9 ADVICE SOUGHT

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

Contact person	*Mike MacCallam 01225 396054*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Wellbeing Policy and Development Panel – 27th January 2012
Agenda Item 15.

Title: Report from the Strategic Transitions Board

Purpose: To provide an update on the work and activity of the Strategic Transition Board, noting areas of achievement and highlighting future priorities.

Background:
The Strategic Transition Board was originally established in 2007 following a review commissioned from an independent organisation – Lifestyles – to review transition processes for the transfer of young adults (all client groups) from Children's to Adult services.

In summary the report found a number of barriers to effective service delivery, including:

- lack of strong leadership and commitment to transition planning processes,
- no strategic overview
- Mixed criteria for accessing services
- Lack of understanding of roles and responsibilities of the different sectors and agencies involved in the transition
- Lack of resources and clear, collated and easily accessible information and communication systems.
- Lack of person centred planning and user involvement

The board's original remit was to implement the recommendations from the Lifetstyles review and a workplan was put in place to address the issues above. Terms of reference and Objectives of the board were established, which are attached as Appendix 1. The Board is currently chaired by Jane Shayler, Programme Director Non Acute Health Social Care and Housing, supported by Mike MacCallam, Associate Director, for Adults with Learning Disabilities and Adults with Physical and Sensory Impairments.

In 2008/09 a three year National Transition Support programme was launched, which aimed to raise the standards of transition support and provision in all local areas. Support was provided to all local authority areas to meet their statutory requirements and minimum standards in transition and go on to develop good practice, as one of the 5 work streams that made up the DCSF/DH Aiming High for Disabled children agenda to transform disabled children's services.

Each local authority was required to complete a yearly Self Assessment Questionnaire (SAQ) to capture their position in relation to a number of key transition indicators set by the National programme. The SAQ was also the tool the Transition Support Programme used to measure progress made by local areas and to determine how well local areas were meeting statutory requirements and guidance in relation to transition. Data from the SAQ was then used by DCSF and DH to make decisions about what support would be offered to local areas in the following year.

Over the course of the three year programme Bath and North East Somerset moved from Band 3 (the lowest rating, noting need for high support) through to Band 1(the highest rating), as the improvements being driven by the Strategic Transition Board were recognised by the National Transition Support team. During this period the workplan of the Strategic Transition Board was regularly amended to reflect the emerging recommendations from the National Transition Programme and the yearly self assessments. The workplan has been continued and is overseen by the Board. Responsibility for implementing the plan sits with a 'core group' of the board which is currently chaired by the Associate Director for adults with learning disabilities and PSI.

Key milestones and achievements of the Strategic Transition Board.

1 Transition Protocol

In the summer of 2010 Bath and North East Somerset, via the Strategic Transitions Board, launched a revised Protocol for Transition Planning for young people with additional needs age 14 to adulthood (in part as a result of the work and support that had been received from the national transition team).

This protocol covers young people with statements of special educational needs (SEN) and their parents / carers. It sets out the expectations of relevant agencies in Bath and North East Somerset throughout the transitions process so they are clear what the specific responsibilities of each agency will be at each stage. It also aims to ensure that these young people and their parents / carers have the right information to make informed decisions throughout the transition planning process.

The protocol also explains the roles of schools, Bath & North East Somerset's Children and Families services, Connexions, Adult Care/ Learning Difficulties /Mental Health services, Health services and Housing services in working together to support young people and families with additional needs and special educational needs in the transition to adulthood.

The protocol emphasises the importance of person centred approaches to transition planning and developing this has been a key priority for the STB.

2. Appointment of Transition Champion

To support the implementation of the transition protocol and in particular to promote person centred approaches to transition planning, Bath and North East Somerset created the post of a Transition champion, first appointed in June 2010 and originally funded through Sure Start grant. From April 2011 this post has been funded through combined commissioning between children's and adult social care.

The postholder has been a key figure in developing revised approaches to transition planning, and is highly thought of, particularly within the two special schools Fosseway and Three Ways, where the majority of students with a Statement of Need(SEN) attend. As a direct result of working with the Transition champion,

Fossewayschool have now built preparation for transition planning into their school curriculum and are adopting a revised transition planning process which is aimed at improving outcomes for their students and providing better information for commissioners of adult care to assist with service planning and delivery. (see item on Database below for more information). In addition in the last year Fosseway school devoted a whole INSET day for the entire staff team to the subject of transition planning and person centred approaches,with training input from the transition champion which was very well received.

