Bath & North East Somerset Council

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

Councillor Vic Pritchard
Councillor Katie Hall
Councillor Lisa Brett
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, 18th May, 2012

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 18th May, 2012** at **10.00 am** in the **Kaposvar Room - 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, 18th May, 2012

at 10.00 am in the Kaposvar Room - 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 16/03/12 (Pages 9 - 22)

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

8. CABINET MEMBER UPDATE (15 MINUTES)

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

9. 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.

10. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK UPDATE (15 MINUTES) (Pages 23 - 26)

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

11. DENTAL ACCESS UPDATE (30 MINUTES) (Pages 27 - 40)

The Wellbeing Policy Development and Scrutiny Panel will receive an update on how Access to Primary Care Dental Services has improved in B&NES.

The Panel are asked to note the update.

12. CARE SERVICES QUALITY ASSURANCE (30 MINUTES) (Pages 41 - 48)

The Wellbeing PDS Panel is asked to note the current Quality Assurance Framework (QAF) for care services and engage with the further development of the QAF, including a clear articulation of the role of the Panel.

13. THE EFFECTS OF DELIVERING ADULT SOCIAL CARE SAVINGS TARGETS ON THE MARKET (20 MINUTES) (Pages 49 - 54)

The Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) for 2012/13 includes a significant savings target to be delivered from efficiencies in purchasing residential and nursing care placements. This report provides an overview for the Wellbeing PDS Panel of the approach to delivering this savings target, the potential impacts on the market and associated mitigations.

The Wellbeing PDS Panel is asked to note the content of this report and use the contents of this report to inform their scrutiny of the performance of the health and social care system.

14. TALKING THERAPIES IN B&NES (20 MINUTES) (Pages 55 - 62)

The purpose of the report is to provide the Wellbeing PDS Panel with an overview of the current provision of talking therapies in Bath & North East Somerset and development in 2012-13.

The Wellbeing PDS Panel is asked to note the current Talking Therapies services and engage with any further developments as necessary.

LUNCH AT 12.25-12.30PM UNTIL 12.50PM

15. ALCOHOL HARM REDUCTION STRATEGY BRIEFING (30 MINUTES) (Pages 63 - 74)

The Refreshed Alcohol Harm Reduction Strategy for B&NES was adopted and key priorities agreed by Cabinet on 11th April 2012. Implementation of the Strategy is overseen by the Alcohol Harm Reduction Steering Group through an annual action plan on the key themes of health and treatment, community safety, crime and disorder, children and young people and partnership working. The Government's new Alcohol Strategy was launched in March 2012 and it was agreed to review the local Strategy in light of the national strategy within 12 months. The involvement of the Wellbeing Policy, Development and Scrutiny Panel in this process is welcomed.

The Wellbeing Policy, Development and Scrutiny Panel is asked to:

- Note the briefing report, the Action Plan for delivery of the Alcohol Harm Reduction Strategy and the intention to review this Strategy in light of the new National Strategy.
- Consider nominating a representative to sit on the Alcohol Harm Reduction Steering Group.
- Consider holding an enquiry day with relevant experts and stakeholders to formulate policy on approaches to key issues such as Early Morning Restriction Orders, late night levies and health bodies involvement in licensing decisions.

16. PUBLIC HEALTH TRANSITION ASSURANCE PLAN UPDATE (30 MINUTES) (Pages 75 - 180)

This paper provides an update on the change of public health responsibilities from NHS B&NES to B&NES Council from April 2013. The accompanying Public Health Transition Assurance Plan outlines the processes being undertaken to manage this transition including the key tasks, milestones and governance arrangements.

The Wellbeing Policy, Development and Scrutiny Panel is asked to note the information contained in the briefing and accompanying report and comment on any areas of concern or potential opportunity.

17. HOME HEALTH AND SAFETY POLICY 2012 (20 MINUTES) (Pages 181 - 218)

The Council is required to adopt and publish a housing renewal policy, referred to as

The Home Health and Safety Policy in this report. This policy is periodically reviewed and revised as required. It sets out how Housing Services will provide assistance, including financial assistance, to help low-income, elderly, disabled and other vulnerable residents to undertake essential repairs and adaptations to their homes. The policy supports the aims of the Housing and Wellbeing Strategy 2012 – 2015, particularly around improving health and wellbeing and reducing inequalities within our communities.
The Council Cabinet adopted a revised policy on the 13th of July 2011 which takes into account the financial constraints caused by the withdrawal of Private Sector Renewal funding by Government. The Cabinet asked for the policy to be reviewed in 1 year.
This report to the Wellbeing Panel proposes some changes to the Home Health and Safety Policy adopted last year.

The Wellbeing Panel is asked to note and comment on the proposed policy.

18. WORKPLAN (Pages 219 - 226)

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, 16th March, 2012

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Lisa Brett, Loraine Morgan-Brinkhurst MBE, Eleanor Jackson, Anthony Clarke, Bryan Organ, Sharon Ball and Brian Simmons

76 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

77 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

78 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Kate Simmons sent her apology. Councillor Brian Simmons was het substitute for the meeting.

Jane Shayler (Programme Director for Non-Acute Health, Social Care and Housing) also sent her apology.

79 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

Councillor Eleanor Jackson declared personal and non- prejudicial interest on the agenda item 'Cabinet Member update' 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 'Cabinet Member update' as he is Council's representative on Sirona Care & Health Community Interest Company.

Councillor Loraine Brinkhurst MBE declared personal and non- prejudicial interest on the agenda item 'Cabinet Member update' as she is Council's representative on Sirona Care & Health Community Interest Company.

80 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

There were none.

82 MINUTES 27/01/12

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

83 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 1 to these minutes).

The Panel made the following points:

Councillor Clarke asked how many empty properties have been actively pursued.

Councillor Simon Allen suggested that the answer will be provided by the officer later in the meeting under agenda item 'Housing Allocations'.

The Chairman said that much of the report had been committed to housing and his particular question was if the reduction in Bristol CC budget on homelessness would have an impact on homelessness in BANES. The Chairman suggested that the answer should have been provided by Councillor Tim Ball (Cabinet Member for Homes and Planning), whose Cabinet responsibilities these are, but thanked Councillor Allen for providing some answers.

The Chairman asked what the outcome of the last Care Quality Commission (CQC) inspection might be. The Chairman also said that the current administration decided to reduce the budget for Care Homes by £1.6m and asked if there will be a review on this issue.

Councillor Simon Allen replied that the review on Care Homes will be produced on quarterly basis and he suggested that the outcomes should be presented to the Panel. The most important thing is that service users receive adequate and quality service. The CQC inspection had been completed and the Commissioning Team from the Council are in contact with the CQC on this matter.

Sarah Shatwell (Associate Director for Non-Acute and Social Care) added that Commissioning Team has bi-monthly meetings with the CQC where they exchange information and data between each other. The embargo on placements in two care homes has been lifted in the last three weeks whilst one more care home is under embargo for a technical rather than quality issue. Sarah Shatwell also explained that any savings associated with the commissioning budget for Care Home placements would be negotiated with providers using a regional care home cost model developed through research on 41 Care Homes across the region. Efficiencies that the Council will have to find will be balanced against the inflation already awarded to care home providers.

Councillor Hall asked what sort of energy efficiency measures in properties will be primarily looked at.

Councillor Simon Allen replied that the Council will predominantly look at the cavity wall insulation although there is still significant amount of work to be done in this area. Councillor Allen suggested that the Panel could have Energy Efficiency report on one of the future Panel meetings.

Councillor Brett asked about refreshed Alcohol Harm Reduction Strategy and how new licensing rules will be incorporated in the strategy.

Councillor Simon Allen responded that there is on-going conversation between different departments in the Council and the Interim Joint Director of Public Health.

Councillor Jackson expressed her concern for the reduction of 10 beds in Julian House. Councillor Jackson suggested that the Panel should check if the situation improved following the Youth Homelessness study. Councillor Jackson also suggested that Councillor Simon Allen should provide an update on Friedman Report at one of the future meetings of the Panel. Councillor Jackson also asked what criteria will be used for residential and nursing homes placements.

Sarah Shatwell responded that the reduction of beds in Julian House was introduced in order to improve the accommodation. National homelessness figures have decreased over the last 10 years and this is due to a greater focus on homelessness prevention, much of which is funded via the Supporting People programme. In terms of the youth housing need – Sarah Shatwell explained that there is an active young people's housing group that looks into youth homelessness and its impact on housing but that she will pass on and the suggestion about Friedman Report. Sarah Shatwell said that the Council does publish set rates for residential and nursing homes placements and that there is also a single panel process in place to consider higher cost placements and packages of care.

Councillor Simon Allen added that he will consider bringing an update on Friedman Report to one of the future Panel meetings.

The Chairman commented that BUPA made an announcement that Local Authorities under-provide for care homes. The Chairman also said that Government's award for homelessness in the city is welcome but the award covers a three year period only. The Chairman commented this may exasperate problems of homelessness at the end of this three year period when the grant/award ceases.

Councillor Simon Allen replied that in those three years Council will have enough information about the homelessness in the city and region. The current administration put extra money in the Adult Social Care.

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

Appendix 1 Cabinet Member update

84 NHS AND CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Chairman invited Ian Orpen (Clinical Commissioning Group - CCG) to give an update.

Ian Orpen took the Panel through the update (attached as Appendix 2 to these minutes) and added that Rhona Macdonald (ex-CEO for BANES PCT) is commissioned to look into future work arrangements between the Council and CCG.

The Panel made the following points:

Members of the Panel commented that there is a great deal of fear between people that, in near future, they will be charged if they visit their doctor.

Ian Orpen responded that this is probably happening because the way the debate on the Health Bill is portrayed in the last few months, but that people should not be worried.

Members of the Panel commented that some people cannot see their GPs as those GPs are quite busy with the reorganisation.

Ian Orpen responded that 3 GPs, out of 160 in BANES, are fully involved in the CCG.

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

Appendix 2 NHS update

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

The Chairman invited Diana Hall Hall to introduce the update from BANES Local Involvement Network (LINk).

Diana Hall Hall took the Panel through the update as included in the agenda.

Members of the Panel recommended that the LINk should include in their report any conclusions that they have as a result of the LINk's visits to Care Homes.

Diana Hall Hall welcomed that recommendation.

Sarah Shatwell suggested that the LINk should correspond with Sirona if they want to say something in the report that is of Adult Safeguarding nature. Also, if there is a genuine concern about the service provided in Care Homes it should be communicated with the Commissioning Team.

Diana Hall Hall agreed with these suggestions and added that LINk would know where to go in case if any of the above occur.

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

86 ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES (RNHRD) PRESENTATION (45 MINUTES)

The Chairman invited Kirsty Matthews (Chief Executive of RNHRD) to give the presentation.

Kirsty Matthews gave a presentation (RNHRD NHS FT update) where she highlighted the following points:

- RNHRD Vision
- RNHRD Purpose
- An introduction to the RNHRD
- RNHRD services
- RNHRD Context
- RNHRD Income
- WTE figures for 2010, 2011 & 2012
- Quality
- Length of Stay
- Length of Stay Neuro Rehabilitation
- Bed provision
- Referrals
- Significant Changes 2011/2012
- Breakdown of PCT income 2009/10 (actual) to 2011/12 (forecast)
- Significant impacts on 2012/13 planning
- 2012/13 Outline Plan for Clinical Services
- Conclusion

A full copy of the presentation from Kirsty Matthews is available on the minute book in Democratic Services.

The Panel made the following points:

The Panel asked what would be the impact of supporting people at home instead of in the hospital.

Kirsty Matthews replied that this is about rehabilitation patients and the RNHRD is quite fortunate on that matter. The hospital built very good relationship with Sirona on how they fit within care pathway. Patients or their families make requests to get out of the hospital and stay at home. Rheumatology patients in particular want to stay in the hospital for the shortest period of time.

The Panel asked about reduction of referrals in chronic pain.

Kirsty Matthews replied that the hospital has to justify measures for referrals. In the next couple of years there will be more and more pressure on the NHS for patients with chronic pain. The hospital will have to demonstrate the benefits on what they can do for their patients, for example providing support to patients who want to go back to work.

The Panel asked about the governors understanding of the hospital position and about the pathway between the GP, RUH and RNHRD.

Kirsty Matthews said that she feels quite fortunate that governors do understand the situation that the hospital is in. Some of the governors are ex-patients and some are still patients. Kirsty Matthews explained that the RNHRD works quite closely with the GPs and RUH. The patient is required to go first to their GP. If the patient suffers from temporary pain then they will be referred to the RUH who will help on short term pain treatment. If the pain is consistent or chronic then the patient will be referred to the RNHRD.

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

87 TRANSITION OF PUBLIC HEALTH RESPONSIBILITIES FROM NHS BANES TO THE COUNCIL - PRESENTATION (30 MINUTES)

The Chairman invited Pamela Akerman (Interim Joint Director of Public Health) to give the presentation.

Pamela Akerman highlighted the following points in her presentation called 'Update on reforms and new Council Responsibilities – Changes to Public Health in BANES':

- Background
- Public Health in the Council
- New roles – Public Health
- Public Health leadership
- Vision and opportunities
- Operating model
- Planning timescales
- Governance of the planning process
- Constraints and concerns
- Key transition programmes

A full copy of the presentation from Pamela Akerman is available on the minute book in Democratic Services.

Pamela Akerman added that the full report on Transition of Public Health responsibilities will be presented to the Panel on one of the future Panel meetings.

The Panel made the following points:

The Panel asked what part of the Public Health the other bodies will have.

Pamela Akerman replied that the Director of Public Health will have the power to challenge the other organisations if they don't deliver services to the public.

The Panel asked about the work between the Director of Public Health and Council services such as Licensing.

Pamela Akerman replied that the Alcohol Harm Reduction Strategy, that has been produced together with Licensing department, will be submitted to the Cabinet in near future.

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

88 PERSONAL BUDGETS: REVIEW OF POLICY FRAMEWORK & RESOURCE ALLOCATION (40 MINUTES)

The Chairman invited Sarah Shatwell to introduce the report.

The Panel made the following points:

Members of the Panel asked when full Equality Impact Assessment will be ready.

Sarah Shatwell replied that formal Equalities Impact Assessment has not been completed in relation to the current policy framework and resource allocation system for Personal Budgets, however advice and guidance has been sought from the Equalities Team. A full Equalities Impact Assessment of the revised policy framework and resource allocation system for Personal Budgets will be completed as part of the development process so that the final product is fully informed and influenced by equalities considerations.

Cordelia Johnney (Equalities and Diversity Officer) said that this will help to ensure that all of the equality issues are either eliminated entirely or transparently linked to the different types and levels of need that do exist between and within different service user groups.

It was **RESOLVED** to agree that:

1. The current policy framework and resource allocation system for Personal Budgets in Bath & North East Somerset is revised to address the equalities and financial concerns set out in the body of the report;
2. The revised policy framework and resource allocation system is more clearly and transparently linked to the Fair Access to Care Services eligibility criteria currently in place in Bath & North East Somerset; and
3. Further wide scale consultation and impact assessment of proposed changes is undertaken prior to any significant operational changes being implemented.

89 HOUSING ALLOCATIONS (20 MINUTES)

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

The Panel made the following points:

Members of the Panel asked if ex-servicemen will have priorities in housing allocations.

Graham Sabourn replied that the Council acknowledged that people in armed forces and ex-servicemen were disadvantaged in the past in terms of housing allocation due to not being able to demonstrate local connection. However, in 2008 the Council acted to make local connection easier for ex-service personnel to achieve. The Government now is now suggesting that ex-service personnel are further

assisted by a) not needing to demonstrate local connection and b) Members of armed forces are given additional priority in housing allocations.

Members of the Panel suggested that option 4.2 in option document (Should we change the age from 8 to 10 when a child will be eligible for their own room?) should not change if the children are same sex. Graham Sabourn took that suggestion on board.

Graham Sabourn highlighted to the Panel that option 2.2. in option document (Give preference to people who make a contribution to the community?) is promoted by the Government and asked the Panel to make their view on that option.

Members of the Panel debated this option. Some Members felt that they would support this option if the families are compared on like for like basis. In general the Panel felt that it would be very difficult to decide who would be making the decision on who made what contribution to the community and that it would be discriminatory towards people with mental health issues. The Panel agreed with officers' initial recommendation that this should not take place at this point in time and ask officers to monitor this or similar issue introduced by other Councils.

Members of the Panel asked how many houses are registered as empty properties.

Graham Sabourn replied that initially there were 500+ properties empty for 6 months and more (according to initial information from different Council sources). Following the investigation it was concluded that there are now around 430 empty properties in total with around 12 them being classed as high priority for recovery action.

The Chairman asked that the final report on Housing Allocations be on Panel's agenda sometime in summer 2012.

It was **RESOLVED** to note the report and for officers to take on board comments and suggestions made by the Panel.

90 WORKPLAN

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

- Care Homes quarterly review – date to be confirmed
- Energy Efficiency report – date to be confirmed
- Alcohol Harm reduction Strategy – date to be confirmed
- Transition of Public Health responsibilities – date to be confirmed
- Housing Allocations report – summer 2012

The meeting ended at 1.45 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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

Wellbeing Policy Development & Scrutiny Panel – March 2012

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1. PUBLIC ISSUES

Severe Weather Assistance for Homeless People

The Severe Weather Emergency Protocol (SWEP) was developed and agreed by the Homelessness Partnership in December 2011. The protocol states that extra measures will be put in place when temperatures fall below 0 degrees on three consecutive nights. During the cold weather in January, over a period of 14 nights, Julian House and the Reach Floating Support Service, in partnership with Genesis Open House Day Centre, implemented the protocol and extended their services to rough sleepers, ensuring that accommodation, food and support were available 24 hours a day. The extra staffing hours needed were covered by staff working overtime and/or flexible hours, but agreement was given for overtime or agency staffing, if necessary. Budgets for the coming year include a sum to cover emergency staffing costs arising from implementation of the SWEP in the coming year, to ensure that this vital element of outreach to rough sleepers can be put into place as soon as temperatures fall to critical levels.

2. PERFORMANCE

Temporary Accommodation

- December 2011 saw a continued reduction in households in temporary accommodation, (twenty one), the lowest figure since May 2010. However, there was an increase in households in temporary accommodation during January and February 2012 rising from twenty four and then twenty nine households. There was also an increase in the use of bed and breakfast, as temporary accommodation. The increased use of temporary accommodation and bed and breakfast accommodation follows increased homeless applications, including a larger number of applicants being discharged from hospital. This, to some extent, reflects pressures being seen in the hospital, with increased levels of activity over the winter period, including referrals to the Social Work team based at the hospital.

Energy Efficiency

- The number of properties receiving energy efficiency measures has gone up from 114 at the end of September (red) to 522 at the end of December (green). This already exceeds the year-end target of 300.

Empty Properties

- A property in South Down that has been empty for 10 years & featured in Empty Property week has now been sold due to the efforts of Housing Services, including garden clearance, in persuading the owner to dispose of the property. The owner thanked Housing Services for their support and stated that without this support he is likely to have continued to do nothing.

3. SERVICE DEVELOPMENT UPDATES

Support for Rough Sleepers

- Housing Services have been working with the Bath Homelessness Partnership to reduce the number of people sleeping rough. The rough sleeper count carried out in November 2011 found 4 rough sleepers which is an improvement on previous estimates. The service that is provided to rough sleepers is going to be enhanced through a successful bid to the Homeless Transition Fund. 190 bids were submitted and the Julian House / DHI partnership bid, supported by the Homelessness Partnership were one of only 41 successful bids. The maximum funding of £250,000 was granted for the three year project, which will develop an assertive outreach team to provide support to rough sleepers and those at risk of rough sleeping to initiate and sustain their use of crisis accommodation, whilst enabling them to make positive lifestyle changes in addressing health, addictions, offending and worklessness. The new service will target this with a focus on prevention, on-going support and the creation of sustainable pathways into independence.

Alcohol Treatment

Recurrent savings of £100,000 have been released from the substance misuse budget through the strategic shift from three to two adult treatment providers. This has enabled additional investment in alcohol treatment capacity, which is identified as a priority in the Refreshed Alcohol Harm Reduction Strategy for B&NES 2010-12 (agreed by Partnership Board for Health & Wellbeing, June 2011) and confirmed by the Joint Commissioning Board for Substance Misuse in December 2011. It is anticipated that this additional investment will increase capacity by 90 clients (from 450 to 540) a year.

Wellbeing Policy Development and Scrutiny Panel
March 16th 2012
Key Issues Briefing Note

1 Cluster Board arrangements

Following previous reports to the panel on the development of cluster arrangements the position on Board governance across the B&NES and Wilts cluster has now been resolved through the establishment of a Joint Board. Subject to the approval of NHS B&NES Board at its meeting on March 22nd and the Wilts Board at its later meeting, the Joint Board will be established from April 1st 2012. The joint Board will be one group of people taking responsibility for governance and assurance across the cluster incorporating both Primary Care Trusts. Both NHS B&NES and NHS Wilts will continue to exist as legal and separate entities and will come together to deliver both Board agendas at the same time under one chairman and a common team of executives and non-executives. The priorities for the board during the next year will be agreed at the first Cluster Board meeting, but will include:

- Commissioning high quality services for the population within available resources
- Leading the reform tasks with CCGs, Public Health, Commissioning Support Services, and the Foundation Trust pipeline
- Closing down the PCT

The Appointments Commission has officially appointed Tony Barron as Chairman of the Boards of NHS Bath & North East Somerset and NHS Wiltshire. Tony's appointment will run from 1 April 2012 until March 2013. Malcolm Hanney has elected to stand down from the end of March 2012.
The following people have been appointed to the joint Board as Non-Executive Directors:
David Smith, David Loosley, Christine Reid, Lis Woods, John Holden, Peter Lucas, David Stevens.

2 NHS Cluster Management Arrangements

A staff consultation on proposals for a management structure to ensure resilience and the effective management of operations during the transition period of the PCT has now completed. New structures are identified with no loss of staff and with the identification of some new roles across the cluster to ensure capacity. The structure will now be put in place over the next few weeks.

Inevitably, further changes in internal organisation will occur over the coming months, so as to ensure appropriate support for CCGs as they develop, and so as to support the CSS as it develops. There is clear commitment to preserving the integrity of the joint commissioning team through these changes.

3 NHS 111

The panel has previously been briefed on the NHS 111 service for non-urgent care. The Government has announced that it would put in place a new service from April 2013 which provides access to non-urgent care in the NHS. 111 is a single telephone number and the plan is for it to co-ordinate the existing variety of non emergency services for patients including the local Out Of Hours arrangements. The 999 emergency system will remain unchanged.

Chairs of Health Overview and Scrutiny Committees are being invited to participate and input in the procurement process currently underway for the

introduction of 111 at an event taking place in Taunton on 28 March 2012, during which presentations will be made on the proposals from the potential providers, including how service user involvement and user satisfaction issues will be addressed. Further briefings will be brought to the panel once the providers have been appointed, building up to the 'go live' date of April 2013.

4 Our Healthy Conversation

The next public meeting of the Health and Wellbeing Network under the *Our Healthy Conversation* programme will take place on April 18th from 10 am – 1pm at Fry Club in Keynsham. The event will be led by Clinical leaders and will focus on JSNA and the urgent care review. Panel members are invited to attend and participate.

5 Clinical Commissioning Group Progress update

The panel have received previous reports on the details of NHS reform as outlined by the Department of Health. A principle element within the reform is the dissolution of PCTs and the establishment of Clinical Commission Groups (CCGs). In line with the reform programme arrangements to move towards the establishment of CCGs are being actively progressed in B&NES. The panel received a presentation on this at its last meeting. An update on progress and development is provided below

Recent developments and issues

In the last 2 months there has been a lot of emphasis on how best to configure CCGs in the wider local area to ensure appropriate and sensible collaboration in particular around our local hospitals, the RUH and RNHRD. It is essential that the groups responsible for commissioning services at these hospitals have a joined up approach and work in unison. This is only way to deliver the best outcomes and services for the people of Bath and North East Somerset as well as the wider population served by the hospitals. It is important to note that B&NES and Wiltshire provide approximately the same volume of work to the RUH of about 45% each.

Configuration discussions has been ongoing with Wiltshire CCGs but there is a clear decision that Bath and North East Somerset will have a separate CCG. There will be close working with the CCG covering West Wiltshire which has the greatest relevance to B&NES. Our CCG has already collaborated effectively with them and are in detailed negotiations on how to formalise this to ensure effective co-operation in the future.

Progress towards Authorisation

CCG leaders and Tracey Cox, Programme Director for Acute Commissioning at the PCT, attended a workshop day run by the SHA and received guidance on the process of Authorisation as far as it currently exists. We are well placed so far but have much work to do to complete all the requirements. There will be 4 waves of Authorisation in July, September, October and November. It is our ambition to apply as early as possible although this unlikely to be in the first wave. We do not anticipate any major problems with authorisation as we meet all the fundamentals required.

Compiled by Derek Thorne NHS B&NES Assistant Director Communications & Corporate Affairs 01225 831861

Bath and North East Somerset

Local Involvement Network

Report to B&NES Wellbeing Policy Development & Scrutiny Panel, 18 May 2012

1. Re-election of the LINk's Officers

At it's April meeting, the LINk held elections for it's Officers. The following were re-elected to their posts for the coming year:

Chair - Diana Hall Hall

Deputy Chairs - Jayne Pye and Jill Tompkins

2. Avon, Gloucestershire & Wiltshire LINks' Visits to A&E Departments

The B&NES LINk has participated in a programme of informative visits to the A&E Departments at acute hospitals in Avon, Gloucestershire and Wiltshire. Each of the seven LINks visited the A&E Departments in its own area, and submitted their findings for incorporation into an overall report for the AGW area. These findings have been sent for comment on the factual findings to the Trusts. As a part of this, B&NES LINk members visited the RUH A&E Department, and produced a report on this.

The overall Report is being coordinated and produced by the Gloucestershire LINk on behalf of all seven. We will ensure that the Panel receives a copy when the report is finalised.

3. Chew Valley Reservoir - Planning Application

The B&NES LINk joined with the Bristol and North Somerset LINks in writing to the B&NES Council's Planning Department to express concern over the application for siting of a toxic waste landfill facility at Stowey Quarry. A copy of this letter is included for the Panel's information at Annex 1 to this Report.

4. LINk's Involvement in Procurement Process for Local HealthWatch Organisation

Following representations to Cllr. Simon Allen by the LINk, it has been agreed that, in addition to representation on the Stakeholder Panel for assessing the tenders for provision of a LINk Host and Local HeathWatch organisation, there will be one LINk representative on the decision-making panel, who will receive appropriate training for the role.

5. Service Changes at Paulton Hospital Minor Injuries Unit

Members of the LINk attended the Equality and Impact Assessments relating to changes to overnight opening arrangements for the Minor Injuries Unit. They felt that the effect on patients of the overnight closure would be absolutely minimal for those who needed the services of the MIU. Some of the patients seen at the MIU would be more appropriately treated at a full A&E Department rather than at an MIU, and the very small number remaining would be perfectly safely and appropriately treated at their GP Practice the following day. The conclusion of the Impact Assessment was that the impact on patients of the change would be very small.

Diana Hall Hall
Chair, B&NES Local Involvement Network
8 May 2012

Annex 1

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

David Trigwell
Divisional Director of Planning & Transport Devpt.
Bath & North East Somerset Council
Lewis House, Manvers Street
Bath
BA1 1JG

19 April 2012

Dear Mr Trigwell,

Restoration of Stowey Quarry by landfilling of Stable Non Reactive Hazardous Waste - Planning Application 10/05199/EFUL

We write to express grave concerns over the potential implications of this planning application for the health and wellbeing of the people of Bath & North East Somerset, Bristol, and North Somerset.

Local Involvement Networks ("LINks") were set up by Parliament, with statutory responsibility and statutory powers to represent the health and social care interests of the people in their areas. In 2013, LINks will become Local HealthWatch organisations, and will have formal places on Councils' new Health & Wellbeing Boards. The three LINks for the areas of Bath & North East Somerset, Bristol, and North Somerset have expressed the same concerns about this proposal.

We feel that the location proposed for the waste-storage is totally inappropriate for toxic waste - including asbestos. It is close to the Chew Valley Reservoir, and to the water-courses that feed into it. As Bristol Water has pointed out, no commercial operator could realistically give a guarantee that protective measures taken to contain the waste would be effective in perpetuity - or even over finite but long timescales. Failure of such protective measures could result in toxic waste entering this major local source of drinking water.. We also feel that the very strongly expressed professional concerns of a body such as *Bristol Water* should be given conclusive weight in the making of the Council's decision.

In view of B&NES Council's important statutory responsibilities as guardians of public health and wellbeing, we would ask the Council to consider and answer the following questions -

1. Can the Council guarantee to local people -
    - that there will be no contamination of the local water supply by the development - either now, or at any time in the future?

- that there will be no similar contamination of local farmland?
- that there will never be any risk to people in surrounding villages from windborne waste particles from this development?

2. Will there be an increase in monitoring to identify leaks? Will the results of this be made public?
3. Who will pay for this? And who will pay for cleaning up any contamination that may result from the development, now and in the future?

In addition to the particular and unique danger from the toxic nature of the waste, the development will bring many other inconveniences and hazards for local people. These include a massive scale of lorry-movements for a rural area with roads inadequate for this, and the inevitable noise that both this and the plant's operation would bring.

The LINks urge you to reject this application unless the Council can assure itself that the above questions and other issues can be answered in a way that indicates that the public's health can not suffer in any way from the proposed development. We are not convinced that such assurances are even possible.

Yours sincerely,

Diana Hall Hall, Chair, B&NES LINk

John Langley, Chair, Bristol LINk

Georgie Bigg, Chair, North Somerset LINk

cc: Councillor Tim Ball, B&NES, Cabinet Member for Homes & Planning
Councillor Vic Pritchard, Chair, B&NES Wellbeing Policy & Development Scrutiny Panel
Councillor Lesley Alexander, Chair, Bristol Health & Adult Social Care Scrutiny Commission
Councillor Reyna Knight, Chair, North Somerset Health Overview & Scrutiny Panel
Dr Pamela Ackerman, Joint Director of Public Health, B&NES
Dr Hugh Annett, Joint Director of Public Health, Bristol
Becky Pollard, Joint Director of Public Health, North Somerset
Glen Chipp, Strategic Director - Service Delivery, B&NES Council

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	Friday 18th May 12
TITLE:	Dental Access update
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 Developments in NHS Dentistry	

1 THE ISSUE

To give an update to the Wellbeing Policy Development and Scrutiny Panel on how Access to Primary Care Dental Services has improved in B&NES.

2 RECOMMENDATION

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

Access to Primary Care Dental Services has improved in B&NES.

3 FINANCIAL IMPLICATIONS

3.1 The PCT has already committed funding for primary care dental access.

4 THE REPORT

4.1 Background

During 2008/09 a task and finish group formed from the Healthier Communities and Older People Overview and Scrutiny Panel to look at access to primary care dental services. The group reported their findings in September 09 and the PCT responded in November 09.

The Wellbeing PDS requested an update from the PCT of progress that has been made since November 2009.

4.2 Activity levels

In 2007/08 the PCT commissioned 233,350 units of dental activity by 2011/12 this has increased to 331,284.

4.3 Number of new patients seen

Date	Number of new patients seen	% Adults	% Children	% of population
Dec 09	92,247	51%	80%	52%
Dec 10	98,797	50%	82%	56%
Dec 11	102,565			57%
Feb 12	103,317			57%

The PCT target is 59% of the population.

Number of practices accepting all categories of NHS patient	12
Number of practices accepting certain categories of NHS patient e.g. children	14
total	26

4.4 Disability access

The PCT carried out a disability survey of dental practices that accept NHS patients and shared the findings with the local Disability Forum. This gave a useful tool for patients to know which practice they could register with.

4.5 Out of Hours (OOH) dental service/dental helpline

From the 1 April 2013 patients will be able to access OOH dental services and the dental helpline via NHS 111 which will be an easy to remember telephone number.

4.6 Dental Access Centre at Riverside
This continues to be a well used service for particularly vulnerable patients including those who are homeless and have drug addiction issues.

4.7 Patient satisfaction
Patient satisfaction with the dentistry they have received is 95.4% which is higher than the Regional and England average. Patient satisfaction with the time they had to wait for an appointment is 91.7% which is also higher than the regional and English average. The GP patient survey also asks patients about their ability to access an NHS dentist. 97% of those who tried to do so succeeded in getting an NHS appointment.

Calls to our Patient Advice and Liaison service enquiring about dental access and dental charges were a prominent feature in 20010-11. This year contacts have substantially reduced indicating greater satisfaction with dental services and a greater knowledge within the public of how to access and receive NHS dental treatment

Further detail about how PCTs locally are delivering NHS dental services are included as appendix 1 for information.

4.8 Issues going forward
The PCT has commissioned enough service for at least 59% of the population to access NHS dentistry. But the number of new patients wishing to access NHS dental services seems to have reached a plateau. The PCT has commissioned targeted initiatives in areas of deprivation to encourage new patients. These have included commissioning pain slots for people in dental pain in a main stream dental practices who will encourage patients to sign up to continuing dental care and a children's club to introduce young children to dental services in a fun way. The PCT also promotes the availability NHS dental services at every opportunity.

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. It is too early to say if the PCT has commissioned more dental services than are needed.

6 EQUALITIES

An Equality Impact Assessment is being formulated on the Avon Dental Commissioning Strategy.

7 CONSULTATION

7.1 Service Users; Local Residents; Stakeholders/Partners; Other Public Sector Bodies;

7.2 When the PCT originally commissioned these services via the Avon Dental Commissioning Strategy during 2008/09 the PCT engaged with members of the public, voluntary sector organisations, dentists, users of the services, the PCT Board and PEC, the Older People Overview and Scrutiny Panel.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Decision not requested.

