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 Eleanor Jackson
Councillor Anthony Clarke
Councillor Bryan Organ
Councillor Kate Simmons
Councillor Sharon Ball
Councillor Douglas Nicol

Chief Executive and other appropriate officers
Press and Public

Dear Member

Wellbeing Policy Development and Scrutiny Panel: Friday, 16th November, 2012

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Friday, 16th November, 2012** at **10.00 am** in the **Council Chamber - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

   Appendices to reports are available for inspection as follows:-

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

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

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

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

6. **Emergency Evacuation Procedure**

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

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

Wellbeing Policy Development and Scrutiny Panel - Friday, 16th November, 2012

at 10.00 am in the Council Chamber - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

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

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

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

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

   (b) The nature of their interest.

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

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

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

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

   There will be few speakers to address the Panel under agenda item 11 (Urgent Care Re-Design Impact Assessment).

7. MINUTES 21ST SEPTEMBER 2012 (Pages 7 - 20)

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

8. CABINET MEMBER UPDATE (5 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. LOCAL INVOLVEMENT NETWORK (LINK) POSITION UPDATE (15 MINUTES) (Pages 21 - 44)

This report outlines the plans for the procurement of a Host service for the B&NES LINk (Local Involvement Network) to run from 1st December 2012 to 31st March 2013. The new service provider will replace the previous one, Scout Enterprises Ltd., which ceased trading on 29 September 2012 and formally went into liquidation on 19th October 2012. A formal update is being presented today to ensure the Panel has current and comprehensive information on the way forward for the LINk, and the way in which we will carry out our statutory duty in providing a LINk Host service.

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

11. REVIEW OF URGENT CARE (30 MINUTES) (Pages 45 - 136)

This document is to present the Panel with the public engagement report on the proposal to relocate the GP-led Health Centre to the Royal United Hospital.
It is also present to the Panel the health & equalities impact assessment on the proposal.

The rationale for this service change is based on the following factors:

- An ageing population
- Increasing demand and expectations
- People living longer often with several long term conditions
- Finite resources and inequitable use of existing resources
- It has the support of local clinicians whose services will be affected by the proposals

- It supports the principle that patients should have access to the right treatment, at the right place and at the right time
- It has taken account of clinical evidence and best practice drawn from reports published by the Primary Care Foundation, Royal College of General Practitioners, NHS Alliance, the Department of Health and the Foundation Trust Network.

The Panel is asked to note both reports and agree the proposal to relocate the GP-led Health Centre to the Royal United Hospital to create an Urgent Care Centre can proceed.

12. CARE HOMES QUARTERLY PERFORMANCE REPORT JULY - SEPTEMBER 2012 (15 MINUTES) (Pages 137 - 146)

Further to the report to panel of the 18th May 2012 which set out the Quality Assurance Framework for social care services generally, this report is the second in a series of quarterly reports which focuses specifically on the quality of care and performance of residential and nursing homes under contract in Bath & North East Somerset.

The Wellbeing Policy Development & Scrutiny Panel is asked to note the contents of the report and to contribute relevant feedback and articulate clearly the role of the Panel in relation to the QAF.

13. MEDIUM TERM SERVICE & RESOURCE PLANNING - 2013/14-2015/16 - (60 MINUTES) (Pages 147 - 218)

The draft Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) is presented for consideration by the Panel:

- To ensure all members of the Panel are aware of the context for Service Action Planning
- To enable comment on the strategic choices inherent in the medium term plan
- To enable issues to be referred to the relevant Portfolio holder at an early stage in the service planning and budget process

The Panel is asked to:

1. Comment on the medium term plan for Adult Social Care & Housing
2. Identify any issues requiring further consideration and highlighting as part of the budget process for 2013/14
3. Identify any issues arising from the draft plan it wishes to refer to the relevant portfolio holder for further consideration

14. IMPACT ASSESSMENT ON THE PROPOSED RELOCATION OF PAEDIATRIC AUDIOLOGY (15 MINUTES) (Pages 219 - 230)

The Wellbeing Policy Development and Scrutiny Panel are requested to determine

whether the proposal to relocate the Paediatric Audiology Service from the RUH to the St Martins Hospital site constitutes a substantial variation or development.

15. LOCAL AFFORDABLE WARMTH ACTION GROUP UPDATE (20 MINUTES) (Pages 231 - 236)

Affordable Warmth is a key determinate for wellbeing and is particularly significant for vulnerable low income households. The inability to benefit from affordable warmth can be described as fuel poverty and this affects 17% of B&NES residents (House Condition Survey 2011).

The purpose of the Local Affordable Warmth Action Group (LAWAG) is to coordinate activities to tackle excess winter mortality, fuel poverty and promote affordable warmth. It comprises representatives from across the community, voluntary and statutory sector with and interest in solutions to these issues. The terms of reference for the group are in the report.

The Wellbeing Policy Development and Scrutiny Panel are asked to note and comment on the report and on the action plan.

16. WORKPLAN (Pages 237 - 242)

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, 21st September, 2012

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Lisa Brett, Eleanor Jackson, Anthony Clarke, Sharon Ball, Michael Evans and Caroline Roberts

Also in attendance:

37 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

38 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

39 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillors Kate Simmons and Douglas Nicol sent their apologies. Councillors Michael Evans and Caroline Roberts were their substitute respectively.

Councillor Bryan Organ also sent his apology for this meeting.

40 DECLARATIONS OF INTEREST UNDER THE LOCAL GOVERNMENT ACT 1972

Councillor Eleanor Jackson declared personal and non-prejudicial interest at this point of the meeting as she is Council's representative on Sirona Care & Health Community Interest Company.

During the meeting, under agenda item 6 (Items from the public or Councillors), Councillor Eleanor Jackson declared interest as a member of the '38 Degrees Bath' group.

Councillor Vic Pritchard declared personal and non-prejudicial interest at this point of the meeting as he is Council's representative on Sirona Care & Health Community Interest Company.

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41 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

THIS MEETING

The Chairman invited Barbara Gordon (from ’38 Degrees Bath' group) to read out her statement on the changes to the NHS.

Barbara Gordon read out the statement in which she highlighted group's concerns on lack of consultation related to the formation of the B&NES Clinical Commissioning Group. Barbara Gordon also said that the draft CCG Constitution became available only a week ago. The national '38 Degrees' group commissioned lawyers to draft clauses that can legally be included in the Constitutions of CCG's. Some local group members, along with a barrister, met with Dr Orpen to consider amending the draft Constitution. Dr Orpen refused to include those amendments. There is now online petition to the B&NES CCG, with more than 600 signatures, asking for those clauses to be included in the Constitution.

Barbara Gordon asked the Panel to recommend to Dr Orpen to reconsider his decision and include those amendments.

A full copy of the statement is available on the Minute Book in Democratic Services.

The Chairman thanked Barbara Gordon. The Chairman said that there is no statutory requirement for the CCG to consult with the public. Nevertheless, the CCG consulted the public on few events that they organised across the area. The Health and Wellbeing Board agreed the Plan at their meeting on 19th September 2012. Without the appropriate evidence, for the closure of this plan, it has become evident that representations of this kind are seemingly too late. The Chairman said that there is little that the panel can do at this stage.

Councillor Eleanor Jackson asked if Dr Orpen could give reasons for rejecting these clauses. Councillor Jackson declared interest at this point as a member of ‘38 Degrees Bath' group.

Dr Orpen said that he is happy to reply but that he feels that he would not be able to draw a line to this issue given the approach adopted by '38 Degrees'. The background to this is that '38 Degrees' presented their views to the CCG and there was a lot of discussion with their representative on proposed clauses. The '38 Degrees' advice was based on 'BMA fairness charter' which was prepared by BMA Law. Dr Orpen said that he is a member of BMA (British Medical Association) and the BMA have a view on the NHS reforms and they, by the nature of the Union, have a political view on this matter. The BMA has many concerns, which are shared with the CCG, regarding the Constitution and particularly concerns about procurement. The CCG took an independent legal advice and advice from the experts in this field who considered current NHS guidance on procurement rules. Dr Orpen said that he absolutely understands and recognised the value of the contribution that '38 Degrees' are making. However, the advice that the CCG were given is not to tie too much its Constitution into context that is different from the guidance at this stage. The CCG is absolutely committed to care for its patients. Dr Orpen also said that he was not given a warning from the '38 Degrees' that they will bring their barrister at the last meeting. Dr Orpen again recognised the contribution and value that '38 Degrees' brought.

Councillor Katie Hall thanked everyone for their comments and suggested that '38 Degrees' be included in the electronic circulation list for the Wellbeing PDS Panel, Health and Wellbeing Board and also future CCG Board meetings.

Diana Hall Hall said that the CCG have included LINk in the consultation and that the CCG addressed the public on several occasions.

The Chairman thanked everyone who participated in this debate. The Chairman said that the Panel took on board concerns raised by the '38 Degrees' but that they will not take any further action.

43 MINUTES 27TH JULY 2012

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

- Page 11, 1st paragraph, third sentence should start with: 'Dr **Orpen**…'.
- Page 11, 3rd paragraph , second sentence should read : '….RUH Bath is the only **district general** hospital …'

The Chair used this opportunity to inform the Panel that he received an assurance from Jane Shayler that gardening services for people with learning difficulties in Radstock, which was initiated by Mendip Care & Repair will continue to exist.

The Chair also said that it was with regret that Cabinet Member for Homes and Planning could not be at the meeting today to comment on the Homesearch Policy (as resolved in the minute 31 of the last meeting).

The Chair also reflected to the resolution on minute 32 of the minutes from last meeting and informed the Panel that Midsomer Norton, Radstock and District Journal did not publish any subsequent comments on the Care Homes Quarterly Performance Report and asked the Panel to draw this matter to the close. The Panel agreed with Chair's suggestion.

44 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 Tony Clarke asked about Adult Social Care Survey for 2012 and if we have benchmark against our neighbouring authorities.

Sarah Shatwell (Associate Director for Non-Acute and Social care) replied that we do have a benchmark of information nationally and for south west region which are compared.

Councillor Clarke asked for the information and comparison with the other authorities to be sent via email to the Panel. Sarah Shatwell took on board this request.

Councillor Michael Evans asked if the figures referred in the survey took into account socio-economic issues and background.

Sarah Shatwell replied that survey is a national survey and done on national basis but she could not answer if the survey took into account socio-economic issues and background.

The Chairman asked about the intentions of the new Rural Social Enterprise service.

Councillor Allen replied that the aim of the service is to support people with mental health problems to learn new skills, or develop existing ones, and provide an opportunity for social contact and encourage development.

Sarah Shatwell added that it also generates employment opportunities for people with mental health problems. It is expanding on non-client basis.

Councillor Eleanor Jackson asked that the Panel send a letter to the Curo group requesting the Equal Opportunities Assessment for changes in management organisation.

The Panel **AGREED** unanimously with the suggestion from Councillor Jackson.

Councillor Allen added his support as the Cabinet Member to this letter.

Appendix 1

45 NHS AND CLINICAL COMMISSIONING GROUP UPDATE (15 MINUTES)

The Chairman invited Dr Ian Orpen (Clinical Commissioning Group – CCG) to give an update to the Panel.

Dr Ian Orpen updated the Panel with current key issues within BANES CCG (attached as Appendix 2 to these minutes).

The Chairman congratulated to Dr Orpen, Dr Douglass, Sarah James and Tracey Cox on their appointments.

The Chairman thanked Dr Orpen for an update.

Appendix 2

46 URGENT CARE REDESIGN PROJECT (15 MINUTES)

The Chairman invited Dr Ian Orpen and Corinne Edwards to introduce the report.

Dr Orpen and Corinne Edwards took the Panel through the report and thanked Jane Pye from LINk for her contribution and involvement in this matter.

Dr Orpen finished the introduction by saying that it was incredibly difficult to find the right venues across the area for consultation meetings.

The Panel made the following points:

Councillor Jackson expressed her concern with choice of locations and timings of consultation meetings as those are not accessible for older people (i.e. 6.30pm too late for people over 70).

Corinne Edwards responded that having one of consultation meetings at 6.30pm is for number of reasons (venue availability being one of them) but the main reason is that the NHS and CCG were criticised in the past if they had meetings during the day by those who work during the day.

Councillor Hall asked about statistics on who is using services in Walk-In Centre (actual physical locations of users) and if that information is available.

Corinne Edwards responded that information is available. In terms of the use of the GP led centre - approximately out of 30,000 people who use services per year, 30% of those are outside BANES (people who work here or who are here on holiday). In particular people from Wiltshire and South Gloucestershire are using GP led health centre. In terms of the age range the greatest use is from those of age of 20-25.

Councillor Hall commented that in terms of visitors and tourists it is not a heavy use and ask if visitors and tourists still can register as temporary patients.

Dr Orpen confirmed that people still do register as temporary patients. Dr Orpen also informed the meeting about the national pilot with dual registration.

The Chairman asked if any other services in the Walk-In Centre in Riverside will be affected.

Dr Orpen said that only Urgent Care services will be transferred to the RUH.

It was **RESOLVED** to note the report and to receive an Impact Assessment on this service change for November meeting.

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

The Chairman invited Diana Hall Hall from LINk to introduce the report.

The Panel welcomed the report and congratulated the LINk on their work and commitment over the years. The Panel also praised the annual report included in the papers and highlighted close working relationship between the Panel and LINk.

Dr Ian Orpen also congratulated LINk on their work so far and thanked for their contribution towards the NHS transition.

It was **RESOLVED** to note the report and to congratulate the LINk for their work and contribution so far.

48 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) - DEMENTIA (20 MINUTES)

The Chairman invited Jon Poole (Research & Intelligence Manager) and Helen Tapson (Public Health Intelligence Analyst) to give a presentation to the Panel.

Jon Poole and Helen Tapson highlighted the following points in their presentation:

- Background - what is JSNA and Panel's request from July meeting.
- The JSNA website
- Dementia in B&NES
- Future Projections
- Community Voice
- What is being done?
- Recommendations

A full copy of the presentation is available on the Minute Book in Democratic Services.

The Panel made the following points:

The Chairman commented that the current situation is that in B&NES 867 people are registered as having dementia on GP practice records whilst the actual number of people experiencing dementia is estimated to be nearer 2,400 which is much bigger volume of those who are not registered, which is worrying. The Chairman also said that the report mentioned that last administration's intentions were to dedicate Community Resources Centres to dementia. There was no more progress on that. The point is what we do with statistics, how we respond to them.

Councillor Roberts asked what is the distinction between dementia and Alzheimer's Disease (AD).

Helen Tapson said that she is not medical expert in that field but in a nutshell, dementia is a symptom, and AD is the cause of the symptom.

Sarah Shatwell commented that Council will be looking for the most appropriate and cost effective way to support people with dementia. In B&NES we are trying to support particularly people with later stage of dementia. Sarah Shatwell suggested that the Panel could have on one of the future meetings an update on what was done since the dementia Strategy was adopted.

It was **RESOLVED** to:

1) Note the report and presentation
2) Agree that the format and layout of the briefing is suitable for future updates
3) Receive an update on Dementia Strategy to one of the future meetings

49 WINTERBOURNE VIEW FINDINGS UPDATE (10 MINUTES)

The Chairman suggested that this issue be discussed at the next meeting of the Panel together with the report from the Care Quality Commission.

It was **RESOLVED** to have this item on the agenda at November meeting.

50 CARE QUALITY COMMISSION UPDATE (20 MINUTES)

The Chairman suggested that this issue be discussed at the next meeting of the Panel together with the input/update from the relevant service officer.

It was **RESOLVED** to have this item on the agenda at November meeting.

51 PERSONAL BUDGETS: REVIEW OF POLICY FRAMEWORK & RESOURCE ALLOCATION (PROGRESS REPORT) (30 MINUTES)

The Chairman invited Sarah Shatwell to introduce the report.

The Panel made the following points:

Members of the Panel debated financial modelling of options for calibrating the Resource Allocation System (RAS). Some Members of the Panel felt the Incremental Method is the fairest of all and that model should be further explored and tested. Some other Panel Members felt that the Percentile Model, as suggested by the officer is the fairest and that model should be further explored.

The Chairman informed the Panel that Sarah Shatwell will have to give Panel's view on the preferred modelling option to the Cabinet Member. Therefore the Chairman invited the Panel to vote on the preferred modelling option.

The Chairman invited Panel Members to vote on the Percentile Model. Voting: 4 in favour and 3 against with 1 abstention.

It was **RESOLVED** that:

1) The Panel **AGREED** that Percentile Model for calibrating the national RAS locally be further explored and tested;
2) Further engagement and consultation with service users, carers and social care staff takes place;
3) Scenario 4 of the five transitional scenarios be adopted when roll out of the national RAS begins; and
4) Implementation of the national RAS should take place in early 2013 following a period of statutory consultation.

52 SPECIALIST MENTAL HEALTH SERVICES UPDATE (20 MINUTES)

The Chairman invited Andrea Morland (Associate Director for Mental Health and Substance Misuse Commissioning) and Arden Tomison (Medical Director) to introduce the report.

The Panel made the following points:

Councillor Jackson asked about the use of units in Salisbury by some of the patients from Radstock area.

Andrea Morland responded that the AWP is quite lucky to use psychiatric intensive care unit whenever they exist. Primarily, units in Brislington are used. When those units are full then units in Salisbury are used. This is in order to reduce the risk for people to go out of area or to go privately.
Arden Tomison added that the pressure on highest dependency units had increased nationally.

The Chairman asked if the demand on highest dependency units increased or this is due the reduction in beds.

Arden Tomison said that those two are connected.

The Chairman asked on the current position of the AWP.

Andrea Morland gave the commissioning background first. The Strategic Health Authority (SHA) did the review with the AWP and highlighted the concerns about being centralised body and local enough. As a result of that local director is in place now. The AWP and CCG will get together to talk about the future arrangements. At the moment they are still waiting for the consultation on what services they might go out to tender and those they might not.

Arden Tomison pointed out to the implementation plan, as printed in the report (section 5). Arden Tomison confirmed that short term actions are on track and that there was quite positive dialogue with Bristol commissioning partners.

The Panel debated the Ketamine abuse in the area and asked Andrea Morland to come back to one of the future meetings of the Panel with a report on the Ketamine abuse in the area.

It was **RESOLVED** to note the report and to have a paper on Ketamine abuse in the area at one of the future meetings of the Panel.

53 TERMS OF REFERENCE FOR ALCOHOL HARM REDUCTION STRATEGY SCRUTINY INQUIRY DAY (5 MINUTES)

The Chairman invited Lauren Rushen (Policy Development and Scrutiny Project Officer) to take the Panel through the report.

Councillor Michael Evans suggested that Community Alcohol Partnership (CAP) be invited as a contributor.

It was **RESOLVED** to:

1) Note the terms of reference and agree to undertake a Scrutiny Inquiry Day
2) Agree to appoint the following Panel Members in the Steering Group:
    a. Councillor Vic Pritchard
    b. Councillor Katie Hall

c. Councillor Eleanor Jackson

54 HOUSING ALLOCATIONS (20 MINUTES)

The Chairman invited Mike Chedzoy (Housing Services Manager) to introduce the report.

The Panel made the following points:

The Chairman commented that this paper was before the Panel a number of times. the officers responded to all comments/suggestions/recommendations made by the Panel. The Chairman also said that he is quite comfortable with the content of the report and asked the Panel if they share his view.

The Chairman also said that the responsible Cabinet Member was not present at this meeting. The Chairman said that he would not be comfortable to amend anything after this meeting and without the debate/consultation with this Panel.
If the Cabinet Member chooses to amend anything, before it goes to the Cabinet, the Panel would need to know what the amendments are.

It was **RESOLVED** to note the Homesearch Policy and ask the appropriate Cabinet Member and the Cabinet to adopt the policy in this format.

55 WORKPLAN

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

- Dementia Strategy update (date to be confirmed)
- Urgent Care Re-Design Impact Assessment - November 2012
- Winterbourne View update (along with Care Quality Commission - November 2012
- Ketamine abuse in B&NES area (date to be confirmed)

The meeting ended at 2.50 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 – September 2012

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1. PUBLIC ISSUES

Bath Paralympic Flame Celebration

The London Organising Committee of Olympic and Paralympic Games (LOCOG) granted permission to the Council to organise its own Lantern Bearer Relay which formed part of a procession through Bath on Saturday 25th August.

The council invited the public to nominate people who they felt displayed the Paralympic values of courage, determination, inspiration and equality, and how they have made a difference or pushed the boundaries of what is achievable. The 9 B&NES residents chosen to lead the 2,000m Lantern Relay included people with physical disabilities and those with learning disabilities. All are inspirational role models who have made significant contributions to their community.

2. PERFORMANCE

Adult Social Care Survey 2012

The results of the B&NES Adult Social Care Survey for this year have been submitted and key ASCOF outcome scores are shown below compared with last year's results for B&NES

Key Outcome Measure	2011	2012
1A Social Care Related Quality of Life (composite measure)	18.8	18.7
1B Proportion of people who use services who have control over their daily lives	77.4%	76%
3A Overall satisfaction with care & support services	66.1%	63.1%
3D People who use services who find it easy to find information	77.4%	73%
4A Proportion of people who use services who feel safe	64.3%	68.3%
4B People who use services who say those services have made them feel safe and secure	60.1%	75.2%

Although some results show a slight downward or upward change since last year, these differences are not statistically significant except the last one (4B) which appears to indicate a significant improvement on last year's response.
The differences in the first 5 indicators may be explained by a slight change in the population sample surveyed this year (notably, it included mental health service users). Some caution needs to be applied to the interpretation of the result for 4B because there was a change in methodology (from asking people a multi-select question last year to a straight yes/no this year). However, the overall results indicate

that performance is being maintained in all areas. We now need to concentrate on improving on them.

3. SERVICE DEVELOPMENT UPDATES

New Rural Social Enterprise service

A new Rural Social Enterprise service has been commissioned via a competitive tendering process. The contract has been awarded to Developing Health & Independence (DHI) and the new service will begin on the 17th September 2012. The main aims of the service are to support clients with mental health problems to learn new skills and / or develop existing ones, provide opportunities for people to realise their potential and raise personal aspirations and to provide opportunities for social contact and encourage the development and use of peer support.

Bath and North East Somerset
Clinical Commissioning Group

Wellbeing Policy Development and Scrutiny Panel
21.9.12
Key issues briefing note

B&NES Clinical Commissioning Group (B&NES CCG) update

B&NES CCG is the new organisation made up of local GPs that will be responsible for planning and arranging around £210 million-worth of health services when it takes over responsibilities from the primary care trust next April.

Appointments

Dr Ian Orpen has been confirmed as Chair of the CCG, following national assessment and support from local GPs.

Following interviews earlier this month, we have appointed the following to the CCG:

- Dr Simon Douglass as Clinical Accountable Officer
- Sarah James as Chief Finance Officer
- Tracey Cox as Chief Operating Officer

Clinical Accountable Officer and Chief Financial Officer status can only be confirmed by the NHS Commissioning Board (NHSCB) as part of the CCG authorisation process. As such both appointments are subject to approval from the NHSCB and will be appointed in a 'designate' capacity until B&NES CCG formally becomes a statutory body through authorisation. Their post will therefore become permanent following a successful authorisation process on April 1st 2013.

Two lay members have also been appointed to the Governing body. They are:
John Paul Sanders, lay member for Patient and Public Involvement
John Holden, audit, governance and vice chair.

Only two appointments remain: executive nurse and secondary care consultant. Interviews for both posts are expected to take place in October.

The CCG will approve the HR process for recruiting to the rest of the CCG structure at its next Clinical Commissioning Committee (CCC) meeting on September 27, 2012.

Authorisation

Before CCGs become legally constituted bodies they must go through a rigorous and extensive assessment process called authorisation. Work continues at a pace to complete the detailed, technical submission covering all 119 criteria across six domains before the end of September.

We expect an authorisation site visit in November, along with feedback which will help us with our development plan with the aim of becoming a legally constituted body from April 1 2013.