3. Revised transition pathway

Fosseway school are piloting a revised approach to transition planning which places greater emphasis on supporting each young person and their family to be better prepared for their transition review, and to have had the opportunity to have thought in a more person centred way about their own needs, wishes and aspirations for the future. (See Appendix 2 at the end of this report).

The aim is to produce a transition support plan that is framed around the 'pathways' of Getting A Life. Getting a Life was a three-year cross government project (April 2008 to March 2011), set up to show and drive change so that young people with a severe learning disability could live full lives when they leave education. It focused on what needs to happen during the vital transition period between ages 14 and 25. Although the programme has now ended, it was cited in the Green paper *Support and Aspiration: A new approach to special educational needs and disability (2011)* as a model of best practice that had produced good outcomes for young people. An illustrative example of the pathways to Getting a Life is included as Appendix 3 at the end of this report. Fosseway school have commenced this from January 2011 with all transition plans for statemented children, and further analysis will be undertaken later in the year to evaluate the process and outcomes for young people.

In addition the core group is now working with Three Ways school to extend the pilot approach to their SEN students, and is in discussion with at least one 'mainstream' school as part of planned rollout of the process.

4 Training Strategy

It is evident that young people, families and carers are often ill prepared for the changing model of adult social care with its particular emphasis on personalised approaches, independent living, and use of personal budgets.

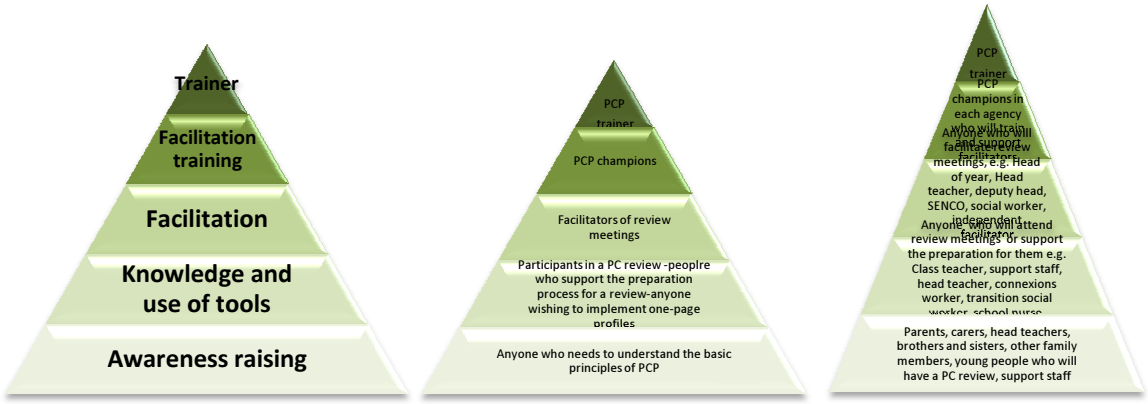
The Board has recognised that driving significant change to the way that people are supported through the transition planning process is a major undertaking and a training programme has been developed and implemented to support young people, families, and professionals from all agencies with this.

The purpose of the draft training strategy is to embed person centred planning (PCP) across all support services in Bath and North East Somerset as a mechanism to support transition for children and young people from 14 - 25 who are disabled, or identified as having a special educational need. This includes all statutory, private and voluntary sector providers and all mainstream secondary schools, special

schools and colleges in Bath and North East Somerset. The strategy aims to build internal capacity to ensure that ongoing training for PCP is self-sustaining and effective mechanisms exist to support and develop high quality single planning processes.

In summary the training strategy identifies 5 levels of training from Level 1 awareness raising through to Level 5 where individual staff are trained as PCP trainers – thus building a sustainable training and development programme for B&NES. The target audience for each level of training is identified and a programme of training for 2011/12 has been delivered. There is little cost involved as the majority of training is delivered by the Transition Champion. The strategy is illustrated in Tables 1 and 2 below.

Table 1 Illustration of training strategy



What level of training is required? Who would need this level of training? Which people might be involved?