9 ADVICE SOUGHT

9.1 How to promote the availability of NHS dental provision.

Contact person	Julia Griffith 01225 831628
Background papers	None.
Please contact the report author if you need to access this report in an alternative format	

Developments in NHS Dentistry

Information paper for Local Authority Health Overview and Scrutiny Committees

Bristol
North Somerset
South Gloucestershire
Bath & North East Somerset

Contents

1 Purpose

To update local authority health overview and scrutiny committees and other stakeholders on progress in delivering NHS dental services in Bristol, North Somerset, South Gloucestershire and Bath & North East Somerset

2 Background

Commissioning of NHS dentistry passed to Primary Care Trusts (from the department of health) in 2006, along with a new national dental contract.

Some dentists left the NHS at this time, and access to dentistry fell to very low levels in some areas.

National investment in access to dentistry has improved this situation, along with better signposting through the use of a local dental helpline. The latest GP patient survey results (December 2011) indicate that 96% of people who tried to find an NHS dentist in the last year were successful[1].

However, many people did not try to find an NHS dentist, and of those, 12% did not think they could get an NHS dentist. In fact there are 65 NHS dental practices accepting new patients across the area as shown below:

	Practices accepting new NHS patients
Bristol	27
North Somerset	13
South Gloucestershire	13
Bath & North East Somerset	12

Providing current information about the availability of NHS dentistry is now one of our greatest challenges to improving access to NHS dentistry and to improving oral health.

Planning and commissioning of dental services from primary care through to hospital services is overseen by a Steering Group with representation from each of the four PCTs, local dental advisors (dentists working in the local area) and a lay member who is a member of the Bristol LINK.

3 Access to General Dental Services

General Dental Services is the term used to describe high street primary care dental services – most people's first point of contact with NHS dentistry will be through this service.

The services provided by General Dental Services are described in the patient charges leaflet which is attached at appendix 1.

[1] Average across Bristol, North Somerset, South Gloucestershire and Bath & North East Somerset

3.1 Availability of NHS dentistry

It is widely known that in some areas of the country availability of NHS dentistry has been poor and that a number of dentists left the NHS at the time of the introduction of the new national dental contract in 2006.

Locally since 2006 we have commissioned new services both by increasing capacity at high quality existing providers and by introducing brand new practices.

Targeting services is based on high need (high levels of decay in the local population) and on availability of existing services, so new practices may be located in areas where there has not been a dentist for some years, and /or in areas identified as at high risk of oral health need.

Since the new practices have opened, many patients have had their first NHS dental appointment, and some have returned to the NHS for the first time since 2006.

However, particularly in Bath and Bristol, there are now more services available than are being used. We think this is partly because people still think they cannot get an NHS dentist. The GP patient survey which now asks questions about access to dental services, certainly indicates this is the case.

The priority for the local PCTs now is to ensure that every effort is made to change perception both about the need to visit the dentist regularly, and the availability of local dental services. Local awareness-raising initiatives, in partnership with practices have included press coverage, participation in events such as the Harbour Festival and direct advertising. A successful bid for DH funding will secure further direct advertising and promotion activities in the early part of 2012.

3.2 Helpline

In order to provide accurate and timely information about the availability of dental services and the locations of practices accepting new patients, the local PCTs commission a dental helpline for signposting patients to available NHS dental services. The helpline opened in 2007/8. It now receives 1400 calls per month (average April – September 2011).

Patients looking for a new NHS dentist are advised of 2-3 dental practices currently accepting new patients close to their home address.

The dental helpline number is 0845 120 6680.

In April 2014, the local Avon dental helpline will transfer to the new NHS 111 service which is being introduced. A separate briefing on NHS 111 was provided to local Overview and Scrutiny Committees in late 2011.

4 Urgent dental services

4.1 In-Hours

Patients who do not have an NHS dentist and are in dental pain, are able to telephone the NHS dental helpline (see above). The helpline will triage patients

and if required can make an urgent appointment for them with a dentist in Bristol or BANES the same or next day.

4.2 Out of Hours

Patients who find themselves in dental pain out of hours can ring the out of hours triage service for advice, which sometimes includes self-care. Some patients are invited to attend an appointment at an Out of Hours base or in some cases an appointment may be made for the in-hours clinics as described above.

The out of hours service is available from 6-9 every evening and from 9-5 on weekends, clinics are not available at all of these times however all patients who need to be, will be seen within 48 hours.

Clinics are held in central Bristol, Bath and Weston.

5 Community dental services

'Community dental services are' best described as primary care dental services for patients who have special needs. The dental treatment the patient receives is consistent with that provided in primary care practices, however due to the patient's other special needs they cannot access care in a practice, or care in a practice would not be appropriate. These patients include the following groups

- Adults and children with learning difficulties
- Adults and children with physical disabilities whose local practice is not in an accessible location or premises (although choice is improving in this area)
- Patients with anxiety about dental treatment,
- Older people who are housebound – either in their own home or in a residential home

A review of the locations aiming to improve equity of access to CDS across the four PCTs is underway and will be reported on separately to health scrutiny committees and LINKs later in the year.

6 Specialist dental services

6.1 Orthodontics

Orthodontic services offer dental treatment that aims to improve the appearance, position and function of crooked or abnormally arranged teeth. These services are provided under primary care contracts with local private providers, and under the secondary care contract with the hospitals. These contracts are paid for by the PCTs.

Orthodontic treatment is only commissioned by the NHS for children under the age of 18 and as such there are no NHS charges payable by patients.

A review of orthodontic services is underway with a view to:

- reducing waiting times
- ensuring equity of access

- ensuring a high quality service
- ensuring value for money

The review is close to completion and health scrutiny committees and LINKs will be updated. It is currently thought there will be very little change to service provision however waiting times should be reduced through close partnership working with the providers.

The PCTs would like to note the positive experience of working with the providers in reviewing and working to improve these services.

6.2 Secondary care services

Secondary care specialist dental services are provided at the Bristol Dental Hospital, Southmead and Frenchay Hospitals, Weston General Hospital and the Royal United Hospitals in Bath.

Priorities are to continuously improve the referral pathway to ensure consistent access to services, to maintain acceptable waiting times for treatment, and to ensure value for money across the service. These services are covered by the 18 week target.

7 Fluoridation and oral health improvement

The PCTs have a responsibility to improve oral health by prevention as well as by access to treatment. This is delivered through initiatives such as:

- training of school nurses and health visitors
- training of care home staff
- targeted tooth brushing advice
- the application of fluoride varnishes to children at high risk of dental decay
- schemes to provide toothbrush and toothpaste to children

In the summer of 2010, the Avon Fluoridation Project Board was formally stood down as it was clear there was insufficient local evidence on the effectiveness of alternatives to adding fluoride to the Bristol water supplies. At this time the Strategic Health Authority was requested by all four Primary Care Trusts to defer making a decision to commission a feasibility study, which was agreed.

From the experience in Southampton, it was clear that local information would be needed in the event that there was to be a formal consultation process. In addition, the Coalition Government's position on fluoridation was not known, nor was the outcome of the Judicial Review into the process applied by South Central Strategic Health Authority available. Subsequently, the Judicial Review found for the Strategic Health Authority, which demonstrated the importance of local robust data on alternatives.

To support the collection of local evidence, the Avon Oral Health Improvement Strategy has been updated, together with an agreed Action Plan and a programme for evaluating the outcomes of the interventions for service users. Work is ongoing to implement this Strategy and collect local data.

8 Patient satisfaction

There is a variety of data available regarding patient experience of NHS dental services, including data collected by the Business Services Authority who process all claims for dental activity submitted by NHS dentists. The national GP Patient Survey also includes a set of questions around dental access every six months. A short description of the relevant indicators can be found below.

8.1 Vital signs patient satisfaction surveys

The guidance for the Vital Signs patient satisfaction surveys is available on the Business Services Authority website[2]. The latest data relates to the quarter ending in December 2011 and is shown below:

	Bristol	North Somerset	South Glos	Bath & North East Somerset	South West Strategic Health Authority	England
% of patients satisfied with the dentistry they have received	95.4%	96.4%	95.5%	95.4%	95.2%	94.6%
% of patients satisfied with the time they had to wait for an appointment	91.5%	94.4%	90.3%	94.4%	91.7%	89.8%

8.2 GP patient survey

In the most recent period (April to September 2011, published in December 2011), 1.4 million adults were asked about access to NHS dentistry in the previous two years. Participants were asked if they had tried to obtain an appointment with an NHS dentist, and if so, whether it was with a practice they had been to before and had they been successful. They were also asked what their overall experience was of NHS dentistry. Patients who hadn't tried to obtain an NHS dentist in the previous two years were asked to select the main reason why they hadn't tried.

Local results are highlighted in the tables below.

[2] http://www.nhsbsa.nhs.uk/Documents/Quarterly_Vital_Signs_Report_Guidance_PCT.pdf (page 5)

Table 1: Patients who succeeded in getting an appointment

	In the last 3 months	In the last 6 months	In the last year	In the last 2 years
Bristol	94%	94%	94%	93%
North Somerset	96%	97%	97%	95%
South Gloucestershire	97%	98%	97%	96%
Bath & North East Somerset	97%	97%	96%	95%

Reasons why patients didn’t try to obtain an appointment:

	Not needed to visit a dentist	No longer have any natural teeth	Not had time to visit a dentist	Don't like going to the dentist	Didn't think they could get an NHS dentist	On a waiting list for an NHS dentist	Stayed with their dentist when changed from NHS to private	Prefer to go to a private dentist	Find NHS dental care is too expensive	Another reason
Bristol	18%	7%	2%	5%	12%	0%	21%	20%	5%	10%
North Somerset	9%	7%	1%	6%	15%	1%	33%	19%	2%	7%
South Gloucestershire	15%	7%	2%	9%	10%	1%	22%	22%	2%	11%
Bath & North east Somerset	12%	5%	1%	5%	15%	1%	28%	24%	3%	6%

8.3 NHS Choices

All local dental practices are included on NHS Choices and users can leave 'ratings' and comments. A priority for the PCTs is to set up providers so that they can update their own NHS Choices page and respond to comments where necessary.

8.4 Enquiries to the Patient Advice and Liaison Service

The PCTs' Patient Advice and Liaison Service deals with a number of enquiries regarding dental services. Many of these relate to patient charges, referrals for specialist treatment and concerns about primary care dental treatment received. The PALS teams often work closely with practices to achieve a satisfactory outcome for both practice and patient. In a small proportion of cases issues raised by patients eventually result in wider involvement by the PCT and other health service bodies with the practice to improve the performance of a practice or an individual dentist through the PCT's contract and performance management arrangements. Formal complaints are dealt with in a similar way.

9 Recommendations

To note the comments above and to provide feedback to the Avon Dental team if wished.

Anna Masserick
16 February 2012

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	18 May 2012
TITLE:	Care Services Quality Assurance
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – "Summary Quality Assurance Framework"	

1 THE ISSUE

1.1 To provide the Wellbeing PDS Panel with an overview of the systems, processes, information gathering and reporting mechanisms that contribute to the current quality and performance assurance framework for care services in Bath & North East Somerset.

2 RECOMMENDATION

The Wellbeing PDS Panel is asked to:

2.1 Note the current Quality Assurance Framework (QAF) for care services; and

2.2 Engage with the further development of the QAF, including a clear articulation of the role of the Panel.

3 FINANCIAL IMPLICATIONS

3.1 There are no specific financial impacts associated with the QAF.

3.2 Over the past two to three years, the financial viability of some providers of care services has come into question as they have been severely tested by the economic downturn and, also, by pressure from commissioners (both Local Authority and NHS) to deliver efficiency savings. This has led to a growing concern that providers may seek to reduce their operating costs by compromising on the quality and/or safety of care service provision by, for example, employing fewer and/or less skilled/experienced care staff.

4 THE REPORT

4.1 An increasing number of safeguarding referrals are being recorded both locally and nationally, particularly, multiple safeguarding alerts in relation to a single care service and/or provider. Analysis of the multiple alerts and the setting is being undertaken and consideration is being given to 3.2 above. However, the increase in referrals has been expected due to the awareness raising activity of the Local Safeguarding Adults Board (LSAB) and, also, the fact that the profile of adult abuse has being raised nationally for example by the abuse identified at Winterbourne View through the BBC Panorama programme, through the review of No Secrets and the Government's commitment to put safeguarding adults on a statutory footing.

4.2 The context within which care services are provided has also changed significantly in recent years. There is an increasingly diverse market; the current economic climate is putting strain on the financial viability of care services providers; and commissioning and contracting arrangements are becoming increasingly complex, which makes communication between commissioners and across the health and social care system more challenging.

4.3 A summary of the current Care Services Quality Assurance Framework (QAF) is set out in Appendix 1. The QAF has developed significantly over in the lifetime of the Health & Wellbeing Partnership. It is likely to need further development in light of the findings from the Winterbourne ViewSerious Case/ Independent Management Reviews by a number of bodies, including the Strategic Health Authority, South Gloucestershire Local Adult Safeguarding Board, and CQC. It is anticipated that findings will be published in August or September this year. The Panel may wish to receive a report following publication and, also, to have input into subsequent local action planning, which could include a necessity to further develop or enhance the QAF.

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

An EqIA has not been completed because this report is provided for information and to assist the Panel in articulating its role rather than for decision making or policy development.

7 CONSULTATION

7.1 No specific consultation has been undertaken on the contents of this report.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

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

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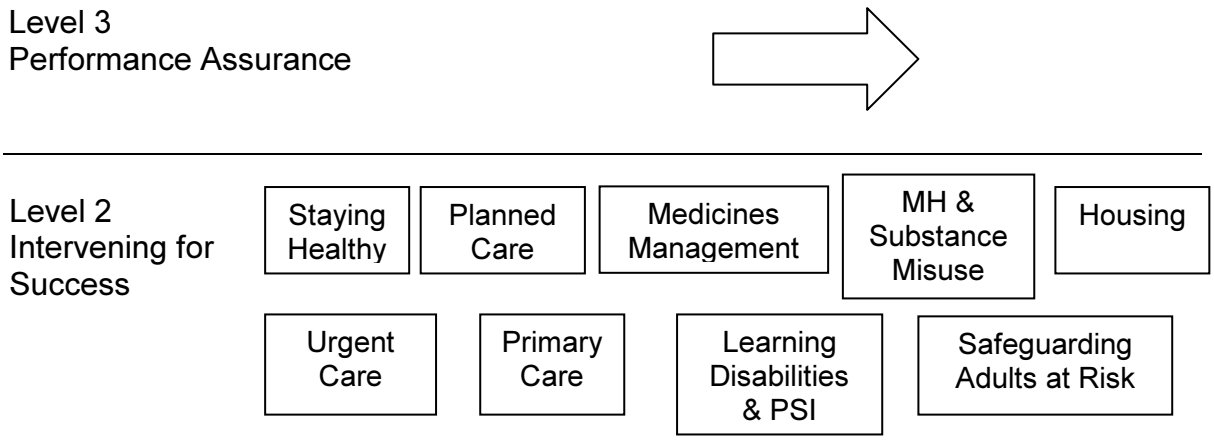
Appendix 1

Summary Care Services Quality Assurance Framework

The Performance Infrastructure – *"Intervening for Success"*

During the first year of the Health & Wellbeing Partnership the infrastructure for adult health, social care and housing performance management was reviewed and a programme of organisational development put in place to move from performance reporting to one of proactive intervention for performance improvement. The 'Intervening for Success' model of performance management, which arose from this work, seeks, amongst other things, to provide assurance to decision makers and accountable bodies that the Partnership has a grip on performance and is proactively managing the system of care to deliver key performance indicators in order to meet our stated strategic objectives.



The Partnership runs three different types of performance meeting:

Level 1 Formal contract review against agreed plans and Key Performance indicators (KPIs) with clear contractuallines to align performance to plan on activity, finance and service quality

Level 2 The commissioned services are now organised into service lines, each of which has a lead Associate Director supported by named information support and management accountant:

Staying Healthy	**Paul Scott**
Urgent Care (including Unplanned Care, Long Term Conditions, End of Life Care) and Adult Social Care	**Corinne Edwards & Sarah Shatwell**
Planned Care (including Cancer, Specialist, Maternity)	**Hester McLain**
Medicine Management	**Joel Hirst**
Primary Care	**Julia Griffith**
Mental Health& Substance Misuse	**Andrea Morland**
Learning Disablities & Physical & Sensory Impairment	**Mike MacCallam**
Safeguarding	**Lesley Hutchinson**
Housing	**Graham Sabourn**

The initial focus in developing this approachwas on each service theme articulating the system of care as we currently understand it, and representing this graphically while also identifying the drivers of performance and the levers available to commissioners to influence performance. Each service line then developed a performance framework setting out this information. Under the “intervening for success” process, each Associate Director brings together their support team of project managers and finance and IT support to review performance and to agree the priorities for some intervention necessary to deliver agreed targets, including the delivery of Key Performance Indicators and QIPP (Quality, Improvement, Innovation & Prevention)/ Savings plans. This process ensures that every Associate Director has a clear understanding of spend in their area and can therefore track the impact of their interventions, including the impact of delivering QIPP plans. Taken together this approach represents a very different way of working from the previous system requiring merely a monthly explanation of historic performance.

Once a month the team of Associate Directors and the Senior Management Team meet to present to the Clinical Commissioning Group (CCG) Accountable GP and Programme Directors the outcome and impact of their interventions and are held to account for the delivery of performance targets and savings plans. Each service line team provides a detailed report including trend data and in-depth analysis based on the components of the care system that have been identified as working at sub-optimal level and the proposed interventions, including those that need to be escalated to the accountable manager(s) and/or body for a decision or action. Over the coming months it has been agreed that the intervening for success process will be reviewed with a view to adopting it as the preferred approach to integrated performance management for the new People & Communities Directorate and B&NES CCG.

Care Services Intelligence Gathering

Information regarding the quality and safety of care services is collected through a number of sources including:

- service user feedback surveys, including those conducted when a service user’s needs and support plan are reviewed;
- complaints, including “lessons learned” from a formal complaint investigation;

- monitoring of safeguarding referrals and auditing of safeguarding processes, including improvement action plans;
- contract reviews;
- concerns raised by GPs, District Nurses and other health and social care staff either informally or formally, including through “Whistleblowing” processes;
- and Care Quality Commission (CQC) inspections of regulated services (both announced/planned inspections and unannounced inspections).

Information is collated on a database by members of the NASCC (Non-Acute & Social Care Commissioning) team, which enables analysis and the identification of particular facilities, services or providers that are the subject of a number of concerns identified form the above intelligence gathering may warrant further investigation including a “whole-service” review. Whole home reviews are more usually prompted by significant safeguarding concerns combined with cumulative intelligence.

Contract Review/Performance Management

Regular/routine contract reviews are undertaken by NASCC team members in accordance with a review “template”, which ensures that all elements of the service are reviewed including record-keeping, service user feedback, staff training, governance/policy & procedures and, in the case of an accommodation based service (care/nursing home or supported living scheme), the environment.

Unannounced reviews, especially those undertaken in response to an increased level of risk identified through intelligence gathering and often include specialist input. Specialist input has most usually been from the Safeguarding & Quality Assurance team in commissioning, Nursing and, in particular, the Tissue Viability Nurse (who is expert in pressure ulcer care), and the GP who leads on Quality Assurance for the Primary Care Trust/CCG. This specialist input has proved to be particular helpful in both understanding the problem(s) and ensuring that improvement plans are rigorous and fully implemented. Action plans may include the temporary suspension of placements and, very occasionally, enhanced or alternative management of the service. Specialist input into a care home has also recently been funded by commissioners on the basis of a risk-assessment, which concluded that this specialist input was necessary and that the small provider would struggle financially to access such a resource.

For larger contracts there are regular formal contract review meetings. In the case of SironaCare &Health these contract review meetings are chaired by the Programme Director, Non-Acute Health, Social Care & Housing and include Sirona’s Chief Executive and Director of Finance. AWP contract review meetings also take place monthly and are chaired by the Associate Director, Mental Health & Substance Misuse. In addition to this specific safeguarding performance meetings take place on a monthly basis with Sirona Care and Health and AWP (as they are the two organisations responsible for the coordination of safeguarding cases), these meetings are chaired by the Assistant Director for Safeguarding and Personalisation.

Additional mechanisms have been developed following the launch of Sirona Care and Health to assure the LA that non delegated responsibilities are carried out these include but are not limited to:

- independent chairs for the safeguarding procedure

- auditing of safeguarding cases that are closed at the 'decision not to progress' stage
- auditing of 10% of assessments, reviews and support plans that fall below LA financial thresholds. (Note all cases above the LA financial threshold are presented at a single panel chaired by the commissioner – the panel scrutinises the support plan and costing proposal)
- mystery shopping, which is being implemented in 2012/13)

Communication and Liaison

Effective communication has an important part to play in assuring the safety and quality of care services. Liaison between commissioners assists with the "triangulation" of information/concerns across geographical or professional boundaries. Commissioner/Provider Forums enable on-going dialogue about future commissioning intentions, service development and redesign; the sharing of good practice; and proposed or planned changes in national or local policy. Provider Forums also support the sharing of good practice and lessons learned as well as being an opportunity for providers to develop partnerships that can be a source of innovation.

Examples of meetings/forums include:

- Bi-monthly CQC Liaison meetings;
- Quarterly Care services Provider Forum meetings – independently facilitated by the Care Forum;
- Quarterly Domiciliary Care Strategic Partnership meetings;
- Quarterly Supporting People & Communities Provider Forums;
- Quarterly Safeguarding Adults Board and sub group meetings; and
- The "Care Home Task Force", which brought together commissioners and practitioners/clinicians to review knowledge, information and intelligence across the health and social care system to ensure that care home quality and safety concerns are addressed in a "joined-up" way and that the full benefits of the integrated health and social care commissioning approach are realised in securing good quality and safe residential care home provision.

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	18 May 2012
TITLE:	The Effects of Delivering Adult Social Care Savings Targets on the Market
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report:	

1 THE ISSUE

1.1 The Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) for 2012/13 includes a significant savings target to be delivered from efficiencies in purchasing residential and nursing care placements. This report provides an overview for the Wellbeing PDS Panel of the approach to delivering this savings target, the potential impacts on the market and associated mitigations.

2 RECOMMENDATION

The Wellbeing PDS Panel is asked to:

2.1 Note the content of this report; and

2.2 Use the contents of this report to inform their scrutiny of the performance of the health and social care system.

3 FINANCIAL IMPLICATIONS

3.1 There are no specific financial impacts associated with this report. The Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) for 2012/13 was presented to the Wellbeing PDS Panel in November 2011 for comment.

4 THE REPORT

4.1 The Placements & Packages Steering Group has been in place for more than two years now and has overseen an ambitious three-year 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 as part of the Adult Social Care & Housing MTSRP. Key elements of the work programme and their relationship with the market are as summarised below:

4.2 **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, including Continuing Health Care Packages, and also to identify pricing differentials between different providers for comparable placements and packages. The Chair of the Panel rotates between a number of joint commissioning managers and includes practitioner and clinician advice and challenge. "Presentations" to the Panel include the options that have been considered and any recommended nursing or care home package must include a fee breakdown, which enables fair and open comparison of costs between providers and, indeed, between service user groups. This has highlighted the significant variation in the proportion of a care home fee that funds direct care provision rather than other provider costs, including "hotel" costs, back-office functions and profit. Historically, some larger providers have refused to provide a full fee breakdown but they are now aware that a placement will not be agreed unless this breakdown is provided as part of the Single Panel process.

4.3 **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. The Policy was formally adopted, following consultation, in April 2011.

4.4 **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. This investment presents providers with opportunities to develop new services in support of business growth in B&NES.

4.5 **Market Shaping** – There are a number of workstreams under the umbrella of "market shaping" as follows:

- Improving understanding of the market by mapping the system of care or "operating model" (see Appendix 1 to the report to this Panel meeting "*Care Services Quality Assurance*"). This articulation of the system of care as we understand it, helps identify the drivers of performance and the levers available to commissioners to intervene and influence performance.

- Improving understanding of local fee levels, through benchmarking against other areas; requiring a full breakdown of fee make-up (as described under "Single Panel" above); modelling the relationship between care-home fee and local capacity (ie at £xxx fee level can we purchase a sufficient number of placements to meet local need). This clearer picture has helped to inform negotiations with providers about whether to agree an inflationary uplift and, if so, what level of uplift is appropriate and necessary to secure and sustain sufficient provision.

- Encouraging existing, smaller providers and potential new providers to extend or change their "offer", with "pump-priming" funding considered on an invest-to-save basis subject to a robust business case.

- Funding "Extended Research Pilots" as described under 4.6 below.

- Market testing, for example, the market for an Older People's Independent Living Service (OPILS) was independently tested before investment was agreed. As with the extended research pilots, market testing by the commissioner enables both commissioners and providers of care services to assess the financial viability of potential service developments ahead of making that investment. In the case of the market testing of the OPILS both the commissioner and the service provider (Somer Community Housing Trust) took the decision to invest in the establishment of this service.

4.6 "Section 256" funding allocated by the Department of Health to support sustainability in the health and social care system during 2011/12 and onwards was transferred in full by NHS B&NES to B&NES Council with a plan for investment, which includes five extended research pilots as follows:

- Integrated Health & Social Care Reablement – delivered through a partnership between Sirona CIC and Way Ahead Domiciliary Care Agency;
- Handyperson Services & Minor Adaptations – delivered by Care & Repair Home Improvement Agency;
- Step Down Accommodation, Care & Support – delivered through a partnership between Sirona CIC and Somer Community Housing Trust;
- Intensive Home from Hospital Support – delivered through a partnership between Age UK and Care & Repair HIA;
- Telehealth (focused on heart failure admission avoidance).

These pilots aim to support independence, sustain people in their own homes, avoid hospital admission and facilitate early discharge from hospital. Most are being delivered through a partnership between two providers as indicated against the pilot description above. "Pump-priming" innovation by providers in these way helps to shape the care services market and enable providers to invest in service developments that may not otherwise be financially viable.

4.6 Risks/barriers to market shaping include:

- Commissioner capacity to re-commission, undertake contract negotiations and rigorously manage contracts in an increasingly complex, diverse and contested environment;

- The shift to Personal Budgets makes it more challenging to use “purchasing power” to achieve cost-efficiencies and shape the market;
- Providers have been reluctant to provide a full, detailed breakdown of their fees, though increasingly they are viewing this as a usual part of the process for agreeing a placement with them;
- Large providers are in a position of power in contract negotiations, particularly given a local shortage of supply of good quality residential and nursing care for people with high levels of dementia; and
- There is a fine balance between controlling fee increases for nursing and residential care, seeking efficiency savings from providers without compromising the viability of the business, and ensuring care services are safe and of good quality (see alsothe report to this Panel meeting “*Care Services Quality Assurance*”)

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

An EqIA has not been completed because this report is provided for information and to assist the Panel in undertaking its scrutiny role rather than for decision making or policy development.

7 CONSULTATION

7.1 No specific consultation has been undertaken on the contents of this report.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Human Rights; Corporate; 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	Jane Shayler, Telephone: 01225 396120
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	18 May 2012
TITLE:	Talking Therapies in B&NES
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – National policy context and NICE Guidance Appendix 2 – Stepped Model of Care	

1 THE ISSUE

1.1 To provide the Wellbeing PDS Panel with an overview of the current provision of talking therapies in Bath & North East Somerset and development in 2012-13.

2 RECOMMENDATION

The Wellbeing PDS Panel is asked to:

2.1 Note the current Talking Therapies services and

2.2 Engage with any further developments as necessary.

3 FINANCIAL IMPLICATIONS

3.1 There are no current financial impacts associated with the provision of Psychological therapies.

3.2 Any future service provision will be within current or attract further investment.

4 THE REPORT

4.1 National recognition during the last ten years of the need to establish primary care mental health services to meet the clinical needs of people with common mental health problems (and return them to employment - a protective factor in maintaining mental health and wellbeing) was accompanied by a series of policy initiatives and a programme of training for new workforce to deliver NICE approved psychological therapies. (Appendix 1) The national implementation and monitoring programme was delivered through the Strategic Health Authorities.

4.2 The new programme was called - IAPT - Increasing Access to Psychological Therapies. Its aim is to deliver a “stepped care” model of service for people with anxiety disorders and depression including (as services progress) people with long term conditions, older adults, children and young people, people with serious mental illnesses and people with medically unexplained symptoms. (Appendix 2)

4.3 In 2008 NHS B&NES Professional Executive Committee agreed to support the local training and development of an NHS B&NES service. This service is now delivered by Sirona Care and Health. The assumption, using national modelling, was that a fully resourced team to meet demand in B&NES would eventually include12 staff treating people with moderate to high needs (current compliment 8.4 WTE) and 10 people working with people with low needs (current compliment 5.6 WTE) . In addition we currently fund 1 FTEAdministrator, 1 FTE Manager and 1 FTE Employment support (working in partnership with the Work Development Team).

4.4 The service was implemented on a 2-year specification with review due in 2010-11. On completion of this review the service was extended until the end of March 2013 and we signalled in our commissioning intentions with Sirona that we would consider re-commissioning during 2012-13. The team initially took referrals from GPs only as the team was developed but now access is mainly through self referral with continued GP/Primary care referral and pathways between specialist mental health services and the Sirona team.

4.4 In addition to the IAPT provision GP practices have, since 2001, received funding to provide counselling sessions for individuals in their practice. It was decided in 08-09 not to re-direct funding/staff from the counselling service in Primary Care into IAPT (as many other areas did) in order to maintain flexibility of approach and the resource attached to it. This arrangement is still in place. Whilst the strength of internal relationships between counsellors and their GPs is valued by many, a governance and assurance challenge of the current system is that whilst IAPT is a centrally supervised service delivered to all GP practices by Sirona, counselling is delivered by individual practitioners within practices or outsourced to a voluntary sector organisation. This also makes accessing services confusing for service users. We are also unable to reliably implement a single service user feedback/outcome system to national standards for the counsellors - a weakness

when we want to be outcome and patient experienced focused. Again we signalled to GPs via their service agreement that re-commissioning would be considered in 2012-13.

4.5 The IAPT service collects outcomes, activity and service user feedback in accordance with national DoH requirements. To date the service has met all locally agreed targets and outcomes and receives good service user feedback. It has not, however, met the national expectation of seeing 15% of the estimated population (by 2014). During 2011-12 the service saw 7.9% of the population. We are still collating the figures for counselling services for 2011-12 but current estimates are that if we include counselling activity in our calculations (not currently "countable" nationally) then this figure rises to nearer 11%. We therefore need to find a way of being able to consider the whole range of our activity for local people to get a clear picture of provision.

4.6 Counsellors and IAPT staff are part of the Mental Health Care Pathways group that supports the improvement of care pathways in B&NES and currently a pilot is being developed to improve pathways between IAPT and counsellors in 3 practices.

4.7 During 2012-13 it is our intention to further review the services as part of our commissioning processes in order to find the best way to implement the national plan, maintain choice and flexibility whilst aligning provision and reducing the confusion for services users about the different services. We also wish to ensure consistency in outcomes and activity reporting in order to be able to measure the impact for local citizens.

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

An EqIA has not yet been completed because this report is provided for information.

7 CONSULTATION

7.1 No specific consultation has been undertaken on the contents of this report.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; *Customer Focus;*

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer (Divisional Director – Legal and Democratic Services) and Section 151 Officer (Divisional Director - Finance) have not had the opportunity to input to this report, which does not have any direct financial or legal implications and is presented for information only. The Strategic Director and

Programme Director have had the opportunity to input to this report and have cleared it for publication.

Contact person	Andrea Morland, Telephone: 01225 831513
Background papers	Talking Therapies – A Four Year Plan of action. DoH 2011
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

National Policy Context for Talking Therapies

- Our Health, Our Care, Our Say (June 2005)
- Layard R. Mental health: Britain's biggest social problem? 2005
- The depression report: A new deal for depression and anxiety disorders. London:LSE Mental Health Policy Group. (2006)
- Initial evaluation of the two demonstration sites by David M Clark, Richard Layard, and Rachel Smithies LSE Centre for Economic Performance Working Paper No. 1648
- Putting People First (DH 2007)
- No Health without Mental Health (2011)
- Talking Therapies: A four year plan of action' (2011).