As part of authorisation IpsosMORI completed a 360 degree stakeholder survey. We had an 87% response rate which is excellent, so thank you to those of you who took part.

The results, which will be fed back to us from September 24, will give us further insight into how our relationships are developing, and guide our future plans.

Communication

Good communication and engagement with the public is essential to the success of these new ways of working in our area.

A website outlining our role and how we work for our local communities will be launched before October 1 - www.bathandnortheastsomersetccg.nhs.uk

We are also putting in place mechanisms for communication and engagement with the public, including patients and carers, and partner organisations.

Commissioning support service

Commissioning support across the country will be provided by 23 organisations known as commissioning support services. In essence commissioning support organisations will provide much of the backroom function not directly provided by the CCG.

B&NES and Wiltshire are part of the Central Southern Commissioning Support Service. Central Southern will be hosted by the National Commissioning Board through Local Area Teams from October 2012 which will offer more stability for staff.

Central Southern Commissioning Support Unit has presented us with a proposal for a package of support with indicative pricing. We are now looking at this and will be working on our final service specifications, with a view to agreement by the end of December.

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	16th November 2012
TITLE:	Local Involvement Network (LINk) position update
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Specification for the delivery of the Local Involvement Network (LINk) Host service in Bath & North East Somerset	

1 THE ISSUE

This report outlines the plans for the procurement of a Host service for the B&NES LINk (Local Involvement Network) to run from 1st December 2012 to 31st March 2013. The new service provider will replace the previous one, Scout Enterprises Ltd., which ceased trading on 29 September 2012 and formally went into liquidation on 19th October 2012. A formal update is being presented today to ensure the Panel has current and comprehensive information on the way forward for the LINk, and the way in which we will carry out our statutory duty in providing a LINk Host service.

2 RECOMMENDATION

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

3 FINANCIAL IMPLICATIONS

The tender for the procurement referred to in section 1 above is for a maximum of £10,000. This is due to a reduction in the services to be provided, as agreed between the Council and the Chair and Deputy Chairs of the LINks. This amount can be met from within the existing revenue budget that was established for Policy & Partnership commissions and thus there will be no funding pressure as a result'.

4 THE REPORT

4.1 Under the *Local Government and Public Involvement in Health Act 2007*, every local authority are required to procure a Host organisation to enable, support and facilitate the Local Involvement Network (LINk) in its activities, under the direction of the LINk. The Host service to the B&NES LINk was, from 1st July 2008 until 19th October 2012, provided by Scout Enterprises Ltd. On the latter date this company was formally wound up and went into liquidation, with the concomitant loss of staff. Consequently, their provision of the Host service to the LINk ceased on that date. A contract variation to end their contract to 31 January 2013 had been negotiated with the Scout Enterprise bit no formal contract had been signed.

4.2 As there continues to be a statutory obligation under the above Act for the Council to make provision of a LINk Host service until 31st March 2013 (after which all LINks will cease to exist and Local Healthwatch will come into existence), we have invited 4 organisations from the south west who are currently delivering a LINK Host role or have extensive knowledge of working with volunteers, to tender for the provision of a Host service to the B&NES LINk from 1st December 2012 to 31st March 2013.

4.3 In the interim, Policy and Partnerships' Funding and Programmes team have provided administrative support to the LINk, including the minuting of the LINk meeting held on 9th October 2012, and making arrangements for the LINk meeting held on 13th November 2012. This support will continue until a preferred supplier has been indemnified and commences delivery of the Host role.

4.4 The specification for this service is contained in the Appendix to this report.

5 RISK MANAGEMENT

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

5.2 Following the liquidation of Scout Enterprises Ltd, various options regarding the provision of the LINk Host service were examined, including no Host service being provided, and the service being taken in-house. However, the advice from the Council's legal department was that the service must continue to be provided until 31st March 2013, as failure to do so would mean the Council would be in breach of its statutory obligations; and that the Council could not provide the service in-house, as that would be in contravention of the Act cited in section 1 above.

6 EQUALITIES

6.1 An EqIA has been completed. No adverse or other significant issues were found.

7 CONSULTATION

7.1 Cllr Simon Allen, Cllr Vic Pritchard, Chair- overview & Scrutiny Panel; Service Users. Chair and Vice Chairs of the current LINKs governance.

7.2 Face to face meetings.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

Other Legal Considerations statutory obligation to provide a LINKs

9 ADVICE SOUGHT

9.1 The Council's Monitoring Officer, Paul Hiscott, Leader Support Services (Director of Finance – Sick Leave). Have agreed by email in support if this report for publication.

Contact person	Susan Bowen 01225 477278
Background papers	Specification for the delivery of the Local Involvement Network (LINk) Host service in Bath & North East Somerset
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

Specification for the delivery of the

Local Involvement Network (LINk) Host service

in

Bath & North East Somerset

Contract Reference No SWCE-8ZLGR9

Contents

1 INSTRUCTIONS AND INFORMATION

1.1 Background

This specification details a service requirement for an organisation to act as the Host to the B&NES LINk from 1st December 2012 – 31st March 2013.

Bidders must utilise the Supplying the South West portal www.supplyingthesouthwest.org.uk as the vehicle to manage this procurement including the relaying of tender documents and to communicate messages so that a transparent, fair and consistent approach is demonstrated.

This Invitation to Tender (ITT) comprises:

- Section 1: Instructions and information;
- Section 2: Background;
- Section 3: Deliverables;
- Section 4: Requirements of the Service Provider;
- Appendices 1,2,3 and 4: Appendix 2 contains the criteria showing the information required from bidders, and the way that bids will be scored.

1.2 Tender Submission

On receipt of this ITT, bidders should examine all the documentation and report any apparent ambiguity or discrepancy in the documentation, and confirm on ProContract whether they intend to respond.

If a tenderer decides not to submit a tender, the tenderer should confirm on ProContract that they wish to opt out.

Any queries in connection with this invitation and associated documentation must be submitted using the 'Discussion' section of ProContract. Please ensure that you do not include any details that could identify your organisation, as the question and the response will be made available to all bidders (if relevant). **Email or telephone enquiries will not be accepted.**

Bidders are required to submit their tender via ProContract by the deadline shown on the Supplying the South West portal. Tenders submitted late or by any other means will not be accepted**.**

Prior to the date for the return of the tenders, the Council may clarify, amend or add to the tender documentation. Tenderers will be notified of any amendments via ProContract and all amendments shall form part of the tender documentation.

All tenders must be submitted in accordance with the following instructions in this section (1) and in Appendix 2.

Prior to the date for the return of the tenders, the Council may clarify, amend or add to the tender documentation. Any instruction will be issued through the Supplying the South West portal, 'Discussion' section, to every bidder and

shall form part of the tender documentation. The bidder shall promptly acknowledge receipt of such instructions.

After submitting their bid, bidders may submit an amended bid at any point up to the deadline, and only the final version will be viewable by the Council. We therefore recommend submitting your bid at least 24 hours before the deadline.

Bidders must state whether any members or officers of the Council have any direct or indirect interest in your business or in the preparation or submission of their tender.

Tenders must be typewritten, preferably in Arial black 11 point, completed in English, and prices must be quoted in GBP sterling. Costs and prices submitted must be exclusive of VAT.

Prices quoted in the tender shall be deemed to include all taxes, duties, insurance premiums, guarantees or other costs associated with the provision and delivery of the services and exclude VAT if and where appropriate.

Tenders must be submitted by 12:00 on **Tuesday 13th November 2012**. No extensions shall be granted to bidders for any reason.

1.3 Tender Evaluation and Award

Responses will be evaluated on the following quality/cost ratio:

Cost (see Appendix 1 below)	50%
Service Delivery (see Appendix 2 below)	50%

The preferred supplier will be the organisation with the highest overall score.

1.4 Scoring Classification

A maximum of 50% is available to the most competitive financial bid, with all other bids awarded marks on a pro-rata basis (i.e. the lowest bid cost, divided by your bid cost, then multiplied by 100). The weighting shall constitute 50% of the total tender score.

The following scoring mechanism will be used to allocate scores against responses contained in the Tender Submissions, which shall constitute 50% of the available marks:

Standard of Bidder Response	Score
Excellent standard of response; exceeds the requirements in a number of areas and is supported by strong evidence which gives the Council a high level of confidence.	8-10
Competent standard of response; meets requirements and is supported by a satisfactory level of evidence although there are a few issues which give the Council cause for some minor concerns.	4 - 7
Inadequate response; fails to meet some requirements and is	1 - 3

generally unsatisfactory and/or has omissions and/or is not supported by evidence. Gives the Council cause for serious concern.	
No response provided and/or substantial omissions which make the response fundamentally unacceptable and give the Council cause for major concern.	0

The Council are not bound to accept the overall best solution based on the methodology as described in this ITT. Nothing in this ITT shall require the Council to award a contract and the Council shall be able, at its sole discretion, to withdraw the ITT before the date for submission or withdraw from discussions at any stage.

1.5 Special Terms and Conditions

The Agreement will commence on 1st December 2012 and terminate on 31st March 2013 unless the contract is terminated before that date (see Terms and Conditions).

Bidders are responsible for obtaining all information necessary for the preparation of the tender. The Council will not reimburse or be responsible for any costs incurred by bidders in connection with the preparation or delivery of the tender.

Tenders must not be qualified, conditional, or accompanied by statements that could be construed as rendering them equivocal and/or placed on a different footing to those of other bidders. Only tenders submitted without qualification, in accordance with this invitation to tender will be accepted for consideration. The Council's decision on whether or not a tender is acceptable will be final and the bidder concerned will not be consulted. If a bidder is excluded from consideration, the bidder will be notified.

The tender documents must be treated as private and confidential. Bidders must not disclose the fact that they have been invited to tender or release details of the tender documents other than on an 'in confidence' basis to those who have a legitimate need to know or whom they need to consult for the purposes of preparing the tender.

Unless otherwise indicated the copyright in all tender documentation supplied with or pursuant to this invitation to tender belongs to the Council.

Bidders should note that copyright in this ITT rests with Bath & North East Somerset Council. The bidder shall treat all information contained within the ITT as strictly private and confidential, details of which should not be disclosed to any party, direct or indirect, except to the extent necessary for the preparation and submission of the tender.

Any bidder who directly or indirectly canvasses any member or officer of the Council or any of its advisers concerning the award of the contract for the provision of the services shall be disqualified.

Any bidder who:

- fixes or adjusts the amount of its tender by, or in accordance with, any agreement or arrangement with any other person; or

- communicates to any person, other than the Council, the amount of its proposed tender (except where such disclosure is made in confidence in order to obtain quotations necessary for the preparation of the tender, for insurance purposes); or

- enters into any agreement or arrangement with any other person that it shall refrain from tendering or that it should withdraw any tender once submitted or vary the amount of any tender to be submitted; or

- offers or agrees to pay or give or does pay or give any sum of money, inducement or valuable consideration directly or indirectly to any person for doing or having done or causing or have caused to be done in relation to this tender or any other tender or proposed tender or any other act or omission;

- Any unauthorised amendment, qualification or deletion of, or addition to the tender documents, issued by the Council, shall invalidate the tender shall be disqualified (without prejudice to any other civil remedies available to the Council and without prejudice to any criminal liability which such collusion may attract).

1.6 Equalities

The Council is committed to equality of opportunity as set out in the Corporate Equality Commitment. It is also committed to meeting its duty under the Equality Act 2010 and expects all contractors working with or providing a service for the Council to support the Council in meeting its obligations under the equality duty.

The Equality Duty

- Eliminate unlawful discrimination harassment, victimisation and other conduct prohibited by the Act
- Advance equality of opportunity by opportunity
- Foster good relations between people who share a characteristic and those who don't.

All goods, services and facilities will be undertaken in line with the Council's equality commitments.

The Council requires Contractors providing supplies, services or works on behalf of the council to adopt policies and practices that, at a minimum, comply with legislation, promote equality of opportunity in employment and service provision.

The Contractor shall notify the Council through the portal, and qualified in writing to the Council's Corporate Procurement Office, as soon as it becomes aware of any investigation of or proceedings brought against the Contractor

under the Equality Act 2010 and the Human Rights Act 1998 or other relevant legislation.

Where any investigation is conducted or proceedings are brought under any of the equalities legislation which arise directly or indirectly out of any act or omission of the service provider, its agents or subcontractors, or the Staff, and where there is a finding against the service provider in such investigation or proceedings, the service provider shall indemnify the Council with respect to all costs, charges and expenses (including legal and administrative expenses) arising out of or in connection with any such investigation or proceedings and such other financial redress to cover any payment the Council may have been ordered or required to pay a third party.

1.7 Legal

The issue of this invitation to tender in no way commits the Council to award any contract pursuant to the tender process. The Council is not bound to accept the lowest or any tender and reserves the right to accept any tender, either in whole or in part or parts. Nothing in this invitation to tender shall require the Council to award a contract and the Council shall be able, at its sole discretion, to withdraw the invitation to tender before the date for submission or withdraw from discussions at any stage.

The tenderer is responsible for obtaining all information necessary for the preparation of the tender. The Council will not reimburse or be responsible for any costs incurred by tenderers in connection with the preparation or delivery or in the evaluation of the tender.

1.8 Local Healthwatch tender

During the period of this tender, the Council will be issuing an ITT for the provision of a Local Healthwatch service.

The Council is unequivocal in stating that the provider of the LINk Host service will not receive any advantage whatsoever should they wish to tender for the Local Healthwatch service.

Similarly, any organisation which has been unsuccessful in their bid to provide the LINk Host service will in no way be disadvantaged should they wish to tender for the Local Healthwatch service.

All bids for all tenders advertised by the Council are assessed strictly against the criteria stated in the ITT: performance in other bids form no part of the assessment process.

2 BACKGROUND

Under the *Local Government and Public Involvement in Health Act 2007*, each local authority was required to procure a Host organisation to enable, support and facilitate the Local Involvement Network (LINk) in its activities, under the direction of the LINk.

The Host service to the B&NES LINk was, from 1st July 2008 until 19th October 2012, provided by Scout Enterprises Ltd. On the latter date the company was formally wound up and went into liquidation, with the concomitant loss of staff. Consequently, their provision of the Host service to the LINk ceased on that date.

As there is a statutory requirement for the provision of a Host service until 31st March 2013, after which LINks will cease to exist and Local Healthwatch will come into existence, B&NES Council now wishes to tender for an organisation to provide a Host service to the B&NES LINk from 1st December 2012 to 31st March 2013.

3 DELIVERABLES

The following deliverables will be required for the duration of the contract:

- to ensure that the B&NES LINk's statutory duties have been met;
- people are able to gain access to the LINk through avenues and opportunities that suit them;
- people know what the LINk is doing and why, and are able to comment on it;
- to organise LINk committee meetings as required by the LINk committee Chair and Vice Chairs; to notify in advance all interested parties of the dates of the meetings; to service the meetings through the provision of agendas, minutes and any other appropriate administrative tasks;
- to support LINk members in their attendance of ongoing representational activity including the Health and Wellbeing Board and Council Scrutiny panels. To attend such meetings where LINk representation is not available unless agreed in advance with the Council;
- to organise and undertake briefing sessions for the Council's Elected Members and officers;
- to compile and distribute a monthly bulletin of LINk activities, both electronically and by post;
- to undertake other appropriate administrative tasks, e.g. payment of LINk members' expenses;
- to pass to the provider of Healthwatch B&NES (Local Healthwatch) any and all relevant information which the Council and provider agree is required for an effective Healthwatch service;

- to liaise regularly with the Council and the LINk's Chair and Vice Chairs regarding the above activities.

4 REQUIREMENTS OF THE SERVICE PROVIDER

- Familiarity with the structure and role of a LINk;
- Knowledge of the contexts in which LINks operate, especially in their relationship with their local authority;
- Knowledge of the demographics of Bath & North East Somerset;
- Administrative expertise, including the organisation of meetings:
    - Sending out notices of meetings;
    - Compiling agendas and other relevant papers in liaison with the LINk Chair;
    - Arranging accessible venues for meetings
    - Organising refreshments
    - Taking and distributing minutes of meetings
- Good interpersonal skills – able to form and maintain good working relationships with the B&NES LINk Chair, Deputy Chairs and other members.

5 TUPE

Please note: Until 19th October 2012 the LINk Host service was provided by an external contractor, Scout Enterprises Ltd. On that date Scout Enterprises Ltd went into liquidation.

Employee information received from Scout Enterprises concerning the three members of their staff who delivered the B&NES LINk Host service is contained in Appendix 3. Tenderers should note that the Council is not able to guarantee the accuracy of the information and will not accept any liability as to its accuracy. Tenderers are advised to seek independent professional advice on the application of TUPE: the Council is not able to offer advice to bidders on TUPE issues.

APPENDIX 1 – Contract value

The maximum funding available for this contract is £10,000 (ten thousand pounds).

APPENDIX 2 - Criteria and scoring method for tender responses

1. Organisational requirements

An organisation will only be considered for this contract if:

1.1 its total budget for the provision of the service does not exceed the amount stated in Appendix 1 above, unless notification of an amended sum is issued to bidders through ProContract;
1.2 it submits the documents listed in Criteria 1. below;

2. Criteria and scores for tender responses

A Fail for Criteria 1 below will result in the bid being excluded from the assessment process.

You are required to provide the documents specified in section 1 below and a written response to each of sections 2.1 – 2.3 and 3. below. Do not amalgamate responses to two or more sections into a single response. Each response will be scored as shown.

We would prefer you to use Arial 11 point black for your responses. All responses must be in English.

Please do not include hyperlinks, attachments or any other material in your responses, as they will not be taken into consideration.

Criteria	Scoring
1. Provide hard or soft copies of the following documents from your organisation, which should be current at the time they are submitted: • **Safeguarding policy** • **Health and safety policy** • **Equal opportunities policy** • **Public liability insurance certificate**	Failure to provide one or more of these documents will result in a Fail
2.1 How will you operate within B&NES to ensure that the interests of the whole of the B&NES demographic continue to be addressed? Response (200 words maximum):	15%
2.2 Demonstrate: **(a) how you will prioritise the deliverables listed in section 3 above;** **(b) how you will work with the LINk's Chair and Deputy Chairs to ensure that they remain efficient and effective in delivering the LINk's statutory duties.** Response (200 words maximum):	20%

2.3 How will you ensure that the current LINk members remain involved in delivering the LINk within B&NES? Response (200 words maximum):	15%
Sections 2.1 – 2.3 above will each be scored as follows:	
Excellent standard of response; exceeds the requirements in a number of areas and is supported by strong evidence which gives the Council a high level of confidence.	8 - 10
Competent standard of response; meets requirements and is supported by a satisfactory level of evidence although there are a few issues which give the Council cause for some minor concerns.	4 - 7
Inadequate response; fails to meet some requirements and is generally unsatisfactory and/or has omissions and/or is not supported by evidence. Gives the Council cause for serious concern.	1 - 3
No response provided and/or substantial omissions which make the response fundamentally unacceptable and give the Council cause for major concern.	0
The total marks awarded for sections 2.1 – 2.3 will comprise 50% of the overall score.	
3. Please state the total cost to the Council, excluding VAT, for supplying this service over the full period of the contract.	50% of overall score

3. Overall scoring

Responses will be evaluated on the following quality/cost ratio:
Quality (Criteria 2.1 – 2.3 above) 50%
Cost (Criterion 3 above) 50%

The preferred supplier will be the organisation with the highest overall combined score.

APPENDIX 3 – B&NES LINk Host: Employee Information (see section 5 above)

Employer	M/F	Contract	Job Title	Location	Type of Contract	Weekly Contracted Hours of Work
Scout Enterprises Ltd	M	B&NES Link	Contract Manager	Bath	Standard	18.5
Scout Enterprises Ltd	F	B&NES Link	Administrator	Bath	Standard	25
Scout Enterprises Ltd	F	B&NES Link	Co-ordinator /Development Worker	Bath	Standard	18.5

Annual Gross Salary	Additional Notes	Employment Start Date	**Age:** Note please do not enter date of birth	Does the employee currently work for, or have they ever worked for the civil service or other public sector employers (under the meaning of the Cabinet Office guidance on fair deal for staff pensions?)	Remarks	Holiday entitlement (excluding national holidays)	This year	Remaining
£28,876.00	None	24.11.2003	63	Yes	Early retirement from NHS following redundancy	23	23	23
£11,452.00	None	12.10.2009	47	No	None	21	21	12
£11,337.00	None	06.10.2008	46	No	None	13	13	13

Booked	Disciplinary/ grievance	Court/ Tribunal	Sickness (2 years)	CRB Status	Right to Work
0	None	None	0	Yes	Yes
4	None	None	8	No	Yes
0	None	None	4	Yes	Yes

Job Title: **Administrator**

Responsible to**: LINk Co-Ordinator/Development Worker**

Base: Bath

Hours: 25 per week

Job Summary: The post holder will be responsible for the provision of effective administrative support to the LINk Co-Ordinator/Development Worker and Contract Manager working with the Bath & North East Somerset LINk.

Main Responsibilities:

1. Establish and maintain administrative systems which support the effective operation of the LINk.
2. Ensure effective use of IT systems to store and disseminate relevant information.
3. Maintain database of information for all LINk, members, participants and contacts
4. Co-ordinate diaries of staff and take responsibility for the organisation of LINk meetings
5. Maintain list of LINk meeting venues and room bookings.
6. Take notes/minutes of meetings when requested to ensure accurate notes/minutes/letters/emails are sent out appropriately.
7. Support liaison between Host staff and LINk participants.
8. Act as a contact point for all enquiries/requests from LINk members and the public either by telephone, email or face-to-face, and deal with accordingly during agreed office hours.
9. Prioritise workload to ensure deadlines are met.
10. Support LINk meetings in the absence of the Development Worker or Contract Manager in B&NES.
11. General office duties, to include photocopying, filing, post, distribution log and any other duties commensurate with the post.
12. Involvement in producing newsletters, LINk publicity materials and bulk mailouts.
13. Operate within Data Protection Legislation and LINk Confidentiality Policy
14. Undertake other duties appropriate to the post as directed.

Job Description

Job Title: **LINk Co-Ordinator/Development Worker**

Responsible to**: Contract Manager**

Base: Bath

Hours: 18.5 per week

Job Summary:

The post holder will be responsible for the promotion of the LINk to people and organisations throughout Bath and North East Somerset, and for the recruitment and development of Members of the LINk. He/she will also assist the LINk in the understanding of health and social care issues and the development and carrying out of its work programme.

The post holder will also be responsible for co-ordinating the LINk's work plan and to ensure provision of effective administrative support for BANES LINk.

Main Responsibilities:

- to support involvement and consultation with residents of Bath & North East Somerset for the purposes of developing and promoting the LINk.
- to recruit individuals and groups to participate in the LINk, and to develop and maintain public awareness of the LINk and its activities.
- to carry out all work with close attention to equalities and accessibility issues, and to promote diversity in the LINk membership, work and public engagement.
- to ensure a representative spread of involvement and the involvement of traditionally "hard-to reach" groups within the community through "outreach" work and other innovative techniques of engagement.
- to identify training and development needs of LINk Members, and to develop ways of meeting these needs.
- to work with the LINk members and the Host team to identify realistic objectives in respect of workplan projects, and to assist with the prioritisation of this work.
- to research background information as necessary, and gather information to inform projects and LINk activities.
- to assist the Contract Manager in the support and monitoring of LINk project work.
- to work with the Contract Manager to develop engagement tools (including questionnaires for surveys). and to collate, analyse and interpret data and the findings from the LINk's work.
- with the assistance of the Administrator, to organise meetings and events on behalf of the LINk, such as LINk workshops and public health initiatives.
- to develop good working relationships with the relevant NHS Trusts, B&NES Primary Care Trust, Bath & North East Somerset Council and the statutory regulators of health and social care, as well as other appropriate statutory and

voluntary agencies and groups.