Table 2 – Training Participation at each level

Level 1: Awareness raising • **Who needs it?** Anyone who needs to understand the basic principles of PCP • Parents, carers, head teachers, brothers and sisters, other family members, young people who will have a PC review, support staff
Level 2: Knowledge and Use of tools • **Who needs it?** Participants in a PC review • Anyone who will attend review meetings e.g. Class teacher, support staff, head teacher, connexions worker, transition social worker, school nurse, therapists
Level 3: Facilitation • **Who needs it?** Facilitators of review meetings • Anyone who will facilitate review meetings, e.g. Head of year, Head teacher, deputy head, SENCO, social worker, independent facilitator, Class Teacher
Level 4: Facilitation Training • **Who needs it?** PCP champions • PCP champions in each agency who will train and support facilitators
Level 5: Trainer Training • **Who needs it?** PCP trainer

Table 3 Summary of training activity 2010/11 (to date)

Level	Professionals (multi agency)	Parent carers/students
L1 Awareness raising	201	26 parents; 25 students
L2 Participant Workshop	82	
L3 Facilitator training	38	
L4 Facilitation	Access to 2 trainers from Helen Sanderson associates	
L5 Trainer Training	2 trainers in post	

Work will continue to roll out the training programme particularly at levels 1 and 2. In addition further support will be offered to young people and families to build understanding of local options, particularly around housing, employment and personalisation. As an example we intend to organise seminars to better explain what supported living actually means, what can you use personal budgets for etc, to help people prepare ahead of transition planning.

5 Engaging young people

The core group has recently re-established links with Off the Record, and as a result Off the Record have set up a participation group comprising approximately 8 young people, who are linking in to the Strategic Transition board and its workplan. Off the Record have also produced a DVD to assist young people which will be made widely available across Bath and North East Somerset. It is planned to make this available via an updated information page on the Council website.

6 Information

For some time it has been acknowledged that there is an unsatisfactory provision of information available to young people and their families with regard to transition and transition planning. The core group is currently working with a web author to establish a single point of contact on the public website to hold a range of up to date and useful information, which is expected to be developed in shadow form by April 2012. This will then be tested with a range of stakeholders, including schools, carers, and the participation group referred to above before going live at a point later in the year.

7 Strategic Commissioning and service planning – Database

To support strategic commissioning, particularly in adult social care, the transition board has established an up to date database of information regarding SEN students which provides a range of high level (anonymous) information including prevalence of different disabilities, SEN students by school year. This is an extremely useful planning tool, and has for example allowed us to identify a ‘spike’ of students with Autism in current year 11, which can be built into strategic planning for the future.

Changes to the individual transition plans completed with each year person, currently being piloted at Fossewayschool as above, mean that in the near future strategic commissioning and service design will be able to be more closely aligned to individual needs particularly in relation to commissioning services to meet housing and employment needs. Information from the transition plans can be taken in

anonymous form and populated into the database to give a very detailed and accurate picture of needs of young people which will enable B&NES to ensure that it is commissioning services that accurately reflect demand for services.

8 Priorities for further action.

In addition to continuing with the above, the Strategic Transition Board has identified further priorities which will be built into future workplans. These include:

- Developing a system for allocating personal budgets for 16-18 year olds to prepare for purchasing individual support as an adult, in line with the personalisation agenda
- Strengthening the local strategy for supporting the NEET (not in Education Employment or Training) population of young people
- Developing a particular strategy for supporting young people who may not be eligible/ on the cusp of eligibility for services under FACs criteria, in particular young people with a previous SEN of Autism or ADHD.
- Identifying young people who have forensic history and are at risk of offending behaviour as an adult. Commissioning of services to minimise this risk
- Building on the recommendations of the Green Paper to implement a single 'Health Education and Care Plan' for young people in transition.

Summary and conclusions

- Strategic leadership and commitment to transition planning is now very strong within Bath and North East Somerset. The Strategic Transition Board is well represented by a number of agencies and key stakeholders, and there is a clear vision for services set out in the Transition protocol.
- There is an active workplan overseen by the Core Group which is delivering many improvements that meet the recommendations of the original review of transition planning in 2006 and the subsequent findings of the National Transition Support Programme.
- Links between Children and Adult social care services are strong and well established, both at operational and strategic level.
- There is a momentum towards embedding person centred approaches within transition planning that is strengthening particularly within special schools.

Mike MacCallam/Jane Shayler

Appendix 1

1. Purpose

To ensure that appropriate and effective arrangements are in place to meet the needs of young people with physical and/or learning disabilities and/or with mental health problems aged between 14 – 25, as they move from childhood to adulthood.

2. Objectives

2.1 To develop a transition protocol and local transition pathway covering the transition from childhood to adulthood that ensures that appropriate transition planning and assessments of young people with disabilities approaching adulthood are in place and that the planning and commissioning of services tosupport young people is undertaken.