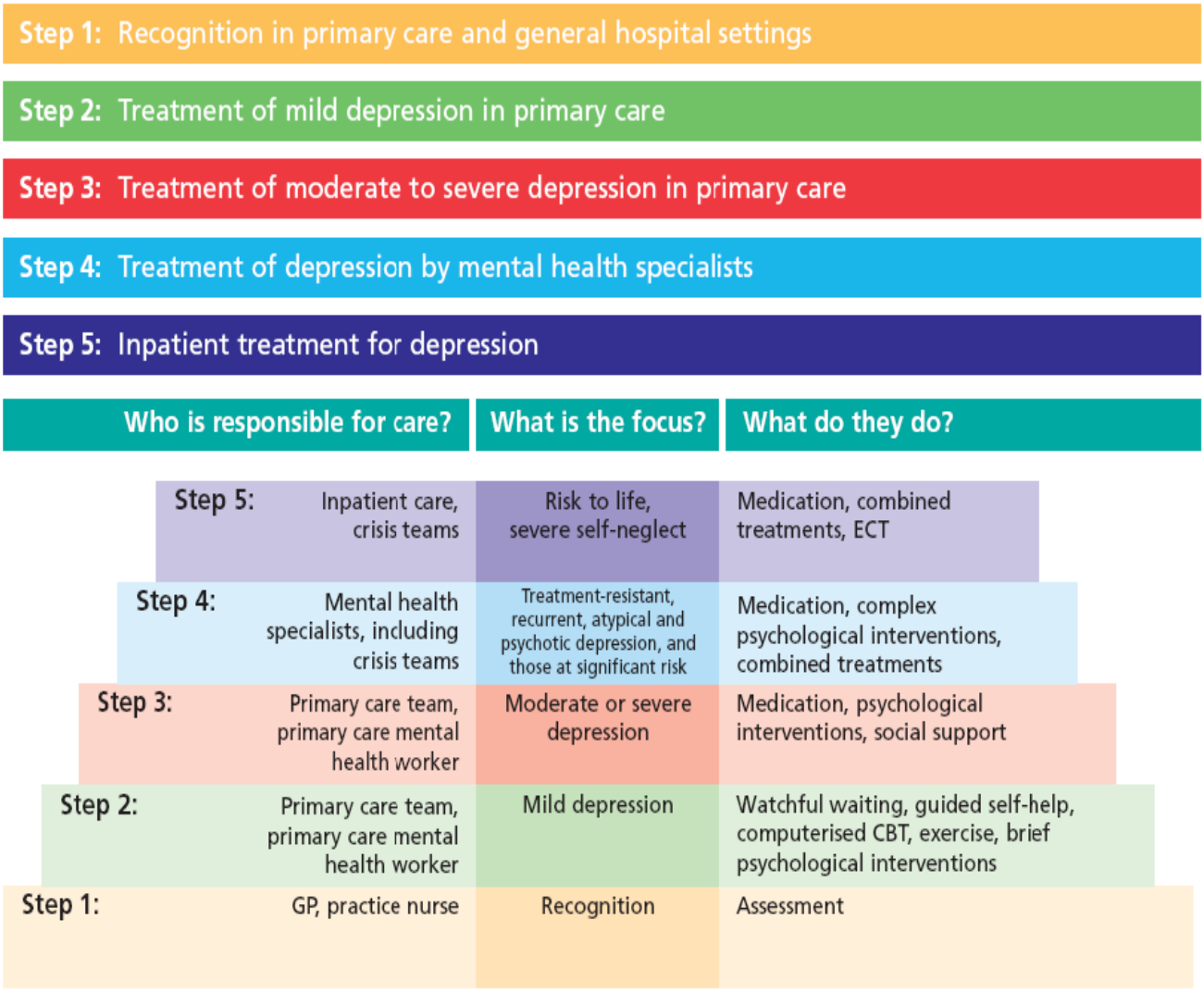
NICE Guidance for Primary Care Talking Therapies

- CG 90 Depression in adults
- CG91 Depression in adults with a chronic physical health problem
- CG 113 Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults
- CG31 Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD)
- CG26 PTSD
- CG16 Self–harm:The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care.
- CG 123 Common Mental Health Disorders
- CG78 Borderline Personality Disorder
- CG45 Antenatal and postnatal mental health

Appendix 2

The stepped care model

The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. Each step represents increased complexity of intervention, with higher steps assuming interventions in previous steps.



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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	18th May 2012
TITLE:	Alcohol Harm Reduction Strategy – Briefing Paper
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: **Alcohol Harm Reduction Strategy Action Plan 12/13**	

1 THE ISSUE

1.1 The Refreshed Alcohol Harm Reduction Strategy for B&NES was adopted and key priorities agreed by Cabinet on 11th April 2012. Implementation of the Strategy is overseen by the Alcohol Harm Reduction Steering Group through an annual action plan on the key themes of health and treatment, community safety, crime and disorder, children and young people and partnership working. The Government's new Alcohol Strategy was launched in March 2012 and it was agreed to review the local Strategy in light of the national strategy within 12 months. The involvement of the Wellbeing Policy, Development and Scrutiny Panel in this process is welcomed.

2 RECOMMENDATION

The Wellbeing Policy, Development and Scrutiny Panel is asked to:

2.1 Note the briefing report, the Action Plan for delivery of the Alcohol Harm Reduction Strategy and the intention to review this Strategy in light of the new National Strategy.

2.2 Consider nominating a representative to sit on the Alcohol Harm Reduction Steering Group.

2.3 Consider holding an enquiry day with relevant experts and stakeholders to formulate policy on approaches to key issues such as Early Morning Restriction Orders, late night levies and health bodies involvement in licensing decisions.

3. FINANCIAL IMPLICATIONS

2.4 The financial implications of the Alcohol Harm Reduction Strategy were agreed by Cabinet on 11th April 2012. The key implications are listed below:

2.5 Recurrent funding of £100,000 has been made available from within the pooled substance misuse budget through the strategic shift from three to two adult treatment providers. It has been agreed by the Joint Commissioning Group for Substance Misuse and the B&NES Clinical Commissioning Committee (23 Feb 2012) that these savings are used to increase alcohol treatment capacity. Specifically the funding will be used to deliver increased and enhanced services in line with NICE Guidelines CG115 on alcohol use disorders, specifically a programme of community detoxification support which includes access to psychological therapies. It will also provide additional Alcohol Treatment Requirements delivered through the Criminal Justice System.

2.6 B&NES Primary Care Trust has committed to continue funding the Alcohol Harm Reduction Project Officer post for 2012/13, based within the Council Public Protection Team. This post supports implementation of the Action Plan in relation to primary prevention work and building capacity for identification and brief advice within the community. The other elements of the action plans will be delivered through core business and existing resources.

2.7 From April 1st 2013, subject to Parliament, B&NES Council will have a duty to protect the health of the population, with overall responsibility for Public Health across B&NES. This includes the commissioning of alcohol and drug services. PCT budgets for Public Health will be transferred to the Local Authority from this date. Decisions relating to budgets for alcohol and drug services from 1st April 2013 will be the responsibility of the Council and therefore will be subject to review as part of the 2013/2014 Council Budget process and the corporate priorities of the Council and subject to approval by the Health and Wellbeing Board

2.8 Three year funding has been secured from Comic Relief to expand the work of the Young People's Alcohol Project within Project 28. This will enable the roll out of the Think/Drink Brief Intervention Tool to increase the skills of the local children's workforce in identifying alcohol problems, delivering brief interventions and/or refer on appropriately. The Comic Relief funded work is a standalone project which will build local workforce skills in early intervention and embed processes into mainstream delivery, ensuring sustainability once grant funding ends. There are no additional funding implications beyond the period of the grant.

2.9 Where additional needs are identified invest to save proposals/business cases will be developed as required.

3 THE REPORT

3.1 The Alcohol Harm Reduction Steering Group, chaired by the Director of Public Health, formed in April 2011 to take forward implementation of the Strategy. The group is currently meeting bimonthly to drive forward the Strategic priorities.

The following is a summary of key progress made to date:

- Development of a multiagency Action Plan which is monitored and updated regularly.

- Funding identified during 2011/12 for 10 additional Alcohol Treatment Requirements for clients in the criminal justice system via the Joint Commissioning Group for Substance Misuse.

- Identification of recurrent funding of £100K to increase access to community detoxification, psychosocial programmes of support in the community and enable on-going delivery of Alcohol Treatment Requirements from April 2012.

- Training delivered for over 100 professionals from health, social care, police, housing and mental health in Alcohol Identification and Brief Advice/Intervention. This has now led to the development of an Identification and Brief Advice (IBA) Training Network for professionals.

- Scoping of an enhanced data collection project in the Royal United Hospital Emergency Department which aims to provide detailed information on alcohol related attendances and violence/assault to support multiagency targeted prevention work. This project aims to start collecting data from September 2012.

- Introduction of a Community Alcohol Partnership in Midsomer Norton

- Co-ordination of a programme of alcohol awareness sessions between education, police and health in schools, colleges and with University students.

4.2 The Government's Alcohol Strategy was launched in March 2012. It commits to a number of key actions at a national level aimed at reducing binge drinking and associated crime and antisocial behaviour in particular:

- raising alcohol duty by 2% above retail inflation (RPI) each year to 2104/15

- changing criteria for lower rates of duty on cider which will ensure high strength ciders no longer qualify

- aligning duty more closely to alcohol strength

- the introduction of a minimum unit price on alcohol

- a review of the alcohol guidelines for adults

- inclusion of an alcohol check within the NHS Health Check for adults from April 2013

- a consultation on a ban on multi-buy promotions in the off-trade

- a review of current commitments within the Mandatory Code for Alcohol in relation to irresponsible promotions in pubs and clubs

- a consultation on anti-fraud measures, including the introduction of fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers

- Increasing the maximum fine for persistently selling alcohol to a person under 18 years to £20,000

- Encourage hospitals to share non–confidential information on alcohol related injuries with the police and other local agencies

- Amend the statutory guidance on the Licensing Act 2003 to clarify that Cumulative Impact Policies apply to both the on-trade and off-trade.

The Strategy also commits to giving local agencies additional powers to tackle alcohol related crime and antisocial behaviour. These include:

- From April 25th 2012, licensing authorities and local health bodies become 'responsible authorities' under the Licensing Act 2003, meaning they will automatically be notified of an application or review and can instigate a review of a licence themselves. There will also be a consultation on a new health-related objective for alcohol licensing related specifically to cumulative impact.

- The vicinity test on licensing is also removed, meaning anyone, no matter where they live, will be able to input into a decision to grant or revoke an alcohol licence, not just those that live in the immediate vicinity.

- A requirement on licensing authorities to publish key information about new licensing applications, including details of the address of the premises and guidance on how to make representations to the licensing authority

- From October 2012, there will be extended powers to make Early Morning Restriction Orders to support local areas to restrict alcohol sales late at night if they are causing problems and a new late night levy for businesses that sell alcohol late into the night, which can be used to cover the cost of policing and wider local authority action.

4.3 It is recommended that the Alcohol Harm Reduction Strategy is reviewed in light of the above and specifically in relation to agreeing an approach to the application of additional powers such as Early Morning Restriction Orders, late night levies and health bodies involvement in licensing decisions.

RISK MANAGEMENT

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

4 EQUALITIES

An EqIA has been completed on the Alcohol Harm Reduction Strategy. No adverse or other significant issues were found.

5 CONSULTATION

5.1 Ward Councillor; Cabinet Member; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer

5.2 Consultation has taken place throughout the whole process of Strategy refresh including meetings, workshops and one to one communication with stakeholder agencies and groups. Stake holders in the process included.

Strategy drafts were presented to:

- B&NES Children's Trust Board (Dec 2010)
- B&NES PCT Professional Executive Committee (Feb 2011)
- Responsible Authorities Group – (July 2011)
- Overview and Scrutiny Panel Healthier Communities and Older People (Mar 2011)
- Partnership Board for Health and Wellbeing (June 2011)
- Adopted by Cabinet (11th April 2012)

6 ISSUES TO CONSIDER IN REACHING THE DECISION

6.1 Social Inclusion; Young People;

6.2 The implementation of this strategy is relevant to social inclusion, young people, vulnerable people and vulnerable families and addressing health inequalities.

7 ADVICE SOUGHT

7.1 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	*Cathy McMahon, Public Health Development and Commissioning Manager, NHS B&NES cathy.mcmahon@banes-pct.nhs.uk 01225 831539*
Background papers	*Refreshed Alcohol Harm Reduction Strategy 2012*
Please contact the report author if you need to access this report in an alternative format	

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Health and Treatment						
Key Objective/Activity	**Outputs**	**Outcomes to be achieved**	**Lead agency**	**Lead postholder**	**Deliverable Date**	**Progress**
To increase treatment capacity for those who misuse alcohol.	Business case supporting reinvestment of unallocated funding.	Increased access to alcohol treatment services.	PCT/Council	Joint Commissioning Manager	Mar-12	JCG and CCC agreed that unallocated funds should be prioritised for re-investment in alcohol treatment services. Increased capacity now being implemented
To consolidate in primary care identification of local people who misuse alcohol and offer them brief interventions.	To ensure all GP practices are fully partcipating in the Direct Enhanced Service and all key practice staff are contributing.	Early identification of people who are misusing alcohol and access to appropriate level of support.	PCT	Assistant Director Primary Care/Public Health	On going	23 GP surgeries participating in DES for newly registered patients, 5 not participating at present. More support to be offered to encourage engagement.
To roll out identification of local people who misuse alcohol and to offer them brief interventions to other settings.	To offer brief intervention training to all frontline staff.	Frontline staff in a range of settings are confident to discuss alcohol and offer brief advice or intervention as appropriate.	PCT	Public Health Specialist	On going	Over 100 people from health, social care, mental health and voluntary sector trained. 18 trained as trainers. Evaluation currently underway. Trainer Network being developed during 12/13.
To support the implementation of workplace alcohol policies through the Workplace Wellbeing Programme.	•Alcohol policies developed with identified workplaces. • Delivery of alcohol awareness training session.	• Increased number of alcohol policies in local workplaces. • Improved awareness of how to address alcohol issues in the workplace.	Council/PCT	Project Officer Alcohol Harm Reduction	Mar-13	Work in progress. Alcohol Awareness Sessions delivered to May Gurney Staff.
Evaluate how effective alcohol harm reducing local services are and set up systems that routinely report their effectiveness.	Identify performance indicators and set up reporting mechanism.	Effective, evidence based and value for money treatmnet services.	PCT/Council	Commissioning Manager	Mar-12	Work in progress
To produce a comprehensive care pathway for people with alcohol misuse in B&NES that is clear to users, citizens, commissioners, and providers.	Review of pathways to be completed by sub group.	Clear route through pathway agreed across settings and with service users.	PCT	Police Inspector	Mar-13	To align with re-commissioning of adult and young people's substance misuse services in 2012/13.

Community Safety, Crime and Disorder						
Key Objective/Activity	**Outputs**	**Outcomes to be achieved**	**Lead agency**	**Lead postholder**	**Deliverable Date**	**Progress**
Increase awareness of processes for involvement in review of individual business licences.	Production of clear guidance and information regarding process and protocol for involvement.	Increased involvement of stakeholders in review process.	Council/Police	B&NES Licensing team	Mar-13	
Engage local communities and citizens on reducing alcohol related harm.	• Launch of community alcohol partnership in Midsomer Norton. • Community perception of alcohol related harm identified.	Active involvement of community in addressing local alcohol related harm.	Council	Community Safety Lead/Project Officer Alcohol Harm Reduction	Mar-13	Partnership meetings taking place.
Gather local evidence on inappropriate promotion of alcohol to inform debate on irresponsible promotions	• Report on local activity and concerns. • Engagement with off licence retailers where identified problems. • Review local information on where young people are accessing alcohol from.	• Reduction in irresponsible promotions of alcohol. • Reduction in access to alcohol via family & friends.	Council	Project Officer Alcohol Harm Reduction	Mar-13	
To widen access for people with alcohol dependency with Probation Services who cannot access specialised health services currently.	Business case supporting reinvestment of unallocated funding.	• Increased access to Alcohol Treatment Referrals. • Reduction in re-offending.	PCT/Council	Commissioning Manager	Mar-12	10 further ATR's funded via JCG Substance misuse until Mar 12. Further recurrent funding now agreed through JCG for Substance Misuse to continue this service.
To produce a code spelling out the clear and consistent messages around alcohol and the behaviour expected of B&NES citizens and visitors that local statutory agencies and citizens expect.	Produce code and consult to achieve a final version.	Clear messages communicated to the public.	Police/ Night Time Economy Group	Alcohol Harm Reduction Officer	Dec-12	Action adopted by the NTE group. Will report back on progress

Partnership Working						
Key Objective/Activity	**Outputs**	**Outcomes to be achieved**	**Lead agency**	**Lead postholder**	**Deliverable Date**	**Progress**
Identify the key local data & information sources for alcohol misuse priorities as part of JSNA.	• Information provided to JSNA development group to inform local priorities. • Local data gaps identified and action plan developed to address needs.	• Alcohol harm reduction agenda incorporated in JSNA. • Improved data sharing and understanding of local needs across agencies.	PCT/Council	Public Health Specialist	On-going	Alcohol Steering Group consulted on data gaps and information needs. Data included within JSNA. Data collection project initiatied within RUH Emergency Department
To better communicate to the general public and all stakeholder agencies the good local work that is tackling alcohol-related disorder in B&NES.	AHRSG Communications Plan for 2012.	• Increased positive reporting of local work to support alcohol harm reduction. • Improved co-ordination of campaign messages/targetting.	Council/PCT/ Police	AHRSG members	Jun-12	Work in progress.

Children and Young People						
Key Objective/Activity	**Outputs**	**Outcomes to be achieved**	**Lead agency**	**Lead postholder**	**Deliverable Date**	**Progress**
Timely access to effective specialist treatment provided to young people with alcohol problems.	Re-commissioning of specialist treatment to young people and monitor effectiveness through NTMDS reports and local quarterly reporting structures.	Timely access to effective specialist treatment provided to young people with alcohol problems.	Council	Imelda Murphy Strategic Planning Officer and Liz Ball, Manager of Project 28	Mar-13	Re-commissioning process now agreed and will start in June 12
Increase skills of the local children's workforce to identify alcohol problems and deliver brief interventions and / or refer on appropriately.	• Secure funding to extend scope of ASH project. • Train up to 100 staff from children's workforce to deliver Think/Drink Brief Intervention. • Deliver motivational interviewing training.	Children's workforce confident and skilled to address alcohol misuse with young people and undertake brief interventions as appropriate.	ASH (Alcohol and Sexual Health Steering Group)		On going from Feb 12	Comic Relief Funding secured. ASH Steering Group to write implementation plan.
Reduce alcohol misuse in targetted groups.	• Monitor numbers of young people receiving brief interventions. • Run 1 Happiness Zone Course. Project 28 Outreach service to work with CSP to identify and target hotspots.	Equitable access to services amongst vulnerable groups of young people.	Project 28	Liz Ball, Manager Project 28	Mar-12	Funding was identified and Happiness Zone Course run. Work on hotspots suspended due to Involve liquidation. Will start again when new service provider established.
Increase understanding amongst young people of alcohol related harm and where to seek help.	• Review The Big Act drama project which ran in 9 Secondary Schools and seek sustainable model for future delivery. • Under the influence programme to be rolled out to secondary schools. • Develop and roll out new PSHE resources to include alcohol resources. • Work with Alcohol Education Unit to provide free resources to all B&NES Secondary Schools. • Deliver programme of awareness sessions in Colleges and Universities.	Young people well informed of harm related to alcohol consumption.	Council/Police	Alcohol Project Worker/Police Youth Strategy Officer/PSHE & Drug Consultant	Mar-12	• Survey of participants currently being analysed. Under the Influence on track and Drug and alcohol sessions being delivered in 13 Secondary schools and 2 special schools (YR 8, 9 and 10). • 850 Students received harm reduction messages in Freshers week and advice and information has been provided to Bath College and Norton Radstock College Students (6 sessions to date).

Children and Young People						
Parents better informed about alcohol related harm and supported to encourage children to adopt a sensible approach to alcohol	• Plan and deliver a programme of alcohol awareness raising sessions for parents. • Produce leaflets for parents about young people and alcohol.	Informed parents.	Council	Alcohol Project Worker/PSHE & Drug Consultant	Mar-12	Work on-going and to be delivered through existing parents forums
Regulate and restrict supply of alcohol to young people	Intelligence lead test purchasing to continue.	Access to alcohol appropriately regulated and restricted.	Council	Trading Standards with support from Alcohol Project Worker	Ongoing	• Test purchasing continues and targets areas where local intelligence suggests underage sales may be taking place. • Proxy sale posters have been issued to off licences explaining law re; buying alcohol for young people.
Greater clarity on the extent of problematic alcohol use and better systems developed to monitor impact of work to address alcohol related harm	• Work with health to obtain data on numbers of under 18's alcohol presentations and admissions to RUH. • Pilot SHEU survey in Secondary Schools.	Improved intelligence to inform local activity.	PCT/Council	Alcohol Project Worker/Public Health/PSHE Consultant	Mar-12	• Data collection initiatied with RUH. • SHUE survey completed with 3438 pupils in year 8 and 10. Will repeated every 2 years and to be extended to include older young people via colleges in next round
Improve understanding of the support needs of children of substance misusing parents	Investigate current activity /needs and make recommendations for service delivery	Improved understanding of need to inform local activity	Council /Project 28	Liz Ball, Manager Project 28/ Young People Substance Misuse Group/Public Health	Mar-13	

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy, Development and Scrutiny Panel	
MEETING DATE:	Friday 18th May 2012	**AGENDA ITEM NUMBER**
TITLE:	Public Health Transition Assurance Plan. An update on transition of public health responsibilities from NHS B&NES to B&NES Council by April 2013	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Public Health Transition Assurance Plan		

1 THE ISSUE

1.1 This paper provides an update on the change of public health responsibilities from NHS B&NES to B&NES Council from April 2013. The accompanying Public Health Transition Assurance Plan outlines the processes being undertaken to manage this transition including the key tasks, milestones and governance arrangements.

2 RECOMMENDATION

The Wellbeing Policy, Development and Scrutiny Panel is asked to:

2.1 Note the information contained in the briefing and accompanying report.

2.2 Comment on any areas of concern or potential opportunity.

3 FINANCIAL IMPLICATIONS

3.1 Financial implications are being managed by the Public Health Transition Steering Group with input from finance colleagues of both the Council and the PCT Cluster.

3.2 Guidance has been published on the financial allocations for the transition year 2012/13, however public health and finance teams are still working to clarify the exact detail of available spend for the transition year by programme area. The future budget for public health work in the local authority has not yet been published. There is a risk, being monitored and managed by the Public Health Transition Group, that future resources available to B&NES Council may not match the requirements being asked of the council.

4 THE REPORT

4.1 Please see the attached report.

5 RISK MANAGEMENT

5.1 Key risks from the transition are being managed through the Public Health Transition Steering Group and are reported to the Change Programme Board monthly. In reference to section 3 above, the possibility that the new local authority allocation for public health is not equal to the demands of the new responsibilities is on the public health transition risk register. Ensuring sufficient project management capacity to support and implement the transition plan is another key issue currently being addressed by the transition group.

6 EQUALITIES

6.1 A key aim of public health is to reduce inequalities in health and social outcomes between different groups in the population. Securing a strong public health function will help identify the needs of vulnerable and high risk groups, help prioritise these in partnership strategies and support work to target interventions, improve outcomes and keep track of progress. There are no detailed proposals for changes to service delivery or staff at this stage so there is not yet and equality impact assessment. However, this is planned as part of the Change Programme Board reporting process as we move towards 2012/13.

7 CONSULTATION

7.1 Public engagement to discuss public health changes has happened through a Healthy Conversation event in February 2011 and a Local Involvement Network (LINk) meeting in April 2011. Similar communication with key partners and the public will be repeated later this year, as we begin to implement key parts of the transition plan. This is being dealt with by a specific communications and engagement strategy for the public health transition supported by communications officers from the council and the PCT. This is included in the attached report and appendices.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 There is no specific decision being sought at this point in time.

9 ADVICE SOUGHT

9.1 The Strategic Director for People and Communities has reviewed this report. The Monitoring Officer and Section 151 Officer have been copied into the report and will be asked to make formal comments as further detailed work is undertaken prior to any formal transfer of function.

Contact person	Paul Scott, Assistant Director of Public Health
Background papers	The Plan takes account of the following publications: • Healthy lives, healthy people: our strategy for Public Health in England (November 2010) • Healthy lives, healthy people: update and way forward (July 2011) • The new public health system: summary (December 2011)

	• Public Health in Local Government Factsheets (December 2011) • Public Health England's Operating Model (December 2011) • Public health transition planning support for primary care trusts and local authorities (January 2012) • Healthy lives, healthy people: Improving outcomes and supporting transparency (January 2012)
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Public Health Transition in Bath & North East Somerset

An Assurance Plan for the Public Health System in 2012/13 and 2013/14

Version 4, March 2012

Preface

This document sets out the plan for transition of the public health system in Bath and North East Somerset (B&NES) during 2012/13 and 2013/14. It has two key aims:

- To implement the changes set out in *Healthy lives, healthy people: our strategy for Public Health in England* (November 2010)

- To ensure continued delivery of all public health programmes in B&NES, maintaining high levels of quality and performance and maximising financial efficiency.

Within the plan there are many areas where planning continues to develop or where further guidance is expected and further analysis of the financial implications of the transfer needs to take place. This document represents the plans in place as at March 2012.

Dr Pamela Akerman
Acting Joint Director of Public Health
NHS Bath & North East Somerset & Council

22 March 2012

Version Control

Version	Status	Details	Lead Author	Date
1	Draft	First draft of document	Paul Scott	7/03/12
1	Draft	Input of specific information	Pamela Akerman and Denice Burton	09/03/12
1	Draft	Working draft	Paul Scott	12/03/12
1	Issued for comment to signatories, Cluster Executive Team and Public Health Transition Group			12/03/12
1	Draft	Amendments to: • finance • infection control • consultant appraisal • health protection • resilience • governance • overall formatting	Paul Scott	15/03/12
2	Final draft	Final draft – submitted to SHA		16/03/12
3		Amendments to: • finance • risk register • signatories	Pamela Akerman and Paul Scott	21/03/12
4	Final version	Amendments to: • governance • risk register • signatories • health protection rota	Pamela Akerman and Paul Scott	22/03/12

Contents Page

1 Purpose

In line with the 2012/13 NHS Annual Operating Plan requirements, public health directorates are required to submit a transition assurance plan. This needs to be done as part of the overall Primary Care Trust cluster integrated plan, which is due for submission to NHS South of England by 16th March 2012.

The information set out over the following pages forms the public health transition assurance plan for 2012/13 and beyond. It will be the key resource for local agreement on transition issues, jointly between B&NES Council and NHS B&NES / NHS Wiltshire.

2 Background

In 2010, the Department of Health set out changes to the public health system as part of the NHS White Paper. These included the creation of a national public health service, Public Health England, and the transfer of local public health responsibilities from Primary Care Trusts (PCTs) to local authorities.

During December 2011 and January 2012, a large number of policy updates were published by the Department of Health. These included:

- Public Health in Local Government, including policies on:
  - commissioning responsibilities
  - public health advice to NHS Commissioners
  - the role of the Director of Public Health
  - Public Health Human Resources Concordat
- The Operating Model for Public Health England
- Public health transition planning support for primary care trusts and local authorities
- The public health outcomes framework.

A summary for local stakeholders of key issues arising from these policy papers is provided in Appendix 1.

Guidance has also been published on the financial allocations for the transition year 2012/13, and public health and finance teams are currently working to clarify the exact detail of available spend for the transition year by programme area. Detail about the future local authority public health budget is to be published during 2012/13.

3 Vision for new public health system

The Department of Health sets out a new vision for local government leadership of public health. In B&NES, we support this vision and the intention for local authorities to use their new responsibilities and resources to put health and wellbeing at the heart of everything they do.

This vision encapsulates key themes:

- including the consideration of health and wellbeing in all council policies so that each decision seeks the most health benefit for the investment
- making effective and sustainable use of all council resources, using evidence and information to help ensure these are appropriately directed to areas and communities of greatest need and that represent excellent value for money for local people
- investing the new ring-fenced grant in high-quality public health services
- encouraging health promoting environments, for example, access to green spaces and active transport and reducing air pollution
- promoting community renewal and engagement
- tailoring services to individual needs, making them easier to reach and taking a more holistic approach to lifestyle change and wellbeing rather than a one focused on single issues

We envisage the council showing leadership across the three key areas of public health responsibility. These are:

Health Improvement (including people's lifestyles as well as inequalities in health and the wider social influences of health)

- strategy development and prioritisation
- development, commissioning and/or provision of healthy lifestyle services
- leading partnerships and development of strategies to tackle the underlying determinants of health and health behaviour
- contribution to health economy Quality, Innovation, Productivity and Prevention (QIPP) programmes

Health Protection

- emergency preparedness, resilience and response

- leading, co-ordinating and commissioning of immunisation programmes
- leading, co-ordinating and quality control of screening programmes
- outbreak management
- development and commissioning of community infection control and tuberculosis (TB) health services
- management of environmental incidents or concerns, with the potential to harm local people's health

Health Service Improvement

- support for Joint Strategic Needs Assessment
- support for B&NES Clinical Commissioning Group and general practice clusters
- facilitation of care pathway redesign
- evidence based policy development and prioritisation processes

4. Operating model for public health in B&NES during transition and from 2013/14 onwards

It is proposed that a public health service will be situated in the People and Communities Directorate of B&NES Council. The Director of Public Health will be a Chief Officer of the local authority and will have direct accountability to the Chief Executive Officer of the Council, and also to the Chief Medical Officer for England, through joint appointment with Public Health England.

Although public health staff will work closely with colleagues in the People and Communities Directorate (for example on child health, drugs, safeguarding and mental health), there will be strong links embedded across the wider council. These will be at the strategic level, through the influence of the Director of Public Health in meetings with Strategic and Divisional Directors and Cabinet Members, and the operational level through officer collaboration on a wide range of projects. These include the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy, licensing, active leisure, culture, spatial and transport planning. Many of these relationships are already in place, but could be strengthened further. Others are just beginning and a key role of the Director of Public Health will be to ensure that

impacts on population health and local inequalities can become a consideration in policy making that all parts of the council can commit to.

In delivering this transformation and vision, there are of course constraints to be identified and managed. Specific consideration of the key areas of human resources and IT are discussed in sections 10 and 12, later in this document on pages 45 and 46. A risk register for transition is in place and discussed later in the document. Separate to these are:

Constraints

The financial allocation for 2012/13 needs to be further analysed and understood, see section 12 on finance. In addition the financial settlement for 2013/14 will not be known until autumn 2012. These plans are subject to change arising from these analyses.

Sufficient human resources to plan and implement the changes. This includes ensuring enough people with the right mix of skills are sufficiently able to focus on transition issues in addition to their normal roles. To mitigate this, we are currently seeking additional project management capacity to support the public health management team in coordinating and delivering the plan during 2012/13.

This change comes at a time when the system is focused also on increased quality and productivity, so resource must be maintained on delivering robust public health programmes throughout the transition period.

Assumptions

- A key assumption for the project is the successful passage of the Health and Social Care Bill through the Houses of Commons and Lords and the Bill eventually receiving Royal Ascent.

- The B&NES Clinical Commissioning Group is authorised by 1st April 2013, and will work in shadow form from April 2013.

- The NHS Commissioning Board is established and functioning locally within 2012/13.

- Public Health England is established and functioning locally within 2012/13.

- Ring fenced public health allocations are made to local authorities by April 2013

- The Public Health Commissioning team will be part of an agreed council management structure in shadow form during 2012/13 before formal transfer in April 2013.

5. The B&NES approach to transition and local governance

In B&NES, the approach to transition has been a joint venture between the council and the PCT from the start building on the existing arrangement whereby the Director of Public Health is a Joint appointment and Public Health has been part of a broad integrated partnership arrangement between the council and PCT overseen by the Health & Wellbeing Partnership Board.

The local process has been managed through a Public Health Transition Group, chaired by the Strategic Director for People and Communities of B&NES Council and with representation from key senior officers of council, NHS and Health Protection Agency. The membership and Terms of Reference of this group are included in Appendix 2. Minutes of meetings are available upon request.

This group is managing key processes including accountability, finance, staff, risks and performance. The group reports on progress to the monthly Change Programme Board of the Council, and regularly, though less frequently, to the Health and Wellbeing Partnership Board, the PCT Board and the Wellbeing Policy, Development and Scrutiny Panel of the Council.

A draft outline transition plan was submitted in January 2012. This is included in Appendix 3.

The plan set out in the remainder of this current document forms the basis of the work programme for 2012/13 in relation to public health transition in B&NES. The risk register for the public health transition process is also attached, in Appendix 4.

The local public health system during 2012/13

The Public Health Transition Group has agreed that the public health team will continue to operate largely in its current way during the transition year 2012/13 and will be functioning both in a PCT role and increasingly as part of the People and Communities Directorate of the Council. However, the DPH in particular will be operating across the wider council building new shared areas of work with colleagues in the other two council directorates ('Places' and 'Resources'). The DPH will also be working closely with elected members to build the future public health roles of the wider council.

Transition milestones for 2012/13

The key milestones for the B&NES transition plan are as follows:

Key Milestone	Timeframe	Progress
Agree local transition plan for public health as part of the overall integrated PCT Cluster plan	March 2012	Complete

Develop a communication and engagement plan	March 2012	Complete
Agree approach to the development and delivery of the local public health vision	June 2012	On track through discussions with Strategic Directors and Cabinet Members of the Council.
Agree arrangements on public health information requirements and information governance	September 2012	Work plan in place (see later in document) and on track
Test arrangements for the delivery of specific public health services, in particular screening and immunisation	October 2012	
Test arrangements for the role of public health in Emergency Planning, in particular the role of the DPH and LA based public health	October 2012	
Ensure early draft of legacy and handover documents produced	October 2012	A PCT Cluster document has been produced and includes a dedicated public health section. This will be updated by October 2012, as new arrangements become more concrete.
Ensure final legacy and handover documents produced	January 2013	Draft document described above will be completed by January 2013 as part of overall integrated PCT cluster legacy document arrangements.

6. Providing leadership for health and wellbeing in B&NES

6.1 Health and Wellbeing Board

B&NES is part of the early implementer network of shadow health and wellbeing boards. This means that we are expected to transition from the current arrangement (a partnership board between council and PCT that governs commissioning of public health, health services and social care) to the 'shadow' board by April 2012 although it is noted that the Health & Wellbeing Partnership Board in B&NES will also continue to maintain its current responsibilities related to joint commissioning. A modified board arrangement will be in place by April 2013 at the same time as the clinical commissioning group (CCGs) takes on shadow responsibility for the NHS budget. We are on target to meet these timeframes.

Revised Terms of Reference for the Board are in draft format and will be approved by the Cabinet in the spring / summer 2012. The Terms of Reference set out the ambitions of the Board to:

- prevent ill health
- promote equality, health and wellbeing
- improve service quality
- deliver best value
- provide leadership and champion health and wellbeing.

Key successes to date include:

- Established partnership and strong commitment from Board members (including PCT, Council and developing CCG)
- Supportive of partnership and joint commissioning between health and social care
- Board member involvement in the developing JSNA

6.2 Board development

A development plan for the Board has been drafted. The Plan identifies a number of areas for development including the following:

Governance including legal responsibilities and relationship with scrutiny and other partnership boards, for example the Crime and Disorder Reduction Partnership and the Children's Trust.