- to develop and maintain own knowledge base on national and local health and social care issues and activities.
- to assist in the research for and production of newsletters, bulletins, and other information, and to develop the LINk's marketing and publicity materials (including leaflets and posters).
- to work with the LINk team in the production and delivery of public presentations on the LINk and its work.
- to help the LINk to increase understanding and knowledge of local health and social care issues.
- to ensure effective use of IT systems to disseminate relevant information, and to make a major contribution to the promotion, monitoring and updating of the LINk web site.
- to identify and develop public involvement opportunities on behalf of the LINk.
- to undertake other duties related to the LINk as necessary or at the direction of the Contract Manager.
- Provide line Management for the LINk Administrator and Assistant Development Worker, to ensure effective Administration is provided for the LINk contract.
- Set up office systems and ensure effective use of IT for storing and disseminating relevant information, including record keeping and maintaining database of information for all LINk contacts
- Prioritise workload to ensure that own and team deadlines are met.
- Operate within Data Protection Legislation and LINk Confidentiality Policy

Job Description

Job Title B&NES LINk Contract Manager

Location: Bath

Hours: 18.5 per week

Main Purpose of Job:

To provide the strategic lead function for the B&NES LINks, including management of staff, work planning and service delivery.

Reporting Structure:

You report to:	Divisional Manager
Those that report to you:	LINk staff and volunteers of LINk

Key Tasks and Responsibilities:

Management:

- To be responsible for planning and implementing the work of the LINk team in line with the requirements of the organisation, contract manager and the LINk governance structures;
- To develop and ensure the implementation of processes, protocols, policies and partnership agreements as required by the LINk membership;
- To develop and support the governance arrangements for the LINk;
- To be responsible for monitoring and reporting against the operational plan for the LINk, reporting to the governance structures as agreed;
- To manage the process of mapping engagement activities and developing engagement mechanisms to meet the LINk needs;
- To develop and manage a communications strategy and implement information sharing processes.

Strategic Work:

- To develop and support the LINk to have a high profile within the community and amongst service providers;
- To develop strategic relationships with statutory and VCS partners;
- To liaise with appropriate individuals and organisations such as NHS bodies, Councils, Overview and Scrutiny Committee and strategic partnerships;
- Support the LINk to implement transparent and accountable work practices
  e.g. overseeing the governance structures, managing membership, dealing with complaints and ensuring standards are met;
- To promote the work of the LINk throughout the area, and to encourage engagement from all sections of the community;
- To effect relationships through partnership building with senior strategic managers in the statutory sector;

- To liaise with partners to effect change in organisations and service delivery;
- To attend diverse partnerships and forums to promote the work of the LINk;
- To work with a diverse range of stakeholders, to manage conflict and competing interests;
- To complete presentations and reports to a variety of audiences.

Financial:

- To manage the budget for the LINk in line with organisational policy and contractual obligations;
- To work with the management team and LINk governance structure to review and plan expenditure;
- To complete reports and monitoring information as required.

General:

- To be responsible for the day to day management and supervision of the LINk support staff;
- Develop and oversee a volunteer recruitment and support programme and ensure staff/volunteers are supported and appropriate training available;
- Ensure there is adequate induction and support for staff, LINk members, the network itself and volunteers;
- To work with volunteers and empower all members of the community to engage with the LINk;
- To analyse complex information and be informed by relevant legislation and specific guidance in relation to LINk;
- To produce quality written reports, presenting accessible information to a diverse audience;
- To work to combat all forms of discrimination, and to ensure that the principles of equal opportunities are implemented in all work undertaken on behalf of the Company and LINk;
- To work as a member of management team adhering to all policies and procedures, and to contribute to the development of policy and good practice within the Company;
- To work flexible work patterns if necessary in response to the needs of the LINk membership and other partners. This may include weekend and evening working;
- To carry out the above duties, and any other duties commensurate with the responsibilities of the post which may reasonably be required, in a manner which actively supports and promotes Company's aims and policies;

APPENDIX 4 - Abbreviations and Definitions used in this document

The following abbreviations and terms are used throughout this document:

B&NES -	Bath & North East Somerset
(The) Council -	Bath & North East Somerset Council
Healthwatch B&NES -	Healthwatch B&NES always refers to the B&NES Local Healthwatch unless stated otherwise
ITT -	Invitation to Tender
LINk -	Local Involvement Network
TUPE -	Transfer of Undertakings (Protection of Employment)

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	Friday 16th November 2012
TITLE:	Review of Urgent Care
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Health & Equalities Impact Assessment Appendix 2 – Full Patient & Public Engagement Report	

1. THE ISSUE

To present to the Panel the public engagement report on the proposal to relocate the GP-led Health Centre to the Royal United Hospital.

To also present to the Panel the health & equalities impact assessment on the proposal.

The rationale for this service change is based on the following factors:

- An ageing population
- Increasing demand and expectations
- People living longer often with several long term conditions
- Finite resources and inequitable use of existing resources
- It has the support of local clinicians whose services will be affected by the proposals
- It supports the principle that patients should have access to the right treatment, at the right place and at the right time
- It has taken account of clinical evidence and best practice drawn from reports published by the Primary Care Foundation, Royal College of General Practitioners, NHS Alliance, the Department of Health and the Foundation Trust Network (these are set out in section 9 of the report).

2. RECOMMENDATION

The Panel is asked to note both reports and agree the proposal to relocate the GP-led Health Centre to the Royal United Hospital to create an Urgent Care Centre can proceed.

3. FINANCIAL IMPLICATIONS

The redesign of urgent care services is taking place within the context of the local NHS needing to become more efficient to meet the challenges it faces over the next few years as a result of an ageing population and people living longer with long term conditions. The

aim of the proposal is to release funding in order to reinvest in services where there is the greatest need eg dementia, diabetes and end of life care. There are, however, no direct financial implications for the Council from this proposal.

4. THE REPORT

Strategy Background
In 2006 B&NES Primary Care Trust (PCT) published an Emergency & Urgent Care Strategy which had seven key objectives, one of which was about ensuring patients are assessed and treated by the right professional with access to the right interventions first time. At the time the aim was to establish an integrated face to face (walk-in) service to provide that assessment and treatment on the basis that people didn't always know which service to use and when.

Service Background
In April 1999, the Department of Health announced the first nurse-led walk-in clinics to improve access to health care and in 2001 the PCT opened such a facility in Henry Street. In 2008 PCTs were required to commission GP-led Health Centres as part of the Department of Health's strategy to improve access to primary care. The nurse-led walk-in service was integrated to create the GP-led Health Centre, which opened in April 2009 at Riverside. This unfortunately meant the PCT had to deviate from its strategy outlined above.

In 2004 the PCT commissioned GP out-of-hours services (evenings, overnight, weekends and Bank Holidays) from Bath & North East Somerset Emergency Medical Services (BEMS), a non-profit making organisation made up of mainly B&NES GPs. When it was first launched the GP out-of-hours service was based at the RUH. It then moved to Riverside with the GP-led Health Centre and other services. The service moved back to the RUH site in October 2010 as the benefits of being on the RUH site outweighed being based at Riverside.

Focussing on the future of the GP-led Health Centre based at Riverside in Bath and the GP out-of-hours service has been a priority as firstly they have to be re-commissioned by 2014; secondly they both centre around primary care and thirdly their services complement each other.

There are three other main reasons for looking at urgent care services as a whole:

- Ensuring patients are clear about where to get the best treatment
- Needing to balance the affordability of the different services offered
- Knowing that the number of patients who use urgent care services will continue to grow and the CCG needs to redesign local services to ensure that there is provision for those with the greatest needs.

The Proposed Service Changes
The urgent care services in B&NES include:

- 27 GP practices
- GP-led Health centre at Riverside
- Bath & North East Somerset Emergency Medical Service – the GP out-of-hours service based at the RUH and Paulton Hospital
- Minor injury unit at Paulton Hospital
- Emergency Department at the RUH

- Great Western Ambulance Service

Various options for redesigning urgent care services have been considered by the CCG along with Wiltshire and Somerset CCGs, hospital consultants, primary care professionals, managers and lay members. The aim in considering the options has been to ensure:

- High quality care
- Clinical safety
- Best use of available resources
- Simplified access

Four options have been assessed against these criteria and it was clear to the CCG that one option was the best fit against these criteria. The bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre.

Whilst this model would stabilise and increase the level of service over 24 hours, it would also increase the ability to ensure patents get the right care from the right people at the right time. The CCG also believe having GPs based at the Emergency Department will improve the care of older people, which will become an increasingly important role for primary care.

5. RISK MANAGEMENT

The key risks of not making the proposed changes can be described as:

- Wider impact for the local population if the CCG does not use its resources efficiently with potentially less available for other crucial services to support older people, people with long term conditions and people with mental health problems.
- Loss of a real opportunity to get the best possible urgent care system across our local community.
- Demand continues to spiral upwards with an inability for services to match the capacity required if the system is not changed.
- The urgent care system continues to be fragmented with unclear governance and management responsibility for delivering high quality and clinically safe services.
- Erosion of general practice as the bedrock of the urgent care system.
- The management of patients with long term conditions is not integrated into urgent care.

6. EQUALITIES

Appendix 1 sets out the health impact assessment and high level equalities impact assessment which was carried out by a stakeholder group on 18th October 2012. An in-depth equality impact assessment will be completed by the CCG and commissioning team as part of the process to develop the specification.

The potential adverse impacts were considered in detail by the stakeholder group and took account of the impacts before and after mitigating actions which in their view would reduce the impact of the proposed changes. On that basis the group did not feel it was a substantial variation.

Subsequent to this providers who would be affected by the proposal were asked for a view. This included Assura Minerva LLP, Sirona Care & Health, the RUH and Bath &

North East Somerset Emergency Medical Service. The scoring for the providers is reflected in the impact assessment and as would be expected, the staff of the GP-led Health Centre, assessed the impacts more negatively than the other providers. At the time of submitting the impact assessment it had not been possible to obtain a view from Assura Minerva LLP. A verbal update can be provided on 16th November if required.

However, on the basis of the mitigating actions and the fact there would be a 24 hour, 365 days of the year walk-in service, albeit in a different location, the proposal was not felt to be a substantial variation overall.

7. ENGAGEMENT & CONSULTATION

The PCT and CCG undertook a public engagement process from 25th September 2012 to 31st October 2012. A series of seven public meetings were held at which 120 people attended. This represents 0.06% of the registered population of B&NES. An engagement document and questionnaire was made available in printed format as well as on-line at the CCG's website. A 208 people completed the questionnaire, 51 on-line and 157 were sent back in the stamped addressed envelopes provided. This represents 0.1% of the registered population of B&NES.

Appendix 2 sets out the full report on the public engagement process. This report has been made available on the CCG's website and will be circulated to those members of the public who requested a copy. This report will also be shared with the providers via the Bath Health Community Urgent Care Network in order to jointly consider and reflect on what other improvements and changes could be made to services in light of the feedback received.

Addressing the Key Concerns
The key concerns that have been raised at the public meetings as well as raised through the questionnaire responses can be summarised as:

- GP access – being able to get through on the phone and getting a same day appointment
- Provision of services for vulnerable people, particularly the homeless
- Access for visitors and tourists to the city
- Availability of car parking at the RUH
- Car parking charges at the RUH compared with free parking at Sainsbury's
- Public transport and getting to the RUH
- The GP-led Health Centre is convenient, particularly for students and people working in the city
- The GP-led Health Centre is high quality and customer focussed – concern this would not be replicated by the Urgent Care Centre
- The savings assumptions were not clear

GP Access
The PCT and CCG will be working with local GP practices over the next 18 months to improve their ability to see patients with urgent care needs through an incentive scheme. The scheme includes the requirement for practices to carry out a survey of their practice populations about access in the first six months (from October 2012 to end of March 2013) in order to address the areas of concern as well as tackling the reasons for patients not attending (DNAs) to see the GP or nurse. Analysis suggests that the DNA rate across the practices ranges from 3% to 10% and this is wasted capacity that is already paid for.

The scheme also involves ensuring that telephones are answered promptly between the hours of 8 am and 6.00 pm with no closure during lunch time periods. It also involves improving the response time of GPs visiting unwell patients at home instead of waiting to do the traditional home visits at the end of the morning or afternoon surgery.

The scheme will continue from April 2013 to the end of March 2014 to ensure improvements are made and embedded before the proposed service changes.

Vulnerable People
The homeless service will not be affected by the proposed changes. It will continue to be provided from Julian House. The number of visits at weekends to the GP-led Health Centre by people who are homeless was 13 during the period April to September this year. However, that said the CCG recognises that there is a need and consideration will be given to a potential out-reach worker service at weekends.

The impact assessment identified other vulnerable groups including gypsies, travellers, itinerant workers and boat people, many of whom have poorer health than that of their age/sex matched comparators. Potential solutions for improving access to health care, wider than just urgent care, for these groups was considered by the stakeholder group including the development of a health visitor role to visit people rather than expecting them to come to services.

Visitors & Tourists
All practices are funded to see temporarily registered patients; before the nurse-led walk-in service and the GP-led Health Centre were developed, hotels, B&Bs and guest houses, etc used to advise guests to seek medical attention from a local practice. This still does happen and the intention would be to ensure that proprietors and managers are well informed about their nearest practice.

RUH Car Parking & Charges
The issue of parking management at hospitals often attracts regular debate and in response to this the British Parking Association has produced guidelines to help Trusts and car park operators deliver effective and efficient parking for users – many of whom have particular needs. The RUH is a member of this Association and car parking charges at the RUH are one of the lowest compared with other hospitals in the South West.

The RUH has increased the number of disabled spaces over recent years and free parking is available for blue badge holders close to the main entrance and in designated spaces. If these are full, patients can park in any of the pay and display car parks also free of charge when blue badges are displayed.

However, it is worth noting that the GP-led Health Centre has no dedicated patient parking and although there is free car parking for up to 90 minutes in Sainsbury's car park, no specific patient spaces exist. The GP-led Health Centre is also situated in zone 6 of the residents parking scheme so there is limited free street parking.

That said, the issue of car parking and charges at the RUH was such a significant theme from the engagement process that improved access to disabled spaces and drop off points will be considered and discussed with the RUH as the plans progress.

Getting to the RUH

Bath is well served by public transport with various operators operating in the area. Although most routes go to the central bus station, there are a number of services that have the RUH as a stop on their routes:

- Service 42 from Odd Down Park & Ride site which runs from 6.40 am to 7 pm Monday to Friday and takes approximately 20 minutes. Children under 16 travel free when accompanied by an adult - maximum of 5 children per adult.
- Service 14 / 714 - Odd Down, Bear Flat, Bus Station - Dorchester Street, Royal United Hospital, Weston Village (every 10 minutes). Stops in the hospital grounds.
- Service 20A - Bus station, Weston, Royal United Hospital, Twerton, Whiteway, Combe Down, University of Bath, Bus Station (hourly from 9.30am). Most journeys stop in the hospital grounds.
- Service 20C - Bus Station, University of Bath, Combe Down, Whiteway, Twerton, Royal United Hospital, Weston, Bus Station (hourly from 8am). Most journeys stop in the Hospital Grounds.
- Service 17 - Weston, Penn Lea Road, bus station, Moorlands, Kingsway, (every 30 minutes). Stops close to the hospital on Newbridge Road and Penn Hill Road.

The First Group also offer the FirstDay ticket which enables people to make more than one journey a day. It offers unlimited travel within Bath zones 1, 2 and 3 on the day of issue, zone 3 includes the RUH. The tickets can be bought from the bus driver any time of day and it lasts until the last bus of the night. Young people and students benefit from discounts on the FirstDay tickets as well as tickets for a week (unlimited travel for seven consecutive days), a month (unlimited travel for 31 consecutive days) or a calendar year.

Some patients will also be able to claim a refund under the Healthcare Travel Costs Scheme of the cost of travelling to hospital. Patients must be receiving one of the qualifying benefits or allowances or meet the eligibility criteria of the NHS Low Income Scheme. The qualifying benefits and allowances are:

- Income support
- Income-based Jobseeker's Allowance
- Income-related Employment & Support Allowance
- Pension Credit Guarantee Credit

Convenience
Although the CCG appreciates that the GP-led Health Centre is a convenient service, particularly for students and people working in the city, the CCG needs to prioritise the use of its resources to support those with the greatest needs.

The majority of people are attending the Centre with routine primary care needs such as sore throats, earache, low back pain, viral illnesses, urinary tract infections and abdominal pain and could otherwise be seen by their GP or practice nurse or for some by a community pharmacist.

There are 15 practices in Bath, half in a one mile radius of the Centre. The vast majority of people using the Centre are already registered with these practices and for some people their practice will be closer to them than the Centre or the RUH.

Those who are not registered with a practice if they work in the city, but live outside B&NES and need urgent medical attention, can register as a temporary patient at one of the local practices; this is the case for visitors and tourists.

Addressing the needs of the student population was again identified through the impact assessment. Although students new to Bath are encouraged to register with a practice as part of Freshers week, particularly those practices that are either based on campus or provide clinics on site, some chose not to and remain registered with their 'home' practice. They can still obtain medical services from practices in Bath as a temporary patient, but it would be preferential for them to register permanently with a local Bath practice whilst studying in the area in order to have access to their full medical record and therefore be able to provide better care.

The practices predominantly serving the student population have also taken steps to improve access by offering walk-in and wait services. A GP at one practice has developed an innovative smart-phone app aimed at helping students to know where to go when and if they need medical attention. It was also suggested that students attending the Urgent Care Centre could be encouraged to register with a practice there and then by providing good access to Wi-Fi.

Quality & Customer Focussed
People have praised the staff at the Centre who provide a high quality and customer focused service. The expectation is that this philosophy of care would continue to be delivered. The specification for the Urgent Care Centre will be explicit about the expectations of the provider in delivering a high quality, clinically safe and customer focused service.

Savings Assumptions
High level savings assumptions have been calculated based on bringing together the GP-led Health Centre and GP out-of-hours services. The contract for both these services amounts to £2.9 million per annum (£1.3 million for the GP-led Health Centre and £1.6 million for the GP out-of-hours service). The CCG is assuming approximately £500,000 will be saved as a result of commissioning an integrated service model. The assumptions have been based on reducing governance and management overhead costs; reducing duplication at weekends; reviewing the skill mix and; by reducing unnecessary emergency hospital admissions. As the plans move forward a more detailed business case will be developed.

8. ISSUES TO CONSIDER IN REACHING THE DECISION

Besides the key reasons for change set out above, the other key issues considered by the CCG include:

- Whether the changes deny people of an essential service; essential meaning that there is no alternative equivalent provision. This is not felt to be the case as alternatives do and will continue to exist, such as GP practices and the new Urgent Care Centre which will retain the GP and nurse-led walk-in service, but in a different location.

- The 27 practices have open lists signifying that supply is at least matching demand. Provision is evidenced as being high quality through the annual quality and outcomes framework scores. There are also a high number of GP training practices and the recruitment of GPs is not considered a problem locally.

- The GP-led Health Centre is predominantly used by people living in Bath, which means funding is disproportionately spent on Bath residents rather than equitably across the whole of B&NES as demonstrated in the map in annex 1.

- The two services that are well recognised, understood by the public and available 24 hours, seven days per week are the Emergency Department and the ambulance service. They are always likely to be used as key access points of care, especially in urban and inner city areas.

- Risk of re-commissioning services in isolation from one another reducing the potential to develop an integrated model thereby creating an unsustainable model for the future to meet the increasing demand.

- The launch of NHS 111 in April 2013. NHS 111 is the new three-digit telephone service that is being introduced to improve access to urgent care services. Patients will be able to use this number when they need medical help or advice that is not urgent enough to call 999. Patients will be signposted to the right service for their needs. NHS 111 will operate 24/7, 365 days per year and will be free to use from a landline and a mobile.

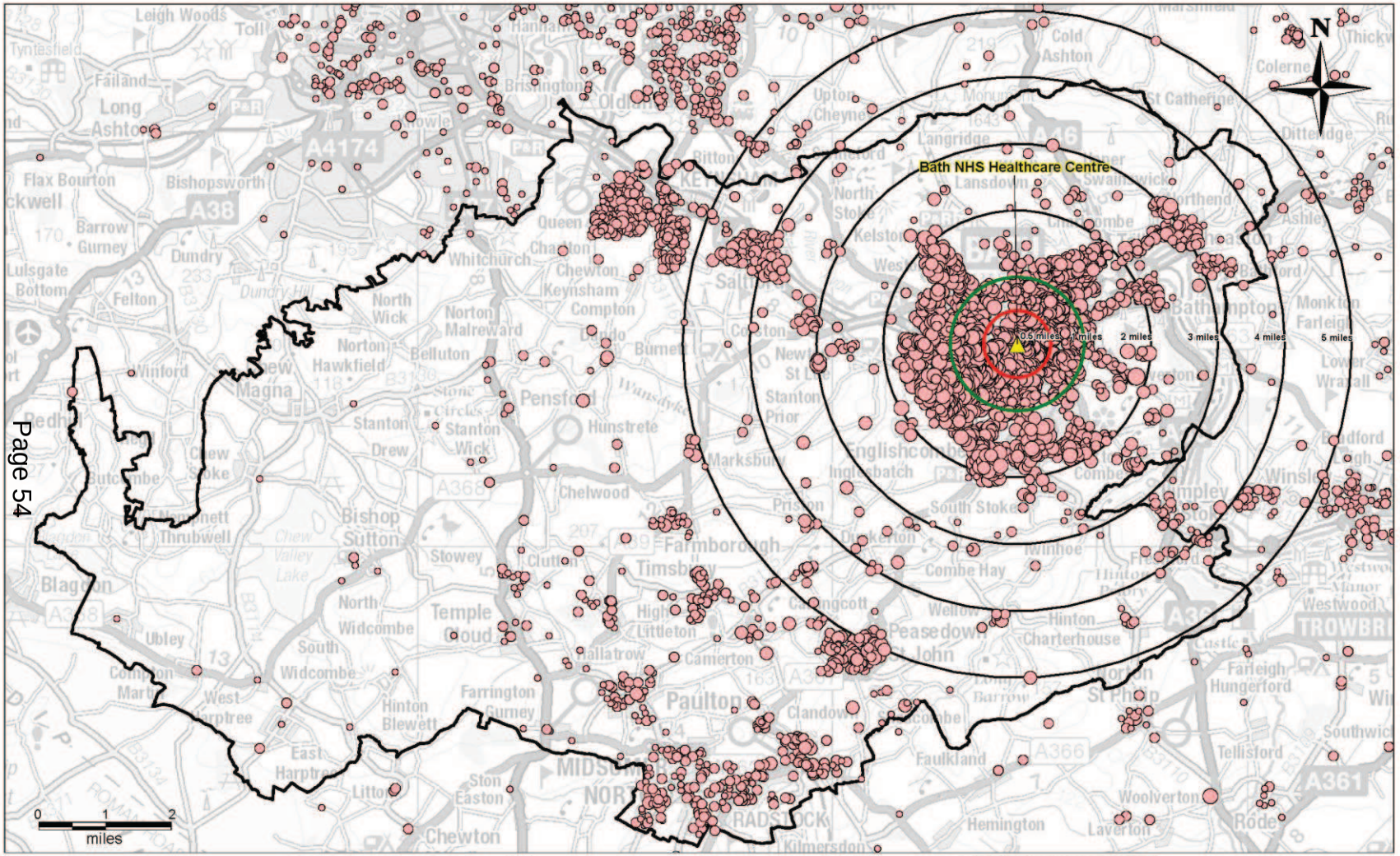
- The current 30,000 patient visits to the GP-led Health Centre will not transfer to the Urgent Care Centre at the RUH as the majority of patients are not presenting with urgent care needs. The expectation is that people will either visit their practice, visit a community pharmacist, self-care or be directed back to their practice via NHS 111.

9. ADVICE SOUGHT

The Council's Monitoring Officer (Council Solicitor) or the Section 151 Officer (Strategic Director – Resources & Support Services) have cleared this report for publication.