2.2 To ensure that transition processes are multi agency, addressing all of a young person's needs using a person centred approach and that the transition plan is meaningful, detailing the young person's aspirations and howthey can be supported to achieve them.

2.3 To ensure all young people have the opportunity to reach their potential and maximise quality of life, participation in education, training or employment and independence.

2.4 To identify and plan to meet training needs for professionals working within the transition process

2.5 To ensure that schools have mechanisms in place to share information to aid planning and commissioning services to meet future demand

2.6 To oversee development of the personalisation agenda for young people through the transition stage.

2.7 To ensure that there are clear and effective transition processes for young people with identified health needs including mental health so that health needs continue to be met in adulthood

2.8 To examine how service provision can be improved and developed and to make recommendations as required.

2.9 To monitor the effectiveness of multi-agency working, including role of lead professional, in relation to the policies, procedures and protocols and to resolve issues and problems where identified.

2.10 To ensure provision of clear and accessible information for all about the transitions processes, future options and progression routes relating to young people and their families.

2.11 To ensure high quality transition service across Bath and North East Somerset is provided and to receive reports on service provision as requested by the board.

2.12 To establish any groups/action groups and board believes will be required to sustain and promote the transitions policy. The terms of reference of these groups will be determined by the board.

2.13 To champion work on transitions across all services.

2.14 To establish mechanisms to ensure that disabled young people and their families have a voice and that their views are communicated appropriately.

2.15 To ensure that services meet the whole needs of each young person taking into account ethnic origin, culture, religion, sexuality, gender and language, as well as social and emotional needs.

2.16 Linking into sub-regional work and sharing sub-regional learning

3. Working arrangements and conduct

3.1 The Bath and North East Somerset Strategic Transition Board will report annually to the Children's Trust board and to the Partnership Board for Health and Wellbeing, and any other relevant Boards/Partnerships as required. This reporting function will be the responsibility of the chair of the Strategic Transition Board.

3.2 The Board may invite non-members to attend Board meetings as appropriate, or to co-opt members to undertake work as required. Should a Board member be unable to attend when s/he has an item on the agenda, then a representative may attend on his/her behalf for that item.

4 Membership

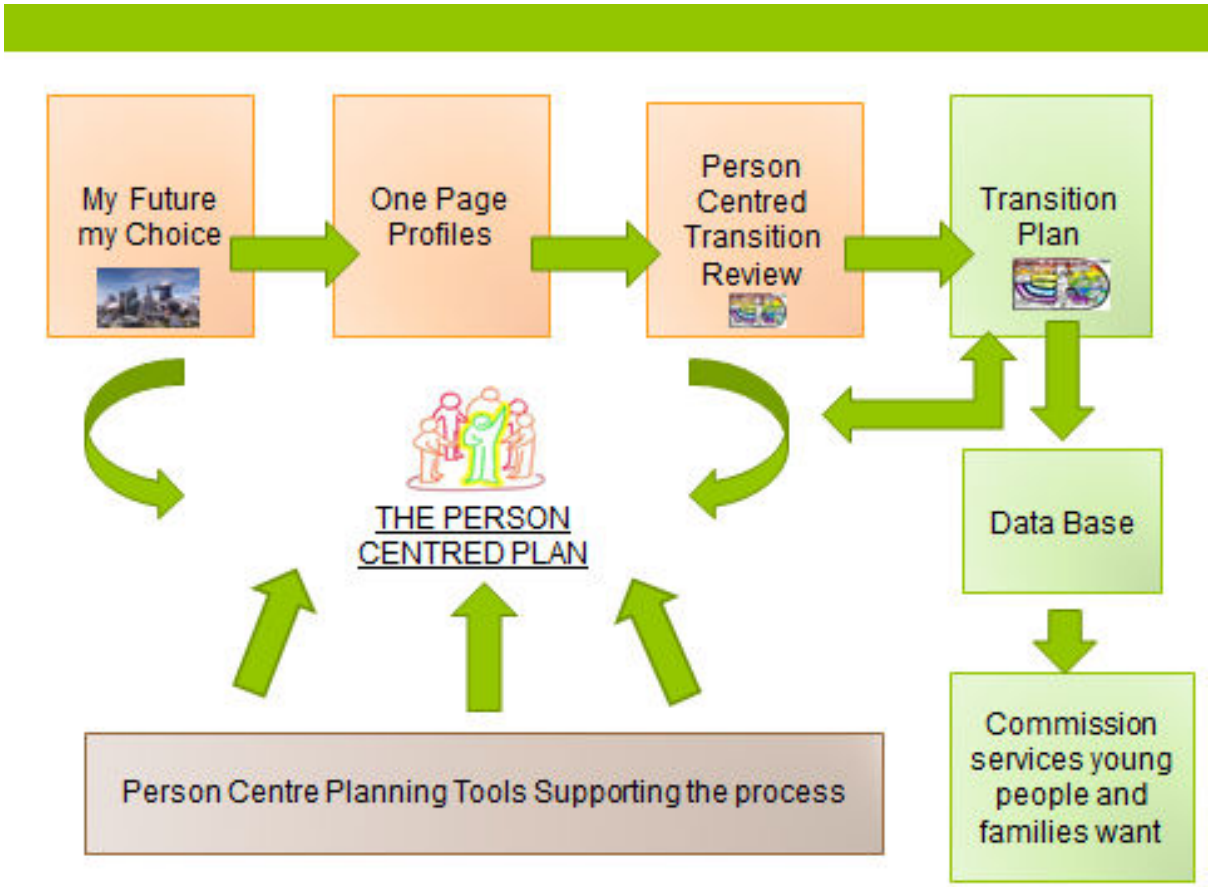
- Children's Social Care
- Joint Health and Social Care Provider
- Acute Health Providers – Children's and Adult services
- Connexions
- Mental Health Joint Commissioning
- Learning Difficulties Joint Commissioning
- Joint Children's commissioner
- Education Liason Manager
- FE Providers
- Mental Health – AWP
- Child & Adolescent Mental Health Services
- Shared Commissioning Services
- Special Schools
- Mainstream schools
- Third Sector/Voluntary organisations
- Disabled young people and parents/ carers
- Supported employment
- Advocacy Services