Development and engagement of HealthWatch as a credible partner (as well as other public involvement). We will be developing a stakeholder engagement plan that will address some of this issue.

Engagement with providers especially large acute trusts

6.3 Joint Strategic Needs Assessment (JSNA)

The B&NES JSNA is being refreshed. Governance has been established through a JSNA steering group, comprising lead officers from Public Health, CCG, PCT Cluster, Local Authority Social Services, Children's Services and Policy. This group reports regularly to the existing Partnership Board for Health and Wellbeing Board. Terms of Reference for the group have been approved by the Health and Wellbeing Board and are attached in Appendix 5.

The overall process is project-managed by the Assistant Director of Public Health and the Local Authority Research & Intelligence Manager.

A project team consisting of analytical professionals from public health and local authority are responsible for the primary work and draw on knowledge from other departments/agencies as required.

The work is on target to complete in April 2012. This will involve:

- A short 15 page summary document of key JSNA outputs will be published, alongside a web-portal that will contain all the data and

evidence used in the JSNA process. A draft copy of this document is in circulation currently with the key information providers before being circulated further for comment from all partners.

- An ongoing work programme forming a continuous process that will inform on-going Board discussions and strategic priorities (departing from a previous emphasis on a single document, updated every one to two years).

The next Board meeting in April will focus on the outputs from the JSNA.

6.4 Health and Wellbeing Strategy

Following completion of the JSNA in March work will begin on Board priorities and the Health and Wellbeing Strategy.

The Board has agreed to focus on a series of top (15) priorities that will inform its work programme.

We are on target to have a draft Health and Wellbeing Strategy ready in the summer 2012.

Discussions are underway with CCG to ensure links with the CCG Plan.

6.5 HealthWatch

- Contract with current Link host extended to end of June 2012. New provider will continue LINk provision and manage HealthWatch pathfinder during period up to implementation.
- Clear vision in place informed by engagement and consultation and HealthWatch specification now completed.
- Cabinet has approved principles and plans for procurement.
- Procurement process commenced late February 2012.
- Expected to appoint provider in May/June.
- Resources are lower than hoped. Contract value expected to be around £80k.

7. Accountability and performance arrangements for public health during 2012/13

7.1 Accountability

During 2012/13 in B&NES, the B&NES PCT Board will retain the statutory responsibility for public health functions and outcomes until April 2013. The partnership arrangements that already exist within the council mean that a formal secondment is not necessary during the transition year. However, given the envisaged diminution of PCT capacity as we move towards October

2013 it may be appropriate to transfer functions utilising Section 75 of the National Health Service Act 2006 prior to formal transfer in April 2013. This will be decided by the Health and Wellbeing Board. From April 2013, the full accountability for public health responsibilities will transfer to the council and the DPH will have line management responsibility to the Strategic Director for People and Communities with professional accountability jointly to the Chief Executive of B&NES Council and the PCT Cluster.

Many of the decisions about public health issues are also influenced or taken at the B&NES Partnership Board for Health and Wellbeing and the GP led Clinical Commissioning Committee of the PCT.

The Health and Wellbeing Partnership Board will become the central point that brings together planning and accountability for delivery of NHS, social care and public health services. However, accountability for critical operational and financial decision making in relation to public health will remain with the PCT Cluster Board during the transition period until April 2013.

In addition, public health plans which have a direct relationship to NHS commissioned work and are of significant scale will need engagement with the Clinical Commissioning Group (CCG). This might be through the Clinical Commissioning Executive Board, the CCG, the PCT's Clinical Commissioning Committee, or through CCG representatives at the Health and Wellbeing Partnership Board or the Public Health Transition Group as relevant to the issue.

The Department of Health guidance on the development of Public Health England states that robust systems must be put in place to ensure that PCT cluster Chief Executives and their executive teams are fully cognisant of the public health responsibilities they retain and act accordingly.

This includes the requirement to have governance systems and management functions that enable each PCT DPH to fulfil their Executive Director function and Public Health advisory role for the relevant PCT until such time formal transfers of responsibilities take place. Processes for enabling this in B&NES will include:

- The DPH will continue to fulfil their role as an executive director on the PCT Board during the transition period.

- The DPH will ensure that public health advice is available for the PCT Cluster executive team. This advice may be sought from the B&NES or Wiltshire DPH, or both, as relevant to the issues under discussion.

- The DPH will be a core member of the Health and Wellbeing Partnership Board

- The DPH attends the Clinical Commissioning Committee, though in a non-voting capacity.

In terms of management arrangements, it is proposed that the DPH, the Assistant Director of Public Health and the Assistant Director for Health Improvement have authority under Section 113 of the Local Government Act 1972. This will allow the post holders to discharge duties on behalf of B&NES Council and to act as senior officers of the new People and Communities Department. Similarly, the Strategic Director for People and Communities, who is already accountable to the PCT CEO, operating under section 113 to manage children's and community health commissioning on behalf of the PCT, will have this arrangement extended to include managing Public Health responsibilities on behalf of the PCT.

7.2 Performance and risk

Performance and risk reporting will continue through the existing partnership arrangements during 2012/13. This involves monthly reporting on key indicators required through the NHS Operational Framework for 2012/13, alongside new or changed risks, through a report that goes to Clinical Commissioning Committee and the Health and Wellbeing Board.

Preparation has already begun within the council to enable us to monitor indicators from the public health outcomes framework, whilst recognising that this won't be operational until April 2013. An early framework for local monitoring of these indicators is being developed by the public health consultant and the strategic performance manager for the council.

NHS B&NES will receive assurance for their public health responsibilities in relation to performance and risk through the joint meetings of Cluster and Council Chief Executives with the DPH and also through the Health and Wellbeing Partnership Board.

A separate risk register dealing specifically with the transition process has been produced. This will be reviewed by the Public Health Transition Group and key risks will be reported to the council's Change Programme Board each month. The register will continue to be updated as Public Health England and associated national guidance develop further and as the transition progresses. This risk register is attached in Appendix 4

8. Transfer of commissioning arrangements and building relationships with partners across the new public health system

The new public health system places responsibility for improving public health and commissioning public health interventions with several national and local agencies namely; Public Health England, NHS Commissioning Board and Clinical Commissioning Groups (CCGs). Whilst this document focuses mainly on the transition arrangements for public health moving to the council

it is important to provide assurance for the transition of public health responsibilities to other destinations.

After April 2013 B&NES Council will be responsible for commissioning key public health services it will also have a responsibility for improving the health of the population it serves and will be taking an overall leadership role for public health arrangements in B&NES. This means that through the DPH and the Health and Wellbeing Board there will be a requirement to work together with all organisations responsible for public health and to advise and challenge the local plans of these other organisations for public health delivery in B&NES.

8.1 Public health functions and commissioning arrangements migrating to NHS Commissioning Board and Public Health England

The NHS Commissioning Board will be accountable for commissioning and delivery of the national screening and immunisation programmes. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening. This is a big shift from the current arrangements in which PCTs commission these programmes.

Directors of Public Health will provide challenge and advice to the NHS Commissioning Board on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board.

During 2012/13 B&NES public health will continue to hold accountability and commissioning responsibility for these programmes for the local population. However, we will be working closely with colleagues in the newly emerging NHS Commissioning Board and Public Health England to transfer this responsibility in a safe and effective manner in readiness for the new arrangements starting in April 2013. It is not anticipated that any of the staff from the public health team will transfer to these new organisations. Those staff with a remit including these programmes will continue to provide local scrutiny and play a part in quality improvement with the new national partners though the mechanism for this is still being set out by the newly emerging NHS Commissioning Board and Public Health England. Screening and immunisation are both covered in the more programme specific section that follows this one.

The NHS Commissioning Board will also lead the commissioning of public health funded services for children under five, including health visiting, the Healthy Child Programme and Family Nurse Partnership. And we will work closely during 2012/13 with our new partners to ensure that local public health priorities are incorporated and addressed by national specifications and contracts.

In B&NES the commissioning Contracts Stocktake, is being divided and grouped across the new landscape of commissioning leads, including the Council, CCG, NHS Commissioning Board and Public Health England. A copy of this available if required.

8.2 Public Health Commissioning responsibilities and public health advice (the mandatory 'core offer') to the Clinical Commissioning Group (CCG)

CCGs are taking on the direct commissioning of some services that have a public health or prevention element built into them or for which we are currently commissioning a prevention element. All public health commissioners will need to work closely with CCGs to ensure that appropriate pathways are developed for the population that include prevention and early intervention initiatives such as screening. The Health and Wellbeing Board will be the body to ensure that this coordinated working takes place.

In addition there is a need to address the ongoing role of using public health expertise to provide support to clinical commissioners. This is a core strand of public health work know as health service improvement public health (also known as health care public health). The new public health system requires this public health support to continue to be given to CCGs and has identified support to CCGs as one of the mandatory services to be provided by local authorities. The core functions to be provided will be know as the 'core offer'. Additional functions can be commissioned by CCGs from local authorities under contracts to be agreed. Plans for delivering the core offer are covered in the next section.

Our intention is that this advice forms part of a broader collaborative arrangement between public health, the council and the CCG. Moreover, we intend that collaboration would encompass all aspects of our joint remits across improving health, protecting health and improving the quality of local services. This would ideally be captured in a Memorandum of Understanding and will be developed and agreed during 2012/13 to be in place as soon as possible, and before April 2013.

9. Delivering public health responsibilities in 2012/13 and preparing for 2013/14

This section sets out the current and future arrangements for commissioning of key public health programmes, including (but not limited to) the five mandatory areas set out in recent policy papers from the Department of Health. These mandatory areas are:

- a duty to ensure plans are in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- appropriate access to sexual health services
- the National Child Measurement Programme
- NHS Health Check assessment.

Potential uncertainties or risks are identified for each programme, alongside plans to resolve these during the transition year 2012/13.

Please note, copies of Terms of Reference, Strategies and Minutes are available for these groups on request but given the scale and volume these have not currently been attached as appendices.

9.1 Health Protection

Accountability and governance for PCT Health protection responsibilities is currently to the PCT Board through the Health and Wellbeing Partnership. This will continue in 2012/13 through the shadow Health and Wellbeing Board. From April 2013 that accountability will be through the Health and Wellbeing Board to the Council.

The DPH is the strategic lead for health protection and for joint planning and response alongside the HPU and the council.

Current arrangements with the HPA will continue during transition.

The public health team is preparing an MOU between the PCT and the HPA for arrangements in 2012/13 and this will be finalised and signed by June 2012.

Arrangements between the LA and PHE (ie post April 2013) will be developed with an MOU in place before April 2013.

The Health Protection Agency locally will continue to provide surveillance of incidences as well as coordinating the response to any relevant outbreaks.

Public health specialists in BANES will continue to participate in the Avon health protection on-call rota.

9.2 Public Health Advice to NHS Commissioners

Public Health Advice to NHS Commissioners is currently provided by the DPH, a public health consultant, a public health intelligence analyst and two public health speciality registrars (although these last posts are supernumerary and subject to change). They provide a range of advice to commissioners including intelligence about population needs, analysis of health service variations and evidence about the effectiveness of interventions.

These staff contribute to the following groups, although because of the limited public health capacity available this is often as required rather than as core members. This is not an exhaustive list, but rather an illustration of the role.

- Clinical Commissioning Committee
- Long Term Conditions Group
- Cancer Local Implementation Group
- NICE group
- Quality Strategy Group
- RUH Clinical Quality and Outcomes Group
- Exceptional Funding Requests review group
- QIPP Leads group

We also have shared arrangements across the wider West of England area (encompassing the three BNSSG PCTs/Local Authorities and B&NES) with Bristol-based Consultants leading on dental public health, cancer, cancer screening programmes, some non-cancer screening programmes such as AAA screening and child death review panels.

These arrangements will continue throughout the transition period (2012-13) until superseded by the Core Offer (see below) and/or other suitable arrangements.

The Public Health West of England (WoE) Functions Project Group (which includes the three BNSSG PCTs and B&NES) was set up in October 2011 to take forward developmental work on the potential for collaboration with a Core Offer and ensuring PH advice to commissioners. It is currently shaping options and will then engage more widely with clinicians and partners and report in the summer.

In addition the Wiltshire and B&NES public health teams are exploring opportunities for collaboration on a Core Offer.

The Core Offer from April 2013 will consist of delivery of selected functions from the list of possible support functions as agreed between the Public Health team and the CCG. These would include more detailed aspects of the list below and would complement the contribution of other colleagues within the council, the CCG and the future commissioning support organisation:

- Assessing needs (Strategic planning)
- Reviewing service provision (Strategic planning)
- Deciding priorities (Strategic planning)
- Designing shape and structure of supply (Procuring services)
- Planning capacity and managing demand (Procuring services)
- Supporting patient choice, managing performance and seeking public and patient views (Monitoring and evaluation)

Our intention is that this advice forms part of a broader collaborative arrangement between public health, the council and the CCG. Moreover, we intend that collaboration would encompass all aspects of our joint remits across improving health, protecting health and improving the quality of local services. This will ideally be captured in a Memorandum of Understanding and will be developed and agreed during 2012/13 to be in place as soon as possible, and before April 2013.

9.3 Sexual Health

Access to all services providing contraception and sexually transmitted infections (STIs) testing and treatment services will remain free and confidential and available to all regardless of age, gender and place of residence. Contracts are in place with all providers to ensure this continues through 2012/13, with many beyond into 2013/14. Specialist providers, CASH and GUM will continue to offer a combination of walk in and booked appointments delivered 6 days a week, whilst general practice provide a comprehensive service ,including all LARC methods through booked appointments.

The sexual health programme board, chaired by the Joint Director of Public Health has council, primary care and PH membership and is responsible for providing strategic leadership and vision for improving the sexual health of B&NES, inline with the PH outcomes framework and JSNA. The board will ensure that the population of B&NES has and continues to have access to open-access, accessible and confidential sexual health services.

A post within the PH team currently has responsibility for oversight of the sexual health programme, this includes contract and performance management, service development/redesign. The post works directly to the DPH with a work programme agreed by the board. The current post holder commits a minimum of 2.5 days a week to sexual health. This post will be responsible for maintaining the provision of high quality accessible sexual health services during the transition and discharging the council responsibilities after April 2013.

Specialist sexual health services are provided by a number of organisations:

- The local acute trust (Royal United Hospital) provides the genitourinary medicine service including specialist HIV treatment. The contract and funding for this service does not currently sit with PH, this will have to be addressed as part of the transition work during 2012/13.

- Since October 2011 contraceptive and sexual health services have been provided by Sirona Care & Health CIC, a contract and service specification is in place which will ensure continuity of the service beyond April 2013. The budget for this service will be moved to PH during 2012/13, exact arrangements are yet to be finalised.

- PH commissions a full time sexual health improvement specialist post. The post, part of the Health Improvement service is provided by Sirona. A contract and service specification is in place until 2016 clearly setting out the role of the post. Key responsibilities include, delivery of the free condom scheme and young person's branding scheme, training and campaign work. The funding for this post currently sits with PH and will be transferred to the council.

- The Avon Chlamydia screening programme is commissioned to provide the necessary infrastructure to ensure a local providers offer Chlamydia screening to young people. The programme also manages results, signposts service users for treatment and encourages partner testing. NHS Bristol is the lead commissioner for the Avon programme and a contract is in place for 11/12, commissioners have agreed to sign a new contract for 12/13. Funding for the programme sits with PH and will move to the council. Commissioners will consider the future of the programme post March 2013 during 2012. NHS B&NES remains committed to offering Chlamydia screening through a wide range of services and reducing the prevalence of asymptomatic infections.

- Public Health has a LES is in place with 26 community pharmacies to provide free emergency hormonal contraception, pregnancy testing, condoms and Chlamydia treatment. The funding for this service sits with PH whilst payments are made through the medicines management team. This arrangement will continue in 2012/13 and whilst there is a commitment to continue contracting with pharmacies beyond 12/13 exact details on contractual arrangements will need to be agreed during the transition period and as a result of further national guidance.

- A range of initiatives specifically aimed at reducing teenage pregnancy rates are funded via the council with strategic leadership provided by the sexual health programme board. These include training for professional working with young people, looked after children's service. These projects are overseen by the Teenage Pregnancy Training and Development Officer, whilst employed by the council this post works in partnership with

the PH programme lead. Funding is currently committed for 12/13 with a work plan in place and agreed by the board.

- GP practices have been invited to sign up to a long acting reversible contraception LES for 2012/13. The LES will be jointly funded by PH and the primary care team, with budgets being aligned during 2012/13. It is not clear if the council will directly commission services from primary care contractors, if this is not the case then the necessary arrangements will be made to ensure the continuation of the service.

- Enhanced sexual health provision in schools and youth centres is delivered by the school nursing service (provided by Sirona) and offered on a drop in basis. This service is part of the school nursing contract, commissioned and performance managed by the council and in partnership with the PH team. Arrangements for this are being discussed in order to clarify transition issues to the NHS Commissioning Board for commissioning of school nursing contracts and how council concerns can continue to be incorporated from April 2013.

- The Health Protection Agency locally will continue to provide laboratory services, surveillance of incidences of HIV and STIs, as well as co-ordinating the response to any relevant outbreaks. From April 2013 Public Health England will take over these responsibilities.

To ensure all elements of the care pathway and patient journey remain joined up it is critical that the sexual health programme board and PH commissioner works closely with both the CCG and NHS CB during transition and beyond. Whilst primary care is already represented on the programme board a member of the CCG will be invited to join thus promoting and developing a shared strategic vision. The Health & Wellbeing board will provide the opportunity to ensure joined up commissioning for sexual health services by bringing together key stakeholders including GPs, commissioners and PH representatives.

9.4 National Child Measurement Programme

Child obesity, underpinned by National Child Measurement Programme (NCMP) data, is a public health outcome indicator and the programme is well supported and implemented locally. It is also one of the services mandated to be commissioned by the council from April 2013 onwards.

The delivery of the weighing and measuring of children for the NCMP is agreed through a Service Level Agreement (SLA) with the School nursing service in Sirona Care and Health, with a regular virement of funding on a recurring basis.

Public health commissioning managers have worked alongside public health intelligence and wider partners (local authority, school nursing, schools and third sector), to develop a process for safely and effectively sharing NCMP data which does not contravene guidelines and protocols around the sharing of data. In particular data have been useful for the targeting of healthy weight interventions and activities, informing priorities for schools working on initiatives such as healthy schools/healthy schools plus. We have also trained school nurses so that they are able to effectively support schools to interpret and use their findings as part of a wider school health profile in the future. We plan to continue to use NCMP data as part of school health profiles into the future.

There is still some uncertainty about the roles and functions the current school nursing team will undertake in the future given the changes to the national funding and organisation of health visiting and school nursing services.

We work closely with child health partners in the local authority and the emerging NHS Commissioning Board during 2012/13 to ensure that the council is in a position to continue commissioning the NCMP from April 2013, and that this ties in with the commissioning of these related services for which the council will not have responsibility.

9.5 NHS Health Checks

NHS B&NES has made significant progress rolling out the NHS Health Check programme during 2011/12. The implementation of the programme has been overseen by the NHS Health Checks Commissioning Group, the group is chaired by a local GP and has public health, finance, IT and commissioning membership and is supported by a dedicated Public Health Commissioning manager.

To maximise uptake the commissioning group consider that general practice is best placed to provide NHS Health Checks. Currently all GP practices in B&NES provide NHS Health Checks to their eligible population and this is delivered via a local enhanced service. Practices are paid for all completed checks and not for the administrative function of sending out invitations etc, it

is anticipated this will result in an uptake of over 50%. Early data suggests practices are making the required number of offers and uptake is as expected however it is difficult to validate this until a full year's data is received.

A full roll out is planned for 2012/13 and the commissioning group has agreed that general practice should continue to provide Health Checks, a LES will be issued during March. The commissioning group meets quarterly and will continue to monitor performance and outcomes, this will continue during 2012/13 and beyond.

From April 2013 the council will provide the necessary resources, (this will include a PH commissioning manager post that will move from the PCT to the council) to ensure NHS Health Check's continue to be offered every five years to those eligible aged 40-74. This is one of the services mandated to be commissioned by the council from April 2013 onwards.

The commissioning group will continue to provide strategic and clinical leadership and it is anticipated that use of locally agreed contracts with practices will continue, however consideration will be given to the use of other providers if this is felt beneficial. The budget for the NHS Health Checks programme currently sits will Pubic Health, and should therefore minimise complications when transferring to the council, and this is part of the current stocktake activity.

The NHS Health Checks Commissioning Group will be responsible for the overall quality of the programme. There are rigorous systems in place to ensure general practice provides a constantly high quality service, this is supplemented by the use of the LES which sets out the specific requirements of delivering NHS Health Checks.

Commissioners will continue to offer training updates for practice staff and maintain effective lines of communication, this is important to ensure national and local guidance is cascaded as appropriate. There will also be the opportunity to share best practice across all practices.

Practices are required to submit data on a quarterly basis, this will be analysed and if the data indicates potential problems then the practice will be contacted and if necessary support offered. Practice visits and audits will be undertaken if required. From April 2013 the PH team will work closely with the local clinical commissioning group (CCG) to link quality in the Health checks Programme to the quality programme led by the CCG.

The assessment and if necessary offer of lifestyle interventions is a key part of the NHS Health Check offer made by GP practices, this is underpinned by a contractual framework (local enhanced service). In line with national guidance the LES clearly describes what the assessment should look like and when lifestyle interventions should be offered. All practices have received a copy of the most recent national guidance.

It will be critical that the programme continues to have clinical leadership and support to ensure its long term success. The NHS Health Checks Commissioning Group will continue to oversee the contractual arrangements with general practice to ensure pts with high risk are managed appropriately and safely, within primary care. The council will work with the CCG as part of future collaborative arrangements, to ensure robust clinical pathways are in place across both primary and secondary care. In is proposed that this will form a component of the future Memorandum of Understanding between Public Health and the CCG.

9.6 Screening programmes

NHS B&NES currently commissions all of the National Screening Committee (NSC) recommended screening programmes. These include:

Antenatal and Child Health Screening

- Sickle Cell and Thalassaemia
- Antenatal Infectious Diseases
- Newborn Blood Spot
- Newborn Hearing
- Down's Syndrome
- Fetal Anomaly 18+6-20+6
- Newborn & Infant Physical Examination

B&NES is an associate commissioner with NHS Wiltshire being the lead.

Abdominal Aortic Aneurysm Screening
B&NES is an associate commissioner with NHS Bristol being the lead.

Diabetic Retinopathy Screening
B&NES is the lead commissioner on behalf of NHS Somerset and NHS Wiltshire.

Bowel Cancer Screening
B&NES is an associate commissioner with NHS Wiltshire being the lead.

Breast Cancer Screening
B&NES is an associate commissioner with NHS Bristol being the lead.

Cervical Cancer Screening
B&NES is an associate commissioner with NHS Bristol being the lead.

All of these programmes are governed by multi-disciplinary programme boards and report on Key Performance Indicators and National Quality Standards on a quarterly basis, either to the Department of health or to local Programme Boards.

National policy cited earlier has indicated that from April 2013 commissioning screening programmes will be the responsibility of the NHS Commissioning Board, mandated by Public Health England (PHE). The NHS Commissioning Board will need to work in collaboration to achieve this, particularly with GP Clinical Commissioning Groups. PHE will have responsibility for national screening programme policy and programme quality assurance. There will also need to be more local arrangements for assurance and oversight of safety and quality, where the Director of Public Health will play a significant role.

During 2012/13 PCT Clusters will retain the commissioning responsibility for screening programmes during transition and to ensure provision of public health screening expertise in the commissioning arrangements.

Public health, commissioning colleagues and service providers will work together during the transition year, along with the newly emerging NHS Commissioning Board 'local offices', to bring all the constituent parts of screening programmes together to ensure effective future governance, performance management and risk management from April 2013 onwards.

In creating these arrangements, public health within the local authority will retain a scrutiny and review role of local screening programmes on behalf of the local population. The Director of Public Health will therefore continue to maintain this function, which is currently led by a consultant in public health with lead responsibility for screening programmes.

In addition to handover processes for contracts and commissioning, it will be an important priority to create a model that enables the DPH to continue to effectively engage with the governance and safety of screening programmes from April 2013 onwards.

9.7 Immunisation programmes

Child immunisation programmes in B&NES are part of the standard primary care contract and additional services such as child health systems are commissioned by NHS Children's Services commissioners, hosted within B&NES Council.

Children's services and public health monitor performance for these programmes and report regularly to the Health and Wellbeing Board. Although commissioning of these programmes will move to the NHS Commissioning Board from April 2013, the council will continue to provide scrutiny of these immunisation programmes to ensure that population uptake is adequate across the district and within different groups. How this role will work is still to be determined during 2012/13 with the emerging NHS Commissioning Board and Public Health England, and also as part of collaborative arrangements with the CCG.

Arrangements for immunisations for teenagers, including HPV vaccination and the teenage booster will need to be clarified further during 2012/13 but with current expectation that these will be commissioned by Children's Services within the council which retains responsibly for commissioning health programmes aimed at children aged 5-19 years.

Seasonal flu vaccination is commissioned by adult services within the PCT at present, however this will switch to the NHS Commissioning Board from April 2013, and so a similar need for clarification will be established during 2012/13 about commissioning arrangements for clear routes for local public health scrutiny and influence.

For pandemic flu arrangements, the model used during the swine flu pandemic would still be used during transition and are in a state of readiness, should they need to be activated. This is the position for the whole of the South West and all Local resilience fora.

As the new Emergency Preparedness, Response and Recovery (EPRR) structure and model of operations is developed under Local Health Resilience Partnerships (LHRP), public health leads will agree and confirm any changes to the model that would be used. Until then, existing models and procedures will remain operational.

9.8 Drugs and alcohol services

No changes are proposed to the existing arrangements for commissioning substance misuse services, which have been in place for four years. During this period significant improvement has been seen in Key Performance Indicators and Outcomes, which has been acknowledged by the National Treatment Agency.

The LA already administers the substance misuse pooled budget and the integrated commissioning of substance misuse services falls within the portfolio of the Strategic Director, People & Communities. The Programme Director, Non-Acute Health, Social Care & Housing Chairs the Joint Commissioning Board, which has strong participation from all public sector partners.

There are clear lines of accountability from the Substance Misuse Commissioning Manager through the Associate Director for Mental Health & Substance Misuse to the Programme Director and on to the Strategic Director.

The Joint Commissioning Group for Substance Misuse, chaired by the Programme Director, and attended by the Director of Public Health currently oversees delivery of services funded by the pooled treatment budget. This group reports to the Responsible Authorities Group & Clinical Commissioning Group. Both the Director of Public Health and Chair of Clinical

Commissioning Group are represented on the Health and Wellbeing Board which ensures strong Governance.

Treatment services are currently commissioned via two main providers: DHI and SDAS which have contracts until March 2013. The needs assessment is being refreshed for 2012-13 which supports the annual strategic treatment plan. Baseline estimates for 12/13 service provision have been identified and agreed.

Young people's substance misuse services are commissioned & managed separately via local authority staff in Children's services at present (allocated staff member in place to do this) however a plan has been agreed to jointly re-commission adult and young people's services together during 2012-13. New contracts to be awarded from 1st April 2013. The children and young people's substance misuse group oversees this work and reports in to the Joint Commissioning Group for Substance Misuse.

Public Health lead the delivery of the B&NES Alcohol Harm Reduction Strategy, which has been agreed by the Professional Executive Committee (prior to the creation of the new Clinical Commissioning Committee), the Health and Wellbeing Partnership Board and the Children's Trust. The Strategy will be presented to B&NES Council Cabinet in April 2012. There is dedicated staff resource in place to lead the Strategy implementation, monitoring and evaluation. The Strategy is overseen by the Alcohol Harm Reduction Steering Group which is a multiagency alliance, facilitated by Public Health Development and Commissioning Manager. Strategy covers key areas of health and treatment, crime and community safety, children and young people and partnership working.

Alcohol Harm Reduction services are commissioned from the local authority via a service level agreement until 31st March 2013 which provides funding for a project worker to focus on prevention activities and capacity building amongst the local workforce. These services are reviewed annually and our intention would be to continue to commission services in 13/14 subject to confirmation of budgets.

The Alcohol Harm Reduction commissioning arrangement will need to be reviewed in light of the transfer to Local Authority and relationships across departments within the Local Authority.

A single route of accountability is needed in to the Health and Wellbeing Board for all Alcohol and Drug services (Prevention through to Treatment for Adults and Children & Young People) and this needs to be agreed during 2012/13 between local partners in order to simplify and strengthen accountability for Alcohol and Drug Prevention and Treatment work.

The Home Office element of the DIP funding (from pooled budget) will transfer to Police and Crime Commissioner and therefore needs to be

reviewed and agreed between partners agencies during 2012/13 to ensure allocation is retained for Drug and Alcohol Treatment services.
For this issue in relation to children and young people, Public health has commissioned the Schools Health Education Unit (SHEU) health related behaviour questionnaire for state schools in B&NES in 2011. We have plans in place to undertake repeat surveys every two years with pupils in years 4,6, 8 and 10. The rationale is to provide self reported lifestyle information on a range of health behaviour issues to inform the Joint Strategic Needs Assessment in relation to children and young people. Over time, the data will provide smoking prevalence data among young people and we will be working with local authority partners and to inform a range of initiatives e.g. in relation to healthy schools activity and targeting of schools for the ASSIST programme.

Public Health has purchased a 3 year licence for the delivery of ASSIST (evidence based peer influencing smoking prevention programme targeted to children aged 12-13 years). We have plans to renew the licence in 2013. The programme is delivered by the Health Improvement Service (Sirona) as part of our 5 year contract with the service.

9.9 Tobacco control and smoking cessation services

Public Health currently lead on the commissioning of Smoking Cessation and Tobacco Control work in B&NES. B&NES is part of a South West Regional Commissioning Group for Tobacco Control which delivers agreed Tobacco Control priorities through Smoke Free South West.

A Band 7 Development and Commissioning manager in the Public Health team is responsible for commissioning Tobacco Control & Smoking Cessation Services.

Current commissioning arrangements for Smoking Cessation and Tobacco Control are via a number of local providers: Sirona Care and Health (Specialist Stop Smoking Service and Tobacco Control work), GP surgeries/Pharmacies via LES, Wiltshire Maternity Services (Pregnancy) and Avon and Wiltshire Partnership (Mental Health).

All of the above contracts are reviewed annually and services commissioned until 31st March 2013. The Sirona Contract is a 5 year contract to 2016; however it can be reviewed from April 2013. Additional Tobacco Control work is also commissioned collectively via Directors of Public Health across the South West, through the provider 'Smoke Free South West'. Currently, Smoke Free South West are negotiating with Directors for a further 3 year contract which is likely to be agreed before April 2012.

Our intention is to continue to commission services as above into 2013/14, subject to confirmation of budgets. There is a need to clarify the future link between maternity services contract management and public health as

funding is no longer from a public health budget, it is now part of block contract.

There is also a regional Options Appraisal taking place regarding the commissioning of Stop Smoking Services across the South West. The outcome of this appraisal will be known by end of March 2012. This may affect how specialist support services are commissioned and delivered in the future and may require change during 2012/13 in preparation for 2013/14 when the council takes on this responsibility.

Discussions have not yet taken place in relation to the emerging NHS Commissioning Board and CCG's responsibilities for related commissioning to optimise referral/data monitoring and prescribing of cessation pharmacotherapy. These will be taken forward by public health leads during 2012/13.

In relation to young people, smoking prevention with children and young people is addressed through PSHCE in schools. There is a lead post for PSHCE in the School Improvement and Achievement Service in the local authority.

School nurses also give input to PSHCE in class time in addition to offering smoking cessation support as part of their core contract

Public Health has commissioned the Schools Health Education Unit (SHEU) health related behaviour questionnaire for state schools in B&NES in 2011. We have plans in place to undertake repeat surveys every two years with pupils in years 4,6, 8 and 10. The rationale is to provide self-reported lifestyle information on a range of health behaviour issues to inform the Joint Strategic Needs Assessment in relation to children and young people. Over time the data will provide smoking prevalence data among young people and we will be working with local authority partners and to inform a range of initiatives e.g. in relation to healthy schools activity and targeting of schools for the evidence based ASSIST programme.

Public Health has purchased a 3 year licence for the delivery of ASSIST (evidence based peer influencing smoking prevention programme targeted to children aged 12-13 years). We have plans to renew the licence in 2013. The programme is delivered by the Health Improvement Service (Sirona) as part of our 5 year contract with the service.

The future of the lead PSHCE consultant post is unclear beyond March 2013 as is the future of the whole School Improvement and Achievement Service. They are moving toward primarily targeting vulnerable children and young people. Public health leads will work with local partners to ensure that public health commissioning responsibilities are clearly set out and taken forward by April 2013.

9.10 Breastfeeding services

At present, there is a commissioning lead for breastfeeding within the public health team, who is working closely with the Early Years and Extended services (children's centres) and the children's health commissioners to commission breastfeeding services. Joint commissioning is being considered to increase value and ensure coverage across all of B&NES. The SLA in place may be affected by the move to commission health visiting from the National commissioning team and the impacts of these need to be worked through during 2012/13.

PH managers contribute to the monitoring of the Health visiting service contract, and are involved in the setting of the outcomes in relation to public health indicators.

The strategy is in draft format and local implementation meetings have not been held regularly due to capacity; however action against the strategic vision has continued despite this. Discussions are in place considering the relationship between Wiltshire and B&NES and the benefits of a joint strategy considering the commissioning arrangements of maternity services and the cluster arrangements.

The breastfeeding strategy needs to be monitored more effectively and there are mechanisms in place for it to feed into the Children's Trust board, through the Children's Healthy Lifestyle group or the Children's 0-5 group which could improve monitoring. There is a question about how or whether it should feed into the healthy weight governance structure as well and this needs consideration / agreement during 2012/13.