Contact person	Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS Bath & North East Somerset, Tel: 01225 831868
Background papers	Primary Care Foundation, *Urgent Care Centres: What works best,?* October 2012 Primary Care Foundation & NHS Alliance, *Breaking the Mould without Breaking the System*, November 2011 Primary Care Foundation, *Primary Care & Emergency Departments*, March 2010 Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, May 2009 Royal College of General Practitioners, *Guidance for Commissioning Integrated Urgent & Emergency Care*, August 2011 NHS Alliance, *A New Approach to 111: Re-establishing General Practice as the Main Route into Urgent Care*, June 2011 NHS Alliance, *Getting to Grips with Integrated 24/7 Emergency & Urgent Care*, October 2012 Department of Health, *Reforming Emergency Care*, November 2001 Department of Health, *Direction of Travel for Urgent Care: A Discussion Document*, October 2006 Department of Health, *Emergency Access Clinical Case for Change*, December 2006 Foundation Trust Network Briefing, *Driving Improvement in Elderly Care*

	Services, March 2012 Foundation Trust Network Briefing, *Driving Improvement in A&E Services*, October 2012 NHS Bath & North East Somerset Clinical Commissioning Group's *Integrated Commissioning Plan*, September 2012
Please contact the report author if you need to access this report in an alternative format	



NHS Bath & North East Somerset PCT:

Bath NHS Healthcare Centre Attendances by Postcode
(October 2011 to September 2012)

Bath NHS Healthcare Centre
0.5 miles
1 miles
PCT boundary

Attendances by postcode

98	to	821	(10)
22	to	98	(295)
7	to	22	(896)
2	to	7	(2266)
1	to	2	(3038)

Note: 1.0% of attendances could not be located.

Buffer of WIC	Attendances	% in buffer
0.5 miles	5,833	17.6
1 miles	7,121	21.5
2 miles	10,524	31.8
3 miles	1,023	3.1
4 miles	687	2.1
5 miles	647	2.0
Outside 5 miles	7,263	21.9
Total	33,098	100.0

Avon IM&T Consortium NHS

Jurong Zheng - 23 October 2012
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REPORT TO THE WELLBEING POLICY DEVELOPMENT & SCRUTINY COMMITTEE AT BATH & NORTH EAST SOMERSET COUNCIL

PROPOSED CHANGES TO: Urgent Care Services – relocation of the GP-led Health Centre to the RUH to create an Urgent Care Centre

Prepared by: Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Date: Stakeholder Meeting was held on Thursday 18th October 2012

DECISIONS REQUESTED

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

PART ONE – Description of proposed service changes

Strategy Background

In 2006 B&NES Primary Care Trust (PCT) published an Emergency & Urgent Care Strategy which had seven key objectives, one of which was about ensuring patients are assessed and treated by the right professional with access to the right interventions first time. At the time the aim was to establish an integrated face to face (walk-in) service to provide that assessment and treatment on the basis that patients found it confusing about which service to use and when.

Service Background

In April 1999, the Department of Health announced the first nurse-led walk-in clinics to improve access to health care and in 2001 the PCT opened such a facility in Henry Street. In 2008 PCTs were required to commission GP-led Health Centres as part of the Department of Health's strategy to improve access to primary care. The nurse-led walk-in service was integrated to create the GP-led Health Centre which opened in April 2009. This unfortunately meant the PCT had to deviate from its strategy outlined above.

Since 2004 the PCT has commissioned GP out-of-hours services (evenings, overnight, weekends and Bank Holidays) from Bath & North East Somerset Emergency Medical Services (BEMS), a non-profit making organisation made up of mainly B&NES GPs. When it was first launched the GP out-of-hours service was based at the RUH. It then moved to Riverside with the GP-led Health Centre and other services. The service moved back to the RUH site in October 2010 as the benefits of being on the RUH site outweighed being based at Riverside.

The contracts for the GP-led Health Centre and the GP out-of-hours service come to an end in March 2014 and this has given the CCG an opportunity to look at the future of urgent care services in B&NES.

The proposed service change would relocate the existing GP-led Health Centre to the RUH to create a 24/7 GP-led Urgent Care Centre.

2. What are the proposed service changes?

The urgent care services in B&NES include:

- 27 GP practices
- GP-led Health centre at Riverside
- Bath & North East Somerset Emergency Medical Service – the GP out-of-hours service based at the RUH and Paulton Hospital
- Minor injury unit at Paulton Hospital
- Emergency Department at the RUH
- Great Western Ambulance Service

Various service options for redesigning urgent care services have been considered by the CCG along with Wiltshire and Somerset CCGs, hospital consultants, primary care professionals, managers and lay members. The aim in considering the options has been to ensure:

- high quality care
- clinical safety
- best use of available resources
- simplified access

Four options have been assessed against these criteria and it was clear to the CCG that one option was the best fit against these criteria. This is set out below.

A new model for urgent care in B&NES
Increasingly people are being encouraged to go to their GPs wherever possible for their urgent care needs. This is important for a number of reasons including patient continuity of care, ease of access to medical records and, most importantly, that GPs are best assessors of urgent treatment options. They are able to manage a large proportion of the care themselves as well as refer on. Access to GP assessment and care is, therefore, the key driver for our local strategy.

However, from the engagement work undertaken to date it is clear that some patients have a problem with getting a same day appointment at their practice which an urgent need would warrant. This therefore requires a solution to improve access.

As a result the PCT is progressing work with local GP practices to improve their ability to see patients with urgent care needs. This involves ensuring that telephones are answered promptly between the hours of 8 am and 6.00 pm with no closure during lunch time periods. It also involves improving the response time of GPs visiting unwell patients at home instead of waiting to do the traditional home visits at the end of the morning or afternoon surgery.

In addition, the proposed new model would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre. Whilst this model would stabilise and increase the level of service over 24 hours, it would also increase the ability to ensure patents get the right care form the right people at the right time. The CCG also believe having GPs based at the Emergency Department will improve the care of older people, which will become an increasingly important role for primary care.

3. Why are these changes being proposed?

This change is being proposed to help patients to make the right choices so they get the right care at the right time to remove duplication of services as well as hand-overs and

hand offs. By doing this it will enable the local NHS become more efficient and meet the demand and financial challenges it faces over the next few years.

The three main reasons for looking at urgent care services as a whole are:

- To ensure patients are be clear about where to get the best treatment
- The need to balance the affordability of the different services offered
- The number of patients who use urgent care services is growing and will carry on growing in the future

Reason 1 – Confusion over where to go
All patients should get the right care, first time, and the aim is to ensure that they use the service that is best-placed to help them. Having listened to local people it is clear they are not sure which service they should use when they or a family member have an urgent care need despite the local publicity campaigns such as Choosing Well.

At the moment patients can choose between NHS Direct, GPs, walk-in centres, GP-led health centres, minor injury units, pharmacies, dentists and emergency departments. Choice is important, but it can be confusing, especially outside usual working hours and when someone is feeling unwell. This uncertainty undermines the delivery of timely and appropriate care.

NHS 111 which will be the new national urgent care number should help with getting people to the right service, first time, but some people will still choose to go directly to a service without phoning beforehand.

Reason 2 – Value for money & affordability
The GP-led Health Centre duplicates the services already offered by GPs. This is because the majority of patients who use the Centre are already registered with a GP locally who are already funded to provide urgent care. Out of the 27 GP practices, 15 are in Bath with half in a one-mile radius of the GP-led Health Centre. 17.6% of people attending the GP-led Health Centre live within 0.5 mile radius of the Centre, 21.5% within a mile and 31.8% within two miles.

The PCT is therefore paying for the GP, the GP-led Health Centre and in some cases for an Emergency Department attendance. The result is that taxpayers' money is not being used effectively and in these financially challenging times this needs addressing.

Reason 3 – Increasing demand
The Office of National Statistics (ONS) project that the population of B&NES will increase from 180,000 (estimate in 2010) to 198,800 by 2026, a 12% increase. This increase is expected to mainly be in older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026. People are also living longer often suffer with more than one long term condition increasing the demand for urgent care and other health care services.

The increasing demand for urgent care services is at a time when the NHS is faced with no growth in health funding. In real terms this means the CCG will have to live within its existing budget. This poses some tough challenges for the future which is why the CCG is considering changes to urgent care services. The reality is that if changes are not made money will have to be taken from other crucial services in order to fund this urgent care demand.

When the GP-led Health Centre opened in April 2009, it was staffed to see 30,000 patient visits per year with the aim that it would help reduce demand at the Emergency Department, which has not been the case.

The preferred option is on the basis that this continues to deliver a GP and nurse led walk-in service, simplifies access and makes best use of the available resources.

4. Rationale

As set out above four service options have been considered by the CCG. Each option, as set out in the engagement document, is presented below along with their strengths and weaknesses.

Option 1 No change

This option assumes no change to the existing services, which would remain in current locations. A review of the type of patient conditions the GP-led Health Centre dealt with over the past year shows that an overwhelming majority of people could have been assessed and treated by staff in general practice

Strengths	Weaknesses
• No disruption to existing services	• Not affordable with poor use of clinical resources – duplication of services available in general practice
• No need to communicate change	• Poor use of financial resources as NHS is potentially paying for some patients care more than once across GPs, the GP-led Health Centre and the Emergency Department
• Additional convenience remains for those living in a two to three mile radius of the Centre and those working in Bath	• The GP-led Health Centre has not reduced demand at the Emergency Department
• Provision of additional access to primary care	• Financially not sustainable given the increasing demand for urgent care services and an ageing population
• Offers services to some patients who would not otherwise use them at all	• Fragmented services leading to patients having to be transferred to another service and clinical governance risks
• Retention of skilled staff in existing settings	• Extended GP opening hours have reduced need for the extra access offered by the GP-led Health Centre
	• The GP-led Health Centre has no on-site diagnostics such as X-rays. This means some patients have to visit the Emergency Department, disrupting care and increasing cost

Option 2 Expand GP-led Health Centre

The GP-led Health Centre could be expanded to include additional diagnostic services which could mean investment in X-ray equipment. This could for example enable fracture clinic services to allow the treatment of patients with more complex conditions.

Strengths	Weaknesses
• Retains all benefits identified in option 1 – local and accessible	• Not affordable as it would require significant investment and duplicates services
• Treats more complex cases closer to those able to access the service	• Additional accommodation, staff and equipment required to deliver new services
• May reduce demand on the Emergency Department	• No back up of specialist doctors to diagnose more complex problems
• Further development of skilled workforce	• There is an increased risk for patients if services are delivered away from specialised facilities with additional support
• Improve access to healthcare for local communities	• Comparatively small number of patients could leave staff unable to retain their skills
	• Transportation of patients to the Emergency Department if needed
	• No access to enhanced diagnostics and specialist opinion

Option 3 Create Urgent Care Centre at RUH with Improved access to primary care

Strengths	Weaknesses
• It is affordable and makes more efficient use of resources as it reduces duplication. Patients arriving at the Emergency Department with primary health care needs can be directed to the Centre. This will cost less	• An urgent care centre at the RUH could mean its harder to access for some patients who live and work in the city leading to a poorer experience
• There will be 24 hour, seven day GP presence	• The RUH location may pose transport issues for some patients
• GP presence will help the prompt assessment and treatment of frail elderly patients and ensure that they are safely transferred to an appropriate setting as GPs have better knowledge of the services available in the community	• The GP-led Health Centre provides more primary care access
• Better integration of GPs and nursing staff with the Emergency Department will mean there is support if a patient requires more help than first thought. This will potentially enhance the quality of care	• Students who are not registered with a GP practice will need to do so
• Location is good for some people	• Patients may dislike being re-directed back to their registered GP
• Provides good access to diagnostics and other specialist staff and services	• Availability of car parking at RUH
• Provides opportunity for developing	• Car parking charges at RUH

pathways of care and clinical links between primary and secondary care clinicians	
• Provides a single primary care focus which can offer a consistent message to patients	
• Retains the 'walk-in' aspect that is a valued feature of the GP-led Health Centre	
• All B&NES patients know where the Emergency Department is located	
• Encourages patients with primary care needs to use their GP in the first instance	
• Enables high quality data collection of activity to monitor performance of service and future planning of services	
• Provides the clinical and managerial hub for other urgent care services such as Paulton Minor Injury Unit, homeless service and the community based deep vein thrombosis service	
• There are good transport links from the city centre to the RUH	

Option 4 Close GP-led Health Centre
Complete removal from B&NES of the service provided by the GP-led Health Centre.

Strengths	**Weaknesses**
• Would save £1.3 million annually to reinvest in other health care services	• Closure could mean a poorer experience for some patients
• Allows resources to be redirected to those most in need and to those areas where there is increasing demand, eg dementia care, diabetes care	• Overall reduction in primary care service on offer
• Can support the reduction in health inequalities	• Break up of skilled clinical team
	• Demand will increase elsewhere because some patients attend other health services such as the Emergency Department instead
	• The GP-led Health Centre is popular with patients who use it

5. Summary of involvement outcomes

There is a well established Health & Social Care Urgent Care Network across B&NES, Wiltshire and Somerset. This has been in place for a number of years and includes primary and secondary care clinicians, health and social care practitioners, commissioners and, more latterly, lay membership.

In April 2012 the PCT and CCG held a 'Healthy Conversation Event' with stakeholders, patients & public to present proposals for redesigning urgent care. Attendees were asked to consider questions in relation to the proposals. Subsequent to this an event was held with the Urgent Care Network to consider in more detail the potential options for redesigning the services.

Taking all the above into account, the PCT and CCG decided to proceed with a public engagement process on the proposed service change. This began on 25th September 2012 and concluded on 31st October 2012.

As part of the process, an impact assessment and equality impact assessment session was held with stakeholders and patient representatives on 18th October 2012.

The outcome of this session revealed that there was broad agreement that the proposal would not have a significant negative impact upon the population of the B&NES. However, there were clear mitigating actions that needed to be implemented in order to assure ongoing quality of services.

6. Timescales

The aim is to commission the new model to be in place from April 2014. A detailed project plan will be developed as part of the procurement process.

7. Additional information

In considering the impact of the proposed changes, information about the reasons for people going to the GP-led Health Centre and the Emergency Department was shared. This essentially showed that they are similar to one another as follows:

GP-led Health Centre	Emergency Department
➢ tonsillitis, ➢ otitis media/externa (earache) ➢ lacerations ➢ local skin infection ➢ low back pain ➢ viral illness ➢ urinary tract infections ➢ abdominal pain ➢ dressings of wounds	➢ ankle and wrist sprain & strain ➢ abdominal & pelvic pain ➢ pain in throat & chest ➢ head injury & wounds ➢ hand & wrist fractures ➢ wounds to hand & wrist ➢ fractures of forearm ➢ syncope & collapse

Another key consideration was whether the changes denied people of an essential service; essential meaning that there is no alternative equivalent provision. This is not the case as alternatives do and will continue to exist, such as GP practices and the new urgent care centre which will retain the GP and nurse-led walk-in service, but in a different location.

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

No. Although there would be no city centre presence, the GP-led service would be relocated to the RUH to provide a 24/7 GP service. This would lead to improved value for money, releasing approximately £0.5 million funding to reinvest in other services, simplified access and continue high quality services.

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

A range of stakeholders representing patients and the public, students, older people, carers and disabled people were involved in the impact assessment session on 18th October including:

- The Carers Centre
- B&NES Age UK
- Equality B&NES
- Bath Spa University
- B&NES Local Involvement Network (LINk)
- Public Health

Benefits of the proposed service changes	Increase in opening hours as a result of moving the service so in effect increases the service offered. Integrates with the existing out-of-hours GPs. Single system is simpler. There is already good signage to A&E from in and around the city, making it easier to find. Increased attendance at a GP practice may improve the care and understanding and relationship with that GP, particularly for people with long term heath conditions. Right service at the right time ability increases in terms of timeliness both into the RUH but also into community services in some instances. GP services will be used more efficiently. B&NES Age UK and The Carers Centre already based at the RUH so increased front door benefits through access to partner agencies by the urgent care centre. Integrating the GP out-of-hours service with the GP-led Health Centre would be beneficial, particularly at the weekends enabling better use of GPs and emergency nurse practitioners.

Any dis-benefits, including how you think these could be managed	Riverside is a good location and convenient for students, visitors, tourists and people who live centrally. Some patients would have to travel one mile to the RUH from the centre and two to three miles if living the other side of Bath. Would put pressure on car parking and disability parking at the RUH. Staff working at the GP led Health Centre subject to organisational change. May result in some loss of existing skills through staff not wanting to relocation/change their working patterns etc.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	Getting to the RUH from certain areas of Bath. Would potentially mean catching two buses. This could have an impact on people on low incomes. Availability of car parking and charges.
How do you think the proposed changes will affect the quality of the service/services	There will be 24 hour, seven day GP presence. Better integration of GPs and nursing staff with the Emergency Department will mean there is support if a patient requires more help than first thought. This will potentially enhance the quality of care. Provides good access to diagnostics and other specialist staff and services. Provides opportunity for developing pathways of care and clinical links between primary and secondary care clinicians and partner agencies such as Age UK and the Carers Centre. People who really need a clinical service will have access to wider range of services and support The savings generated will be reinvested into services for people with the greatest need, eg the frail elderly, people with dementia.

Impact of the proposed changes on health inequalities	A high level analysis set out below. An in-depth EIA will be completed by the commissioning team and CCG as part of the process. However, the 2012 health profile for B&NES shows that the health of people is generally better than the England average although two wards are in the most deprived 20% of the country across a range of indicators. Deprivation is lower than average and over the last ten years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is better than the England average.
Any other comments	Retains the 'walk-in' aspect that is a valued feature of the GP-led Health Centre. The majority of people in B&NES, Wiltshire, Somerset and South Gloucestershire know where the Emergency Department is located in Bath. Encourages patients with primary care needs to use their GP in the first instance or visit a community pharmacist. Given few patients have to be referred to the Emergency Department at the RUH from the Centre, this suggests that the majority of people do not have urgent care needs.
If you are a representative of an organisation, such as LINKs, please indicate how you have drawn on the views of others from your group	LINks have attended the public meetings. LINKs drew attention of the proposal to its committee at the last meeting on 9th October 2012.

Assessment of impact: 'Equality analysis'

How does the change:

A. Meet any particular needs of equalities groups or helps promote equality in some way.

B. Have a negative or adverse impact for any of the equalities groups and how could this be addressed?

		A	B
3.1	**Gender**	Emergency Department attendances and admissions for females aged over 80 are higher than males.	Women are often dependent on public transport, so transport problems to the RUH will predominantly be experienced by women. Women also tend to be

			primary carers of children and older people.
3.2	**Pregnancy & Maternity**	Maternity unit based at the RUH as well as the early pregnancy assessment clinic which is an emergency clinic for women with pain and/or bleeding in early pregnancy from 6 weeks to 14 weeks gestation.	No adverse impact anticipated.
3.3	**Transgender**	More likely to go to an anonymous service such as the Urgent Care Centre rather than a family GP.	No adverse impact anticipated although might prefer to be seen by a regular sympathetic GP.
3.4	**Disability**	People with long term conditions who suffer an acute exacerbation of their condition such as asthma would benefit from the availability of observation beds not available at the GP-led Health Centre.	Disabled people are more dependent on public transport. Insufficient disabled car parking spaces. **Potential Solutions** The Blue Badge scheme provides a range of parking concessions for people with severe mobility problems as a result of physical and/or sensory disability and can be used at the RUH. SWAN Volunteer Transport Scheme provides transport for elderly and disabled people on low incomes. The transport is free to clients and although it has to be pre-booked it does take patients to their GP practice for an appointment. The Dial-a-Ride scheme is also keen to explore opportunities to address transport issues and access to GP practices.
3.5	**Age**	All ages will benefit from integrated primary care and secondary care services, in particular the frail elderly, the numbers of which are set to increase. GPs have better knowledge of the services available in the community. Unwell children will have access to the full paediatric back up.	Students find the city centre location convenient. The main practices with the majority of registered students do have walk-in services. Need to work with the Universities and City of Bath College to ensure students are registered with a practice. App specifically developed for students by local GP and free to download. This explains how and where to access services.

3.6	**Race**	Migrant workers potentially find open access centres helpful and also know that Emergency Departments exist and where to find them.	No adverse impact anticipated.
3.6	**Sexual orientation**	More likely to go to an anonymous service such as the Urgent Care Centre rather than a family GP.	No adverse impact anticipated.
3.7	**Marriage & civil partnership**		No adverse impact anticipated.
3.8	**Religion/belief**		No adverse impact anticipated.
3.9	**Socio-economically disadvantaged**		Expense of public transport. **Potential Solutions** Healthcare travel costs scheme exists for people on range of benefits to claim a refund of the cost of travelling to hospitals. The Diamond Travelcard offers free off-peak bus travel for older people and those with disabilities. SWAN Volunteer Transport Scheme provides transport for elderly and disabled people on low incomes. The transport is free to clients and although it has to be pre-booked it does take patients to their GP practice for an appointment.
3.10	**Rural communities**	Less knowledgeable about the GP-led Health Centre and know where the Emergency Department is. Some people travelling from Keynsham / Midsomer Norton Radstock / Wiltshire and South Gloucestershire will benefit from the move as they will be able to avoid travelling through central Bath.	Public transport routes from rural communities are not direct. **Potential Solutions** Odd Down park & ride bus service direct to the RUH every 30 minutes.
3.11	**Homeless people**	The service provided at Julian House continues Monday to Friday.	The group recognised that there might be an adverse impact on homeless people at weekends. **Potential Solutions** Development of an out-reach worker service at weekends.

3.12	**Other Groups eg gypsies, travellers, itinerant workers & boat people**		The group recognised that there might be an adverse impact on these groups, but felt that gypsies, travellers and itinerant workers would be guided by A&E road signs and therefore be directed to the RUH. However, some people do not have daily transport and parking a large truck & trailer at the RUH would be very difficult. Members of these communities can have poorer health than that of their age/sex matched comparators. This was not felt to be the case for boat people who often remain living on the canal for long periods of time. **Potential Solutions** The GP incentive scheme has been explicit about the requirement of practices to accept registrations from these groups of people. Development of a health visitor type service to visit people rather than expect them to come to services.

PART THREE – Impacts at a glance

Table 1 below shows how the impacts were assessed ***before*** mitigating actions and table 2 shows how the impacts were assessed following mitigation.

Table 1

Impacts	Sirona View*	RUH View	BEMS View	Patient/carer/public representatives' view
Impact on patients				5 x green; 1 x amber
Impact on carers				6 x green
Impact on health inequalities				6 x amber
Impact on local health community				5 x amber; 1 x green

Table 2

The mitigating actions can be described as:

- Strengthen access across GP Practices – especially those located around GP Led Health Centre
- GPs to develop walk in and wait systems – good for young people
- Enable people to get GP prescriptions dispensed at RUH
- Improved disability parking at RUH
- Consider re-charging practices for use of the centre for non-urgent work
- Ensure money saved in RUH not "lost" internally and recycled into primary care
- Design of Urgent Care Centre has to be well thought through to ensure that it physically and psychologically feels like a GP practice (versus an Emergency Department). Must ensure GP front door model is implemented so it is seen as a separate service
- The reception/streaming function must be able to book people into their GPs as well
- The ability to register unregistered clients would be beneficial - particularly students - so admin function needs to be adequately resourced
- Nurse assessment facility is also crucial
- Must avoid wrong assessment
- Ensuring access to services for vulnerable groups – homeless clients, people with serious mental health problems, itinerant workers is crucial, for example, health visitor type role
- Working with the Council to promote bus routes that relate to GP practices
- Get service running before the contract ends
- Robust specification is crucial

Impacts	Sirona View*	RUH View	BEMS View	Patient/carer/public representatives' view
Impact on patients				7 x green
Impact on carers				6 x green; 1 x amber
Impact on health inequalities				7 x green
Impact on local health community				6 x green; 1 x amber

*Sirona Care & Health employs the nursing and administrative staff at the GP-led Health Centre.