5. Frequency of meetings

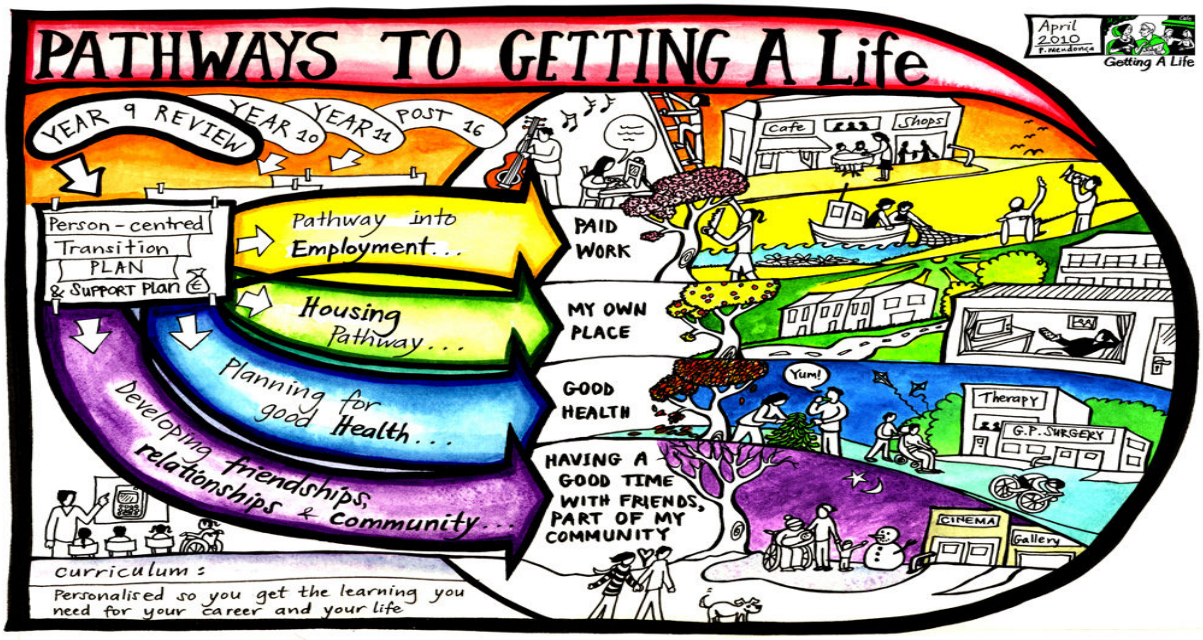
5.1 The Board will meet on at least 4 occasions each year. Additional meetings may be required as agreed by the Board.

The terms of reference, objectives and outcomes of the Board will be reviewed annually.