The public health intelligence function in the public health team routinely analyses the breastfeeding data which is shared with relevant providers in the form of a scorecard and used to target services

The local children's centres, NCT, La Leche League and local women were involved in the development of the draft local strategy and will be invited to join in the local implementation meetings. The commissioned services are tasked with engaging local women in peer support programmes (offering women to women support). These women's experiences are considered routinely.

The local Maternity Services Liaison committee which covers Wilshire, B&NES, Salisbury and Swindon is working on its engagement of service users and facilitates a service sub-group. Women feed into the agenda through an issues tracker.

Significant local inequalities in infant feeding are highlighted in the JSNA, the local Health and Wellbeing Board will decide on local priorities based on local needs. In B&NES the overall breastfeeding rates are consistently higher than regional and national averages and thus breastfeeding may not necessarily

be deemed a high priority in B&NES. The need for targeted work continues to be highlighted.

A SLA is in place with the Health visiting service in Sirona Care and Health to deliver the final stage (3) of UNICEF UK accreditation. Wiltshire Maternity Services (Great Western Hospitals trust) are commissioned by NHS Wiltshire to progress to the final stage (3). Both services will be assessed in Autumn 2012. A financial commitment will need to be maintained in order to maintain the standards. Re-assessment will be undertaken in 2014.

B&NES has signed up to the national Breastfeeding Welcome scheme. Local materials have been produced. The SLA with the health visiting service has been amended to incorporate non-recurring initial set up and co-ordination time. Consideration to the maintenance of the scheme will need to be embedded into the overall SLA for breastfeeding services.

9.11 Public mental health services

Current delivery mechanisms for adult public mental health are led through the Suicide Prevention Group. This is a multi-agency group chaired by a Consultant in Public Health with membership including commissioners, secondary care, mental health trust, community and voluntary mental health groups, Child and Adolescent Mental Health services and improving access to psychological therapies. The group has a remit that covers suicide prevention and self-harm reduction.

The current B&NES Suicide Prevention Strategy and action plan are under review and a refresh will be completed by September 2012. Emotional wellbeing work has been included in the general contract for 2011/12 with the PCT's main provider of community health improvement services and this is intended to continue for 2012/13 and beyond.

Suicide prevention and self-harm reduction feature in the Public Health outcomes framework and so it is anticipated this work will continue in a similar format after April 2013. It is anticipated that the lead commissioner for mental health will be situated from April 2013 in the People and Communities directorate of B&NES Council. This will make joint working on these issues relatively straightforward and similar to current arrangements.

In future, there may be less contact and therefore influence with clinical staff and NHS commissioning staff and so the public health lead will ensure continued clinical engagement with the suicide prevention group and the work to refresh the strategy and the action plan during 2012/13. Public health will also seek to continue engagement with clinical mental health pathway work during 2012/13 and beyond.

There is a potential risk that data sharing becomes more difficult between local health service providers and public health situated within the council.

This needs to be considered as part of new data sharing protocols with existing and emerging NHS organisations and this is picked up specifically later on in this document under the IT and Intelligence transition workstream with an associated work programme.

9.12 Dental public health services

During 2012-13, current shared arrangements for Dental/Oral Public Health Services (across the four West of England PCTs) will continue. A Dental Survey and an updated needs analysis are in progress (and due to report in 2013 and summer 2012, respectively). These will provide up-to-date analysis to inform local JSNAs (regarding local needs and prioritisation), and will be available on transfer of responsibilities (e.g. to PHE, the NCB and the Local Authority).

Dental Services are currently commissioned though the PCT's Dental Commissioning Team. Service developments and reconfiguration of services are informed by the needs of the population and co-ordinated through the Avon Dental Project Steering Group and an Oral Health Improvement Task and Finish Group, both of which have inputs provided by a Consultant in Public Health. This arrangement will continue until superseded (e.g. by the Core Offer or PHE resource).

Public Health will continue to lead on Oral/Dental Health Improvement commissioning functions during the transition and in the Local Authority from April 2013.

Bristol PH will continue its West of England lead role until the Core Offers to CCG are finalised and local leadership and shared responsibilities arrangements and roles are redefined. The public health West of England Functions Project Group (inc. BNSSG and B&NES) is taking forward this developmental work, shaping options and will report during 2012/13.

The Pan-Avon (West of England) Oral Health Improvement Strategy continues to be implemented (2010-15) and current arrangements will remain the same throughout the transition period.

9.13 Accidental injury prevention

Public health currently lead on the commissioning of Injury Prevention work across B&NES and work in partnership with NHS Bristol, NHS South Gloucestershire and NHS North Somerset to maximise efforts across the 'Avon' area.

The Avonwide Injury Prevention Partnership works to the Avonsafe Injury Prevention Strategy 2008 – 2013 which prioritises evidence based prevention activity for children under 5 years and older people (over 65's). The partnership is steered by NHS Bristol, NHS South Gloucestershire, NHS

North Somerset and NHS B&NES who jointly fund a co-ordinator post and employ local injury prevention workers to deliver local interventions.

The Strategy will be reviewed from April 2013. There is currently a memorandum of understanding across the 4 PCT's to fund the co-ordinator post until March 2013 and the intention is to continue this approach for 13/14.

The PCT is represented by the co-ordinator post on the West of England Road Safety group and South West Home Safety Council. There is also an Avonwide Older People's group which co-ordinates multiagency falls prevention work across the area.

Public Health currently fund an Injury Prevention Officer based within the local authority via a service level agreement until March 2013. This post facilitates the local multiagency Avonsafe partnership which delivers on an annual action plan focussing on home safety for children and older people. The work of this group is reported to the Local Safeguarding Board and Children's Services are represented on the Avonsafe group.

Our intention is to continue this work into 13/14 following confirmation of budgets however commissioning arrangements are likely to change due to the move to local authority and need to worked through in anticipation of the new arrangements during 2012/13.

Falls prevention is currently the responsibility of a senior NHS commissioner. It is anticipated that this function will move to the People and Communities directorate of the council and so during 2012/13 we will need to confirm arrangements for future commissioning from April 2013.

9.14 Behaviour and lifestyle campaigns to prevent cancer and long term conditions

Local leadership for cancer prevention work comes mainly from the Avon, Somerset and Wiltshire Cancer Network and separately from a jointly funded Consultant in Public Health who leads aspects of this work on behalf of the four West of England PCTs (B&NES, Bristol, North Somerset and South Gloucestershire).

The work focuses on supporting and acting upon the National Awareness and Early Diagnosis Initiatives, on bowel cancer and lung cancer and continuing local initiatives on awareness and early diagnosis of urological (kidney, bladder), lung cancers and supporting Cancer Network wide initiatives such as Signs for Survival.

This is supported more directly in B&NES through the Local Implementation Group (LIG) which is a multi-disciplinary group of commissioners and clinicians, with specialist public health input as required.

We will also continue to undertake small opportunistic campaigns linked to national awareness weeks or months, such as Cervical cancer awareness week in June, and Breast cancer month in October.

Long term conditions (LTC) work in B&NES is led through a multi-disciplinary project team, linked to the National LTC Development Programme. A consultant in Public Health is part of this work programme. During 2012/13 and beyond we will be working with our integrated community health and social care provider to ensure that the behaviour change skills available from the Healthy Lifestyle Service (also now situated in the community provider) become linked to all of the other more clinical services working with people who have long term conditions, through robust referral pathways and also through training and support for the more clinically orientated staff.

This work will become an example of the collaborative approach to public health issues that we are looking to foster with the Clinical Commissioning Group from 2012/13 onwards.

9.15 Workplace health

Sirona Care and Health are commissioned to support a limited number of workplaces with routine and manual workers per year and to develop a network of workplace champions. The contract is until 2016. Plans are in place to establish a workplace steering group to promote the roll out of the workplace charter. Capacity to lead this is within the public health commissioning development team. There is potential to develop / expand this programme subject to funding. There are no immediate risks due to transition.

9.16 Lifestyle, weight management services and nutrition initiatives for adults

Public Health currently lead on the commissioning of Adult programmes to increase physical activity and promote healthy eating.

Physical activity work is led via the multi-agency Get Active partnership which is chaired by the Assistant Director – Health Improvement. The partnership works to the Get Active Strategy 2011- 2015. It has a core commissioning and development group which meets quarterly and two wider stakeholders events per year. The Local Authority fund and commission the provision of Leisure facilities in B&NES. The local Authority lead a Cycling cross departmental group which is attended by the Assistant Director – Health Improvement. It is chaired by a councillor.

Healthy weight is coordinated via a healthy weight strategy group also chaired by the Assistant Director – health Improvement. A core commissioning development group with terms of reference is established and it works to implement the Shaping Up strategy 2011 – 2015. Both groups report to the Health and Wellbeing partnership.

In relation to wider determinants, the sustainable food agenda is currently being reinvigorated and the B&NES Environmental Sustainability Partnership has adopted sustainable food as a theme. The West of England Joint Sustainable Transport Plan was successful in securing phase one funding. A full bid has been completed and submitted. The outcome of this will be known later in the year.

Capacity to commission services is currently within the Public Health team. 1 WTE Commissioning development manager is dedicated to this role which also includes addressing the related wider determinants such as transport planning and green infrastructure and food policy.

A service level agreement is in place with the sport and active lifestyle service to deliver Passport to Health (exercise referral scheme) and community activators. This agreement is in place until 2013 and will need reviewing during transition year. It is our intention to continue these services subject to ongoing sufficient funding.

A new tripartite agreement between the University of Bath and the local authority is in place March 2012 – March 2014 to fund a research associate for two years located in the Sport and Active Leisure team. This post will evaluate the options within the passport to health programme and provide training and toolkit for providers to effectively evaluate their own programmes.

A service level agreement is in place with Sirona Care and Health until 2016 to deliver a healthy lifestyle hub to provide a single point of access s for all healthy lifestyle services including those provided by the local authority.

Services commissioned and delivered by Sirona Care and Health include: Slimming on referral – a voucher scheme providing free access to Weight watchers and Slimming world. Lifestyle advisors (formally health trainers) are able to see clients on a 1-1 and raise awareness in the community about the lifestyle services.

A service specification is included in the block contract for Dietetics services for the dietetic support for the Counterweight programme. This is delivered in primary care and the dietician provides recruitment, training and ongoing support.

An SLA is in place with the Learning Disabilities services to deliver Feel good foods project – a food box scheme providing ingredients and recipes.

The commissioning posts will transfer to the local authority in 2013 and the exact nature of peoples posts will be determined and part of the transition process and integration to new council structures. However it is anticipated that leadership for these areas of work will remain a key part of public health staff functions. Delivery of services is all within contractual arrangements and therefore should be unaffected by the transition.

In terms of risks, much of the delivery is within a block contract with Sirona Care and Health. It is not yet clear how the public health elements of this block contract will be monitored beyond 2013 and so the public health lead will review contract monitoring arrangements for the elements that will be commissioned from the council.

The Counterweight dietician is included in a block contract which will be the responsibility of the Clinical Commissioning group in future. It is not clear how this will continue to be monitored from the Local authority. Public Health is currently not involved in this contact monitoring but receives reports direct from the provider. The public health lead will agree with CCG during 2012/13 how public health aspects of block contracts will be monitored and reported.

9.17 Lifestyle, weight management services and nutrition initiatives for children

A service level agreement is in place with the community health and social care community interest company Sirona Care and Health to deliver a healthy lifestyle service which includes a Cook it service, Let's Get Healthy with HENRY, Food in Educational Settings Post, Adult weight management, smoking cessation. This contact is agreed until end March 2016. This will not be affected by the transition. This will be reviewed in the light of the transition, and any emerging evidence of effectiveness from 2013.

A SLA is in place until July 2012 with Aquaterra (local leisure provider) to deliver weight management for children (currently the MEND programme for 5-13 yr olds) Consideration is being given to going out to tender on all children's weight management services in April – July 2012 This would include services for 13-16 year old. We have recognised that there currently a gap in provision for this age group and we would like to ensure the pathway is complete. We have identified funding for this work 2012-13. This commission would be for a 3 year SLA. This will not be affected by the transition, however procurement support from the LA would be beneficial.

A SLA is in place with Early Years and Extended services for the Healthy Early Years Award scheme and the coordination of the HENRY programme. This award is currently being aligned with the new Director of Public Health Award for Healthy Schools (launching in April 2012). The HEY /HENRY SLA is agreed until end March 2013. Discussions will need to be undertaken to assess whether this service becomes a core function of the Early Years team or whether PH continues to hold a SLA with them for the service. The benefits and risks of this are unclear at this point.

Public Health has commissioned the Local Authority to develop and deliver a new programme for healthy educational settings, specifically; early years, schools, including the independent sector, and FE colleges. It is called the Director of Public Health Award and has been commissioned until March 31st 2012. In terms of continuity, our commissioning intention is to continue to commit public health funding to commission the programme into the future.

However we are awaiting further confirmation on definitive budgets and therefore allocation for this work as well as further review of providers (the current School Improvement and Achievement Service in the Local Authority where the current post sits may not be in existence beyond April 2013) before confirming contractual arrangements beyond this date. We anticipate we will be in a position to make these decisions in November 2012. We are also introducing a modest charging structure for schools to help subsidise the costs of the initiative.

PH is not currently involved with the dietetics contract or any links to community food. A new Sustainable food policy has been drafted and public health has been involved in its development and its inclusion in the LA Green Infrastructure work.

Public Health has commissioned the Health Improvement Service (Sirona) to provide a 0.6wte Health Improvement Specialist post to work specifically to support schools and other educational settings in support of their work to achieve the DPH Award (see above) and other evidence based food and health related activity. The current contract is until March 31st 2012. As with the wider DPH Award contract we will be in a position to re-commission the service once our definitive budget has been decided later this year.

Assurance should be given that governance arrangements are being developed to ensure a broad strategic focus for improving healthy weight and well being, based on need as outlined in the Joint Strategic Needs Assessment, and in line with appropriate measures held in Public Health Outcomes Framework;

There is no current working arrangement for the monitoring of the healthy weight strategy, although the governance structure exists. The key commissioners need to be identified and engaged in progressing the action plans for adults and children.

This work is the responsibility of an Assistant Director for Health Improvement and the programme is led for adults by a Public Health Development and Commissioning Manager and separately for children and young people by a Public Health Development and Commissioning Manager. These posts are within the public health team and will maintain their roles during 2012/13. The posts will transfer to the local authority with public health, and the exact nature of people's roles will be determined as part of the transition process and integration with new council structures. However, it is anticipated that leadership for these work areas would remain a key part of public health staff functions.

9.18 Public health services to children and young people (aged 5-19) including: Healthy children programme, school nursing and the health of looked after children

Currently commissioning of child health services is led by Local Authority Partners. Public Health are associate commissioners and contribute funding to the school nursing service as part of the core contract. In addition, public health commissioners work in partnership with local authority colleagues to contribute to the monitoring of the contract and determining outcomes in relation to PH indicators.

It is unclear how national changes to the commissioning of school nursing will affect current arrangements and the determining of public health priorities and indicators, particularly in relation to local priorities. For example, the current service specification covers provision for a whole time equivalent post to work exclusively in the two local FE colleges, there are also similar specific posts and it is unclear beyond the transition how we can influence this level of detail within the service specification and the monitoring of performance.

Currently, local authority (teenage pregnancy) funding is used to cover additional hours for a Looked After Children's Nurse. It is unclear how this will be affected by the transition and will be resolved during 2012/13 through programme conversations with colleagues in the People and Communities Directorate.

Sirona Care and Health are commissioned to provide core school nursing services and the commissioning is led by children's services. The school nurses are also commissioned to provide additional public health services such as NCMP and SAFE sexual health services in out of school settings. There are no immediate risks to this due to transition. The SAFE services will be included in any retendering for integrated sexual health services in the future but this is not anticipated during transition year. These services have an agreement until 2013 and will need to be extended.

9.19 Reducing excess deaths and seasonal mortality

The 2010 Local Authority Health Profile for B&NES revealed that B&NES had the highest excess winter mortality index in England. In response the B&NES Local Affordable Warmth Group took on the remit for tackling excess winter mortality. It should be noted that B&NES has a consistently lower overall mortality rate and that part of the reason for this rise in our season mortality ratio was a drop in summer deaths at the same time as a slight rise in winter deaths, leading to a significant change in the ratio. Overall mortality remained relatively constant during this period.

The B&NES affordable warmth group is a multi agency partnership with strong engagement from the Local Authority, PCT and local Community and Voluntary Groups. It aims to tackle fuel poverty and promote affordable warmth. An action plan was developed and its work is funded by the Public Health department and the Local Authority. The action plan focuses on the identification of vulnerable individuals, promoting community engagement around the issue of affordable warmth, and the development and

maintenance of appropriate capacity, to advise and assist these individuals to achieve affordable warmth. The action plan and governance arrangements are currently under review. A revised action plan and governance arrangements will be agreed by September 2012.

The group is chaired by the Director of Public Health and this will remain the case during the transition phase.

The PCT has participated in the MET office cold weather warning system for COPD

The PCT has worked with colleagues in the Local Authority to implement the NHS cold weather plan for England. Equally the organisations have a hot weather plan that aims to reduce excess mortality during hot weather.

Warm Streets is the Local Authority's flagship scheme for promoting and co-ordinating affordable warmth and fuel poverty action. It has been set up in partnership with six neighbouring local authorities and Scottish and Southern Energy. The scheme offers free heating improvements and insulation through to heavily discounted energy efficiency measures for those who are able to pay. Everyone who contacts the scheme if offered a free benefits check to ensure they are not missing out on benefits and to maximise household income, which is an important factor in tackling fuel poverty.

There are no changes envisaged on moving to the council as leadership and membership should remain the same.

9.20 Community safety, violence prevention and response

The Director of Public Health sits on the Responsible Authorities Group (RAG) which has oversight of all community safety issues.

The public health commissioning manager for alcohol liaises closely with the substance misuse team and reports on progress with the Alcohol Harm reduction Strategy (draft) which has dual reporting through the RAG and the Health and Wellbeing partnership.

9.21 Tackling social exclusion

Public Health staff currently contribute to a number of projects aimed at tackling social exclusion within B&NES. Although a generally affluent area, B&NES still has neighbourhoods and communities for whom health and social outcomes are not as good as other parts of the district.

Work is underway to commission University of Buckinghamshire to conduct a health needs assessment for Gypsy and traveller and Roma communities. This will be completed during transition year and therefore is not at risk.

There is an identified lead in the public health team for this group who will continue to liaise with the local authority.

We have worked with the B&NES Race Equality Council over the last 3 years to improve our engagement with local Black and Minority Ethnic (BME) Communities and more recently we have started discussions with council colleagues to broaden our approach to engaging with a more diverse range of people with protected characteristics such as disabilities and sexual orientation. This work is likely to begin in 2012/13 and will continue through new joint arrangements within the council from 2013/14. We anticipate that this will also be part of the intelligence about the population that we can share with CCG colleagues to support the tailoring of NHS commissioning to meet diverse local needs.

9.22 Infection prevention and control

Infection prevention and control is one of the critical public health services transferring to the local authority. As part of their public health responsibilities, local authorities will be required to ensure that plans are in place to protect the local population including plans of acute providers and others for prevention and control of infection, including health care associated.

In the light of this guidance, the responsibility for infection prevention and control in B&NES will be moving from the Director of Nursing to the Director of Public Health in the next few months.

Oversight of infection prevention and control will remain as part of the current Quality strategy delivery during the transition:

- The quality strategy was approved by the Board in Sept 2011
- A quality dashboard with CCC approved measures and targets is in place as proxy indicators of performance against high level outcomes.
- Hospital acquired infections form part of the patient safety quality measures

    - MRSA bacteraemia
    - C Diff infections
    - MRSA screening
    - C diff related deaths.

- Through the RUH Clinical Outcomes and quality assurance process the quality PCT scorecard ensures regular monitoring of selected quality markers for main providers :

    - MRSA bacteraemia
    - MRSA screening requirements
    - C difficile
    - E coli

- Bloodstream infections GRE bacteraemia

The Consultant in Public Health will continue to attend the RUH Clinical Outcomes and quality assurance meetings

Plans for the deliver of infection prevention and control post April 2013 will be developed over the next few months and this will involve:

- We will work with the CCG developing their quality control arrangements for post April 13, to identify the most appropriate arrangements for ensuring that infection prevention and control remains a key part of the quality review of providers. Where existing arrangements work will these will be absorbed into new arrangements.

- Consideration of options for the transfer of employment of the two infection control nurses. Likely options are employment within the local authority or as part of the CCG.

A transition work plan for infection prevention and control is shown in Appendix 6.

9.23 Reducing public health impacts of environmental risks

In B&NES the public health team works with the council environmental services on responding to environmental hazards.

B&NES public health commissions work on management of childhood injuries and alcohol harm reduction from the environmental services department of B&NES council.

Currently the HPA supports us in the management of environmental incidents in partnership with the environment agency as necessary and this will continue with PHE.

Within the West of England there are regular meetings between HPA, environment agency, LA and public health reps to share learning from incidents and there response.

In B&NES the public health team works with the council environmental services on responding to environmental hazards.

All these activities will continue through the transition year and will be further developed following the transition.

9.24 Emergency planning, resilience and response

Current resilience arrangements will be maintained through 2012/13.

BANES PCT will continue to plan and train for incidents/outbreaks with local partners (BANES council, other PCTs within LRFs and acute trusts) through local arrangements and Avon Health Executive Resilience Group (AHERG)

NHS BANES and Wiltshire share executive leadership arrangements and a single cluster Board and have a single on-call rota.

Executive on-call rota is shared with BNSSG for response within the Avon and Somerset LRF.

DsPH and public health specialists will participate in on-call rota with HPA to provide advice and support for management of public health aspects of incident/outbreak management

Planning for resilience arrangements after April 13 is being informed by participation in the existing multi-agency Avon Health Executive Resilience Group (AHERG) and through participation of the Avon and Somerset LRF in a national grouping of six LRFs selected to test out the emerging arrangements by participating in national workshops.

We are still awaiting further clarification of national guidance for the new EPRR operating model. Guidance is needed on:

- Ensuring PHE and NHS CB plans are aligned
- Transfer of existing NHS emergency planners to LHRP to ensure that 'surge' capacity remains within NHS
- Arrangements for PHE to provide advice and support to LHRP and LA.
- Lead DPH arrangements for each LHRP
- On-call rotas for LHRP
- On-call rotas for public health in the LHRP (PHE and local public health specialists), including rotas for DPH participation in the Scientific and
- Technical Advisory Cell (STAC) for the LRF/SCG.

We are starting discussions across the LRF about possible arrangements for a lead DPH.

Testing of new arrangements in the Avon and Somerset LRF will take place between Jan and March 2013 and will be led by NHS South Resilience lead.

Once further guidance is received and local EPRR arrangements are better developed, the DPH, on behalf of the LA post April 13, will be working with PHE and the LHRP to ensure that the emergency planning and response arrangements for the protection of the population's health and wellbeing during major incidents and emergencies are robust. The DPH will advise and challenge and will report to the Health and Wellbeing Board on the planning and response arrangements that will be in place.

9.25 Improving the wider determinants of health

The current public health team contributions to activities with B&NES Council on the wider determinants of health will continue. These are:

- Responding to consultation on the core strategy to ensure opportunities were identified for health improvement and addressing health inequalities.

- The DPH has signed the Memorandum of Understanding on transport and health with West of England Councils and DsPH. The MOU commits the Public Health team in B&NES to ongoing participation in the WOE Transport and Health Forum.

- Providing training for Environmental Sustainability Partnership (ESP) Board members and officers in the transport team on accessing the public health implications of transport policy.

- The DPH is a member of the B&NES Environmental Sustainability Partnership (ESP) Board. Public Health team members contribute to sub-groups of the ESP:

    - Domestic emissions and Green Deal Worksteam, through the B&NES Affordable Warmth Action Group.
    - Transport Workstream, providing health advice to and supporting the Local Sustainable Transport Fund bid which B&NES is submitting with West of England partners.
    - Natural Environment and Green Infrastructure Workstream, providing Public Health advice on the use of open spaces.
    - Food policy, a newly developing work strand.

Discussions have commenced with the current B&NES Council Strategic Director for service delivery (responsible for planning, transport and tourism, leisure, heritage and culture and environmental services) on how to build on and expand these roles in the transition year 2012/13 and post April 2013.

10. Workforce elements of the plan

There has been close working between Human Resources colleagues from NHS B&NES / Wiltshire Cluster and from B&NES Council. The work has been based on the principles and detail encapsulated in the Public Health Human Resources Concordat. The work is governed by the Public Health Transition Group, as mentioned earlier in the document.

A framework has been produced to manage the public health transition from a Human Resources perspective and this is attached in Appendix 7. It includes key assumptions, milestones, timescales and lead managers.

Appraisal and revalidation of public health specialists is an important component of professional competence and registration. Arrangements for revalidation in the future will be established during 2012/13 for the Director of Public Health and any public health consultants (medical and non-medical) in the team, to ensure there is access to appropriate trained appraisers. This may include linking to local Responsible Officers in B&NES, as is the case for other medical specialties.

11. Clinical governance and other governance issues

A critical task is the need to ensure that clinical governance arrangements are in place for all relevant services to be commissioned by the Local Authority. This will include monitoring of Quality standards for training and accreditation, SUIs and Patient Group Directions.

Reporting of SUIs and never events will remain as part of the current Quality strategy delivery during the transition:

- The quality strategy was approved by the Board in Sept 2011
- A quality dashboard, with CCC approved measures and targets, is in place as proxy indicators of performance against high level outcomes.
- Serious incidents and never events form part of the patient safety quality measures
- Through the RUH Clinical Outcomes and quality assurance process the quality PCT scorecard ensures regular monitoring of selected quality markers for main providers including SUIs.

Plans for the deliver of the quality strategy post April 2013 will be developed over the next few months and this will involve:

We will work with the CCG developing their quality control arrangements for post April 2013, to identify the most appropriate arrangements for ensuring that monitoring of serious incidents remains a key part of the quality review of providers. Where existing arrangements work will these will be absorbed into new arrangements.

We need clarity over future liability for the local authority regarding clinical advice back to the NHS post transfer.

Since we are not directly providing services we do not have directly employed staff operating under Patient Group Directions.

11.1 Agreeing a risk sharing based approach to transition between the PCT cluster and the council

A shared Risk Assessment and Mitigation Strategy will be agreed as part of the implementation of the Public Health Transition Plan. A Risk Assessment is already in place and will be updated throughout 2012/13 alongside new information or organisational changes that occur in the system.

The strategy will be subject to approval by the:

- Health & Wellbeing Partnership Board
- Council Cabinet
- Clinical Commissioning Committee (pending authorisation of the Clinical Commissioning Group) will review and make recommendations about the strategy to the PCT Board.
- PCT Board

11.2 Sector led improvement

B&NES is part of the regional group considering the implementation of sector led improvement across the Children's and Adult's landscape. The local authority takes an evidence-informed approach to sector led improvement activity and will continue to work in this manner when assuming public health duties

12. Enabling infrastructure

12.1 Capability and capacity to ensure delivery of the public health transition plan

The current capability and capacity of the existing public health team to deliver the transition plan has been reviewed. This has identified the urgent need for more project management capacity which we are currently working on securing, from within our own budgets.

There is also an increasing acknowledgement that the specialist public health capacity with the team is limited compared to other PCTs in the region (not in spend per head of population but in actual staff on the ground given that B&NES has a smaller population than most PCTs and so spend her head for 200,000 people gets you half the people as an equal spend per head for 400,000 people). In exploring the potential to improve capacity in this area

and meet our new obligations across the wider council work programme and the mandatory area of public health advice to NHS Commissioners (notably the CCG), we are in discussion with partners across the West of England and Somerset area and will reach the point soon at which any new proposals can be made locally.

These need to be considered in the light of the future public health allocation to the local authority, the need to have a more robust function locally, the potential for collaboration within B&NES council on some issues (for example on intelligence and analysis) and with partner councils (for example on public health consultant advice).

12.2 The PCT cluster and LA approach to resolving significant financial issues

The initial review of financial issues will be completed by the end of March 2012, to include:

- Reconciliation of detailed submissions made in September 2011 to proposed local authority allocations, PCT planning guidance assumptions, and current budgets.

- Identification of potential anomalies or adjustments including non-recurring items and new investment assumptions.

- Identification of any issues relating to indirect/support service costs.

Review of financial issues following completion of PCT 2011/12 accounts, finalisation of 2012/13 plans, and any further guidance issued, by end June 2012.

Resolution of financial issues and sign off of proposed transfers by end December 2012 (deadline subject to any national timing requirements and availability of nationally determined information)

Proposed 2013/14 budget detail to be agreed through Council 2013/14 planning and budget setting process - deadline for draft plans expected to be end August 2012 with review and final sign off September 2012 to February 2013.

Handover of finance support implemented by end March 2013.

The Council will deliver the relevant services within the level of resources transferred by the PCT from April 2013 taking appropriate account of the significant savings required from local authority budgets over the medium term financial planning period. The Council will also continue to work with the PCT to reconcile all expenditure and budgets across the 2012-13 financial year.

The Council will seek assurances that the full costs associated with the existing service delivery including appropriate overhead and support costs will be included within the future transfer of resources.

12.3 The PCT cluster and LA approach to novation and other arrangements for the handover of PH contracts

The approach to the handover of public health contracts is set out as follows:

Public Health contracts stocktake to be concluded by end March 2012 in line with overall PCT Cluster Transition Contract Stocktake project. Named lead identified from March 2012 to maintain register for subsequent new, varied or expired contracts. A copy of the Stocktake can be made available on request.

Contracts currently held by Public Health but not transferring/contracts not currently held by PH but due to transfer to be identified by end September 2012.

Contracts requiring novation from April 2013 to be identified by end September 2012.

Novation discussions with other parties to contracts to be undertaken October 2012-March 2013. Agreement on novation or alternative arrangements to be concluded by end March 2013

Contracts to be novated where possible. Where not possible and in the exceptional event that alternative arrangements have not been concluded by 31st March 2013, NHS Commissioning Board to maintain contracts for a limited period to ensure service continuity, supported by appropriate financial flows.

12.4 Ensuring access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during 2012/13 and beyond

The approach to transition of IT and intelligence functions is being taken forward by a knowledge management working sub-group of the Public Health Transition Group. The work plan for this group is set out in Appendix 8, including milestones and responsible officers.

12.5 Resolving issues in relation to facilities, estates and asset registers

The public health team will work within the wider PCT Cluster and council approach to estates and assets. Some of these have addressed separately in this plan, for example in relation to IT systems above. As a small public

health commissioning team (13 people in total) this should be a relatively straightforward process, and will be managed through the public health transition group. We will work closely with our colleagues in relation to this issue during 2012/13 to resolve any issues prior to transfer in April 2013.

12.6 Development of a legacy handover document during 2012/13

A draft PCT legacy document was created during 2011. This includes a section dedicated to the legacy for Public Health in B&NES. Through 2012/13 we will continue to develop this document as part of the overall PCT cluster integrated document. The legacy document will serve the council, CCG, NHS Commissioning Board and Public Health England. Will develop detail during 2012/13 by October 2012 draft and final by January 2013.

13. Communication and engagement

Key issues relating to the public health transition have been presented and discussed at a wide variety of local public engagement events, at public board meetings and at our Local Involvement Network (LINk). We have met with the Cabinet of the council, the Strategic and the Divisional Directors Groups of the council, the PCT Board, the Health and Wellbeing Partnership Board and the Wellbeing Policy and Development Scrutiny Panel.

A dedicated public health transition communication and engagement strategy has been developed with lead involvement from communication managers of the PCT and the council. This focuses primarily on the transition year 2012/13 and will be updated by October January 2013 in readiness for April 2013 and beyond.

A copy of the public health communication strategy and engagement plan is included in Appendix 9.

14. Sign off from accountable leads

John Everitt .....

CEO B&NES Council, Date: 22nd March 2012

Ed Macalister-Smith .....

CEO, B&NES and Wiltshire PCT Cluster, Date: 22nd March 2012

Councillor Malcolm Hanney .....

Chair of NHS B&NES and B&NES Health and Wellbeing Partnership,
Date: 22nd March 2012

Councillor Simon Allen .....

Chair Designate, B&NES Shadow Health and Wellbeing Board
(from April 2012), Date: 22nd March 2012

Dr Ian Orpen .....

Chair of the B&NES Clinical Commissioning Group, Date: 22nd March 2012

Public Health Transition
in Bath & North East Somerset

Appendices for
the Assurance Plan

22 March 2012

Appendix 1 – Summary of key public health transition policy papers

NB: This summary was formally reported to the Health and Wellbeing partnership Board, Change Programme Board and Public Health Transition Group and more informally circulated amongst a wider range of partner departments and organisations during January and February 2012.

January 2012 update, Based on Latest Department of Health guidance
http://healthandcare.dh.gov.uk/public-health-system/

Headlines

Local authorities will take the local lead for:
- improving health
- coordinating local efforts to protect the public's health and wellbeing
- ensuring health services effectively promote population health

Public Health England will:
- deliver health protection and intelligence services
- support the public through social marketing
- lead for public health by building the evidence base and relationships
- support the development of the specialist and wider public health workforce

NHS will:
- continue to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts

Chief Medical Officer will:
- continue to provide independent advice to the Secretary of State for Health and the Government on the population's health

Department of Health will:
- set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities.

Public Health in Local Government

The Government is returning responsibility for improving public health to local government due to their population focus, ability to shape services to meet local needs, ability to influence wider social determinants of health and ability to tackle health inequalities. Their aim will be to create healthier communities.

Having taken on the key role in promoting economic, social and environmental wellbeing at the local level, local government is ideally placed to adopt a wider wellbeing role.
In all they do, local authorities will want to ensure the health needs of disadvantaged areas and vulnerable groups are addressed, as well as giving consideration to equality issues. The goal should be to improve the health of all people, but to improve the health of the poorest, fastest.