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

Bath and North East Somerset
Clinical Commissioning Group

Proposed Changes to Urgent Care Services in Bath & North East Somerset

A Report on the Public Engagement Process

25th September 2012 to 31st October 2012

Contents

Executive Summary

Introduction

From April 2013, Clinical Commissioning Groups (CCGs) will become the statutory bodies responsible for commissioning local health services in England. In preparation for this, Bath & North East Somerset (B&NES) CCG is currently working in shadow form and is taking on a greater degree of accountability for managing NHS budgets and developing commissioning plans.

Since forming last year, the CCG has been working with neighbouring CCGs who use the Royal United Hospital (RUH) in Bath, to review urgent care services and how they all work together in light of four main reasons:

- Ensuring patients are clear about where to get the best treatment
- Needing to balance the affordability of the different services offered
- Knowing that the number of patients who use urgent care services is growing and will continue to grow
- The contracts for the GP-led Health Centre based at Riverside in Bath and the GP out-of-hours service end in March 2014.

The review has focussed on a preferred option which would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre. This preferred option also includes improving the ability of GP practices to see urgent care patients.

The CCG believes this is the best model of care for the future as it not only addresses the reasons above, but creates a model which is financially sustainable. The CCG also believes having GPs based at the Emergency Department will improve the care of older people and people with long term conditions, which will become an increasingly important role for primary care.

Public Engagement Process

The CCG wanted to hear the views of the public about its proposals to relocate the GP-led Health Centre to the RUH. As a result a public engagement process was undertaken by the PCT and CCG from 25th September 2012 to 31st October 2012 to ascertain those views.

A printed engagement document and questionnaire was produced. Around 1,300 documents and questionnaires were circulated together with stamped addressed envelopes to encourage people to respond. It was also made available on-line at the CCG's website with the ability for people to complete the questionnaire on-line. The document was made available in easy read hard copy format as well as on the CCG's website.

The public and stakeholders were invited to attend a series of public meetings at which the CCG set out the rationale for the proposed relocation of the GP-led Health Centre.

Media

A proactive media release was circulated on 25th September 2012 to seek their support in asking local people to put forward their views about how urgent care is delivered in B&NES. The release set out where and when the public meetings would be held and included details about how to access the engagement document and questionnaire.

The local press published articles as well as letters from people who opposed the proposal for the relocation. The chair of the CCG also did a couple of radio interviews about the engagement. A follow up media releases was circulated on 2nd October 2012.

Local Political Engagement
The CCG wrote to the two MPs representing Bath & North East Somerset to inform them of the proposed relocation of the GP-led Health and sent them details of the engagement process.

Staff Engagement
Members of the CCG and PCT met with the nursing and administrative staff of the GP-led Health Centre on 24th October. The purpose of the meeting was to give the staff an opportunity to ask questions and gain further clarification on the potential relocation of the service.

Wellbeing Policy Development & Scrutiny Panel
A paper was presented to the scrutiny panel on 21st September 2012 setting out the proposal and proposed engagement process as well as the draft public engagement document and questionnaire.

B&NES LINk
LINk supported the engagement process and helped organise the stakeholder session to complete the health impact assessment and equality impact assessment.

Public Engagement Results
A total of 208 people responded to the questionnaire - 51 people completed it on-line and 151 people returned the questionnaire in the post. The overall figures for people's preferences on the GP-led Health Centre move were:

- 84 people (40.4%) said it was a good idea
- 98 people (47.1%) said it wasn't a good idea
- 26 people (12.5%) said they weren't sure

A petition was launched by the Bath Constituency Labour Party Action Team opposing the proposal to relocate the GP-led Health Centre. At the time of submitting this report, it had been signed by 1,028 people.

What the CCG Heard
Throughout this extensive engagement process, many views and comments have been made by members of the public, staff, councillors and stakeholders. Having reviewed all the feedback, the following were the main objections and concerns expressed regarding the relocation of the GP-led Health Centre:

- Inadequate GP access – in particular, respondents cited difficulties booking a short notice appointment that fits around work and family commitments, getting a same day appointment and being able to get through on the phone.
- Insufficient car parking at the RUH
- Car parking charges at the RUH
- Public transport (including the associated cost) and getting to the RUH

- Comments that the RUH can be an unpleasant and stressful environment with long waits in the Emergency Department
- The GP-led Health Centre is convenient and easy to access, particularly for students and people working in the city
- Provision of services for vulnerable people, particularly the homeless
- The GP-led Health Centre is high quality and customer focussed and some respondents were concerned that this would not be replicated by the Urgent Care Centre
- Concerns that the new model would result in more pressure on both GP practices and the Emergency Department resulting in increased difficulty accessing GP appointments and longer wait times at the RUH
- The savings assumptions were not clear
- Access for visitors and tourists to the city

Conclusion

This report has been made available on the CCG's website and will be circulated to those members of the public who requested a copy. It will also be shared with the local providers of urgent care services via the Bath Health Community Urgent Care Network in order to jointly consider and reflect on what other improvements and changes could be made to services in light of the feedback received.

B&NES CCG would like to take this opportunity to thank everyone who has taken part in this public engagement process. The feedback has been invaluable and will be considered at length in developing the model for urgent care services.

Recommendation

This report along with the health & equalities impact assessment will be presented to the Wellbeing Policy Development & Scrutiny Panel on 16th November 2012 with a recommendation that the proposal to relocate the GP-led Health Centre to the RUH to create an Urgent Care Centre can proceed.

Introduction

From April 2013, Clinical Commissioning Groups (CCGs) will become the statutory bodies responsible for commissioning local health services in England. In preparation for this, Bath & North East Somerset (B&NES) CCG is currently working in shadow form and is taking on a greater degree of accountability for managing NHS budgets and developing commissioning plans.

B&NES CCG consists of 28 member practices (27 general practices and the GP-led Health Centre) . The CCG covers the city of Bath, the towns of Radstock, Midsomer Norton, Paulton, Keynsham and the Chew Valley area and has a registered population of approximately 195,000. The CCG covers the full geographic area of NHS Bath & North East Somerset PCT and its geographic boundaries are co-terminous with B&NES Local Authority.

1.1 Demographic Change

The Office of National Statistics (ONS) projects that the population of B&NES will increase to 198,800 by 2026. This increase is expected to be mainly in the older age groups; in particular the 80+ population is projected to increase by 40% from 9,900 in 2010 to 13,900 in 2026. The age profile of B&NES is similar to the national average and growing older:

- In 1981, 5,600 people were 80 years or older
- In 2010, 9,900 people were 80 years or older

1.2 Mortality & Life Expectancy

The health of people in B&NES is generally better than the England average. Over the last ten years, annual mortality rates for all causes have fallen, with all-cause mortality decreasing from 731 per 100,000 in 1993 to 495 per 100,000 in 2010, a 32% reduction. This downward trend is reflected in England and similar authorities. Female life expectancy is three years longer than men and women experience lower mortality rates.

Mortality from treatable conditions is also significantly lower than the England average. In addition, all-cause mortality has decreased in the under 75s, and the current rate for the area is lower than national, regional and comparator areas. Infant mortality rates are similar to the England average (however numbers are very small) and child mortality rates are lower.

1.3 CCG's Strategic Objectives

The above information together with the CCGs experience as clinicians working in the local health system has enabled them to identify six key strategic objectives:

- Responding to the challenges of an ageing population
- Improving quality and patient safety
- Promoting healthy lifestyles and wellbeing
- Improving the mental health and wellbeing of the population
- Improving access and consistency of care
- Reducing inequalities and social exclusion

In developing these strategic objectives, the CCG has identified four key service priorities as follows:

- Redesign of urgent care
- Services for people with long term conditions
- End of life care
- Dementia care

1.4 Redesign of Urgent Care

Since forming last year, the CCG has been working with neighbouring CCGs who use the Royal United Hospital (RUH) in Bath, to review urgent care services and how they all work together in light of four main reasons:

- Ensuring patients are clear about where to get the best treatment
- Needing to balance the affordability of the different services offered
- The growing number of patients using urgent care services which will carry on growing in the future
- The ending of the contracts for the GP-led Health Centre based at Riverside in Bath and the GP out-of-hours in March 2014.

1.5 The Current Services

There are a number of urgent care services who see patients in different locations in B&NES including:

- Bath & North East Somerset Emergency Medical Service (GP out-of-hours) – when your GP surgery is closed at night and over the weekends, a GP is available to provide advice, arrange to see you at one of two locations or visit you at home
- The Minor Injury Unit at Paulton Hospital
- GP-led Health Centre at Riverside in Bath
- The Emergency Department at the RUH in Bath
- Great Western Ambulance Service

1.6 Strategy Background

In 2006 B&NES Primary Care Trust (PCT) published an Emergency & Urgent Care Strategy which had seven key objectives, one of which was about ensuring patients are assessed and treated by the right professional with access to the right interventions first time. At the time the aim was to establish an integrated face to face (walk-in) service to provide that assessment and treatment on the basis that patients didn't always know which service to use and when.

1.7 Service Background

In April 1999, the Department of Health announced the first nurse-led walk-in clinics to improve access to health care and in 2001 the PCT opened such a facility in Henry Street. In 2008 PCTs were required to commission GP-led Health Centres as part of the Department of Health's strategy to improve access to primary care. The nurse-led walk-in service was integrated to create the GP-led Health Centre which opened in April 2009. This unfortunately meant the PCT had to deviate from its strategy outlined above.

In 2004 the PCT commissioned GP out-of-hours services (evenings, overnight, weekends and Bank Holidays) from Bath & North East Somerset Emergency Medical Services (BEMS), a non-profit making organisation made up of mainly B&NES GPs. When it was first launched the GP out-of-hours service was based at the RUH. It then moved to Riverside with the GP-led Health Centre and other services. The service moved back to

the RUH site in October 2010 as the benefits of being on the RUH site outweighed being based at Riverside.

1.8 The Proposed New Model

The PCT and CCG is progressing work with local GP practices to improve their ability to see urgent care patients. The aim is to ensure that telephones are answered promptly between the hours of 8 am and 6.00 pm with no closure during lunch time periods. The aim is also to improve the time taken for GPs to visit patients at home who are unwell instead of waiting to do the traditional home visits at the end of the morning or afternoon surgery.

The proposed new model would see the bringing together of GPs and nurses currently provided by the GP-led Health Centre and the GP out-of-hours service with the Emergency Department at the RUH to create an Urgent Care Centre.

The CCG believes this is the best model of care for the future as it not only addresses the reasons for change, but creates a model which is financially sustainable. We also believe having GPs based at the Emergency Department will improve the care of older people, which we know will become an increasingly important role for primary care.

Currently, the GP-led Health Centre provides a walk-in service at Riverside in James Street in Bath. The services are high quality and delivered by dedicated and skilled staff. They include general health advice, treatment for urgent health needs and information about the NHS and social services. However, many of the patients who attend the GP-led health centre are attending for routine primary care needs, that could be managed by GP practices in B&NES. This is supported by the fact that on average only 10 patients per week have to be re-directed to the RUH.

The RUH is situated at Combe Park, approximately a mile away from the GP-led Health Centre. The RUH provides a suite of medical and surgical services to a population of 500,000, dispersed across West Wiltshire, Bath, North East Somerset and Somerset.

The Trust offers a range of acute medical and surgical services including accident and emergency and trauma & orthopaedics, as well as paediatrics, clinical support services and hosting maternity services on site for the Great Western Hospital NHS Trust.

The development of the Urgent Care Centre would lead to improved access to x-rays; extended access to blood tests; and easy access to other diagnostic tests such as ultrasound scans. A further advantage to relocating the service would be the availability of observation beds. This would make further onsite monitoring possible, for example, following a head injury or asthmatic episode. Currently, these patients would need to be transferred from the GP-led Health Centre which can be distressing.

As there are clinicians already working at the hospital there is also the potential to access their expertise on site. For example, doctors who specialise in the care of older people (geriatricians) run clinics at the hospital. Also, there are regular out-patient fracture clinics in operation. There is potential for clinical staff already on duty at the hospital to provide support to the staff working with urgent care patients.

Therefore, B&NES CCG believe that urgent care services in B&NES could be significantly improved by relocating it to the RUH and after careful consideration propose to create a 24/7 GP-led Urgent Care Centre at the hospital.

1. The Engagement Process

2.1 Developing the Process

In April 2012 the PCT and CCG held an event with stakeholders, patients and public where the proposals to redesign the urgent care system were presented. Attendees were asked to consider how people use urgent care services along with the NHS financial changes. The following was considered:

- The demand for services
- Clinical quality and patient safety
- The size and needs of the population served including the demographic changes
- The health needs of the population
- The clinical evidence base and best practice
- Access to GP appointments
- When, why and where patients attend from

Attendees were then posed three questions to consider:

- What are the most important patient experience issues for people when using the urgent care system?
- What are the key principles to hold on to when planning any changes?
- How can we help people understand the different parts of the urgent care system and how best to use it?

The key messages from these questions were as follows:

- Good accessibility and waiting times for all services, including car parking and transport
- Customer and quality focussed
- Need for joined up and integrated services
- Good triage systems
- Maximising the use of technology
- Communication and education

Subsequent to this, the Bath Health Community Urgent Care Network held a specific event at the end of April 2012 to consider in more detail the potential options for redesigning the services which looked at:

- The demand for services
- The size and needs of the population served
- Options of the type and location of urgent care services
- The costs of providing the current services
- The fact that patients should be seen safely in the most suitable environment for their needs, whilst ensuring that public money is spent wisely

All the above, together with previous patient survey results, helped shaped the proposals further and resulted in the CCG and PCT deciding to proceed to a full public engagement process, which began on 25th September 2012 and concluded on 31st October 2012.

2.2 Who the CCG Engaged With

The CCG wanted the engagement to be as wide and inclusive as possible. To support this printed engagement documents and questionnaires were produced which were also made available on-line at the CCG's website. Around 1,300 documents and questionnaires were circulated together with stamped addressed envelopes to encourage people to respond. People could complete the questionnaire on-line as well.

Your Say Advocacy an independent advocacy service working primarily with people with a learning disability converted the engagement document into easy read format which was made available on the CCG's website.

2.3 Public Meetings

In the first instance the CCG organised four public evening meetings to inform people and stakeholders of the proposed relocation of the GP-led Health Centre, to answer questions and concerns and gather feedback.

Members of the Wellbeing Policy Development & Scrutiny Panel expressed concern that evening meetings were not convenient for older people and as a result two further daytime events were organised. They were as follows:

Evening of 2nd October at the Centurion Hotel in Midsomer Norton
Evening of 4th October at the Hilton Hotel in Bath
Evening of 9th October at Fry's Conference Centre in Keynsham
Evening of 10th October at Bath Royal Literary & Scientific Institute in Bath
Afternoon of 25th October at the Methodist Church Hall in Radstock
Morning of 26th October at St Luke's Church Hall, Bath

An impromptu additional evening meeting on 15th October at the Methodist Church Hall in Radstock was organised by a B&NES Labour Councillor.

At each meeting a presentation was made by the CCG explaining the national changes to commissioning and the development of CCGs. The presentation went on to explain the urgent care redesign proposals which was followed by a question and answer session. Attendees were also provided with a set of frequently asked questions as well as the engagement document and questionnaire.

2.4 Publicity

A number of organisations as well as the media were asked to publicise the public meetings and promote the document and completion of the questionnaire as follows:

- All B&NES GP practices
- The GP-led Health Centre
- Paulton Minor Injury Unit
- Bath & North East Somerset Emergency Medical Service (the GP out-of-hours service)
- The Care Forum via their e-bulletin to the health and social care voluntary sector network forum in B&NES
- Bath Tourism's e-newsletter circulated to nearly 500 tourism businesses
- B&NES Age UK
- The Carers Centre via Facebook and Twitter
- Bath Spa University via Facebook, Twitter and the students union website

- Your Say Advocacy supported service users at a network event to complete the questionnaires

2.5 Media

The first press release outlining the plans went out on 13th September 2012, the day the plans were presented to full Council. The following week, on 19th September 2012, this was re-issued with the dates of the first four public meetings organised.

On 25th September 2012 another full release with additional information about the engagement process, including a link to the online questionnaire, was issued. On 2nd October 2012 dates were issued about the extra two daytime meetings to the media.

During this period a number of queries were answered from the Bath Chronicle, Somerset Guardian, Chew Valley Gazette, Midsomer Norton and Radstock Journal and The Breeze FM. Interested journalists were also provided with copies of the Frequently Asked Questions.

A journalist from the Somerset Guardian attended the first meeting in Midsomer Norton on 2nd October, as did a photographer from the Midsomer Norton and Radstock Journal. A reporter from the Bath Chronicle attended the meeting at the Bath Royal Literary & Scientific Institute in Bath on 10th October.

The media coverage all helped draw attention to the engagement work, including the meetings and the online questionnaire. There were also a number of letters and two commentary / editorials in local newspapers.

Media coverage included:
15th September:
- Bath Chronicle story online

20th September:
- Bath Chronicle story and comment piece
- Somerset Guardian story
- Midsomer Norton & Radstock Journal story

25th September:
- The Breeze FM – interview with Dr Orpen

27th September:
- Bath Chronicle letter
- Somerset Guardian – story promoting local meeting

October:
- Chew Valley Gazette covered the story

4th October:
- Bath Chronicle comment from columnist

11th October:
- Bath Chronicle article and two letters
- Somerset Guardian report on meeting and letter

- Midsomer Norton & Radstock Journal story and photograph

18th October:

- Bath Chronicle report on meeting and two letters

25th October

- Bath Chronicle article and two letters
- Midsomer Norton & Radstock Journal article about meeting with Radstock Councillors

2. What People Said

This section looks at all feedback received during the engagement and includes:

- feedback from staff
- feedback from the public meetings
- feedback from B&NES Local Involvement Network (LINk)
- questionnaire analysis

3.1 Staff Feedback

Members of the CCG and PCT met with the nursing and administrative staff of the GP-led Health Centre on the evening of 24th October 2012. The purpose of the meeting was to give the staff an opportunity to ask questions and gain further clarification on the potential relocation of the service. All questions asked were answered and a report of this meeting can be found at annex 1.

3.2 Feedback from the Public Meetings

These meetings were attended by varying numbers of people, including members of the public, staff, councillors and representatives from the voluntary and statutory sector. Table 1 below provides a breakdown of the attendees at the public meetings. A summary of the questions and answers from each meeting can be found at annex 2. The notes of these meetings are not verbatim, but capture the key points raised.

Table 1

Date of Meeting	Numbers Attending	Breakdown of Attendees
02.10.12	16	11 Members of the Public 1 Town Councillor 1 B&NES Councillor 1 GP Out-of-Hours Staff 1 Dorothy House Hospice Staff 1 Nursing Home Staff
04.10.12	43	31 Members of the Public 6 GP-led Health Centre Staff 1 Sirona Staff 1 GP Out-of-Hours Staff 1 DHI Staff 1 Boots Staff 2 Members of Bath Labour Party
09.10.12	10	3 Members of the Public 1 GP Out-of-Hours Staff 1 B&NES People First Staff 2 Mental Health Reablement Staff 1 B&NES Councillor 2 Members of Bath Labour Party
10.10.12	29	19 Members of the Public 2 CAB Staff 1 GP-led Health Centre Staff 1 Age UK B&NES Staff

		1 Sirona Staff 1 Red Cross Staff 1 Bath Chronicle Staff 1 B&NES Councillor 2 Members of Bath Labour Party
15.10.12	10	2 Members of the Public 6 Radstock Town Councillors 1 B&NES Councillor 1 Radstock Action Group
25.10.12	4	2 Members of the Public 1 B&NES Councillor 1 Nursing Home Staff
26.10.12	8	7 Members of the Public 1 Care Provider Staff
Total	**120**	

3.3 B&NES LINk Feedback

B&NES LINk provided feedback on the proposals as follows:

- Concerns that the practices, particularly those in the city centre have signed up to the new model of care and will step up to improve their access.
- Access at the RUH and to the RUH from central Bath for tourists, those who work and live centrally and for those who have mobility problems.
- The provision of more statistical information about the use of the GP-led Health Centre and the Emergency Department at the RUH looking at who, when and where people come from.

3.4 Questionnaire Analysis

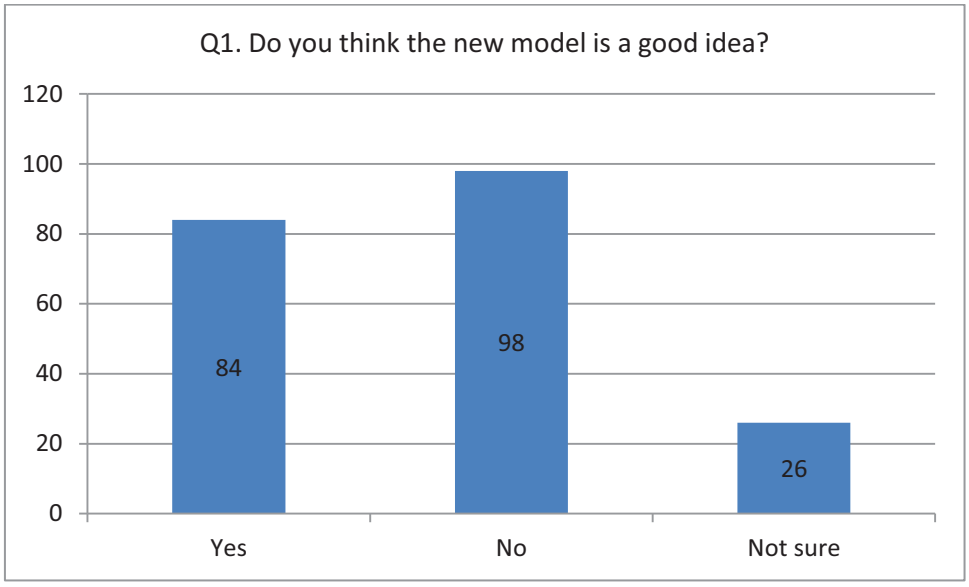
A total of 208 people responded to the questionnaire and this section looks at the feedback received via the questionnaires during the engagement period. Demographic data is also included along with the respondents reported use of the GP-led Health Centre as well as the Emergency Department at the RUH.

3.4.1 Respondents Feedback

Q1 Do you think the new model proposed is a good idea?

Of the 208 questionnaire responses received, 40.4% of respondents thought that the proposed new model was a good idea and 47.1% thought it wasn't a good idea. 12.5% respondents were not sure. Figure 1 shows the breakdown of responses received.

Figure 1



86 of the 98 people who were not in favour of the new model made a comment explaining why they did not support the changes. Comments included:

"The centre sees 30,000 people who as a result do not see their GPs. 9,000 are not registered with GPs. Getting these people seen by a different practice doesn't make a saving - it just moves cost onto GPs at the RUH"

"Until GP surgeries are open longer hours and at weekends, they will continue to provide inadequate services to the communities they should be serving. GPs are better place to treat older patients and those with chronic long term conditions who are likely to be able to get to them from their home and to see GPs and nurses who they can build up relationships with/ continuity. Younger working persons continue to need more central access with parking and where it is less essential to know the Dr or nurse they are seeing."

"Because this service helps workers who commute to the city to attend medical appointments, without having to take sick time off work. My surgery is only open working hours - useless for working people."

"GP services need to be accessible to all in various places and not centralised which makes it difficult for some to access"

"Loss of walk in centre in Bath to the RUH defeats the object, will increase demand elsewhere."

"More confusing - who is going to educate patients re 'prompt care'. I don't know what it means. Poor location - out of town, encouraging minor illness to attend hospital setting. Are we not trying to prevent this?"

"RUH more difficult to get too. Parking limited and expensive. It will confuse people even more. In recent years they have been told not to go to the emergency department."