Appendix 2 Transition Pathway



Appendix 3 Illustration of Pathways to Getting a Life



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Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **27th January 2012**
TITLE: **WORKPLAN FOR 2012**
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 required to set out its thoughts/plans for their future workload, in order to feed into cross-Panel discussions between Chairs and Vice-chairs - to ensure there is no duplication, and to share resources appropriately where required.

2 RECOMMENDATION

2.1 The Panel is recommended to

(a) consider the range of items that could be part of their Workplan for 2012/13

3 FINANCIAL IMPLICATIONS

3.1 All workplan items, including issues identified for in-depth reviews and investigations, will be managed within the budget and resources available to the Panel (including the designated Policy Development and Scrutiny Team and Panel budgets, as well as resources provided by Cabinet Members/Directorates).

4 THE REPORT

4.1 The purpose of the workplan is to ensure that the Panel's work is properly focused on its agreed key areas, within the Panel's remit. It enables planning over the short-to-medium term (ie: 12 – 24 months) so there is appropriate and timely involvement of the Panel in:

a) Holding the executive (Cabinet) to account

b) Policy review

c) Policy development

d) External scrutiny.

4.2 The workplan helps the Panel

a) prioritise the wide range of possible work activities they could engage in

b) retain flexibility to respond to changing circumstances, and issues arising,

c) ensure that Councillors and officers can plan for and access appropriate resources needed to carry out the work

d) engage the public and interested organisations, helping them to find out about the Panel's activities, and encouraging their suggestions and involvement.

4.3 The Panel should take into account all suggestions for work plan items in its discussions, and assess these for inclusion into the workplan. Councillors may find it helpful to consider the following criteria to identify items for inclusion in the workplan, or for ruling out items, during their deliberations:-

(1) public interest/involvement

(2) time (deadlines and available Panel meeting time)

(3) resources (Councillor, officer and financial)

(4) regular items/"must do" requirements (eg: statutory, budget scrutiny, etc)?

(5) connection to corporate priorities, or vision or values

(6) has the work already been done/is underway elsewhere?

(7) does it need to be considered at a formal Panel meeting, or by a different approach?

The key question for the Panel to ask itself is - can we "add value", or make a difference through our involvement?

4.4 There are a wide range of people and sources of potential work plan items that Panel members can use. The Panel can also use several different ways of working to deal with the items on the workplan. Some issues may be sufficiently substantial to require a more in-depth form of investigation.

4.5 Suggestions for more in-depth types of investigations, such as a project/review or a scrutiny inquiry day, may benefit from being presented to the Panel in more detail.

4.6 When considering the workplan on a meeting-by-meeting level, Councillors should also bear in mind the management of the meetings - the 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.

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 Equalities will be considered during the selection of items for the workplan, and in particular, when discussing individual agenda items at future meetings.

7 CONSULTATION

7.1 The Workplan is reviewed and updated regularly in public at each Panel meeting. Any Councillor, or other local organisation or resident, can suggest items for the Panel to consider via the Chair (both during Panel meeting debates, or outside of Panel meetings).

8 ADVICE SOUGHT

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

Contact person	Jack Latkovic, Senior Democratic Services Officer. Tel 01225 394452
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Last updated 17.01.12.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
27th Jan 12						
	Cabinet Member update					
	NHS update					
	LINks update					
	Update on proposed merger between GWAS and SWAST		Brigid Musselwhite/ John Oliver			
	Service Action Plans	AA	Jane Shayler			
	Coroner service changes		tbc			
	High Dependency Unit (Hillview Lodge) Impact Assessment		Andrea Morland			
	Strategic Transitions	AA	Mike McCallan			
16th Mar 12						
	RNHRD Update (tbc)		RNHRD rep			As a result of the meeting between the Chair and Vice Chair and CX from RNHRD in Sep 2011
	Transition of Public Health responsibilities from NHS BANES to the Council		tbc			
	Housing Allocation Policy		Graham			

Last updated 17.01.12.

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
			Sabourn			
	Personal Budgets policy framework	AA	JS			
18th May 12	Dental Access Services update		tbc			
	Psychological therapy services for adults (including the provision of counselling services in BANES)		Andrea Morland			
27th Jul 12	HealthWatch update		Derek Thorne			
21st Sep 12						
16th Nov 12	Further update on Dementia		tbc			
18th Jan 13						
22nd Mar 13						
Future items						
	Tobacco plain packaging consultation				Cllrs Hall and Pritchard	
	'What is it like to be an older person in BANES – to look at the life overall rather than under the series of separate headings'			Possible review - tbc		