The role of the Cabinet lead for health within the council is critical, but there needs to be a much broader engagement in this agenda among all local political leaders.

DH will publish a Public Health Workforce Strategy, accompanied by a formal public consultation. This will include options for how public health knowledge can best be embedded across the wider workforce. The new arrangements will provide opportunities and challenges for employers, including the wider local authority workforce.

Mandatory steps

DH set out some areas that require greater uniformity of provision or are a duty delegated by the Secretary of State for Health to local government and therefore need to be mandated. These are:

- a duty to ensure there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- appropriate access to sexual health services
- the National Child Measurement Programme
- NHS Health Check assessment.

The net result of these steps will be that local authorities have key responsibilities across the three domains of public health – health protection, healthcare public health and health improvement.

Although there had been signals to mandate elements of the Healthy Child Programme 5-19, this is not going to happen for 2013. Consideration is being given to the future models of delivery.

The role of the Director of Public Health

Each authority, acting jointly with the Secretary of State for Health, must appoint an individual to have responsibility for its new public health functions, known as the Director of Public Health. That individual could be shared with another local authority where that makes sense.

New guidance on appointments to existing Director of Public Health vacancies and transfer to local government, has been published by DH and LGA.
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132048.pdf
Subject to Parliament, DH will add Directors of Public Health to the list of statutory chief officers in the Local Government and Housing Act 1989. After Royal Assent, DH intend to issue statutory guidance on the responsibilities of the Directors of Public Health, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Services.

DH say that the organisation and structures of individual local authorities is a matter for local leadership, by that they are clear that these legal responsibilities should translate into the Director of Public Health acting as the

lead officer in a local authority for health and championing health across the whole of the authority's business.

DH would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.

The Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services. He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing.

In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality. With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the local authority, but we would expect day-to-day responsibility for the grant to be delegated to the Director of Public Health.

Commissioning responsibilities

Local authorities will be responsible for commissioning the services below. The list is not exclusive. Local authorities may choose to commission a wide variety of services under their health improvement duty.

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes

- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

DH are now proposing that abortion should remain within the NHS and be commissioned by clinical commissioning groups. A consultation on this revised recommendation starts soon. Responsibility for sexual assault services, including SARCs, rest with the NHS Commissioning Board.

Early diagnosis programmes for cancer will be a responsibility of both Public Health England and the NHS Commissioning Board.

The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening. Directors of Public Health will provide challenge and advice to the NHS Commissioning Board on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board.

Only some of the above services are to be mandated (see previous section above).

The commissioning of other services will be discretionary, guided by local results from the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy.

Children under five

In the first instance, the NHS Commissioning Board will lead the commissioning of public health funded services for children under five, including health visiting, the Healthy Child Programme and Family Nurse Partnership.

DH aim to unify responsibility for these services within local government by 2015 when the increased health visiting workforce and new health visiting service model and the Healthy Child Programme offer to families should be in place.

In line with this direction of travel, we are also transferring responsibility for commissioning effective Child Health Information Systems to the NHS Commissioning Board, also to be funded by the public health budget.

This decision will be reviewed in 2015 to determine longer-term plans. We will engage further on the detail of these proposals, particularly in respect of transition arrangements and the best way to begin to involve local authorities in local commissioning of these services in partnership with the NHS.

In the meantime, Public Health England will retain a close interest in the specification of Child Health Information Systems, to ensure public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.

Emergency preparedness

New guidance on the Local Resilience Forum (LRF) is provided, with a lead Director of Public Health from a local authority within the LRF area coordinating the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.

Public Health England will continue to provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.

The NHS Commissioning Board will appoint a lead director for NHS emergency preparedness and response at the LRF level, and provide necessary support to enable planning and response to emergencies that require NHS resources.

Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. LHRPs will consist of emergency planning leads from health organisations in the LRF area and will ensure effective planning, testing and response for emergencies.

The lead director appointed by the NHS Commissioning Board and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning. Resources will be required to support the LHRP to provide continuous readiness.

DH will publish further details on the new system. DH will also produce operational guidance to support incident management at a local level, which will cover the working relationship between the NHS, Public Health England and the local authority.

Population healthcare advice to the NHS

Clinical commissioning groups (CCGs) will require a range of information and intelligence support via local authorities, other commissioning support organisations and potentially Public Health England. It is important to note that although there are some similarities in the nature of these services they will have a different focus (for example on strategic population issues on the one

hand and more clinical processes and activity on the other). These should be complementary.

Local authority public health advice to CCGs is proposed in 6 key ways:

- Strategic planning: assessing needs
- Strategic planning: reviewing service provision
- Strategic planning: deciding priorities
- Procuring services: designing shape and structure of supply
- Procuring services: planning capacity and managing demand
- Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views

More specific guidance on public health contribution to CCGs is provided at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131902.pdf

Public Health England – Operating Model

Public Health England will have three main business functions:

1. Delivering services to national and local government, the NHS and the public
2. Leading for public health
3. Supporting the development of the specialist and wider public health workforce.

Working with local authorities

Local authorities, supported by their Directors of Public Health, are the local leaders for public health. Public Health England will not duplicate the work that they do. Instead, Public Health England will be the expert body with the specialist skills to support the system as a whole. Public Health England will carry out functions and activities that would not be practicable to replicate in each local authority. Public Health England will support local authorities in their new role by providing services, expertise, information and advice in a way that is responsive to local needs. It will support local authorities to ensure action taken is on the basis of best available evidence of what works.

Working with the NHS Commissioning Board

Public Health England will provide a public health service to the NHS Commissioning Board to support the commissioning and delivery of health and wellbeing services and programmes. Public Health England will be providing public health and population healthcare advice to the NHS Commissioning Board. It will work with the NHS Commissioning Board to ensure that the prevention of ill health and promotion of good physical and mental health and wellbeing are addressed systematically across services and care pathways. Further work will be done in 2012 to establish and publish the arrangements of how Public Health England and the NHS Commissioning Board will work together.

Public Health England's structure will have three elements:

- A national office, including national centres of expertise.

- Four hubs, coterminous with the four sectors of the NHS Commissioning Board and Department for Communities and Local Government resilience hubs, covering London, the South of England, Midlands and East of England and North of England.

- Units that deliver its locally facing services and act in support of local authorities, other organisations and the public in their area. When appropriate, units will provide coordination across several local authorities in managing incidents and outbreaks. DH clarify that Directors of Public Health are the local leaders for public health and provide a core offer to the NHS.

  Early in 2012 Public Health England will be seeking the views of local authorities, health and wellbeing board early implementers and local partners on how Public Health England can best prove its responsiveness and expert contribution to localities.

  Public Health England expect to appoint a Chief Executive designate in April 2012 to further develop and implement the operating model for Public Health England through 2012/13. Public Health England will assume full powers in April 2013.

Public Health Human Resources Concordat

PCTs and local authorities will be responsible for developing public health transition plans and consulting with their constituent trade unions and staff on these and the associated workforce plans. Key guidance and support are being developed at national level, which outline the human resources (HR) processes and expectations on PCTs, councils, NHS and local government trade unions in managing this important change.

The Public Health HR Concordat, developed by the Department of Health with NHS Employers and the Local Government Association, and in partnership with NHS and local government trade unions, has been published. This provides a best practice framework.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131111

The Concordat is followed by more detailed transition guidance as follows:

- PCT Transition Planning Guidance
- Local Government Transition Guidance. This is aimed at HR specialists in councils who will be managing the staff transfers. This will be available in January 2012.

Sender guidance is also being developed by the Department of Health, providing practical advice, templates and guidance for sender organisations to

implement the People Transition Policy(s) at local level. Items particularly relevant for primary care trusts and councils to use will be signposted.

A Public Health Workforce Strategy will also be published in early 2012, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a future professional public health workforce for all sectors.

Public Health Outcomes Framework for England, 2013-2016

A new public health outcomes framework has been published. This still requires technical development during 2012/13 and so for that transition year the NHS Operating Framework for 2012/13 provides the headline performance measures required for public health. The public health outcomes framework is summarised below. There are clearly intended overlaps with NHS and Social Care outcomes and commissioning areas.

High level outcomes

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities.

1. Improving the wider determinants of health

- Children in poverty
- School readiness
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness *and or disability* in settled accommodation
- People in prison who have a mental illness or significant mental illness
- Employment for those with a long term health condition including those with learning difficulty / disability or mental illness
- Sickness absence rate
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime
- Re-offending
- The percentage of the population affected by noise
- Statutory homeless
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- Social connectedness
- Older people's perception of community safety

2. Health Improvement

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- Child development at 2-2.5 years
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- Emotional wellbeing of looked after children
- Smoking prevalence – 15 year olds
- Hospital admissions as a result of self harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health check programme – by those eligible
- Self reported wellbeing
- Falls and injuries in the over 65s

3. Health Protection

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board approved sustainable development management plans
- Comprehensive, agreed, inter-agency plans for responding to public health incidents

4. Healthcare public health and preventing premature mortality

- Infant mortality
- Tooth decay in children aged five
- Mortality in causes considered preventable

- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases
- Excess under 75 mortality in adults with serous mental illness
- Suicide
- Emergency readmissions within 30 days of discharge from hospital
- Preventable sight loss
- Health related quality of life for older people
- Hip fractures in over 65s
- Excess winter deaths
- Dementia and its impacts

Appendix 2 Terms of Reference - PH Transition Group

NB: These were formally agreed in June 2011 by the Public Health Transition Group and have been accepted by the Partnership Board for Health and Wellbeing.

1. Purpose

The purpose of this group is to oversee the transition of public health responsibilities from B&NES Primary Care Trust in its current form to B&NES Council and, where appropriate, to the GP Commissioning Consortium and the PCT Cluster. The group will also identify and manage risks or barriers that could negatively affect the transition. This work will include the following:

Coordination of the transition of public health responsibilities

- Propose timescales for different aspects of the transition (eg. Functions, governance, transfer of staff, budgets, etc) and seek agreement though the appropriate PCT and Council decision making processes.
- Develop a business continuity plan to ensure stability for the existing public health programmes during the period of transition.

Capacity, capability and design of future public health programmes

- Support the recruitment of a new Director of Public Health.
- Identify future public health responsibilities of existing and new organisations.
- Design a model for future public health arrangements in B&NES, showing how public health could work in the new organisational forms.
- Identify existing resources that will transfer or contribute to these arrangements.
- Identify potential gaps in resources or guidance.

Finance and resources

- Identify historic NHS and council spend on public health work streams and advise both organisations on recommended spend in future, in line with guidance as this emerges, taking in to account local financial position.
- Agree a process for identification and final sign off of budgets, spend and financial accountabilities of key partners in relation to public health programmes.
- Scope the implications for finance, HR, management, IT support and advise on the necessary capability and capacity.

Communications and marketing

- Coordinate reports to the executive teams of the Council, the PCT and the GP Consortium.
- Oversee the coordination of a consultation response to the Department of Health for the Public Health White Paper and associated documents
- Scope the implications for communications support and advise on the necessary capability and capacity.

Information and intelligence

- Scope implications for intelligence support and advise on the necessary capability and capacity.

Workforce

- Identify staff that will be involved in the public health transition process.
- Identify workforce development needs within and outside of public health to enable an optimal transition of roles.
- Develop a HR framework for secondment and transition of staff.
- To oversee the HR framework and to ensure appropriate consultation with appropriate employee/union representatives.

2. Membership

Name	Role or representation
Ashley Ayre (Chair)	Strategic Director, People and Communities, Council
Ed MacAlister-Smith	PCT Cluster CEO
Dr Pamela Akerman	Acting Joint Director of Public Health
Cllr Simon Allen	Cabinet Member for Wellbeing
Ros Brooke	Non-executive Director, Trust Board, NHS B&NES
David Trethewey	Divisional Director, Policy and Partnerships, Council
William Harding	Head of Human Resources, Council
Suzanne Tewkesbury	PCT Cluster Director of HR, Governance & Comms
Ian Orpen	GP Commissioning Consortium Chair
Paul Scott	Assistant Director of Public Health (Project Lead)
Denice Burton	Assistant Director – Health Improvement
Sarah James	Deputy Director of Finance, PCT Cluster
Tim Richens	Divisional Director, Finance, Council
Dr Mark Evans	Acting Unit Director, Health Protection Agency

The group will seek representation and advice as required from HR, finance, IT, communications, Council Legal Services and other key colleagues.

3. Meeting frequency

Meetings will be held 6 weekly during 2012/13.

4. Constitution, reporting arrangements and links

The group has no executive powers but will report monthly to the Change Programme Board of B&NES Council.

5. Interfaces

The group needs to relate to the Commissioning Support Unit scoping project, the emerging arrangements for the PCT Cluster and the GP Consortium.

6. Administration

Agenda and papers to be sent out one week before the meeting. Minutes of the meeting to be sent within one week of the meeting.

7. Review

The terms of reference will be reviewed in April 2012.

Appendix 3 B&NES - Public Health Transition – Draft Outline Plan.

Version 1, February 2012. Author: **Paul Scott**. Accountable Director: **Pamela Akerman**

Transition Issue	Accountable Director	Operational Lead	Commentary on current position
1 Ensuring a robust transfer of systems and services			
1.1 Is there an understood and agreed (PCT cluster/LA) set of arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013?	CEOs of Council and Cluster, DPH and SD People and Communities	Paul Scott	Local Transition Plans had been agreed locally but the publication of new papers by the Department of Health in December 2012 have implications that mean we will need to review local arrangements and reconsider local transition plans.
1.2 Is there a clear local plan which sets out the main elements of transfer including functions, staff and commissioning contracts for 2013/14 and beyond?	Functions – DPH Staff – HR Director of Council / Cluster Contracts – DPH	Denice Burton, Paul Scott Steve Graham Denice Burton, Paul Scott	Following the publication of key guidance by DH in the last month, a plan will now be produced. This process is part of a bigger local process looking at the transfer of all PCT staff and the commissioning stock take of contracts.
1.3 Are there locally agreed transition milestones for the transition year, 2012/13?	CEOs of Council and Cluster, DPH and SD People and Communities	Paul Scott	The key milestones have been set out clearly nationally. Many of the key issues are already underway and we are now awaiting the shadow budget to enable concrete plans to be developed.

			The B&NES Public Health Transition Group is overseeing this process.
1.4 Is there a clear local plan for developing the JSNA in order to support the H&WB strategy?	DPH and DD Policy & Partnerships	Jon Poole, Paul Scott	This process is well underway. There is a dedicated JSNA governance group with membership from CCG, Council and PCT. The work is well integrated with the H&WB Strategy process and includes members who are working on both projects. We anticipate a final JSNA document will be signed off by H&WB Partnership Board in April 2012, with a web-portal launch and a public engagement event. This will also give rise to a clear ongoing work programme that work sit alongside further H&WB Strategy work and future prioritisation and review processes.
1.5 Is there a clearly developed plan for ensuring a smooth transfer of commissioning arrangements for the services described in *Healthy Lives, Healthy People* that Local Authorities will be responsible for commissioning?	DPH	Denice Burton, Paul Scott	Following the publication of key guidance by DH in the last month, a plan will now be produced. This process is part of a bigger local process looking at the transfer of all PCT staff and the commissioning stock take of contracts.
1.6 Is there a clearly developed plan for ensuring a smooth transfer of those PH functions	DPH, SD People and Communities, HR Director	Denice Burton, Liz Price, Paul Scott	We will be working with local, regional and national partners to produce an assurance plan ready for March 2012.

and commissioning arrangements migrating to NHS CB and PHE?			
1.7 Is there local agreement on the delivery of a core offer providing LA based public health advice to Clinical Commissioning Groups?	DPH, CCG Chair, Cluster Director of Commissioning Development, DD Service Development, HR Director	Mike Bowden, Steve Graham, Ian Orpen, Paul Scott	These discussions have begun and the recent DH guidance has been a helpful resource to guide this. We anticipate having an agreement on the core offer ready for March 2012.
2 Delivering public health responsibilities during transition and preparing for 2013/14			
2.1 Is it clear how future mandated services and steps are to be delivered during transition and in the new local public health services:	CEOs of Council and PCT, with DPH		Following the publication of key guidance by DH in the last month, a plan will now be produced. We are also working closely to integrate these transitions processes in to the broader organisational changes occurring in the council and health service as they go through their own reorganisation. This provides a more robust footing for the future, but does mean plans are still in production as partners develop their own processes and structures for commissioning and delivery. We anticipate having an agreement on these programmes ready for March 2012.
a. Appropriate access to sexual health services,	DPH, CCG Chair	Daniel Messom	
b. Plans in place to protect the health of the population,	DPH and DD Risk & Assurance	Chris Williams	
c. Public health advice to NHS commissioners,	DPH, CCG Chair, Director of Commissioning Development	Mike Bowden, Paul Scott	
d. National Child Measurement Programme,	DPH	Denice Burton	
e. NHS Health Checks assessment?	DPH	Daniel Messom	

2.2 Is there clarity around the delivery of critical PH services/programmes locally, specifically: screening programmes; immunisation programmes; drugs & alcohol services and infection prevention & control?	Screening/immms: DPH and SD People and Communities Drugs and alcohol: DPH and SD People and Communities Infection control: DPH and Cluster Nursing Director	Liz Price, Paul Scott Pamela Akerman, Jane Shayler Pamela Akerman, Mary Monnington	
3 Workforce			
3. Have the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat?	HR Directors for Council and Cluster	Steve Graham and William Harding	Local commissioning staff, managers, executives and boards have been briefed regularly about updates nationally and locally for the public health transition. Informal conversations have occurred with the relevant Trade Union representatives, but as we have not yet reached the point of defining new structures or terms and conditions of transfer, we have not had more formal consultations. We are in the process of matching people to functions and identifying the destination of those functions. The recent HR Concordat has been shared with

			key officers and processes are underway to clarity the workforce elements of the overall public health transition process.
4 Governance			
4.1 Does the PCT cluster with LA have in place robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate?	DPH, HR Director, DD Legal and Democratic Services	Steve Harman, Paul Scott, Derek Thorne, Jeff Wring	Internal accountability and performance monitoring has been going through transition within the PCT cluster and the council and public health is part of that process. Arrangements for these functions in 2012/13 are the subject of forthcoming meetings and will be agreed by March 2013.
4.2 Are there robust arrangements in place for key public health functions during transition and have they been tested e.g. new emergency planning response to include: a. Accountability and governance, b. Details of how the DPH, on behalf of LA, assures themselves about the arrangements in place, c. Lead DPH arrangements for EPRR and how it works	CEOs of Council and PCT Cluster, with DPH and DD Risk and Assurance	Chris Williams	These arrangements are being developed locally alongside the still emerging national arrangements. Roles and responsibilities will be clarified by March 2012 and tested by October 2012.

across the LRF area?			
4.3 Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of SUIs/incident reporting and Patient Group Directions?	DPH and PCT Cluster Nursing Director	Pamela Akerman, Mary Monnington	To be agreed as part of overall transition plan by March 2012.
4.4 Has the PCT cluster with the LA agreed a risk sharing based approach to transition?	CEOs of Council and Cluster, with DPH	Ashley Ayre, Pamela Akerman	To be agreed as part of overall transition plan by March 2012.
4.5 Is there an agreed approach to sector led improvement?	DPH, SD People and Communities	Ashley Ayre, Pamela Akerman	To be agreed as part of overall transition plan by March 2012.
4.6 Is the local authority engaged with the planning and supportive of the PCT cluster approach to PH transition?	B&NES Joint Public Health Transition Group	Paul Scott	B&NES has a formal public health transition group which meets every 6 weeks, chaired by a Strategic Director of the council, with representation at senior level from the CCG, public health, the PCT cluster and the council. The group has an action plan and a risk register which are monitored at each meeting and reports monthly to the Council's Change Programme Board and every other month to the Health and Wellbeing Partnership Board.
5 Enabling infrastructure			
5.1 Has the PCT cluster with LA identified sufficient capability and capacity to ensure	DPH and SD People and Communities	Paul Scott	An assessment is underway and additional project management capacity will be discussed with the Council's Change Programme Board in February

delivery of their plan?			2012.
5.2 Has the PCT cluster with LA identified and resolved significant financial issues?	Finance Directors of Council and PCT Cluster	Denice Burton, Sarah James, Richard Morgan, Giles Oliver	Plan to be agreed by March 2012 A finance return to the Department of Health was made by PCTs in September 2011. It is important to remember that this return was based on actual spend in 2009/10 and differs from commissioning budgets in 2011/12 in the following respects: It reflects underspends in 2009/10 that were used to balance the overall Trust budget. It excludes investments in 2011/12, principally for Health Visiting and Health Checks. In the letter to Local Government Chief Executives on 25th November a potential cut in 'administration' staff was mentioned. This would include all staff not working directly with the public face to face. It would include the DPH, Public Health consultants, intelligence staff and those directly involved in the design of service delivery. A 30% cut in these staff, would severely reduce the ability of Local Authorities to deliver their new Public Health functions, including support to NHS Commissioners.

5.3 Has the PCT cluster with LA agreed novation/other arrangements for the handover of all agreed PH contracts?	Finance Directors of Council and PCT Cluster, with DPH	Denice Burton, Sarah James, Richard Morgan, Giles Oliver	A stock take of existing PH contracts is underway. Plan to be agreed by March 2012
5.4 Are all clinical and non-clinical risk and indemnity issues identified for contracts?	Finance Directors of Council and PCT Cluster, DD Legal & Democratic Services, with DPH	Denice Burton, Vernon Hitchman	Clinical and non-clinical risks are being identified as part of the PH Contracts Stock take. Plan to be agreed by March 2012
5.5 Are there plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer?	DPH, IT Programme Director of Council and PCT	Angela Parratt, Cathryn Poole, Helen Tapson	Discussions have begun with key people in the PCT and the council and the regionally developed Knowledge Management Transition Plan has been used to inform enquiries and will support future planning. A plan will be agreed by March 2012. Arrangements agreed by October 2012
5.6 Have all issues in relation to facilities, estates, asset registers been resolved?	DPH, PCT Finance Director, DD Property, PCT Head of Estates	David Brain, Denice Burton, Tom McBain	Plan to be agreed by March 2012, Arrangements agreed by October 2012
5.7 Is there a plan in place for the development of a legacy handover document during 2012/13?	DPH	Denice Burton, Paul Scott	Plan to be agreed by March 2012 Legacy document to be produced by January 2013
6 Communication and engagement			
6.1 Is there a robust communications plan? Does it consider relationships with the	PCT AD Communications and Corporate Affairs Council Communications &	Jonathan Mercer and Derek Thorne	Public health transition has been discussed at public engagement events, at public board meetings and at our Local Involvement Network

Health and Wellbeing Board; clinical commissioning groups and NHSCB; Health Watch; local professional networks?	Marketing Manager		(LINk). We have met with the Cabinet of the council and the Strategic and Divisional Directors Groups. A dedicated communications strategy will be developed, in parallel with communications strategies for other Council and NHS commissioning changes by March 2012 to cover the transition year 2012/13 and for April 2013 onwards. The communications strategy will include engagement events.
6.2 Is there a robust engagement plan involving stakeholders, patients, public, providers of PH services, contractors and PHE?	PCT AD Communications and Corporate Affairs Council Communications & Marketing Manager	Jonathan Mercer and Derek Thorne	

Appendix 4 B&NES Public Health Transition - RISK REGISTER

Workstream	Risk Description	Risk Likelihood 1-5	Risk Impact 1-5	Risk RAG	Risk Owner	Risk Mitigation & Intended Impact	Risk Actionee	Action Completed by
Business Continuity	Ongoing provision of support services beyond secondment regarding HR, Communication, Finance and IT	2	4	**Amber**	Ashley Ayre	PA to secure arrangements with key leads as part of overall discussions between PCT Cluster, Council, CCG, SE, etc. SJ can provide fairshare planning calculations.	Pamela Akerman	Ongoing - to be monitored.
Business Continuity	Loss of regional programme support networks (including *Healthy Weight, Healthy Lives, Healthy Schools Plus, Social Care, Alcohol and You're Welcome*)	3	3	**Amber**	Pamela Akerman	Planning for public health programmes and support is happening at a regional, sub-regional and local level. Local public health leads are participating in these discussions.	Denice Burton	Apr-12
Finance	PH budget transferred to LA is insufficient to deliver the range and quality of service accountabilities transferred	2	4	**Amber**	Ashley Ayre	Detailed analysis of Indicative budgets between PCT and LA Reconciliation of figures between PCT/LA and DH prior to acceptance/sign off between PCT and LA Prioritisation of PH activities to financial envelop informed by JSNA refresh and resultant Health and Wellbeing Strategy	Denice Burton/J Oakley/Richard Morgan	2012/13 budget to be agreed by end of April 2012.
Workforce	Failure to secure/appoint Joint DPH during 2012-13	3	4	**Amber**	Ashley Ayre & Ed Macalister Smith	Recruitment Pack revised (Nov 11) Partnership agreement that LA to provide capacity to facilitate DPH appointment (recognising that PCT retains final authority) CT/LA agreement to refresh interim DPH arrangements for 2012013	Paul Scott	Subject to new regulation.

Workforce	Implications of secondment and transfer arrangements for individual public health team members, including practical aspects and affect on morale	3	3	**Amber**	Pamela Akerman	Ensure clear HR advice and support available to public health team. Await national Framework. Maintain regular team meetings and communication.	Denice Burton	Ongoing - to be monitored.
Communications	Risk of poor communication around transition to staff, executive and partners undermines confidence in and the effectiveness of the change process.	1	3	**Green**	Pamela Akerman	Monthly briefings provided to Change Programme Board, and bi-monthly to the Partnership commissioning staff (*In Touch*). PCT Board have received draft Governance Plan at May Board meeting.	Paul Scott	Ongoing - to be monitored.
Public Health England arrangements	Lack of clarity about roles and responsibilities of local public health and national Public Health England, and implications for local programmes and required capacity/capability.	3	3	**Amber**	Pamela Akerman	DH have produced detailed guidance on the Public Health England Operating Model and the role of Public Health and the DPH in local government, and this now needs to be worked through during 2012/13 to create new local arrangements.	Paul Scott	October 2012
Health Protection arrangements	Lack of clarity about roles and responsibilities of local public health and national Public Health England, and implications for local programmes and required capacity/capability.	3	3	**Amber**	Pamela Akerman	DH have produced detailed guidance on the Public Health England Operating Model and the role of Public Health and the DPH in local government, and this now needs to be worked through during 2012/13 to create new local arrangements.	Pamela Akerman	October 2012

Emergency Preparedness arrangements	Lack of clarity about roles and responsibilities of local public health and national Public Health England, and implications for local programmes and required capacity/capability.	3	3	**Amber**	Pamela Akerman	DH have produced detailed guidance on the Public Health England Operating Model and the role of Public Health and the DPH in local government, and this now needs to be worked through during 2012/13 to create new local arrangements.	Pamela Akerman	October 2012
NHS Commissioning	Lack of clarity about local public health role in NHS Commissioning.	3	3	**Amber**	Pamela Akerman	DH have clarified the mandatory expectation of public health advice from the council to the CCG. Public health will work with the CCG to develop a MOU around this issue during 2012/13.	Paul Scott	June 2012
Information & Intelligence	A range of intelligence risks, including lack of access to data by moving from the NHS N3 secure 'spine', and Information Governance issues if staff are moved to non-NHS contracts but still need to work with patient identifiable data	2	4	**Amber**	Pamela Akerman	AM to work with SJ and JP to develop an assurance plan using the regional Knowledge Management Transition Plan template. AM to work with Lynda Bird and Angela Parrett at B&NES Council and Cathryn Poole at NHS B&NES AM to work with West of England Public Health Intelligence Transition Group.	Helen Tapson	Assurance plan for knowledge management in place by September 2012

Appendix 5 Terms of Reference - JSNA Steering Group

1. Aim

To inform the Health and Wellbeing Board (HWB) in their development of the Bath and North East Somerset Health and Wellbeing Strategy by publishing an assessment of health and social needs in the population and how local services are meeting those needs.

To support development of a vehicle to present more detailed health and wellbeing data via the internet.

2. Approach

The assessment will be based on the normal resident population of Bath and North East Somerset, unless otherwise stated in specific analysis.

Headline chapters

The following is proposed as an outline structure, based on proposals by the Health and Wellbeing Board from September 2011.

Inequalities (as a cross-cutting issue)

- Wellbeing and other broader social determinants
  - Community Capacity (social capital) and other social assets
  - Cultural activities
  - Employment and Benefits (including Local Economic Assessment)
  - Education and Skills
  - Climate Change and Severe weather
  - Crime and Disorder (Community safety strategic assessment)
  - Housing
  - Benefits
  - The broader environment (e.g. Core Strategy Evidence base)

- Health determinants
  - Early years, breastfeeding, immunisations
  - Public health & lifestyle determinants
  - Smoking, obesity, physical activity
  - Drugs & alcohol

- Broad conditions and trends
  - Morbidity, mortality and life expectancy
  - Planned and Unplanned Care
  - Safeguarding

Managing Long term conditions

- Primary Care
- Planned and urgent health and social care system (including mental Health)
- Medicines Management
- Learning difficulties, physical and sensory impairment

Demographic Trends and Future Forecasting

- Population and demography
    - Explicit focus on equalities dimensions/groups as well
- To draw from all of above as relevant where trends/changes can be identified

Analytical approach:
Analysis of each subject will be developed with HWB members and other stakeholders as relevant and will based on the following questions. For more detail about each section, please refer to Appendix 1.

- What does the data say?
- What does the community say? (public engagement summary)
- Are we meeting the needs?
- What can we realistically do/change? (context)

3. Outputs

A distinct JSNA document, no more than 15 pages long to be published by the board and used as a key document to influence the on-going development of the Health and Wellbeing strategy.

A web-portal holding in-depth analysis referenced in the JSNA document (and other research published by or on the authority).

Milestones

October:
- Engage with Health and Wellbeing Board members
- Finalise ToR,
- Steering Group meeting,
- Engage with key officers/partners as relevant to collect information
- Collate analytical work and commission existing

November
- Health and Wellbeing Board sign off ToR
- Health and Wellbeing Board assess data gaps and prioritise analysis
- analysis & other engagement with key officers/partners as appropriate

December
- Draft JSNA produced
- HWB comment
- Further analysis/engagement as relevant

January – Final document

Ongoing – Online JSNA library

4. Governance

The Health and Wellbeing Board will act as project sponsor for this work. Jon Poole and Paul Scott (see below) will act as project managers.

5. Membership

Name	Role or representation
Pamela Akerman	Director of Public Health, B&NES H&WB Partnership
Mike Bowden	Divisional Director, People and Communities
CCG Board representative as available	B&NES Clinical Commissioning Group
Tracey Cox	Programme Director, B&NES H&WB Partnership
'Helen Edelstyn'	Strategy and Plan Manager, Policy and Partnerships
Jon Poole	Research and intelligence Manager, Policy and Partnerships
Paul Scott	Assistant Director of Public Health, B&NES H&WB Partnership
Derek Thorne	Assistant Director, Communications and Corporate Affairs, B&NES H&WB Partnership
David Trethewey	Divisional Director, Policy and Partnerships

6. Meeting frequency

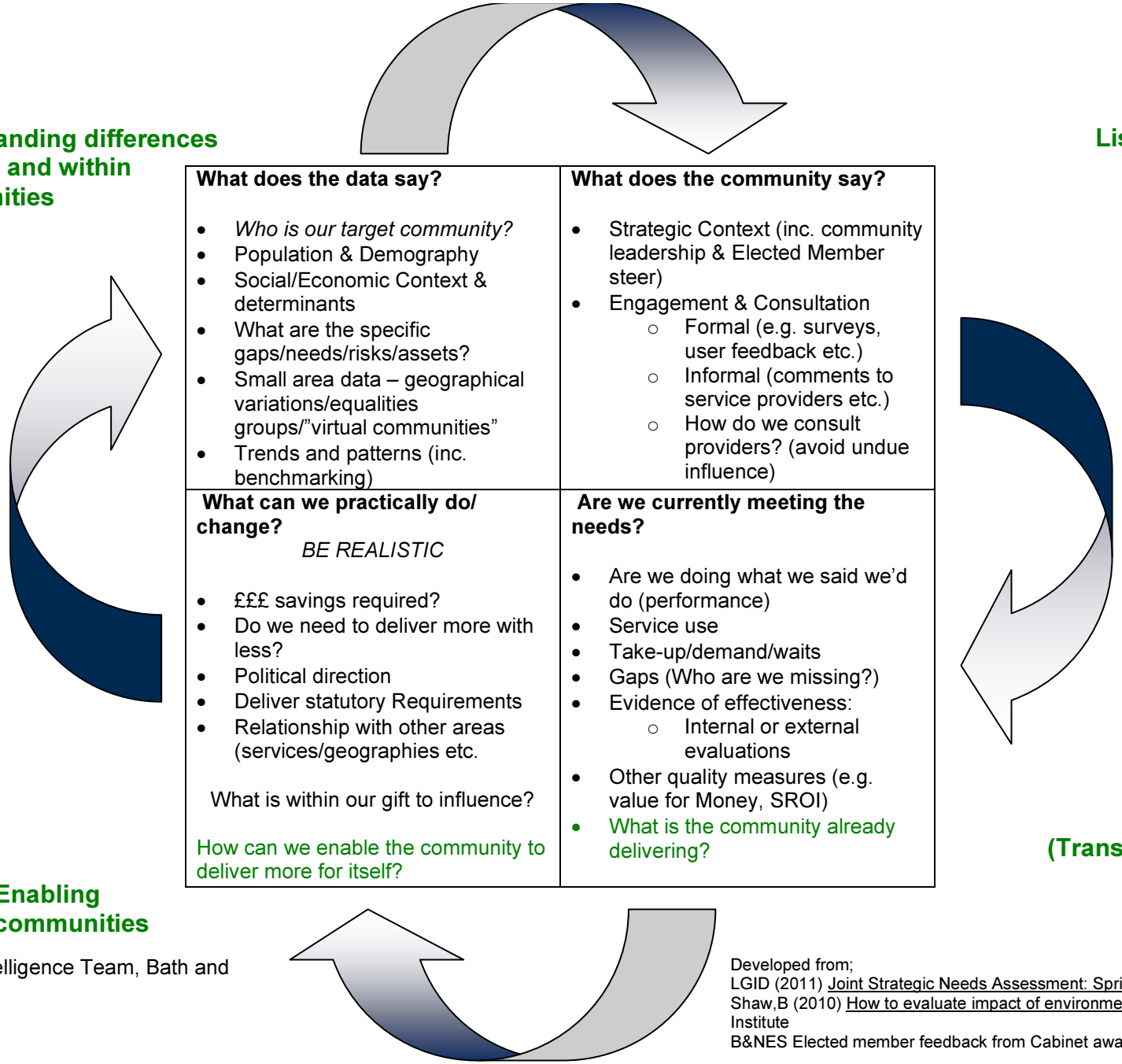
To be discussed at first meeting.