"The RUH isn't as accessible as the Riverside centre - or as convenient for those who live/work in Bath

The model proposed, with the walk in centre being co-located at the RUH, promises a poorer service for users used to the existing service. The CCG cannot force GPs to extend their hours, therefore most users will have to go to RUH and share triage with A&E. Leading to long delays, more difficult travel, parking difficulty and increased costs and time lost. Additionally, GPs provide no cover at weekends. Savings forecasts appear to be 'guesstimates' and included savings to be made from costs of out of hours provision. I can see the loss of service, I can't see any cost reduction or increased efficiencies happening."

"RUH is very difficult to access if you have no transport and are disabled in any way. Riverside is accessible for people to the east of Bath as well and for people working in the city."

"I'm sceptical that I will be able to access a weekend/out of hours service via my GP easily. I struggle to get through on the phone now. 'Walk-in' element and weekend access is essential."

Only 5 of the 84 respondents who thought that the proposed new model was a good idea made a comment and all but one of these centred around introducing a more cost effective model and eliminating duplication.

14 of the 26 people who weren't sure whether or not the proposed new model was a good idea made a comment. Comments included:

"Centralisation may be essential to save costs but does not necessarily prove to be customer friendly or indeed cost effective"

"Of the 4 options none had been costed and there do appear to be other options not explored like Bristol's SPA [Single Point of Access]"

"There are a lot of GP surgeries who do not cater for drop in sessions. For example, Oldfield Park surgery offers drop in sessions twice a day, five days a week. However, there are too many surgeries which offer appointments only and these patients may prefer the GP led health centre as they have a better chance of being seen."

"GP surgery hours do not work for those in work. Evening surgery needs to be until 10pm."

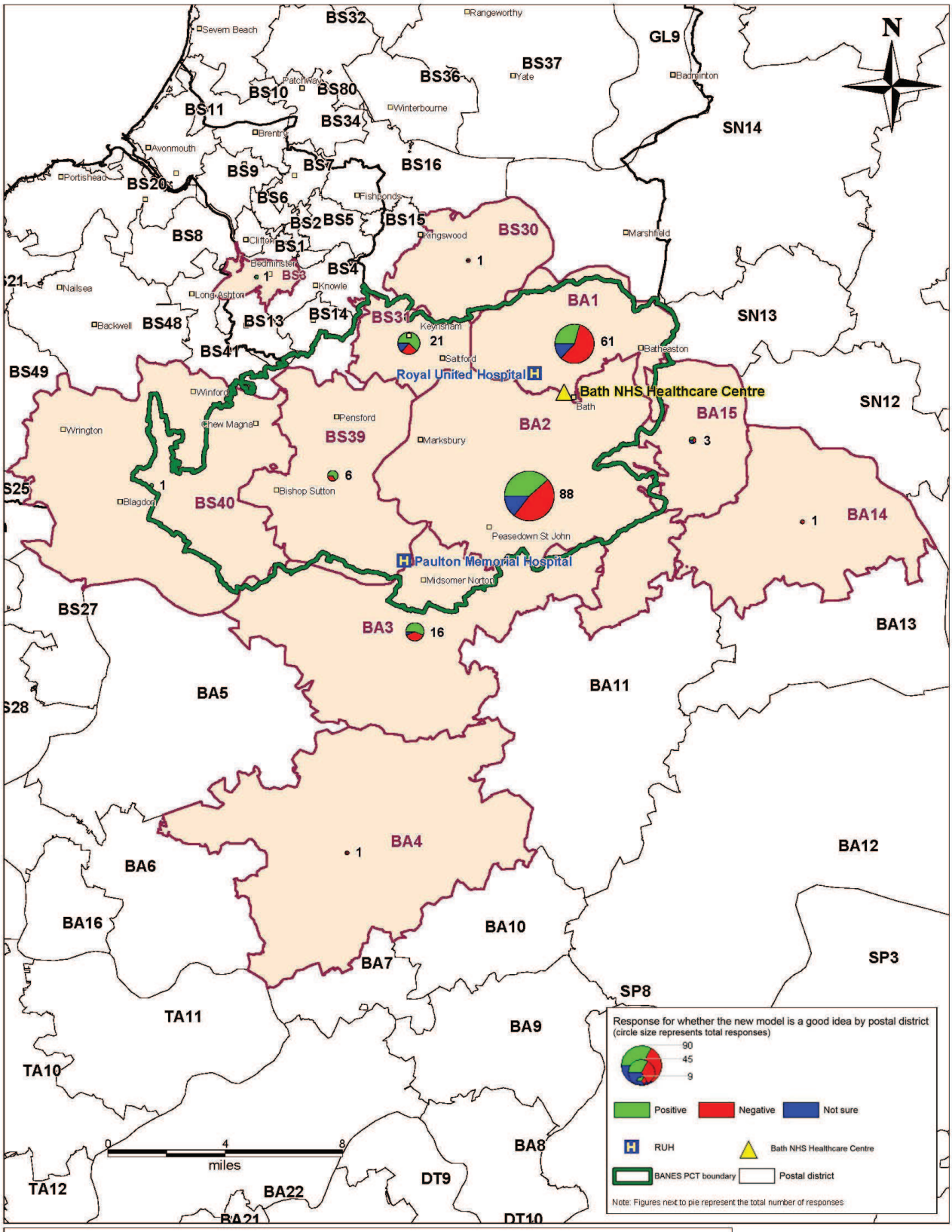
"Can see it's a way to save money but at the expense of the care and availability and ease of getting to it"

"RUH have more work to do. They won't have enough staff."

Map A (overleaf) indicates whether the respondents think that the proposed new model is a good idea by postcode area. It shows that approximately half of the respondents giving BA1 and BA2 postcodes were opposed to the proposed new model but in contrast, over half of the respondents giving BA3, BS39 and BS31 postcodes were in favour of the new model. This split can at least be partly attributed to the proximity to the RUH and the GP-led Health Centre. People living in BA3, BS39 and BS31 postcodes would be highly unlikely to walk to either the GP-led Health Centre or the RUH and for some it would be easier to get to the RUH and would avoid going through Bath city centre. On the other hand, many people from BA1 and BA2 postcodes can easily walk to the GP-led Health Centre, but not

the RUH, and for many people in these areas, the GP-led Health Centre is closer than the RUH too.

Map A



NHS Bath & North Somerset

Urgent Care Redesign Patient Feedback (October 2012)

Avon IM&T Consortium NHS

Jurong Zheng - 1 November 2012

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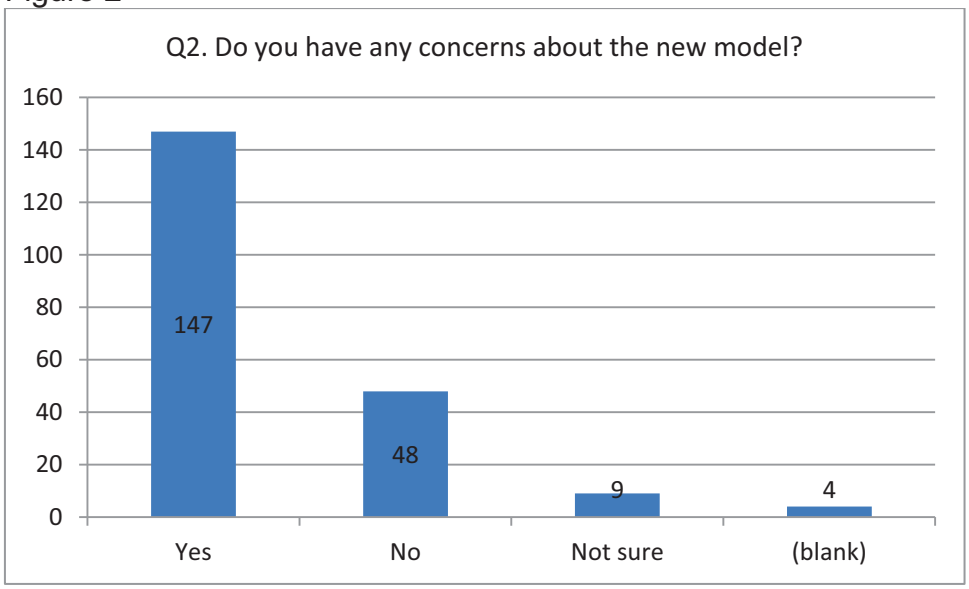
Q2 Do you have any concerns about the new model?

As shown in Figure 2, the majority (70.7%) of respondents expressed concerns about the proposed new model. Concerns were raised by nearly all of the respondents who opposed the change and also 26 of the 58 people who thought the proposed new model was a good idea.

Figure 2



The main concerns about the relocation of the GP-led Health Centre were:

- Inadequate GP access – in particular, respondents cited difficulties booking a short notice appointment that fits around work and family commitments, getting a same day appointment and being able to get through on the phone.
- Insufficient car parking at the RUH and the car parking charges
- Public transport (including the associated cost) and getting to the RUH
- Comments that the RUH is an unpleasant and stressful environment with long waits in the Emergency Department
- The GP-led Health Centre is convenient and easy to access, particularly for students and people working in the city
- Provision of services for vulnerable people, particularly the homeless
- The GP-led Health Centre is high quality and customer focussed and some respondents were concerned that this would not be replicated by the Urgent Care Centre
- Concerns that the new model would result in more pressure on GP practices and the Emergency Department resulting in increased difficulty accessing GP appointments and longer wait times at the RUH
- The savings assumptions were not clear
- Access for visitors and tourists to the city

Comments included:

"GPs are always busy and often you have to wait a couple of days for an appointment. Walk in centres are great because it means you don't have to wait or go to hospital."

"Until we get better access to GP appts this [new model] will only lead to greater frustration amongst users (out of town, no parking, parking charges, over medicalisation of simple general health conditions i.e. a hospital setting)."

"Access is difficult because of lack of parking in and around the hospital. High cost of parking for people on low incomes (who have more health problems) and no hospital buses at weekends."

"There needs to be a frequent bus service from city centre to RUH to compensate for loss of walk in centre in town."

"The walk in centre has a friendly and calming ambience, the A&E department by its very nature does not."

"You would have to wait longer at the RUH emergency department if they shut Riverside."

"My experience of emergency care has been long delays - first a wait for triage and then an even longer wait for treatment. Those in pain and discomfort are continually finding themselves pushed to the back of the queue because of the need to treat those with apparently more likely life-threatening conditions."

"Long waits in a hospital rather than health care environment. Stressful experience."

"I feel the RUH at present could not cope with more patients or staff attending there, the parking for both is currently not sufficient. Also GP practices are working very hard but still have their patients attending the Health Care Centre in town due to difficultly getting appointments."

"There would still be the same amount of people working there, the same outgoings like electricity etc and there will be a huge cost in relocation and setting up the facilities."

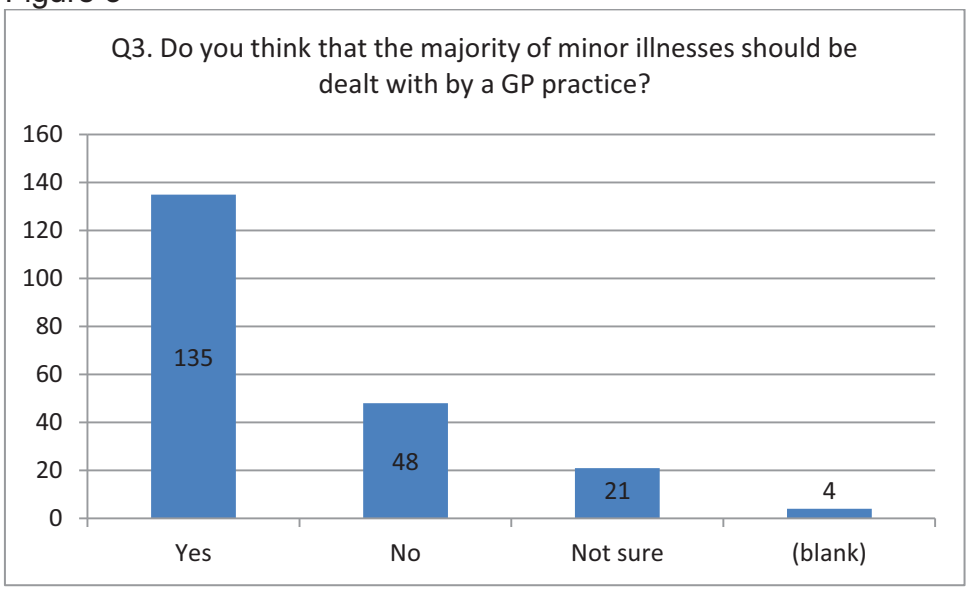
"I have been grateful in the past to walk in surgeries in Bath. Visitors staying with me have also used that service: where would visitors needing treatment go in the future planning?"

"Why change what works for the sake of the cost? No price can be put on a person's health."

Q3 Do you agree that the majority of minor illnesses should be dealt with by a GP practice to avoid duplication?

Figure 3 shows that 64.9% of respondents agreed that the majority of minor illnesses should be dealt with by a GP practice.

Figure 3



Comments made by respondents who disagreed that the majority of minor illnesses should be dealt with by a GP practice included:

"It's very inconvenient for people working to get to their GP surgeries if they fall ill in the day it is difficult to get an appointment there and then. The GP's are full anyway seeing to the local patients who are able to make appointment. There is no duplication as more people are seen."

"Although the majority could in theory be dealt with by a GP practice, the sad fact is that people find it impossible to get appointments at their GP when they need to."

"You cannot always get an appointment with your GP and you have this [walk-in centre] arrangement handy."

"Because it is not always possible to get to your GP. For a general appointment, I will have to wait a week at least. This is a terrible service, at least a walk in centre empowers people to make their own decisions about when they want to see a doctor, not when it suits the doctor!"

"In an ideal world you would get an appointment for a minor illness that was at the scheduled appointment time and with the option of facilitating employment commitments. The reality is that all GPs run offensively behind and it is not possible to arrange an appointment without having to first arrange time off work. Having more staff available through extra centres at peak demand times and at geographically convenient locations does facilitate this to some degree. A walk in centre close to the centre of town respects workers and residents timetables as well as overcoming the nightmare of providing enough affordable parking."

The respondents who agreed that the majority of minor illnesses should be dealt with by a GP practice also made comments about the accessibility of GP services and these included:

"[Yes,] But these plans take no account of people who are employed or study miles away from home and cannot always take time off in the middle of the day."

"I do not see the duplication of the service but I think that you are referring to duplication of payment? GPs appear to being paid a per capita payment and some of their patients are not able to get a convenient service and therefore choose the walk in centre. The GPs whose patients choose to use the walk in centre are being paid for a service that they don't provide on that occasion? Surely some transfer payment system could be arranged to cope with this?"

"Change things only when GPs and practice nurses agree to work more flexible hours to fit in with people using the services...evenings and weekends. GPs currently do not want to do this they want the option to continue to earn large amounts of extra money for doing locum shifts in OOH services."

Comments made by respondents who were not sure whether the majority of minor illnesses should be dealt with by a GP practice included:

"Only if the GP opening hours are extended otherwise people are left with nothing. People who work for example can't usually make GP opening hours."

"Yes for registered patients but access would need to be improved. Access at the time when it is convenient to the patient, an appointment at "11am or not at all" is of no use to a working professional with a minor illness. It is also no use to get put on hold for 30mins in a first come first served same day appt system. Temporary residents are another group who would suffer here."

"I agree that where possible, minor illnesses should be dealt with ones GP. If, as happened to me on several occasions, my GP has not been able to provide an appointment within a week then the walk-in centre provides a back up. This is not duplication."

"They should not be dealt with by the hospital. But this seems to be the effective proposal!"

"Yes, IF GPs are available and easy to get to, which they're not. If you're worried about double paying, re-jig GP contracts or make deductions."

Q4 Would you like to make any other comments about access to GP services in Bath and North East Somerset?

The majority of responses to this question suggested that current opening hours and appointment systems were not adequate and access to GP services needed improvement. Some of the comments received included:

"My GP practice is huge and the service is very poor when it comes to care that is needed the same day."

"Not always able to get appointment on same day. Attitude of reception staff. Lack of communication."

"From observation of the years and from the discussions at the [public] meeting, GPs are overwhelmed by the ageing population and there appears to be a focus on the most 'at risk' groups. The people who lose out and find it most difficult to get convenient treatment are

those working and trying to get an appointment at short notice at a time convenient to their work or childcare appointments."

"No true evening service, although can book online which is good, I can never get an appointment to fit around work commitments in a reasonable time."

"It's very hard for students to find GPs and near impossible to get an appointment to the one available on campus so the walk in centre is extremely beneficial to many of us"

"Very difficult to navigate the maze of 'same day appointments versus appointment on a later day when you are able to make the appointment'. At times, difficult to get past receptionists."

"To sign on with a GP you require two proofs of identity and address. Too bureaucratic and it excludes the vulnerable"

"I am a carer and my mother felt ill when it was 5.30pm. I had to persuade the GP to see my mother as they wanted me to call 999 when there was no need. All they were worried about was they were closing at 6pm and I was only a 5minute drive away. They eventually stayed on to see my mother who needed antibiotics."

"A prompter service should be available and GPs should be prepared to work longer hours for the money they now earn."

"Appointments released on the day are invariably gone within minutes and the telephone is constantly engaged unless you are very lucky."

"More frequent access to surgeries for walk in problems would help, even if it entailed waiting."

Of the 208 responses received, 134 respondents commented that the current service offered by their registered GP practice is not satisfactory. Nevertheless, 20 people said that access to their registered practice was good. However, four of these people stated that they were retired and a further six people stated that they were aged over 65 years so it can be assumed that these people are less likely to be in full time employment and therefore may find it easier to access GP services during their standard opening hours.

Q5 Would you like to make any other comments about access to the GP out-of-hours service in Bath and North East Somerset?

Less than half of the respondents commented on this service, 18 people said that they had never used the service and the remaining respondents left this question blank or wrote about the GP-led Health Centre suggesting that there is a lack of awareness of the BEMS GP out-of-hours service. However, of the comments received about BEMS, 31 were negative and mostly related to the telephone and triage system. 12 positive comments were received. Comments included:

"These are for emergency appointments and they are not very convenient as they are remotely located. Therefore people without transport or disability/vulnerable do not have easy access because of location."

"They are only for emergencies; minor injuries and dressing are not done there."

“I checked at our Pulteney Street surgery and was told about the 0800 out of hours service. I think more publicity is needed about that availability.”

“All locums must be vetted by the authority and qualifications checked as fit to practice - with excellent understanding of the English language and up to date skills.”

“Often patient waiting hours for a call back from triage call centre to even make an appointment in which time the patients have either attended A&E or Bath Health Care Centre.”

“I recently had to use the BEMS service for my one year old son who had breathing difficulty. I found the telephone triage service poor - after taking details of his symptoms, I was told a clinician would phone me back within 1 hour (which seemed an inappropriately long time). After 30 mins of further deterioration in his condition, and still awaiting a call back, I had to ring again and was told that the call back would be upgraded to more urgent but I still had to wait another 10 mins for a clinician to phone. In this time we had decided to put him in the car and drive to the RUH. In the end we were given an appointment straight away at BEMS but we were very close to having to go to A&E because of the failure of the telephone assessment service to recognise the severity of his symptoms and triage him in a timely fashion. Having appointments rather than a walk-in service for BEMS works only if the quality of the telephone assessment is good. This is very important if we are going to divert people away from A&E.”

“Go back to having GPs do it within existing salary, terms and conditions. Most other services are getting staff to take pay cuts or do more work for no extra funding and GPs and other NHS staff do have much better T's and C's than the rest of this country's employees.”

“A bit long winded having to speak to a receptionist, then wait for a nurse to call back before being able to arrange to see a doctor. In the past calls were triaged by nurses who either gave immediate advise or booked appointments to see a doctor or nurse. I worked as a triage nurse within a nurse-led casualty and feel the old system was better. System at Paulton good, apart from initial contact.”

“There are time lapses between the GP's surgeries and the out of hours so what does the patient do then? I often use the out of hours service as my mother has more problems but instead of a GP coming out they call an ambulance when they could deal with it.”

“It always takes quite a long time before someone picks up the phone and then you won't get an appointment unless it is a serious health issue.”

“In emergency, found phone responses stressful and requires repeating problems as calls are redirected.”

“My mum died less than 48 hours after an on-call GP refused to visit her at home. He treated her by phone via carers. Need I say more?”

“You ring and speak to someone who promises a GP will call back within a time and it’s a couple of hours later. Then someone else will ring to give you an appointment and the person you eventually see is not the GP you spoke to initially!”

"You have to ensure that as far as humanly possible the visits are covered by local GPs, not by exhausted/poor English speaking/insufficiently qualified or motivated hacks just doing it for the money."

"Our experience as a carer of a 90 year old was complicated, time consuming and difficult."

"Would like to talk to someone rather than to a machine or listening to options I don't understand."

Q6 Would you like to make any other comments about access to the GP-led Health Centre in Bath?

The majority of comments received in response to this question were positive about the service available at the GP-led Health Centre. Many of the respondents who had used the GP-led Health Centre indicate that a high quality and accessible service is offered and comments include:

"Wonderful, efficient, friendly, professional caring service."

"Good reception and information plus less pressure on consultation time."

"In many ways I prefer the service at Riverside to that provided by my GP."

"If the health centre was closed I would have serious concerns about accessing urgent care."

"Excellent staff, good system, does much needed job. Please don't get rid of it. I have found it better than GP at times - a more holistic approach."

"The Bath walk in clinic has always provided accessible, convenient, timely medical care."

"If the centre is moved to the RUH, there must be proper publicity, not just for local people but also, perhaps via the tourist information office for visitors to the city"

"Never used the service - have heard waiting times are long and patients are turned away."

"It is like a comfort blanket to so many people who know they will be expertly treated shortly. Most people can get there reasonably easily and Sainsbury's car park is close. Perhaps it could be nurse led?"

"My experience has been that the walk in centre fulfils a need and provides a good service."

"I'm not convinced that the walk in centre did not reduced demand at casualty - it must have."

"Suitable for minor illness or injury but not appropriate for on-going complaints which they are unable to refer if [the] patient [is] registered with [a] local GP."

"It is convenient for some but it is an unnecessary duplication of services and therefore cost."

"If GP surgery hours are extended then don't see a need for this [the GP-led Health Centre]."

"I have nothing but praise for the superior service they offer."

"GPs frequently direct their patients to this service when overloaded - especially small practices."

"I dread the prospect of hours spent waiting in A&E. How will this be speeded up?"

Q7 Would you like to make any other comments about access to Emergency Department services at the Royal United Hospital?

The majority of comments received in response to this question related to long waits to see a doctor in the Emergency Department and difficulty in accessing the hospital due to insufficient parking or inadequate public transport and the associated cost. Comments included:

"Recently I experienced a 3-4 hour delay when my wife was taken there with a suspected arm fracture. Also parking is a problem especially for out of town patients and night time."

"A new patients car park with reasonable charges for short stays. Also car park should be multi-level to maximise use of available building space."

"Parking and transport are always difficult / expensive"

"First class people but long waits between each service: reception - triage - specialist – treatment"

"Lack of parking near the A&E department. Cost of parking. No bus service during the night."

"Think they are already overstretched, often hours waiting, not triaged effectively enough so patients seen here that could be managed elsewhere more appropriately. No parking for patients or staff."

"It is important that it exists but it does need to be staffed properly. The experience of my family and friends is that it is to be avoided if at all possible, unless for example one has a broken leg. There are very lengthy waits and the medics are usually foreign with a poor grasp of the English language and certainly do not inspire confidence."

"Very inaccessible and impractical to those with minor health complaints."

"Not good. Very long waiting times and rather scary."

"Direct access by public transport is not available unless you are coming from city centre or the south side Park and Ride and even then not available during the night and infrequently on Sundays. It can be intimidating for the elderly at times when particularly busy."

"You would have to wait longer at the RUH emergency department if they shut Riverside"

"Poor. A multi-storey car park is required but use should be chargeable."