7. Interdependencies

A variety of other individual research projects, including for example '*Understanding our most Vulnerable'*.

Research Library ("Drupal" Project**) -** developing an online system to store and disseminate research documents. This system is necessary to deliver output 3.2 above.

Analytical Framework



Produced by Research & Intelligence Team, Bath and North East Somerset Council
research@bathnes.gov.uk
05/09/11

Developed from;
LGID (2011) Joint Strategic Needs Assessment: Springboard for Action (LGID)
Shaw,B (2010) How to evaluate impact of environmental research Policy Studies Institute
B&NES Elected member feedback from Cabinet away day – Jun 2011

Appendix 6 NHS Bath and North East Somerset Public Health IP&C Transition Plan

IP&C Function	B&NES Current Delivery	Actions to Ensure Maintenance 2012-13
Assurance of compliance with Health and Social Care Bill, CQC requirements and NHSLA risk management standards	All are elements within providers' contracts. IP&C Team (IPCT) have almost completed baseline audit of Nursing Home standards; plan to audit GP practices Q1 12-13. Non-compliance highlighted and improvement actions suggested.	Maintain contractual mandates. Repeat audits of Nursing Homes and GP practices.
Access to IP&C services by health and social care service providers	Phone & email access; monthly meetings with providers' IP&C Leads. Social care liaise with HPA.	Develop links with social care.
Arrangements for community IP&C	Liaise with HPA.	Confirm expectations.
Cluster IP&C arrangements: • IP&C specialists • Lab services • Service interface	B&NES IPCT comprises: • 0.4 Band 7 qualified IPC nurse specialist + 1.0 Band 6 trainee with minimal analyst and admin support. Infection Control Doctor SLA under discussion • B&NES uses accredited HPA lab in Bristol • Monthly collaborative meeting provides interface opportunity with providers	Cluster IPCT to be confirmed.. Review capacity and expertise in current team with consideration for appointment of qualified specialist.
Gaps in capacity and service provision	Loss of 0.6 Band 7 specialist	Review capacity and expertise in current team
Build IP&C into contracts	Automatic inclusion of IP&C specification in providers' schedules; ad hoc additional input by Senior IPCN. Annual review of contracts.	Develop IPCT's involvement in contracting process.
Assure compliance with national and local KPIs: • Reduction HCAIs	Monthly reporting by providers; scrutiny of results at monthly collaboration meeting and PCT quality board. IPC specialist reviews RCAs of all HCAI-related deaths. Quarterly IPC	Maintain current monitoring. Develop reporting mechanisms to CCG.

• Compliance with national standards, policies and NICE guidance • Reporting HCAI deaths	walkabout with providers monitoring clinical and environmental hygiene. Use of surveillance software to corroborate reporting.	
Monitoring providers' performance against national and local objectives and trajectories	Monthly reporting by providers; scrutiny of results at monthly collaboration meeting and PCT quality board. IPC specialist reviews RCAs of all HCAI-related deaths. Quarterly IPC walkabout with providers monitoring clinical and environmental hygiene. Use of surveillance software to corroborate reporting.	Maintain current monitoring. Develop reporting mechanisms to CCG.
Maintenance of collaboration with HPA/PHE; • Mandatory surveillance of HCAIs & reporting SUIs • Support for health protection incidents & outbreaks	HPA attends monthly collaborative meetings. Support available, within resources, for incidents and outbreaks.	Maintain current collaboration; define responsibilities between health protection and infection prevention services.
Preparedness for predictable health protection incidents	Outbreak management advice available to providers with liaison with HPU as necessary.	Maintain current collaboration; define responsibilities between health protection and infection prevention services.

Lauren Tew
Senior Infection Prevention and Control Nurse
NHS Bath and North East Somerset, Service Improvement and Performance Team
6/3/12

Appendix 7 Human Resources - Draft Outline Transition Plan for B&NES

Time Frame	Date	Action	By	Comments
Pre-Royal Assent	May 2012	Establish PH functions in scope for TUPE transfer	PA/SG	
Pre- Royal Assent	May 2012	Determine if any support functions are in scope, liaising with support functions management as appropriate	PA/SG	
Pre-Royal Assent	June 2012	Produce a list of staff that NHS B&NES deem are in scope for the proposed transfer. Identify any current PH staff not transferring and indicate alternative destinations. Determine employment status and rights of any fixed term, temporary or agency staff	PA/SG	This is a vitally important first step: to establish who is "assigned" to the organised group of services / functions that it is proposed will transfer
Pre Royal Assent	June 2012	Determine who in NHS B&NES and the Council will approve final staff transfer list	PA/SG	
Pre- Royal Assent	July 2012	Approve final staff transfer list	see above	
Pre Royal Assent	July 2012	Determine if a TUPE transfer contract is required and who within BANES NHS and the Council will draw this up. Determine if there is a need to engage solicitors. Determine who will sign the contract	PA/SG	Normally "sender" and "receiver" organisations would engage solicitors at this stage to protect respective interests in respect of indemnities etc post transfer.
Pre-Royal Assent	August 2012	Draft TUPE Consultation Document, particularly establishing and including in the consultation document any "measures" proposed by the Council post transfer. Conduct EIA	PA/SG	
Post Royal Assent	ASAP following Royal Assent	Determine which organisation will pay the Government Actuary's Department (GAD) fees in relation to obtaining a "broad comparability"	PA/SG	If not agreed in the contract or elsewhere

		certificate, and include in TUPE transfer contract		
Post Royal Assent	ASAP following Royal Assent	Instruct GAD to act, complete and send Data Collection Template to GAD	SG/JR	
Post Royal Assent	ASAP following Royal Assent	Consultation Document and Paper to Workforce Committee	SG	
Post Royal Assent	ASAP following Royal Assent	Arrange Board Approval of Consultation document	EG	
Post Royal Assent	October 2012	Sign off Consultation Document	PA	
Post Royal Assent	31.10.12 or earlier	Provide advance copy of Consultation Document to Unions and Staff Forum / Representatives	SG	
Post Royal Assent	01.11.12 or earlier	Staff meeting to commence formal Consultation (Staff Representatives and Unions invited). Issue Consultation Document	PA/SG	
Post Royal Assent	01.11.12 or earlier	Ensure communication and engagements with Council staff	Council?	
Post Consultation Start Date	09.11.12 or earlier	Provide due diligence information to Council, including anonymised list of staff	SG	
Post Royal Assent	03. 12. 12.	Receive GAD calculations	SG	
During Consultation Period		Further joint staff meetings to include Council management representation as appropriate. Individual 1 to 1 meetings offered to staff and undertaken as appropriate, keep Council	SG/ Council?	

		employees informed		
During Consultation Period		Set up FAQs on intranet with responses, keep Council employees informed	SG/Council ?	
	31.01.13	End of Consultation		
Post end of Consultation	06.02.13 or earlier	Feedback outcomes of Consultation to Board, staff, Unions and Staff Forum, and publish details NHS B&NES and Council intranets	SG/Council ?	
Post end of consultation	06.02.13 or earlier	Employee liability information to Council (disciplinary, grievance and pending tribunal or other court proceedings)	SG	
Post end of Consultation	11.02.13 or earlier	Draft TUPE transfer letters for PA's approval and EM-S's signature	SG	
Post end of Consultation	01.03.13 or earlier	Issue TUPE transfer letters. Issue termination forms, liaise with Payroll to ensure smooth transfer	SG	
Post end of consultation	08.03 12 or earlier	Final induction arrangements	PA/SG/Council?	
Post end of Consultation	01.04.13	TUPE transfer date		

Key

PA – Pamela Akerman
SG – Steve Graham
JR – Judith Rawlings

Appendix 8 Work plan for the transition of public health IT and intelligence functions

B&NES Public Health Information, Intelligence & Research Transition – Draft Outline Plan.

Version 2, March 2012. Author: **Helen Tapson**. Accountable Director: **Pamela Akerman**

Intelligence, Information & Research

Rationale: To ensure the public health intelligence, information & research functions are successfully embedded in B&NES Council – ensuring that the Joint Strategic needs Assessment (JSNA) remains on track and supports the development of an effective Health and Wellbeing Strategy for B&NES. In addition, this group will have the remit to consider the transfer of Information Technology (IT) infrastructure / functions in line with the emerging ICT strategy from the Council which is moving towards a vision that enables staff and Councillors access to what they need, where and how they need it.

Outcome: Robust public health intelligence, information & research functions that are successfully embedded in B&NES Council. The JSNA is kept on track and adequate support is provided to the new CCG and to develop the Joint Health and Wellbeing Strategy. Information/intelligence is transferred and stored within information governance guidelines. IT infrastructure is successfully transferred. Staff are enabled to continue with business as usual with minimal disruption to working practice.

Progress: A working group has been established to manage and advise on the information and intelligence transition with representation in both the current public health team, in the PCT ICT team and within the council. A draft project plan has been prepared and an initial meeting arranged to discuss and to allocate timescales to the project.

Key Milestones:
Project team to work towards resolving issues and readiness for total system transfer by 1st September 2012

Transition Issue	Accountable Director	Operational Lead	Commentary on current position
1 Data cleanup and assets transferring			
5.1 Is there a clear plan for the transfer of data from public health and personal drives to council drives?	Pamela Akerman	Helen Tapson, Denice Burton, Shelley Oak Individual project leads	Top level folders mapped and discussions regarding restructure and archiving policy in progress. Once folder structure is implemented, individual team members will reorganise subject folders in line with new structure and new archiving rules, making the contents of these sub folders ready for transition and new smaller storage limits in Council. In addition, access and navigation by multiple new users in the council should be considered in relation to clear labelling and storage of folders.
a. Are preparations in place for interim transfer to Wiltshire PCT?		Simone Lucas (Wiltshire)	14th March – migration from B&NES PCT IT to Wiltshire IT. All files deleted from c./ drive before this date.
5.2 Have risks to current data and intelligence sources during transfer been considered?		Avon transition group led by Susan Hamilton. Helen Tapson to check links with B&NES. Helen Tapson, Cathryn Poole	Avon transition group have produced list of public health data sources used by local analysts. This will be presented to team for consultation and addition at next PH team meeting. Risks to these sources will be considered. Secure copies of data and databases considered 'at risk' (including N3 website access and remote link to Avon server) should be made as a precaution prior to transfer. Wiltshire ICT should be consulted on the best methods for this.
5.3 Have individual team members archived their emails in order to reduce the size of their email folders considerably?		PH Team	Size of email folders limited to 50mb in council other than by exceptions agreed by Head of Transformation. Individuals to personally reduce and organise own folders for transition. Note: Will not be able to keep or transfer emails but some could be archived. Archived e-mails in council sit on an individuals G (personal) drive which is limited to 500mb. Any working documents

			would be held on S drive (folders not currently limited though this will come soon)
2 Identifying information Governance Risks			
2.1 Are there plans in place to ensure that confidential data (both electronic and paper based) is protected during the transition and once in the council in line with Information Governance procedures?	Pamela Akerman	Ian Gale (Council)& Pete Drummond – electronic storage Jeff Wring – paper storage Helen Tapson & Individual project leads	It will be necessary that a folder is created on council system with limited access rights for the storage of person identifiable data. In addition, some physical secure storage will be necessary for Public Health team. Pre transition, data that is confidential should be gathered together in the folder p:/public health (new)/directorate/intelligence/Protected Raw Data in preparation for transition. No person identifiable data will be stored in any other folders.
2.2 Has consideration been given regarding council/CCG access to public health data sources? Will any new data protection agreements need to be drafted as a result?		Jon Poole and Helen Tapson to discuss. Glyn Young and Pete Drummond/Amy Ogborne info security and info governance respectively in Council. (both report to J Wring)	Note – we have a secure link between BANES PCT and the Council. It should be possible to move data between the two networks but IG will need to check this. Access permissions will need to be set up so that data and info from PH and Council is available to appropriate staff. Ascertain what data will need to be shared, set up protocol for ensuring that correct permissions are signed and data sharing agreements drawn up in advance between PH, council and CCG's.
2.3 Have individual PH team members ensured that no confidential data is being sent to general email accounts (only NHS.net)		PH Team	Team members need to liaise with data suppliers to remove personal info before sending where possible. If the personal info is necessary then it should be sent securely and stored in folder mentioned in 2.1.

3 Transfer of IT infrastructure			
3.1 Are council teams prepared for extra phone and computer support and provision that comes with arrival of public health team?		Angela Parratt	Laptop and phone provision needs to be organised by council but this will partially depend on where in council team will sit and on how many people will transfer so need to provide provisional structure. PH need to advise what their requirements are for electronic equipment. People and Communities need to confirm they will meet the costs and provide a cost code. Council will then arrange delivery and related annual recharges. To include laptops/PCs, desk phones, mobiles/smartphones.
3.2 Is there any software that will need IT support not already provided by the council IT team		Helen Tapson to scope software needs. Susan Hamilton doing this for Avon. Discuss with IG	List software needs in team and check against software used in local authority. If there are any not supported, then question necessity and consider alternatives?

Appendix 9 Public Health Communication and engagement strategy

COMMUNICATIONS & ENGAGEMENT STRATEGY

PUBLIC HEALTH TRANSITION

NHS BATH AND NORTH EAST SOMERSET & BATH AND NORTH EAST SOMERSET COUNCIL

Version:	Final
Ratified by:	Paul Scott, William Harding, Jonathan Mercer & Craig MacFarlane
Date Ratified:	9 March 2012
Name of Originator/Author:	Craig MacFarlane & Jonathan Mercer
Name of Responsible Committee/Individual:	Public health transition group
Date issued:	9 March 2012
Review date:	15th June, 2012
Target audience:	Employees of NHS B&NES/B&NES Council & stakeholders

NHS B&NES & B&NES COUNCIL

COMMUNICATIONS STRATEGY

CONTENTS

NHS B&NES & B&NES Council

Communications & engagement strategy for public health transition

VERSION CONTROL

Document Status:	To be approved by Public Health Transition Group & B&NES Council's Marketing Manager
Version:	Final

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**

Sponsoring Director: **Author(s):**	Paul Scott Craig MacFarlane & Jonathan Mercer
Document Reference:	Communications & engagement strategy – public health trasition

NHS B&NES & B&NES Council

PUBLIC HEALTH TRANSITION

COMMUNICATIONS & ENGAGEMENT STRATEGY

1. EXECUTIVE SUMMARY

1.1 This strategy sets out how the PCT and council will effectively communicate and engage with its staff and stakeholders on the reorganisation of public health into its new organisational home in the local authority and Public Health England. Details of the work programme are given in the public health transition plan, which sets out the purpose, estimated costs and timescales of full transition and outlines the project approach detailing the basis for the management of the project including risks and mitigation. Background details of the public health transition programme are outlined in the Health and Social Care Bill currently being considered by parliament and to be implemented by April 2013.

1.2 The Public Health Transition Group, comprising key strategic directors from both the PCT and Council, is managing the process of transferring public health from the PCT to the local authority.

1.3 Under this reorganisation the overall objectives of public health will be to increase healthy life expectancy and reduce health inequalities. Local authorities will have a new duty to promote the health of their population as part of the reforms. Through the Health and Wellbeing Board they will lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public's health and wellbeing. Public Health England will be created as a new integrated public health service. It will bring together the national health protection service and nationwide expertise across all three domains of public health.

1.5 As part of the transition programme it is important to build confidence and understanding in the new organisational arrangements. It is also essential to develop an understanding among staff of the planned changes ahead.

This communications and engagement plan is aimed at developing these important aspects.

1.6 The following is a summary of activities:

- Health & Wellbeing Board (briefing): On-going
- Council cabinet (briefing): On-going
- Clinical commissioning group (briefing): On-going
- Staff updates: On-going
- Executive briefs
- Engagement with key stakeholders: On-going
- Stakeholder events & briefings: On-going

2. OBJECTIVES

The key objectives of this communication and engagement plan are:

- To raise awareness of the public health reforms, what they mean and how they will be implemented
- To build and develop confidence and understanding in the new organisational arrangements
- To engage effectively with stakeholders throughout the transition programme
- To manage and protect the reputation of the organisation during a period of intense organisational change.

3. TARGET AUDIENCE

Key stakeholders are:

Clinical
- Clinical commissioners
- GPs

Executive & governance
- Health and Wellbeing Board
- PCT cluster Board (operational April 1 2012)
- Cluster EMT
- Council's strategic and divisional directors
- Council cabinet
- Wellbeing Policy Development and Scrutiny Panel
- Councillors

Staff
- PCT staff
- Council staff

Key providers
- Sirona Care & Health (executive)
- The Healthy Lifestyles Hub

- RUH executive
- AWP executive

Third sector & interested groups
- Local Involvement Network (LINk)
- The Care Forum
- The public – Healthy Network

4. KEY MESSAGES (public facing)

The key messages will be developed and targeted to audiences as the work programme matures and becomes clearer.

- The goal is to continue to improve the health of all people, but to improve the health of the poorest, fastest
- Councils are well placed to adopt a wider wellbeing role having already taken on the key role in promoting economic, social and environmental wellbeing at the local level
- Public health has an important role to play within the local authority
- A new body, Public Health England, will develop and deliver a national approach to public health and be responsible for national programmes such as early diagnosis for cancer etc.

5. METHODS

Briefing reports updating the executive on progress are regularly presented. Stakeholder engagement has been ongoing while staff communications are largely supported by team meetings within public health. In addition staff have the opportunity to raise questions directly with the CEO at his monthly meetings while traditional staff communication channels will be used to support awareness raising. Key mechanisms for briefings, engagement and staff comms are highlighted below and outlined in the action plan (appendix 2).

Engagement:
- Clinical Commissioning Committee (briefing reports)
- GP forum-plus (monthly meetings)
- Health and Wellbeing Board (briefing reports & presentation)
- Cluster Board (briefing reports)
- NHS B&NES & NHS Wiltshire cluster Board (briefing reports)
- Cluster EMT (briefing reports)
- Council's strategic and divisional directors (HOW)
- Council cabinet (HOW)
- Wellbeing Policy Development and Scrutiny Panel (HOW)
- Councillors (HOW)
- Public health commissioners (team meetings)

- PCT staff (newsletter, intranet)
- Council staff (HOW)
- Sirona Care and Health executive (reports)
- The Healthy Lifestyles Hub (team meetings)
- RUH executive
- AWP executive
- LINk/HealthWatch (briefing reports & presentation)
- Health and Wellbeing Network (presentation, breakout discussion & feedback)

Communications (internal):

- Staff briefings (public health team meetings)
- Monthly meetings with the CEO
- Develop intranet x PCT & Council
- Incorporate regular updates in newsletter x PCT & intranet

External comms/reputation management:

- Reactive holding lines
- Q&A
- Press release (promoting H&WB Network)
- Dedicated section on website

6. MILESTONES

Jan 2012: Transition Planning Guidance published by DH

Jan 2012: Local Government HR Transition Guidance published

Mar 2012: Local transition plans completed by PCTs

From Apr 2012: Local areas agree arrangements for any in year delegation of functions and secondments/assignment of transferring staff in line with guidance

By Oct 2012: Local areas test arrangements for delivery of specific public health services in particular screening and immunisation, and Emergency Response

Oct 2012: Local areas agree arrangements on public health information requirements and information governance

Jan 2012: Local areas ensure final legacy and handover documents produced

Apr 2013: Local authorities formally take on new responsibilities.

7. PUBLIC AWARENESS

The NHS reforms are immensely complicated and extensive coverage across both the national press and media has resulted in increased awareness in the public realm. Anecdotally given the level of debate and the nature of this debate we can summarise that the reforms are controversial. It's within this context that we will be communicating messaging to our stakeholders, public and staff. This communications and engagement plan is aimed at increasing awareness and understanding and building confidence in the public health reforms.

8. MEDIA HANDLING

Given the high profile nature of the NHS reforms materials will be prepared in the event that the press/media pick up on the transition programme. These materials will include reactive lines and Q&As. A spokesperson will be identified for consideration if we decide to field broadcast interviews and a press release promoting the H&WB Network, which will incorporate the public health transition programme, will be circulated to press outlets.

8.1. A list of newspapers and publications is shown in Appendix 1.

9. QUALITY CONTROL AND EVALUATION

9.1 No major communications materials should be distributed unless jointly signed off by the project lead (Paul Scott) in partnership with comms colleagues at both the PCT and council.

9.2 During the course of the project judgements will be made on the effectiveness or otherwise of the communications and engagement plan and if necessary appropriate action taken. Any such actions will be a jointly agreed process between the project lead and the communications and engagement team.

APPENDIX 1

List of Press Agencies

Newspapers:

Bath Chronicle
Somerset Guardian
The Week In (Keynsham)
MSN Journal
Chew Valley Gazette

Broadcast:

BBC Radio Bristol
BBC Radio Somerset
Breeze
Heart FM
BBC Points West
ITV West

Online:
All of above

NHS Communication Standards

All communications for the Connecting for Health Technology will adhere to the NHS Communications Standards, which are:

- **Open** - the reasons for decisions are available, decision makers are accessible and ready to engage in dialogue. When information cannot be communicated the reasons for non-disclosure are articulated. Questions are anticipated and answered.
- **Corporate** - communication style and messages reflect a consistent view. Messages articulated should be consistent with the values of the organisation they come from and of the NHS as a whole.
- **Two-way** - systems exist to support communication up and down as well as across organisation boundaries.
- **Timely** - information arrives at a time when it is needed, relevant and able to be interpreted in the correct context.
- **Clear** - messages are communicated in plain English, they are easy to understand and are not open to misinterpretation. Written messages are concise, using short sentences and avoiding jargon.
- **Targeted** - the right messages reach the right audiences, in the right manner, at the right time.
- **Credible** - messages have real meaning, recipients can trust their content and expect to be advised of any change in circumstances that may cause the initial message to be invalidated.
- **Planned** - communication is planned: a communication plan exists and is regularly contributed to and reviewed by senior management. Communication activity is appropriate and contingencies for dealing with likely situations specified in advance. Agreed lines to take on a particular issue are articulated and adhered to.
- **Consistent** - messages are delivered in a co-ordinated fashion so that there are no contradictions during the time period in which the message is relevant.
- **Efficient** - the communication and the way it is delivered is “fit for purpose”, cost–effective, to budget and delivered on time.
- **Integrated** - internal and external communication is consistent and mutually supportive.
- **Straightforward** - communications must not be seen to be “gimmicky” or inappropriate for a public sector healthcare organisation.

Public Health Transition Engagement Plan

	Previous engagement	On-going progress report	Bill being enacted (Possibly April/May)	Start of formal consultation with staff	Ending of formal consultation	Some shadow arrangements in place (partially) and tested as part of national planning: October 12	Local areas ensure final legacy and handover documents produced: Jan 12	Staff transfer to Council and wider public health arrangements go live: April 2013
Priority 1								
Engagement with staff affected	Monthly team meetings	Staff meet monthly to discuss transition agenda	Note to staff explaining this and setting out a broad timetable	Consultation document and approach prepared by HR	Advise staff of the outcome of the consultation and the next steps	Briefing note to staff to explain implications	Not required	Welcome to the Council
Health and Wellbeing Board	Progress updates to Health and wellbeing board (Nov 11, Feb 12)	On-going bi monthly report to Health and wellbeing board	Brief note including timetable	Notify Board of intentions/process	Advise board of outcome at the end of the consultation as part of progress update	Progress report - Briefing note to staff to explain implications	Briefing from PS	Briefing to the Board
Cluster Board (EMT)	Progress updates to cluster board	On-going updates as necessary	Briefing from PS	Notify Board of intentions/process	Brief verbal update from PS	Progress report	Notify Board of intentions/process	No longer in existence
Council cabinet	Updated briefing (Sept 11)	Not required	Progress report to Cabinet setting out timescale for transition	Not required	Brief verbal update Form PS	Progress report	Not required	Briefing by PS
Well Being Policy and development Panel	N/A	Not required	Not required	Not required	Progress report to the panel	Needs to be considered	Not required	Note to members of the Panel
Council SDG/directors	Progress updates to directors	As required	Briefing	Not required	Brief verbal update Form PS	Progress report	Briefing from PS	As required
Clinical commissioning group			Progress report and timetable	Not required	Briefing from PS	Progress report	Briefing from PS	Briefing from PS

Priority 2								
Information to other PCT staff	Monthly team meetings	Not required	Brief note on PCT intranet/newsletter	General information on intranet- no proactive comms otherwise	General update to staff	Not required	Not required	Communication with staff
Engagement with key clinical partners, GP's, Sirona, RUH, AWP, Healthy network, LINk, Care Forum	Transition plan presented at GP forum (Sep 11), Health & Wellbeing Network (March 11) & LINk (April 11). In-depth article featured in Care Forum newsletter	Not required	Letter to key partner organisations	Not required	Not required	Not required	Letter to partners explaining situation	Letter to explain that staff have transferred to Council and other information
Council Divisional Directors	Progress updates to directors	As required	Briefing from PS	Not required	Briefing from PS	Not required	Briefing from PS	Briefing from PS
Council staff working directly under new arrangements	N/A	N/A	Email communication	N/A	N/A	N/A	Programme briefing on personal impact on the changes	Briefing Intranet Newsletter

Priority 3								
Public	Bespoke engagement with public via Healthy network (March 11)	Not required NOTE- PREPARE REACTIVE COMMS	Not required	Respond reactively if required			Website and phone line for public	Communications campaign to the public. Information updated on Council website
General information to Council staff	N/A	Not required	Intranet/newsletter	Not required	Not required	Not required	Not required	Intranet/newsletter
Information to other partners			Insert in regular Newsletter	Not required	Not required	Not required	Article in their newsletters	Confirmation to all partners
Information to Councillors	Priority one members updated (Sep 11)	Not required	Communication with Councillors	Not required	Not required	Not required	Not required	Letter to all councillors – successful transfer

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	18th May 2012
TITLE:	Home Health and Safety Policy 2012
WARD:	ALL
AN OPEN PUBLIC	
List of attachments to this report: Appendix 1: Proposed Home Health and Safety Policy 2012	

1 THE ISSUE

1.1 The Council is required to adopt and publish a housing renewal policy, referred to as The Home Health and Safety Policy in this report. This policy is periodically reviewed and revised as required. It sets out how Housing Services will provide assistance, including financial assistance, to help low-income, elderly, disabled and other vulnerable residents to undertake essential repairs and adaptations to their homes. The policy supports the aims of the Housing and Wellbeing Strategy 2012 – 2015, particularly around improving health and wellbeing and reducing inequalities within our communities.

1.2 The Council Cabinet adopted a revised policy on the 13th of July 2011 which takes into account the financial constraints caused by the withdrawal of Private Sector Renewal funding by Government. The Cabinet asked for the policy to be reviewed in 1 year.

1.3 This report to the Wellbeing Panel proposes some changes to the Home Health and Safety Policy adopted last year.

2 RECOMMENDATION

The Wellbeing Panel is asked to:

2.1 Note and comment on the proposed policy.

3 FINANCIAL IMPLICATIONS

3.1 The funding for the proposed Home Health and Safety Policy 2012 is detailed in the Medium Term Financial Plan previously adopted by the Council. The total funding amounts to £165,000, comprising £45,000 from Housing Services efficiency savings and £120,000 from new monies for adult social care from the Department of Health. This does not include the empty property funding, the capital elements of which have provisionally been allowed for in the affordable housing funding agreed by Council.

3.2 In addition there is £0.9m of mandatory Disabled Facilities Grant (DFG) funding comprising £422,000 Government capital allocation and £478,000 revenue contribution. In addition an agreement with Somer Housing allows for an element of cost sharing on DFGs within their stock which is expected to contribute in excess of £100,000.

4 THE REPORT

4.1 The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 provides local authorities with a general power to offer assistance to improve housing conditions. This assistance may take the form of financial grants, loans or any other type of help and support thought appropriate. Prior to making such assistance available it is a requirement that the Council must adopt and publish a housing renewal policy, referred to as the Home Health and Safety Policy in this document.

4.2 The recent, and at the time of writing still draft B&NES Housing Condition Survey 2011, identified some groups of residents experiencing poor housing conditions, including:

- Owner occupiers & private sector tenants over 65 years of age;
- Lone parents with dependent children;
- Owner occupiers on low income;
- Residents with a disability; and
- Vulnerable residents (as defined by being receipt of certain benefits).

4.3 The proposed Home Health and Safety Policy 2012 contained in Appendix 1 details a number of schemes aimed at the improvement of homes occupied by low-income, disabled, elderly and otherwise vulnerable households. The policy includes an urgent repairs service which responds to national evidence that targeted, small scale works, promptly delivered can have significant positive health benefits for older and vulnerable people.

4.4 The schemes of assistance are summarised below together with the proposed changes to the current policy:

- **advice and home visits** – to help vulnerable people decide what work is required to remedy serious hazards and property defects. There are no proposals for change;

- **mandatory disabled facilities grants (separately funded)** – adaptations to ensure the homes of disabled people are suitable for their needs. There are no proposals for change;

- **urgent repairs grants** – to fast track urgent and small repairs for vulnerable people to reduce illness and accident. The proposal for change is to describe eligible works as those that prevent accident or ill health instead of those that remedy Housing Health & Safety Rating System Category 1 hazard;

- **home improvement loans** – to help vulnerable residents undertake essential repairs and safety improvements for improved health and wellbeing. The proposals for change are: new eligibility for families with dependent children under 16 years of age; reducing length of home ownership required before being eligible for assistance from 2 years to 1 year; new Park Homes Loan product; and new capital loan product suitable for those with a faith which prevents the taking up of traditional loan products;

- **energy efficiency improvement** - home insulation and top up heating/insulation grants to help households with low income keep their homes warm and energy efficient. The proposals for change are to flag that assistance may change when Green Deal begins and also a new Wessex Energy Loan product;

- **community alarms grant** – to help vulnerable people feel safer in their homes by providing community alarms and key safes. There are no changes proposed; and

- **bringing empty homes back into use** – new section of policy covering assistance to encourage empty home owners to bring these homes back into use.

4.5 In summary these changes are driven by the views of stakeholders on service improvement and to respond to changes in legislation and other priorities. For the purposes of this policy a household is defined as vulnerable if the household is a low income household and, aged 60 or over or with a limiting long term illness or disability or has dependent children aged 16 years of age or less.

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

The policy will assist vulnerable households in B&NES access financial assistance to carry out essential repairs and safety improvements and adapt their homes to meet their needs. It is proposed that resources will be aimed at low income residents that are 60 years of age or over or have a relevant disability affecting their ability to work or have dependent children of 16 years of age or less. An equalities impact assessment has been completed. The age related adverse impact is justified below.

6.1 Evidence available nationally and locally shows that the group described in 6 above are more vulnerable to many of the common housing health and safety hazards. Individuals under 60 and able bodied are more likely to be able to obtain work and fund the improvement themselves. Therefore resources are aimed at low income households and, aged 60 or over or with a limiting long term illness or disability or have dependent children of 16 years or age or less.

7 CONSULTATION

7.1 Cabinet Member; Overview & Scrutiny Panel; Staff; Other B&NES Services; Service Users; Local Residents; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Chief Executive; Monitoring Officer

7.2 The consultation was carried out through circulation of a draft policy and questionnaire, face to face interviews, telephone interviews, emails and discussion at meetings.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion: Good quality, suitable housing increases social inclusion, particularly for children and older people on low income. It also assists with the maintenance of good health and comfort, reducing social exclusion caused by poor health and poor living conditions. These factors should reduce the demands on NHS B&NES.

8.2 Sustainability: Relatively small scale targeted intervention can prevent housing falling into excessive disrepair. Also energy efficiency improvements reduce carbon dioxide emissions and the likelihood of fuel poverty.

8.3 Young People: Good quality suitable housing improves the health and educational outcomes for children and young people.

8.4 Customer focus: This policy aims to help meet the needs of vulnerable residents in B&NES living in private sector homes with concerns about their housing conditions.

8.5 Health & Safety: The policy is underpinned by actions in the Housing and Wellbeing Strategy to improve the health, safety and wellbeing of vulnerable households in B&NES.

8.6 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	Chris Mordaunt, Housing Services Manager (01225 396282)
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

Housing Services

Home Health and Safety Policy

(adaptations, repairs and improvements)

July 2012

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This document can be made available in a range of languages, large print, Braille, on tape, electronic and accessible formats from the Housing Services Telephone 01225 396444

CONTENTS

1 HOME HEALTH AND SAFETY POLICY

1.1 This policy sets out how the allocated home adaptations and home safety repairs and improvements budget is to be spent from July 2012.

1.2 This policy sets out how the allocated budget to help bring empty homes back into use is to be spent from July 2012.

Adaptations for disabled people

1.3 This policy will improve the housing conditions of eligible disabled people by providing Disabled Facilities Grants (DFG) to purchase adaptations that assist independent living.

Eligibility for a DFG is determined by an assessment of need by the Occupational Therapy Service and a test of resources by Housing Services.

Home safety repairs and improvements

1.4 This policy will improve the housing conditions of vulnerable owner occupiers by giving them advice and financial support in the form of loans or grants to remedy and alleviate serious health and safety hazards in their homes.

1.5 This policy operates alongside the Housing Services Enforcement policy which deals with the repair and improvement of rented homes to remedy serious housing health and safety hazards.

1.6 For the purposes of this policy a serious health and safety hazard means a hazard falling into Bands A-D under the Housing Act 2004 Housing Health and Safety Rating System.

1.7 For the purposes of this policy a household is defined as vulnerable if the household is a low income household and

- aged 60 or over; or
- with a limiting long term illness; or
- a family with dependent children under 16 years of age.

Home energy efficiency improvements

1.8 This policy will improve the housing conditions of vulnerable people by giving them advice and financial support to help them insulate their homes or make them more energy efficient. These improvements will make it more affordable for vulnerable people to stay warm.

Community alarm grants

1.9 This policy will improve the housing conditions of vulnerable people with low income by giving them financial support in the form of grants for community alarms that makes them safer in their homes.

Empty Home assistance

1.10 This policy will improve the availability of housing in the area by assisting owners of empty homes to bring their properties back into use by giving advice and financial assistance in the form of loans or grants.

Delivery Schemes

1.11 This policy will be implemented by Housing Services and delivered via the following seven schemes:

- advice and home visits – to help vulnerable people decide what work is required to remedy serious hazards and property defects;

- disabled facilities grants – working with the Occupational Therapy Service to help disabled people make their homes safe and suitable to live in;

- urgent repairs grants - to help vulnerable people afford a small repair that needs to be completed quickly to prevent illness or accident;

- home improvement loans – to help vulnerable people afford repairs and safety improvements that help to keep them safe and well at home;

- home energy efficiency improvements – to help vulnerable households to keep their homes warm and energy efficient;

- community alarms grant – to help vulnerable people feel safer in their homes by providing community alarms and key safes.

- Empty homes assistance – to bring empty homes back into use by providing advice and assistance to owners of empty homes.

Budget

1.12 This Policy and the delivery schemes are subject to the availability of funding. Grants and loans are subject to eligibility criteria and a maximum amount to distribute the financial support available in an effective way.

1.13 The Policy will be subject to periodic review particularly if there are substantial changes to funding and resources.

2. POLICY CONTEXT

2.1 Bath and North East Somerset Council has general powers given under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to provide assistance that improves housing conditions in the area.

2.2 The Council's priorities for improving the lives of local residents are set out in the Sustainable Community Strategy 2009-2026. The Policy will contribute towards the aims of the Sustainable Community Strategy and the Housing and Wellbeing Strategy 2010-2015 by:

- improving health and wellbeing and reducing inequalities within our communities: narrowing the gap between people with low income living in poor housing conditions and the better off.

- by helping people to feel confident about carrying out their daily activities inside the home

- making homes more resilient to climate change,

2.3 The Key to Independence 2008-2013 is the Council's Housing Strategy for older people. The Policy will contribute towards the aims of the Key to Independence by providing person centred housing repairs and adaptation support and by improving the health and safety of older people.

2.4 The Joint Strategic Needs Assessment (2012 draft) identifies falls and associated injuries as particular problems for older people and identifies energy inefficient homes as a particular problem amongst older persons and vulnerable persons in the area. The implementation of this policy will contribute to reducing the incidence of hospital admissions because of falls and excess cold and to reducing excess winter deaths amongst older people by targeting advice, loans and

grants to remedy serious hazards and improve home energy efficiency to owner occupiers aged 60 or over.

2.5 The House Condition Survey 2012 (draft) identified

- Almost 50% owner occupiers who are lone parents live in non-decent housing. Lone parents are more likely to have a low income and not able to afford repairs.

- Households where one or more people are receipt of benefit are significantly more likely to live in a dwelling with a category one hazard and therefore live in a non-decent home

- Households which have a disabled resident have a significantly higher likelihood of living in a dwelling with a category one hazard and therefore live in a non-decent home

3 EQUALITIES

3.1 The Policy will be implemented by Housing Services and its delivery partners and the Schemes will be available to all B&NES residents eligible under the terms of the policy including people with protected characteristics in accordance with the Equality Act 2010 and the Council's Single Equalities Scheme.

4 APPEALS

4.1 If an applicant is refused a loan or grant and wants to appeal against the adverse decision they may contact the Housing Services Manager. An appeal will be considered by a Service Manager independent of the Housing Standards and Improvement Team who administer this policy. An appeal must set out the reasons why the applicant wants the decision changed and provide supporting evidence. An appeal should be made in writing within 28 days of the decision unless the applicant's circumstances are exceptional.

5. COMPLAINTS AND COMPLIMENTS

5.1 We want to provide good quality services but sometimes things can go wrong. If this happens we need to know so that we can put it right and learn from the experience. We welcome comments or suggestions that help us to improve the service.

5.2 Complaints will be dealt with according to the Council's Complaints procedure (available on the website). Complaints can also be made to the Complaint Procedure Manager who can be contacted on: 01225 477931.

6 EXCEPTIONAL CASES

6.1 In exceptional cases the Council will consider applications for help with home adaptations, repairs and safety improvements and empty homes assistance that fall outside this Policy. Such applications will be decided by the Housing Services Manager.

6.2 Exceptions to the maximum amount of financial assistance available will be considered by the Housing Service Manager where the maximum is likely to be exceeded due to unforeseen works.

7 HOME HEALTH AND SAFETY DELIVERY SCHEMES

Disclaimer

The Council does not accept responsibility for any loss or damage incurred as a result of the advice and guidance provided by the repairs and safety improvements and adaptations schemes.

The summary table and Appendix 1 provide information on the current schemes. These schemes may change or be withdrawn according to current priorities and the funding available.

Summary Table: Home Health and Safety Delivery Schemes (* all schemes are subject to funding being available).

Assistance Type	Purpose	Eligible client group	Amount available	Additional information
Free home health and safety advice	Home visits by housing Officers to give advice about home repairs and prioritising work to remedy defects.	✓ Low income ✓ Home owners ✗ Tenants	None as this scheme for giving advice only.	Low income is defined as being on income related benefit.
Disabled Facilities Grant	Financial assistance and advice to make home adaptations to promote independent living	✓ Low income ✓ Disabled ✓ Home owners ✓ Tenants	Up to £30,000	All DFG approvals are subject to an eligibility assessment and a test of resources. Funding will only be considered up to the value of the works recommended by the Occupational Therapist.
Home Improvement Loans	To provide loans for repairs and improvements to remove serious health and safety hazards (Category 1 hazards A to C and Category 2 hazards D only).	✓ Low income ✓ over 60 ✓ vulnerable ✓ Low income families	Between £500 and £15,000	Loans are available from Wessex Home Improvement Loans upon a referral from Housing Services. The most suitable type of loan will be identified

		✓ Home owners (including park homes) ✗ Tenants		by Wessex HIL. Low income is defined as having a certain level of disposable income which is assessed by Wessex HIL. Loans are repayable to Wessex HIL. Capital appreciation loans are available for those persons whose religious beliefs prevent them from accepting loans. Park home owners loan limited to £5000
Urgent Repairs Grant	To provide small grants for carrying out urgent repairs quickly to prevent ill health or an accident. For example to fix dangerous electrics or	✓ Low income ✓ over 60 ✓ vulnerable ✓ Home owners	• £1000 per grant • No client to have more that 3 grants in a year and more that £1,500 in a year.	Low income is defined as being on an income related benefit. Clients not on a benefit may be given a Test of Resources to determine their income level.

	repair a broken heating system.	✗ Tenants		
Home energy efficiency improvements **These schemes may be replaced with equivalent and additional schemes under Green Deal**	**Warm Streets/** To provide cavity wall and loft insulation. **Warm Front top-ups** To provide top-up grants to successful Warm Front applicants who need additional money on top of the Government grant to carry out the works. **Energy loans** To provide assistance subject to same eligibility criteria as Home Improvement Loans for energy efficiency measures including solid wall insulation	**All Schemes:** ✓ Low income ✓ Home owners ✓ Tenants **Warm Front Top-up** clients must be successful applicants of the Warm Front Scheme who have been told by Ega that the cost of works they have applied for is more that the maximum allowed by the Warm Front Scheme.	**Warm Streets:** Depending on age and income some people will be provided with home insulation. Otherwise there are discounts of at least 50% (May be subject to changes which are outside the scope of this Policy) **Warm Front Top-ups** Top-up grants are given at an amount that will cover the extra cost required to complete works being funded by the Government Warm Front grant (or equivalent). Excessive claims may be refused. Average grants paid have been between£200 and £1,000.	Low income for the Warm Streets scheme is defined by the Warm Streets scheme and is subject to change. Warm front Top-up clients will have been assessed by the Warm Front scheme as having a low income in order to be entitled for a Warm front grant. **Energy Loans** See Home Improvement Loan section

			Energy Loans Between £500 to £15,000	
Community Alarms Grants	For the installation of community alarms and key safes.	✓ Low income ✓ over 60 ✓ vulnerable ✓ Home owners ✓ Tenants	£200 maximum	Low income is defined as being on income related benefit.
Empty Homes Assistance	To bring empty homes back into use by assisting the owner with financial support	✓ Empty home owners	Max grant £5,000 Wessex Loan between £500 to £20,000	An empty home is a residential property which has been empty for over 6 months. The home must be located within Bath and North East Somerset. Housing Services will determine if an empty home is eligible

APPENDIX 1 – DELIVERY SCHEME DETAIL

1. HOME HEALTH AND SAFETY ADVICE AND HOME VISITS

Who can apply?

This service is for home owners with low income only.

Low income is defined as being on one of the income related benefits listed below:

- *Income Support
- *Income based Jobseekers allowance
- *Employment support allowance (income Based)
- *Council Tax benefit
- *Pension credit (Guarantee credit)
- Likely to satisfy low income eligibility
  (Not likely to be assessed as having full contribution in Housing Services test of resources as determined at point of initial inquiry)

The Scheme

Home visits will be carried out to enable housing officers to give preliminary advice about home repairs and prioritising work to remedy any defects. A list of contractors for repairs can be provided.

Home repairs and improvements advice and support for elderly, disabled or vulnerable people can also be provided by the Home Improvement Agency.

Works that can be included

When an officer visits they will focus on identifying serious health and safety hazards and major disrepair. For example:

Dangerous electrics
Inadequate heating and/or home insulation
Damp and mould
Roof leaks
Dangerous staircases and pathways

How to apply

Call Housing Services on 01225 396444 to ask for an appointment

Funding amount

This scheme is not for giving out grants or loans. It is for advice only.

Requirements and conditions

- Advice and guidance is given subject to available resources and to reflect the best interests of the household.

- The advice and guidance is not a structural survey and the assessment is based on the Housing Health and Rating System under the Housing Act 2004.

- Advice given may be verbal or written.

- The Council may have to take formal action when they discover a serious hazard or disrepair. For example the may have to serve a Hazard Awareness Notice which tells the house owner what the hazards are.

2. DISABLED FACILITIES GRANT

Who can apply?

This grant is available to residents (both adults and children) who are disabled and have been referred for assistance by the Council's Occupational Therapy Team.

It is available to owner-occupiers and private tenants, including tenants of Residential Social Landlords (with the landlord's consent).

The grant is only available to people on low incomes and is subject to a "test of resources" which examines people income and savings. The grant is only available to people who have been assessed by an occupational therapist as in need of the grant.

Applications for children will not be subject to a "test of resources" under current legislation.

The Scheme

Grants are available for disabled people to provide adaptations in their homes which will enable them to live more independently and remain at home.

The grants are mandatory which means that the Council has a legal duty to provide them. The grant can include payment for professional fees and any unforeseen works that are necessary.

Works that can be included

The eligible works include those that are deemed mandatory in accordance with the Housing Grants, Construction and Regeneration Act 1996. This includes essential adaptations to give residents better freedom of movement into and around their home and to access facilities within it. All applicants will have to be assessed by an Occupational Therapist before being referred to the Housing Standards and Improvement Team.

Funding will only be considered up to the value of the works recommended by the Council Occupational Therapist.

In exceptional circumstances funding will be made available for the provision of an additional access ramp into the disabled person's accommodation so that, for example, they have access to the back garden as well as access through the main entrance. As agreed by Occupational Therapist Manager and Housing Services Manager.

Funding amount

The maximum amount of grant will be £30,000.

Home Improvement Loans can also be used to “top up” a Disabled Facilities Grant (DFG) where the cost of work exceeds the maximum of £30,000 allowed for a DFG.

Home Improvement Loans can only be made available to owner occupiers as the loans are put as a charge against the property so that outstanding loans can be reclaimed by Wessex HIL when the property is sold or inherited. See the Home Improvement Loans section to this document for further information about applying for a loan.

How to apply

Contact the Access team on 01225 - 396000 and ask for an assessment by an Occupational Therapist (OT). If the OT judges that the client is in need of an adaptation the case will be referred to Housing Services who will administer the grant application.

The Council’s Home Improvement Agency is also available to help and support clients through the process of applying for a DFG. The first point of contact however is the Access Team.

Requirements and conditions

About the applicant

The property is to be occupied by the applicant following the completion of the work.

Applicants are subject to a test of financial resources except where the works are for children.

About the grant

A valid application and specified conditions are detailed in the Housing Grants, Construction and Regeneration Act 1996. (Assistance with completing forms is available.)

The client will be informed within 6 months of a valid application whether or not their application has been approved or refused. Housing Services will aim to approve a valid application within 6 weeks.

About the works

Estimates for the cost of the works are required, prior to approval, from two contractors (unless otherwise directed by the Occupational Therapist).

Reasonable professional fees will be paid only when considered necessary. Fees from a chartered architect, chartered surveyor or a home improvement agency, or private OT will be considered.

Unforeseen works

Unforeseen works can only be considered upon prior inspection and agreement by Housing Services.

If unforeseen works take the total cost of the works above the grant maximum of £30,000 the client may be asked to pay the additional money.

Payment of works

Payments will be made to the client or will be paid to the contractor(s) only at the client's request.

Final payments are only made on the submission of an acceptable invoice for the works, including any professional fees.

Final payments will be made when all works are completed and meet the client's needs as determined by the Occupational Therapist.

Interim payments will be paid at the discretion of the Housing Services. Clients will be expected to pay any contribution they may have before the Council pays an interim payment.

Interim payments are only made on the submission of an acceptable invoice for the works, including any professional fees, and will be paid to a maximum of 90% of the approved amount. Works to the value of the payment being requested must have been completed and the works must have been inspected by a Housing Services Officer from the Council, or an Officer from the Home Improvement Agency or both.

Recovery of Grant

Disabled Facilities Grant exceeding £5,000 may be reclaimed by the Council where a property is sold or transferred within 10 years of the certified grant completion date. No more that £10,000 will be reclaimed in each case. Grant in excess of £5,000 may be registered as a local Land Charge. The decision to recover Grant will be made on an individual basis by the Housing Services Manager.

A local Land Charge will be registered if the Grant is likely to have added value to the property. For example a land charge may be registered where the property has been extended to provide additional facilities and/or accommodation, but not usually for the installation of stair lifts or other items that would not substantially change the property value.

3. HOME IMPROVEMENT LOANS

Who can apply?

This service is for home owners who are:

- Over 60 years old and on a low income; or
- Vulnerable and on a low income; or
- Have dependent (resident) children under 16 and on a low income.

Low income eligibility will be assessed by Wessex Home Improvement Loans (WHIL) who will carry out a financial assessment to decide whether or not an applicant is able to have a low interest home improvement loan. As part of the assessment they will look at clients' income savings and outgoings.

The criteria for eligibility are a disposable income of less than £125 per week and savings of less than £16,000.

Vulnerable people are defined as people with a limiting long term illness or disability.

The Scheme

Home Improvement Loans will be offered for home repairs and improvements that will remove or reduce serious health and safety hazards band A to D as assessed under the Housing Health and Safety Rating System.

Home Improvement Loans can also be used to "top up" a Disabled Facilities Grant (DFG) where the cost of work exceeds the maximum allowed for a DFG.

Home Improvement Loans can only be made available to owner occupiers as the loans are put as a charge against the property so that outstanding loans can be reclaimed by WHIL when the property is sold or inherited.

Loans are available from WHIL via a referral from Housing Services.

There are several types of loan available. Advice and guidance will be provided by WHIL to ensure applicants are offered the most suitable type of loan for their situation. In some cases WHIL may not be able to lend to the client. In such cases clients will be referred back to the Housing Service who may be able to offer alternative form of assistance.

In some cases where WHIL is unable to lend to a client or where the maximum they can lend is insufficient to complete all the essential works the Council may not be able to offer any further financial assistance. In such cases careful consideration will be given to taking the most appropriate course of action and may be referred to the Housing Manager for a decision.

The Home Improvement Loans will be low cost capital repayment, interest only, interest roll-up, interest free or a combination at the discretion of WHIL.

All loans are repayable to WHIL who holds the loan fund on the Council's behalf.

Who are Wessex Home Improvement Loans (WHIL)?

WHIL is a Community Development Finance Institution who works in Partnership with Bath and North East Somerset Council as well as with other councils in the area. Established in 2002 as a "not for private profit" organisation they provide low cost finance to home owners for essential maintenance and improvement works.

The Council pay an annual subscription to W HIL. The Council is part of the Wessex Consortium. The governing body of WHIL is their board to which the consortium has representation.

Works that can be included

Home repairs and improvements that will remove serious health and safety hazards band A to D as assessed under the Housing Health and Safety Rating System will be considered. For example:

Dangerous electrics
Inadequate heating and/or home insulation
Damp and mould
Roof leaks
Dangerous staircases and pathways

Home improvement loans may also be able to cover works to the common parts of a building, or where a legal notice has been served requiring fire precautions work and when there are insufficient funds held by the management company.

Home Improvement Loans can also be used to "top up" a Disabled Facilities Grant (DFG) where the cost of work exceeds the maximum of £30,000 allowed for a DFG.

Unforeseen works and professional fees may also be included in the loan amount (see below in conditions and requirements).

Funding amount

The maximum that can be lent is £15,000

The minimum that can be lent is £500

All assistance is subject to the availability of funding.

The Council will subsidise each loan given as agreed by the Wessex Consortium. Where required for individual loans paid, the subsidy will be a grant paid directly to WHIL on the client's behalf. The subsidy amount is determined by WHIL on a case

by case basis and will depend on the type of loan the interest payable and the loan period.

If the client chooses to use the service of the Council's Home Improvement Agency then the agency's fees will be included in the loan. Housing Services will approve fees charged at 10% of the cost of the works.

How to apply

Clients can contact Housing Services on 01225 396444 to discuss whether or not they are likely to be eligible.

Clients can also contact the Home Improvement Agency. The Agency can help people make an application for this type of loan and provide help to get the works carried out. For example they will arrange for building contractors to carry out the work.

The following gives a brief out line of how to apply:

- An officer from the Council will visit and decide which works can be included.
- Clients will be provided with a schedule of works by the Council.
- A WHIL advisor will arrange to visit the client/ applicant in their home and assess eligibility for the loan. They will make a decision on eligibility, whether a loan is affordable and if so what type of loan is best for the client.
- Clients must use the schedule of works to get two estimates; one each from two different building contractors. These estimates will be part of the application to the Council which will also include a proof of title (or equivalent proof of ownership) to show who owns the house and completed application forms.
- When Housing Services have a full and complete application they will aim to approve it in writing within 20 working days.
- Clients can only start works when they have written approval from the Council.

The Home Improvement Agency and the Council and WHIL will do what they can to guide and support clients through the process.

Wessex Subscription

The Council will pay from its Housing Renewal budget an annual subscription fee to WHIL to belong to the Wessex Consortium.

Requirements and conditions:

About the applicant

Applicants must own the property.

Applicants must have sufficient equity in the property.

Owner-occupiers are to have owned and lived in the property for the past year. Occupying applicants with shared equity will usually be assessed jointly.

The applicant must be over 18 years old

About the loan

Full repayment of any outstanding loan will be necessary on the disposal of the dwelling. In this instance disposal means the sale of the property or the transfer of ownership, or the inheritance of the property.

Applicants must have a bank account; repayments are made by a monthly direct debit from this account.

The loan will be recorded as a land charge until repayment.

About the works

Funding is only available for the cost of works started after the approval of assistance. This means that applicants must not start works for which they are borrowing the money until the loan is approved by WHIL and the Council.

Reasonable professional fees may be included from a chartered architect, chartered surveyor, home improvement agency or for other associated services approved by the Council.

As part of the application estimates for the cost of the works are required, prior to approval, from two approved contractors.

Works eligible for funding through an insurance claim will not receive assistance but the policy excess amount can be.

Clients can only start works when they have their written approval from the Council. Starting works before written approval may invalidate their application.

Unforeseen works

Unforeseen works are works that were not expected to be needed when the works were originally planned but are essential for the job to be completed safely and in a satisfactory manner.

Unforeseen works can only be considered upon prior inspection and agreement of Housing Services.

Unforeseen works will have to be funded by the applicant. However WHIL may, in agreement with the client, add a maximum of 10% of the cost of the works (including any fees) to the loan when the loan is initially set up. This extra amount can then be used for unforeseen works if needed. If this amount is not used then the 10% must be paid back to WHIL by the applicant when works are complete.

Payment of the works

For clients not being helped by the Home Improvement Agency the Home Improvement Loan payment is only made on the submission of an acceptable invoice for the works, including any professional fees. All works must be completed to the satisfaction of the Council.

Home Improvement Agency (HIA) clients must agree to have their loan held for them by the Agency in the HIA Client account. The loan money will be put in to that account when the loan has been agreed by WHIL and signed up to by the client. The HIA will pay the building contractor when all works have been completed to the satisfaction of the Council and upon receipt of an acceptable invoice. This will mean that HIA clients have to start making repayments to WHIL from the time the loan is paid to the HIA client account and before that works have started.

4. URGENT REPAIRS GRANT

Who can apply?

This service is for home owners who are:

- Over 60 years of age and on a low income
- vulnerable home owners on a low income.

Vulnerable people are defined as people with a limiting long term illness or disability.

Low income is defined as being on one of the income related benefits listed below.

*Income Support
*Income based Jobseekers allowance
*Employment support allowance (income Based)
*Council Tax benefit
*Pension credit (Guarantee credit)

For clients who are not on one of these benefits but who are on one of the following benefits or, who consider themselves to have a low income, Housing Services will carry out a Test of Resources to determine eligibility. In such cases clients may have to make a contribution.

Disability Living allowance
Industrial injuries disablement benefit
War disablement pension
Child Tax credit (Joint income of £15,000)
Working Tax Credit
Pension credit (savings credit)

The Scheme

Urgent repair grants are available for carrying out repairs quickly. The scheme uses a fast track simple application process. For instance; only one estimate for the works is required and the owner will not need to prove that they own their home, only to declare that they do.

This service is different and separate from the Handy Man service and from the Housing Improvement Loans service.

Works that can be included

Grants will be offered for works that will prevent an accident or ill health. For example a blocked toilet or dangerous electrical systems would be eligible.

The Urgent Repairs Service must be the most appropriate way to help the client. It should not be used to cover work that could be carried out by the Handy Man Service or Bobby Van or by a Home Repair Loan.

Examples of eligible work are

- Repairs to a boiler or heating system to ensure that provision of heating and or hot water.
- Repairs to stop water leaking into the property.
- Repairs to dangerous electrics.
- Repairs to fix a broken or leaking WC or cess-pit.
- Works to investigate the condition of power and lighting circuit and establish what repairs are needed.
- Works to investigate the structural stability of a dwelling or part of it and establish what works are needed.
- Repairs or alterations to help prevent falls of various types. For e.g. falls on stairs, falls between levels and in bath rooms.
- Repairs or alterations to make a property secure.

Funding amount

Maximum £1,000 per job

A client can receive a maximum of 3 grants per financial year. While the maximum per job is £1,000 the total maximum each client can receive per calendar year is £1,500.

All assistance is subject to the availability of funding.

How to apply

Contact Bath and North East Somerset Council's Housing Services or the Council's Home Improvement Agency.

Requirements and conditions

About the grant

The payment for urgent repair work is made as a grant and so is not repayable to the Council. Therefore the Council will not seek to recover this grant if the property is subsequently sold or if the applicant moves out for some reason.

About the works

As part of the application, one estimate for the cost of the works is required from one approved contractor.

Unforeseen works

Unforeseen works are works that were not expected to be needed when the works were originally planned but are essential for the job to be completed safely and in a satisfactory manner.

Unforeseen works can be paid for up to the maximum amount of grant allowable under the scheme.

Payments of works

Final payment for work is only made on the submission of an acceptable invoice for the works, including any professional fees. Works must be completed to the satisfaction of the HIA or Housing Services.

Payment of the works will be made directly to the building contractor by the Council or the Housing Improvement Agency (or the Council commissioned provider of this scheme). Applicants will need to agree to this when they sign the application form.

5. HOME ENERGY EFFICIENCY

Who can apply?

This assistance is available to everyone in Bath and North East Somerset with greater benefits for those on a low-income.

The Schemes

These schemes are to provide help to improve energy efficiency within the home and reduce fuel poverty. There are three forms of Assistance:

- Warm Streets scheme (or equivalent)
- Warm Front top-up grants (or equivalent).
- Energy loan (may be offered in the future)

With the start of Green Deal the range of assistance may change.

Warm Streets scheme

Who can apply?

“There is something for everyone”

- Home owners
- Tenants of private rented accommodation who have their landlord’s permission.

What works can be included

Loft insulation and / or cavity wall insulation

Funding amount

Depending on age, income and household circumstances, some people will be provided with home insulation for free. In other cases there are discounts of up to 50%.

How to apply

- Phone the Energy Saving Trust advice centre on 0800 082 2234
- Email on warmstreets@cse.org.uk

An energy advisor will tell you if you are eligible for free or discounted home insulation.

Requirements and Conditions for Warm Streets

- All assistance is subject to the availability of funding.
- The applicant is to be over 18 years old.
- A valid application
- Applicant to meet Warm Streets low income/low savings, household or age criteria

Top-ups for National Warm Front Scheme (or equivalent)

Where the cost of works usually included in the Warm Front Scheme or equivalent exceeds the amount paid by the Warm Front Grant (£3,500) the Council will make up the additional amount on the applicant's behalf. The additional cost must pay for works which help provide affordable warmth or increased energy efficiency. Applicants must apply to the Council for this discretionary funding. An additional estimate may be required.

Who can apply?

Successful applicants to the Warm Front Scheme who have been told by Warm Front that the cost of the works they have applied for are more than the maximum allowed by the Warm Front Scheme.

What works can be included

Works approved by Warm Front (or equivalent). A typical example is central heating system being installed where there was none before or where the existing system was broken and needs replacing.

Funding amount

Top-up grants are given at an amount that will cover the extra cost required to complete the works being funded by Warm Front grant. Excessive claims however may be refused. On average grants that have been paid in the past range between £200 and £1,000.

How to apply

Clients will need to contact Housing Services and pass to them a copy of their approval letter from Warm Front. This letter will say how much extra funding is needed to complete the works.

If the Council can approve the client's application for a Warm Front Top-up they will write to them confirming this. The Council will make the payment to Warm Front on the client's behalf.

Requirements and Conditions for Warm Front Top-ups:

- All assistance is subject to the availability of funding.
- The applicant is to be over 18 years old.
- A valid application to Housing Services.
- Applicant to already be a successful Warm Front applicant.

Payment of works

The Council will pay Warm Front directly on behalf of the client.

Energy loan

To provide assistance to vulnerable households as defined for the Home Improvement Loan scheme above occupying hard to treat homes for energy efficiency measures to remove them from fuel poverty including solid wall insulation.

6. COMMUNITY ALARMS

Who can apply?

This grant is available to low income residents who are over 60 years of age, disabled or otherwise vulnerable.

The assistance is available to owner-occupiers, private tenants and Residential Social landlord (Housing Association) tenants.

Low income is defined as being on one of the income related benefits listed below.

*Income Support
*Income based Jobseekers allowance
*Employment support allowance (income Based)
*Council Tax benefit
*Pension credit (Guarantee credit)

Vulnerable people are defined as people with low income and with a limiting long term illness or disability.

The scheme

Small grants are available for vulnerable people on low income for the installation of community alarms and key safes. This equipment can help people to remain in their own homes as it enables them to call for help easily if they fall or become ill for example.

Works that can be included

Eligible works include community alarms and key safes.

Funding amount

The maximum amount of assistance offered is £200

How to apply

Contact the Community Alarms Service. They will visit the client in their home and decide what equipment is needed and they will help the client apply for the grant from Housing Services.

Requirements and conditions

All assistance is subject to the availability of funding.

The applicant is to be over 18 years old.

A valid application will comprise of a correctly completed and signed application form and specified proof of income. (Assistance with completing forms is available.)

The eligible works are to be specified and arranged by the Community Alarms Service.

Payment for works

Community Alarms and Housing Services will arrange for the payment of the grant when the works are complete.

7. EMPTY HOMES ASSISTANCE

Who can apply

The owners of empty homes can apply. For the purposes of this policy an empty home is defined as a residential property which has been empty for 6 months or longer. The empty home must be within Bath and North East Somerset. The empty home must be on Housing Services Empty Homes List.

The Schemes

The assistance will be given to aid the owner to sell the house or rent the house or renovate the house in order to bring the property back into use. Financial assistance will only be offered to empty homes assessed with a priority rating score. Priority Rating is detailed in Housing Services Empty Property Policy.

Two schemes will be offered:

General Support Package – available to homes rated as P1 to P5. The General Support Package is to provide owners with incentives to help them bring the home back into use.

Priority Support Package – available to homes rated as P1. P2, P3. The Priority Support Package is to provide additional incentives to bring the home back into use. Wessex Loans are included with the Priority Support Package.

Works that can be included

Eligible works will be specified by Housing Services.

Funding Amount

General Support Package
Maximum Grant £500

Priority Support Package
Where a grant is given, the maximum will be £5,000. Where a Wessex Loan is given, the minimum is £500 and the maximum is £20,000.

How to apply

Contact the Empty Property Officer. They will meet you at the empty home to discuss with you your plans to bring the empty home back into use.

Following this visit where it is appropriate, financial assistance may be offered to help sell, rent or renovate the empty home.

A valid application must be made.

Where a Wessex Loan is given, the Home Improvement Section of this policy applies, but not the parts of that section relating to the eligibility of the applicant

Requirements and Conditions

About the applicant

The applicant must own the empty home.
Proof of title will be required
Consent of all owners may be required particularly when a loan is involved.

About the grant or loan

A valid application must be made.

Where a grant is given, the owner and the Empty Property Officer will agree a reasonable time scale for the property to be brought back into use. It is a condition of the grant that the property is brought back into use within this time scale.

The client will be informed within 6 months of a valid application whether or not their application has been approved or refused. Housing Services will aim to approve a valid application within 6 weeks.

About the works

Estimates for the cost of the works are required, prior to approval, from two contractors (unless otherwise directed by the Empty Property Officer).

Funding is only available for the cost of works started after the approval of assistance. This means that applicants must not start works before the assistance is approved.

Unforeseen works

Unforeseen works can only be considered up to the maximum grant limit.

Where a Wessex Loan is given, the Home Improvement Loan section on unforeseen works applies.

Payment of works

Payments will be made to the client or will be paid to the contractor(s).

Recovery of Grant

Where the property is not brought back into use within the specified time period the Council will recover any grant monies given.

Summary of budgets and targets for the year 2012/13

Type of assistance	Maximum assistance available	Targets (No. of grants or loans given per year)	Total budget available for scheme
Free home safety repairs and adaptations advice and home visits	No funding Advice only.	none	No funding
Home Improvement Loans	£15,000	20	£50,000 for Wessex Subscription payment and subsidy payments for individual loans @ April 2011 Wessex Pot total - £250,000
Urgent Repairs Grants	£1,000	30	£50,000
Home Energy Efficiency • **Warm Streets** • **Warm front Top-ups** **Energy loan**	 Cost of Loft and cavity wall insulation Reasonable costs to enable applicant to take up Warm Front grant ?	 160 measures 10 ?	 £50,000 £5,000 Allocated portion of Wessex fund
Community Alarm Grants	£200 maximum	100	£10,000
Disabled Facilities Grants	£30,000 maximum	250	£1,000,000
Empty Home Assistance	£5,000 maximum £20,000 for Wessex Loan	8 5	 £100,000

Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **18th May 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 08.05.12.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
18th May 12 Kaposvar Room						
	Cabinet member update					
	NHS/CCG update					
	LINk update					
	Dental Access update	Tracey Cox	Julia Griffith			
	Care Services Quality Assurance	JS	Jane Shayler			
	The effects of delivering Adult Social Care savings targets on the market	JS	Jane Shayler			
	Talking Therapies in B&NES	JS	Andrea Morland			
	Public Health Transition Assurance Plan		Pamela Akerman			
	Alcohol Harm Reduction Strategy		Pamela Akerman			
	Home Health and Safety Policy 2012	JS	Graham Sabourn and Chris Mordaunt			
27th Jul 12						
	Housing Allocations report (tbc)		Graham Sabourn			

Last updated 08.05.12.

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
	HealthWatch update		Derek Thorne			
	Care Homes quarterly performance report	JS				
	Tobacco plain packaging consultation		Pamela Akerman			
	Joint Strategic Needs Assessment		Pamela Akerman and Paul Scott			
21st Sep 12						
	Energy Efficiency Report					
16th Nov 12						
	Further update on Dementia		tbc			
18th Jan 13						
	Strategic Transition Board update					
22nd Mar 13						
Future items						

Last updated 08.05.12.

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes

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