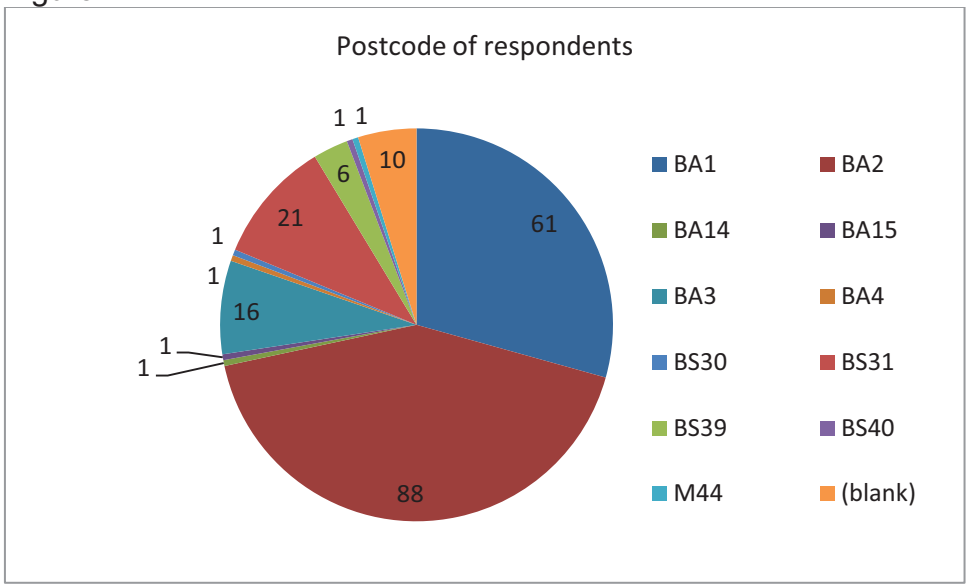
"Already stretched and difficulty in parking, even for disabled."

3.4.2 About the Respondents

Postcode
Respondents were asked to provide the first four letters/numbers of their postcode. Only the first half of the postcode was requested in order to preserve anonymity.

The postcodes below show that the respondents predominantly lived within the B&NES Council boundary with the majority (71.6%) living within BA1 or BA2 postcode areas. Those who didn't live within B&NES, lived in adjacent postcode areas with the exception of one respondent in the BS3 postcode area and another who was from Manchester but visiting family members in Bath. The breakdown of respondents' postcodes is shown in Figure 4 below.

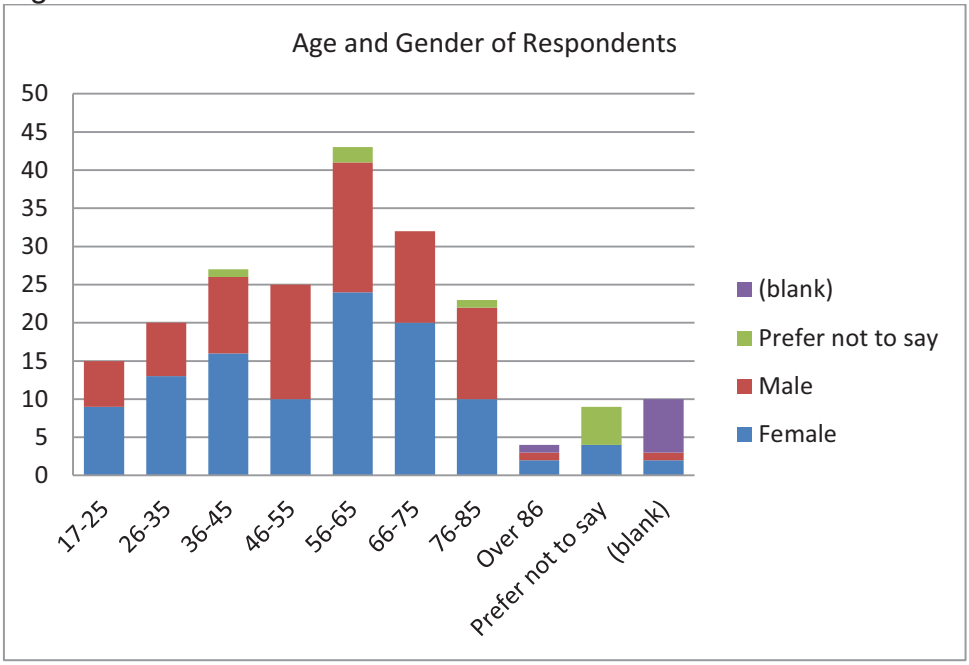
Figure 4



It is not surprising that the majority of respondents were from BA1 and BA2 postcode areas for two reasons. Firstly, Bath is more densely populated than North East Somerset and secondly, many City of Bath residents are likely to find that the GP-led Health Centre is closer and easier to access than the RUH so are therefore more likely to have stronger views on changes to the existing model and complete a questionnaire.

Age & Gender
Respondents were asked to provide their age and gender and the responses are shown in Figure 5 below.

Figure 5



53% of respondents were female and this is roughly representative of the B&NES population. However, with the exception of the 36-45 age band, the age of respondents is not representative. The number of respondents aged between 17 and 25 years is lower and a disproportionately high number of people aged between 55 and 84 years completed questionnaires.

Ethnicity

Respondents were asked to provide their ethnicity and the majority (83%) indicated that they class themselves as 'White British' as shown in Figure 6 below.

Figure 6

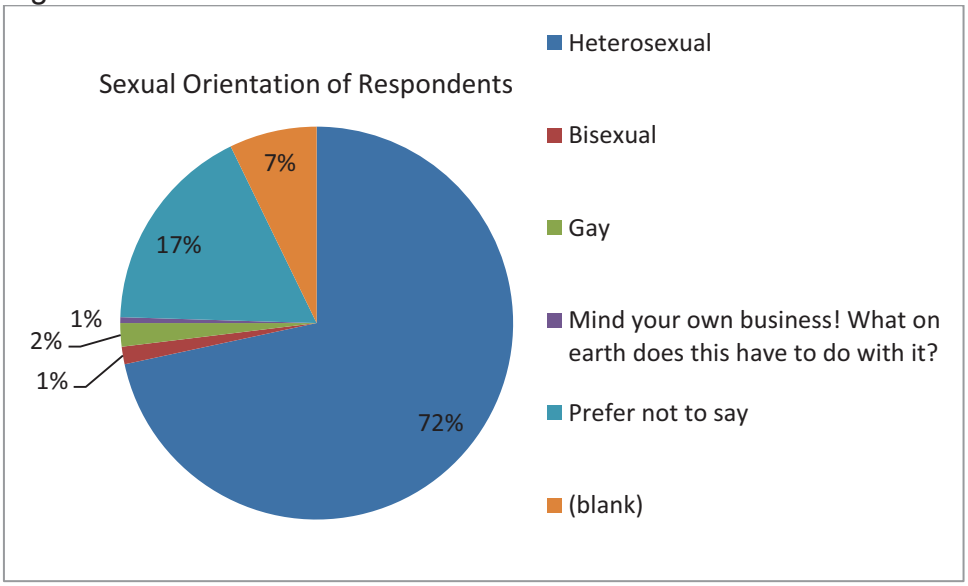
Ethnic Group	Number of respondents
White British	173
Czech (White)	1
European (White)	1
Indian	3
Irish	1
Mixed white and Asian	1
Mixed white and Asian (Pakistani)	1
Other mixed background	1
Other White background (English)	2
Other White background (Jew)	1
Other White Background (Northern Irish)	1
Polish (White)	2
Polish/German (White)	1
Slavic (White)	1
Prefer not to say	10
But why - what does it matter?	1
(blank)	7

Grand Total	208

It is estimated that 88% of the B&NES population would describe themselves as 'White British' so the respondents are representative of the total population in terms of ethnicity.

Sexual orientation
Respondents were asked to provide their sexual orientation and the majority (72%) indicated that they are heterosexual as shown in Figure 7 below.

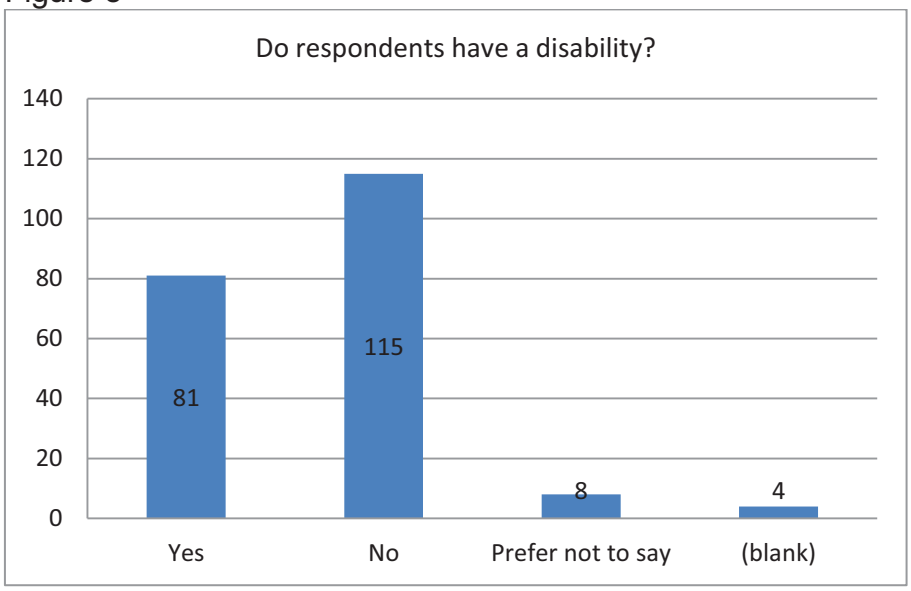
Figure 7



There is currently no data which indicates the proportion of people in B&NES who are gay or bisexual and as one quarter of respondents did not give their sexuality, it is not known whether the respondents are representative of the general population in terms of their sexual orientation.

Disability
Figure 8 shows that 81 of the 208 respondents (39%) indicated that they have a disability and 29 of these respondents were supported to complete the questionnaire by the Your Say advocacy group.

Figure 8

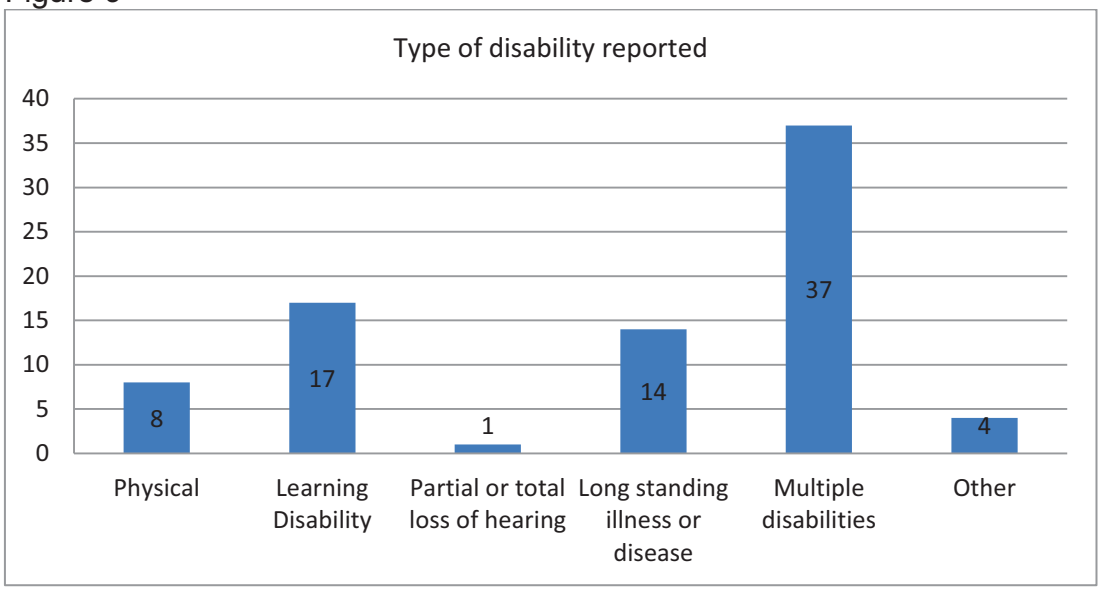


It is estimated that 18% of the total UK population have a long standing illness or disability and have significant difficulty with day-to-day activities. It appears that more respondents reported having a disability than would be expected in B&NES. This may be due to some respondents indicating that they do have a disability but in reality they are not experiencing significant difficulty with daily activities so a fair comparison isn't being made. It may also be affected by the disproportionately high number of respondents over the age of 55 because the likelihood of developing a disability increases with age. However, people with long term conditions are much higher users of health and social care services than average so it is important to ensure their views are captured.

Of the 81 people who reported to have a disability or long term health condition, 46 people were in favour of the proposed new model, 23 opposed the change and 12 people were not sure whether the new model was a good idea or not.

Figure 9 shows the type of disability that people reported. Where respondents, indicate that they had more than one disability, these have been recorded in the graph under 'multiple disabilities'.

Figure 9

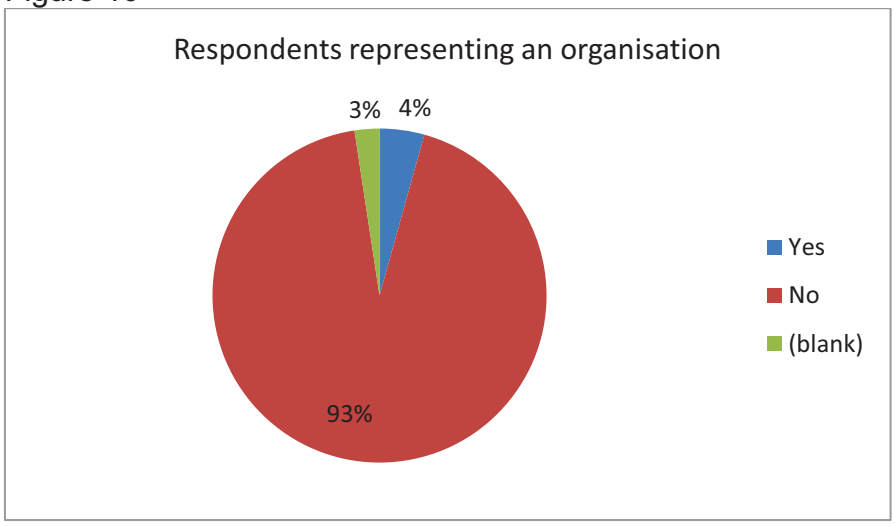


It appears that no respondents reported only having partial or total loss of vision, a speech impediment or a mental health condition or disorder. However, four people reported a partial or total loss of vision and other disabilities so for reporting purposes have been classed as having 'multiple disabilities.' Similarly, five people reported a speech impediment alongside other disabilities and 14 people reported having a mental health condition or disorder alongside other disabilities.

3.4.3 Organisation Representatives

Respondents were asked to indicate whether they were completing the questionnaire on behalf of an organisation. As Figure 10 shows, the majority (93%) of people were not representing an organisation.

Figure 10



The organisations represented via the questionnaires were:

- Friends of St Chad's and Chilcompton Surgeries
- London Road and Snow Hill Partnership
- St Michaels and Beehive Patient Group
- The Batheaston Neighbourhood Group

- The patient group at Batheaston Medical Centre
- Bath Labour Party
- Communication Workers Union

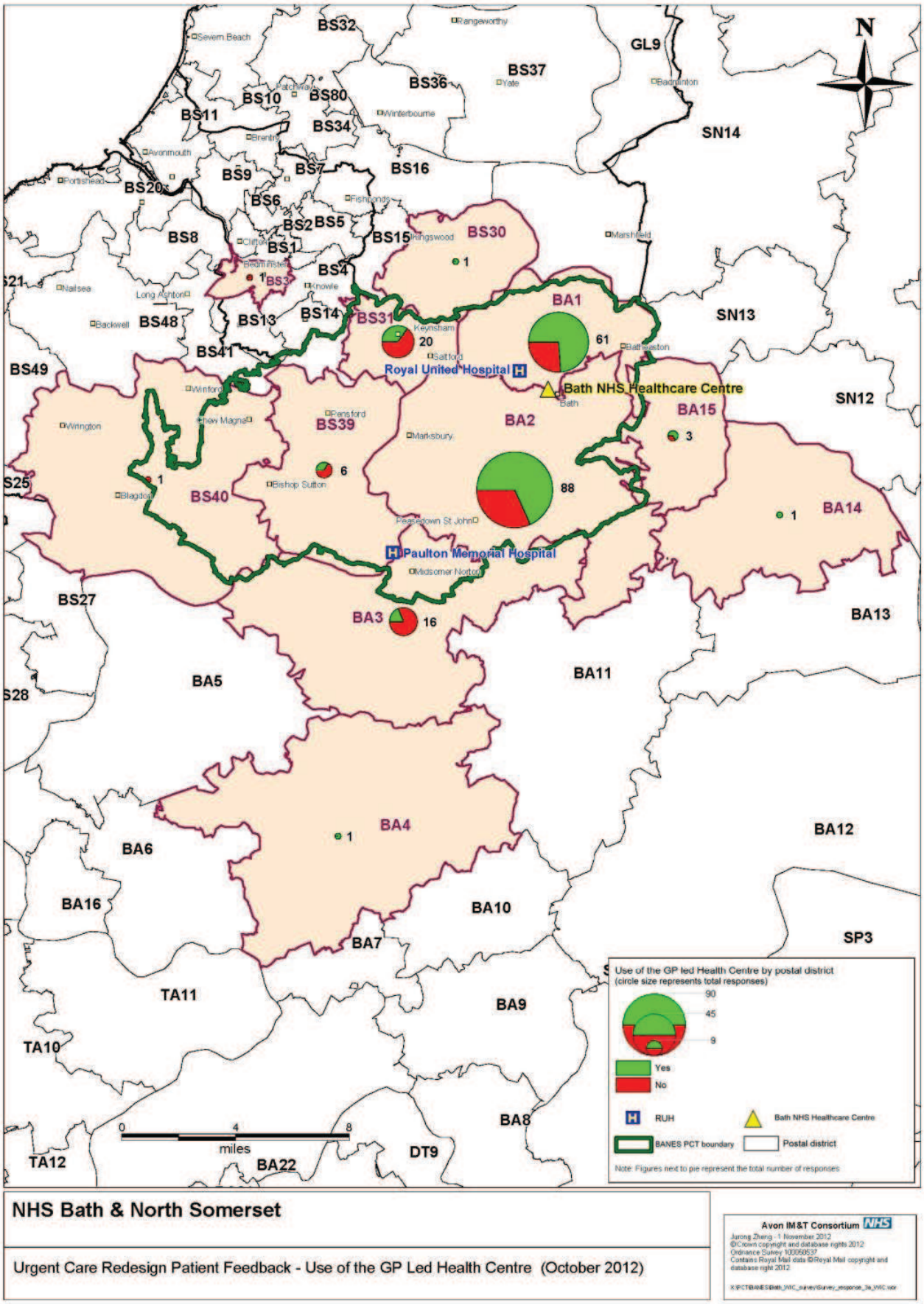
There were 14 respondents who stated that they were representing either the Your Say Advocacy service or B&NES Networks. However, these respondents were completing the questionnaire as individuals with support from these groups and so have not been counted as representing an organisation.

3.4.4 Respondents' Use of the GP-led Health Centre & Emergency Department by Postcode Area

Use of the GP-led Health Centre

61.5% of respondents had used the GP-led Health Centre and map B (overleaf) shows whether or not the respondents had used the GP-led Health Centre at Riverside by postcode area. Approximately three quarters of people living in BA3, BS39 and BS31 have not used the centre whilst a much higher percentage of people living in BA1, BA2 and BA14 postcode areas have used this service. This is not surprising considering the location of the GP-led Health Centre but there is a strong correlation between respondents favouring the proposed new model and not using the GP-led Health Centre.

Map B



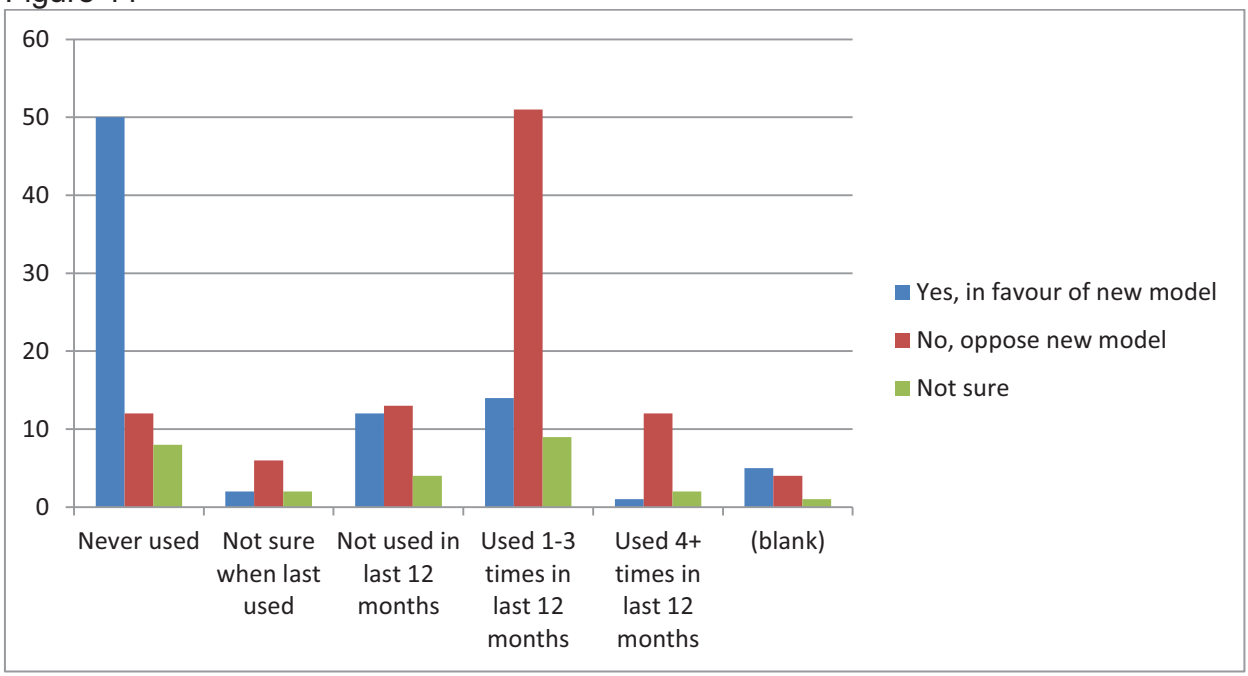
NHS Bath & North Somerset

Urgent Care Redesign Patient Feedback - Use of the GP Led Health Centre (October 2012)

Avon IM&T Consortium NHS

Figure 11 shows the respondents usage of the GP-led Health Centre and whether or not they are in favour of the proposed new model. There is a strong correlation between respondents who support the change and who have never used the GP-led Health Centre. Similarly, there is a correlation between respondents who have used the service in the last 12 months and oppose the new model. Interestingly, the respondents who have not used the centre in the last 12 months are split equally about whether the new model is a good idea or not.

Figure 11

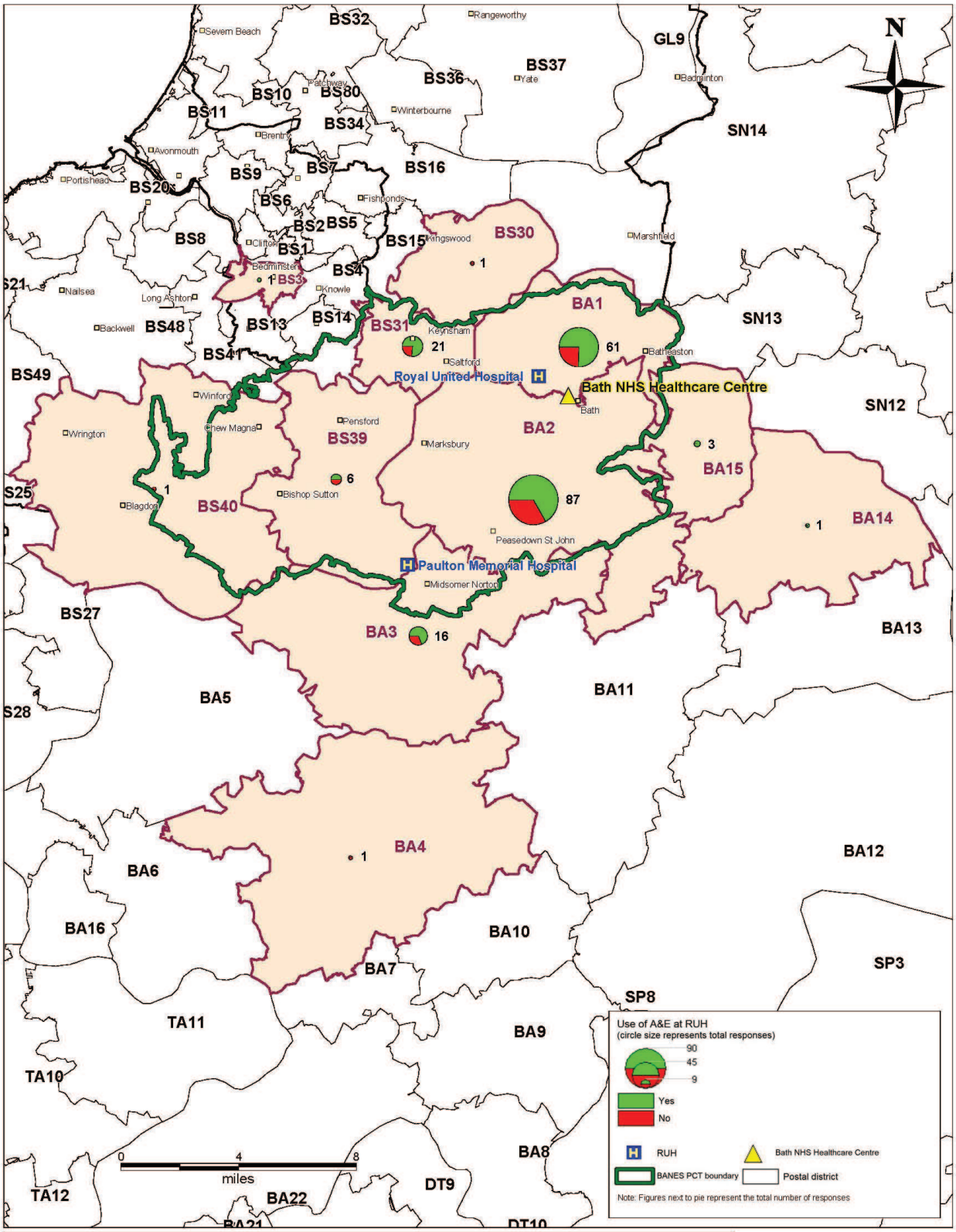


Use of the Emergency Department

68.3% of respondents had used the Emergency Department at the RUH and map C (overleaf) shows whether or not the respondents had used the Emergency Department by postcode area. In the BA1 and BA2 postcode areas, a similar number of respondents had used the Emergency Department as had used the GP-led Health Centre. In BA3 and BS31 postcode areas, approximately three quarters of respondents had used the Emergency Department, but only around a quarter of respondents had used the GP-led Health Centre.

Assuming that there isn't a greater proportion of people in BA3 and BS31 requiring emergency care than people living in BA1 or BA2 postcode areas, this indicates that despite the RUH and the GP-led Health Centre being only a mile apart, people choose to attend the service that is closest and/or easiest for them to access. This is also reflected in Map A where the majority of respondents living in BA3, BS39 and BS31 postcode areas were in favour of a new model located at the RUH.

Map C



NHS Bath & North Somerset

Urgent Care Redesign Patient Feedback - Use of A&E at RUH (October 2012)

Avon IM&T Consortium NHS

Jurong Zheng - 1 November 2012

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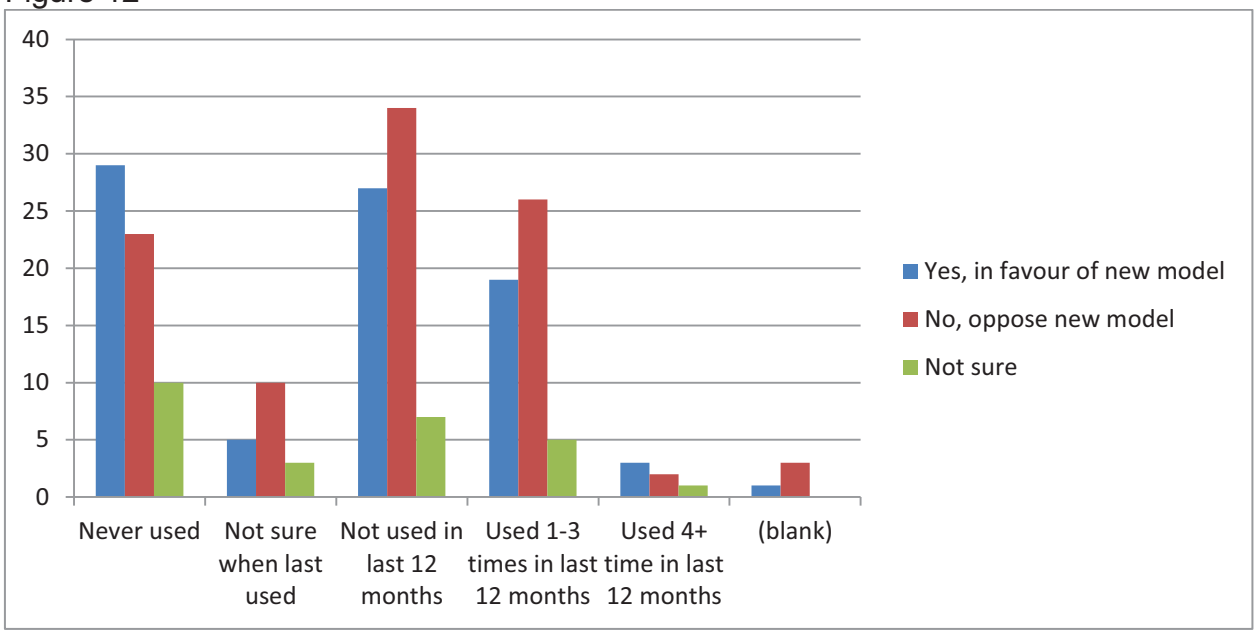
Figure 12 shows the respondents usage of the Emergency Department and whether or not they are in favour of the proposed new model.

Figure 12



Unlike Figure 11 which shows a strong correlation between use of the GP-led Health Centre and support for the proposed new model, there does not appear to be any strong correlation between usage of the Emergency Department and the respondents' opinion on the changes to urgent care services.

3. Conclusion

The majority of people who responded to the public engagement questionnaires disagree that urgent care services currently provided at the GP-led Health Centre at Riverside should be moved to the RUH (47.1% oppose the change). Although 40.4% of respondents support the proposed changes, 70.7% of respondents expressed concerns about the new model.

The concerns raised through the questionnaires as well as the public meetings can be summarised as:

- Inadequate GP access – in particular, respondents cited difficulties booking a short notice appointment that fits around work and family commitments, getting a same day appointment and being able to get through on the phone.
- Insufficient car parking at the RUH
- Car parking charges at the RUH
- Public transport (including the associated cost) and getting to the RUH
- Comments that the RUH is an unpleasant and stressful environment with long waits in the Emergency Department
- The GP-led Health Centre is convenient and easy to access, particularly for students and people working in the city
- Provision of services for vulnerable people, particularly the homeless
- The GP-led Health Centre is high quality and customer focussed and some respondents were concerned that this would not be replicated by the Urgent Care Centre
- Concerns that the new model would result in more pressure on GP practices and the Emergency Department resulting in increased difficulty accessing GP appointments and longer wait times at the RUH
- The savings assumptions were not clear
- Access for visitors and tourists to the city

The majority of respondents (64%) commented that access to GP services was poor stating that same day appointments were hard to access, short notice appointments that fit around work commitments are not available, opening hours are limited, problems getting through on the phone and difficulty accessing out of hours services. Despite this however, 64.9% agreed that the majority of minor illnesses should be dealt with by a GP practice where possible.

Despite wide communication and engagement, only 208 people responded to the questionnaire which equates to 0.1% of the 197,000 registered population of B&NES. However, concerns around the move came through strongly.

Finally, B&NES CCG would like to take this opportunity to thank everyone who has taken part in this public engagement process. The feedback has been invaluable and will be considered at length in developing the model for urgent care services.

GP-led Health Centre Staff Meeting on Urgent Care Proposals
Riverside, James Street West
Wednesday 24th October 2012, 7 pm to 8.30 pm

Present: Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Attended an open meeting with staff from the GP-led Health Centre to continue their engagement process in relation to the urgent care proposals.

10 staff from the GP-led Health Centre – predominantly qualified nursing practitioners but with administrative/reception staff also present. Jenny Theed and Amanda Phillips, Sirona Senior Leadership Team Directors present.

The majority of individuals attending the meeting had also attended the wider public engagement forums and were therefore well informed about the nature and scope of the proposals.

Members of the CCG briefly outlined the redesign proposals

- Escalation – pressure on acute hospitals throughout the year
- Need to streamline services and target resources to those with the greatest need
- the savings assumptions
- Role of the Urgent Care Network and how the proposal has been developed supported by them
- Option 3 has been an aspiration for quite some time.

The meeting was then open for a question and answer session.

Q: Aren't there walk-in centres that have been co-located with emergency departments that have not worked well and have subsequently moved out?

A: Yes there have been examples where the model hasn't worked well, but generally not the case and has been due to the way they have been set up. This is where the specification becomes so critical. Getting the relationships and governance model right will be important. Maidstone was cited as an early implementer of the model and at the time of visiting the service in 2005, it was working well.

Q: How do you envisage it working? We want to avoid wasting money. We currently see 30,000 patients a year and it is not clear what will happen to these patients.

A: Currently funding the GP-led Health Centre to be open at weekends as well as funding the out-of-hours service to provide GPs at weekends. We will want to involve the Urgent Care Network and staff in the development of the specification. Links back to the need to involve key practitioners in the design to make sure it is right. Getting relationships and risks right is important – as are clinicians being signed up to the model.

Q: Will the relocation of the GP-led Health Centre to the RUH not only serve to blur and confuse patients even more?

A: We are aiming to simplify what is available between the GP practice and the Emergency Department. We believe developing an urgent care centre at the front door will help do this as patients do know that ED is one of only two services that is always available 24/7, the other being the ambulance service. We want to ensure that patients with primary care needs visit their practice so we do not expect all the patients currently using the GP-led Heath Centre to go to the urgent care centre. We do need to signpost and change behaviours about attendance and shift patient flows away into primary care and educating the public is going to be important. We will need highly qualified practitioners in the new model who can help individuals understand the pathway.

Comment: People that come to the GP led health centre aren't confused.

A: No we are not saying they are, but it is about getting the pathway right and systems to ensure that we have an affordable model for the future given the pressures we are facing with no additional resources.

Comment: GPs are part of the system that is failing and they can't accommodate their patients that is why they come to us. When Monmouth was based here they regularly redirected their patients to us as they didn't have any appointments. They will need to employ more GPs and nurses and this will cost lots of money.

A: We are very aware that from what we have heard so far that this is a real concern. Work is being done to extend improve access and looking to tackle the number of DNAs which is clearly wasted capacity that is paid for. Overall the system isn't working too badly and they are still seen as handy and convenient to a number of patients – but we do recognize there are issues around access as well as perception and we need to continue to work to change this around.

Comment: Access to GP's is part of the problem. We haven't seen a drop in activity since the GP hours were extended. Patients are still telling us that it is difficult and they appreciate our accessibility and that we are convenient.

A: This has been a consistent message from all the public meetings which we need to listen to and recognize. We are working with practices through an incentive scheme to improve access over the next 18 months which includes ensuring that telephones are always answered between the hours of 8 am and 6.00 pm and not closed over lunch time periods. Also want to ensure practices have their doors open between the hours of 8 am and 6.30 pm so that patients can walk in and make appointments. We are aware that the do not attend rate (DNA) is quite significant in some practices so again we want to work with practices to address this as this is clearly wasted funded capacity.

Q: How is the money going to work? The facts about money aren't readily available and we can't see how you have come up with your savings assumptions without impacting on service or jobs.

A: Option 4, ie close the GP-led Health Centre with no re-provision would release £1.3m to reinvest locally into priority services. Did not want to do this as we recognized the need for some re-provision and know that the skilled work being done is making a valuable contribution. The GP out-of-hours service costs £1.6 m a year - totaling £2.9 million expenditure. We believe the urgent care centre will cost

approximately £2.4 million to operate, therefore releasing approximately £500,000. This is based on streamlining overhead costs (assumption is about 7% given the number of existing providers – BEMS, Sirona and Assura) and skill mix, reducing duplication, but also wider system savings such as preventing unnecessary emergency admissions. We believe the benefits of having primary care at the front door will potentially save for B&NES around three admissions per week. It is this wider 'whole system' approach that will generate the overall savings across the health community. This therefore does not mean that the savings would solely be released from two providers or through a reduction in trained staff at the WiC – who's skills and expertise we need to make the model work well.

Q: What about the costs of creating the urgent care centre and will it be a separate building or in the Emergency Department?

A: Currently the assumption is that there is the potential to use space within the existing emergency department albeit there will need to be changes to the building. This would come from one off capital funding and would not be recurring in future years.

Comment: Patients have concerns about the relocation to the RUH as they can't afford to travel, parking is problematic – with disabled parking being a particular concern.

A: This has also been a consistent message at the public meetings. Parking has improved at the RUH and there are now a greater number of disabled parking spaces. However, we do need to consider this further in terms of drop off points and disabled access. Linkages with the local authority are strong and their responsibilities for transport is helpful in providing alternative solutions around bus routes etc. We do know that for some people they would have to get two buses. We are not necessarily expecting all of the patients currently being seen at the GP-led Health Centre to go to the RUH and that people will increasingly go to their practice. However we do need to keep looking at this because we know it is a concern.

Q: Isn't there a risk that the urgent care centre would just become part of the Emergency Department?

A: We are absolutely clear that the urgent care centre needs to be structurally and philosophically different to the Emergency Department. The ED will continue to work separately. The Centre needs to have consulting rooms rather than ED cubicles and needs to feel like the atmosphere that has been created by your team. The specification needs to be very clear about this delineation. .

Q: How do you see the future role of the community hospitals such as St Martin's developing in terms of rehabilitation and community admissions?

A: Continue to have a crucial role. With the appointment of a consultant geriatrician the aim is to provide 10 step up beds at Paulton Hospital to enable GPs to admit directly rather than to the RUH. Have already appointed two extended nurse practitioners to support the development of both hospitals. Plans to pilot by end of December the relocation of the access team at the front door of the RUH will help inform the specification for the urgent care centre.

Q: How do you see the reception operating at the front door?

A: This still need to be worked through, but essentially it will be important to ensure that it is adequately resourced through some sort of joint reception arrangements and

that we have senior nurse streaming at the front door to ensure that patients are directed into the right service. Input into the specification would be welcomed.

Q: Are there areas where they have this model?

A: Croydon have a similar model. A joint visit to see how it works could be useful.

Q: Why don't you do more to educate the public?

A: This is very difficult and the evidence suggests that general education about how to use services has limited impact but we will continue to do whatever we can and initiatives such as the new 111 number should help. Evidence suggests that opening new services such as walk-in centres, GP-led Health Centres and NHS Direct has created new demand but only some of it is for urgent care and a high percentage should be redirected to primary care. This wont happen overnight and we need practitioners across a range of disciplines to talk to people about how best to access services appropriate to their needs. Staff like district nurses, reablement workers, practice nurses etc also play a key role in letting people know how best to get the service that they need.

Comment: Is there going to be a job I want? Need to consider whether the role would be what I would want to do in the future and what it means for me and others in the team. Are our skills going to be transferable? Will the shift patterns suit?

A: Understand this represents a change for all staff working at the current GP led health centre. We do need the specialist skills that are within this team in the future. There will be variety in the same way as now by the very nature of the 'drop in' nature of the service. But it is hard to predict exactly what the changes will be in terms of patients who present for treatment. There will be an opportunity to interface with acute setting and learn new skills. We recognize that inevitably things will be different – but hopefully in ways that also provide opportunity as well as change. We will be working with the new provider(s) to do as much as we can to maintain stability and skills – but it will be different and it will affect individual staff in different ways.

Q: Who will be the provider? We have concerns about private service tenders.

A: We will need to go through a procurement process so we cannot say who the provider will be. There are national rules about competition and choice and private providers cannot be excluded from the process. The detailed ways of working will be part of the provider bid (within the constraints determined by the commissioners of the service). We recognize that the team does a good job; we want to work with you to provide a model that builds on this – albeit in another location/setting.

Q: What are the next steps?

A: A report including the outcome of the public engagement process as well as the health impact assessment and equality impact assessment will be presented to the Wellbeing Policy Development & Scrutiny Panel on 16th November 2012. The report has to be submitted by 6th November. Depending on the outcome of the Scrutiny Panel, the aim would be to present a paper recommending to proceed with the proposal to the Clinical Commissioning Committee and to the next Public Board meeting where the decision will be made in January 2013 – with a view to the service going 'live' in 2014

Jenny Theed agreed to attend the next team meeting for a major item on new service model. Experiences and understanding of existing team really important and valued – need to get the specification right and have people who understand how things work on the ground.

Ian, Simon and Corinne thanked for their attendance. Through the bespoke session staff had greater understanding. Inevitably concerns about impact of organization change on individual members of staff – but discussions strongly focused on needs of users/patients and staff were open to new ideas and ways of working in support of these aims.

Staff at the meeting agreed that the notes of the meeting could be included within the final engagement report.

Urgent Care Public Engagement Event
Centurion Hotel, Midsomer Norton
Tuesday 2nd October 2012, 6.30 pm to 8.00 pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Elizabeth Hersch, Urgent Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Q: Is the ambulance service involved?
A: Yes, Great Western Ambulance Service (GWAS) is a member of the Bath Health Community Urgent Care Network.

Q: How is the ambulance service funded?
A: The PCT funds the service and has a contract with GWAS.

Q: How is Sirona funded?
A: The PCT and Council have a tripartite contract with Sirona who were established when PCTs had to 'divest' themselves of provider services.

Comment: Sirona can prevent people going into hospital?
A: Agree. They provide a range of community services as well as having knowledge of other services available in the community so are able to signpost. Equally clinicians need support with signposting too.

Q: What about the administration/management costs of the CCG?
A: Given the size of the NHS budget overall management costs are low and some would say too low and it is undermanaged. The CCG budgets will be less than the PCTs partly due to reduced responsibilities, but the CCG needs good managers and we are fortunate to have skilled and dedicated managers. However, the CCG team will be smaller and will have £24 per head of population to spend on its running costs.

Comment: Years ago matrons and doctors ran the RUH now it's administrators.
A: Evidence shows management costs are lower than other business sectors. Also, years ago there were significant waiting list problems and lengthy waits in the Emergency Department. Without good managers these would not have improved so we absolutely need them.

Comment: My wife had a poor experience at the RUH.
A: The hospital has developed systems for talking to patients, staff and relatives to get feedback. Complaints are scrutinised in detail to identify lessons that can be learnt and where the hospital can improve.

Q: Why the increase in diabetes?

A: The increase is associated with type 2 diabetes. It used to be known as maturity onset diabetes, but is no longer a later life problem. One of the reasons for the increase has come about as a result of the increase in obesity levels. This is not just an issue for the UK and is a world-wide problem with India seeing a massive increase in type 2 diabetes.

Q: With the RUH becoming a Foundation Trust what will the relationship be with the CCG?

A: Although FTs are independent organisations they still need to work in partnership with other organisations as no one organisation can do things on their own. The NHS was more homogenous, but divided between primary and secondary care. However, as a result of the changes there are better links and integration between primary, community and secondary care.

Q: Do you buy services from the RUH?

A: Yes, B&NES is about 45% of the RUH's business, Wiltshire is about the same and the other 10% is Somerset and South Gloucestershire.

Q: What is the cost/price of RUH services to the CCG?

A: For most secondary care services, there is a national tariff, eg out-patient appointments and in-patient episodes of care. The in-patient tariff reflects different conditions and complexity of conditions. As a result of the ageing population and complexity of needs, the costs of secondary care are rising. It is therefore really important that services work well together and benefit from the expertise at the RUH.

Q: Do Bristol hospitals provide some services?

A: Yes they do and they also provide some of the regional specialist services which are not provided by the RUH for example neurosurgery and burns.

Q: Parking is a real problem at the RUH so what will be done about this?

A: The CCG is aware that this is a real issue and concern for people so will work with the RUH to explore potential solutions as the plans progress.

Comment: Member of the public at the meeting stated that he had attended the RUH's AGM where it was announced that a new car park would be built on the site of the old path labs as a new path lab is being built.

A: RUH's Director of Estates has also done a lot of work to improve parking as well as transport services to the RUH, including the Odd Down Park & Ride service which now goes to the RUH and the Wiltshire Hopper service. More disabled spaces and drop off points have been provided at the hospital.

Q: Sometimes during out of hours we know we don't need to be hospitalised but need some specific help?

A: NHS 111 is the new national number for people to ring 24/7 and they will be able to signpost into the appropriate service and if it is life threatening the service will be able to transfer the request to the ambulance service. NHS 111 will also have access to something called 'special patient notes' which provide patient specific

information about needs or end of life wishes. This will enable services to be more joined up and improve the patient experience.

Q: The Health Centre has other services what will happen to these?

A: The contraception & sexual health service, dental access service and the specialist drug & alcohol services will remain. There are no changes to these services.

Urgent Care Public Engagement Event
Hilton Hotel, Bath
Thursday 4th October 2012, 6.30pm to 8.30pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Ruth Grabham, Clinical Director, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Jim Hampton, Planned Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Joel Hirst, Associate Director of Medicines Management, NHS B&NES

Q: Who appoints lay members?
A: The CCG is responsible for appointing the lay members based on national guidance.

Q: Who was on the panel for these appointments?
A: Dr Ian Orpen was on panel that made the appointments.

Q: ***Why are there no Local Authority members on the CCG?***
A: The Governing Body has very well developed joint working arrangements at a strategic level through the Health & Wellbeing Board and at operational level. There has been a partnership with the Local Authority for four years and recently a joint partnership framework has been agreed and fully endorsed by the Council. Ian Orpen also attends the Wellbeing Policy Development & Scrutiny Panel meetings every two months.

There are also several joint posts with the Local Authority. A Health & Wellbeing Partnership Board has been up and running in B&NES for a while, but the new policy requires Health & Wellbeing Boards.

Q: How do we, as members of the public, contact the PPI Lay Member?
A: The post has only just been appointed and not currently in post. However, details will be made directly via the CCG's website.

Q: Is this a paid post and local?
A: It is a paid post and is a local resident who previously worked in Plymouth Council.

Q: Please can you provide more details about the Governance and Audit structures?
A: The Audit and Assurance Committee is chaired by a lay member. There will be a process of external audit to ensure that there is robust governance. The CCG is currently going through its authorisation process which will also involve a process of ensuring that the governance structures and processes are robust. The formal assessment is on 9th November 2012.

Q: What will happen to the homeless service at Julian House?
A: This service will not be affected by these proposals.

Q: Is the service seven days per week and if not, what will happen at weekends?

A: No the service isn't available at weekends and we will need to review the impact of the proposals for the homeless.

Q: How much will you save?

A: A full business case still needs to be developed, but we have made some high level savings assumptions on the basis of bringing the services together.

Q: Have you made the decision to close the service?

A: The service is not closing, but relocating and the redesign of services is using the resources we have more efficiently. We need to invest to support the most vulnerable – shift resources to support people with the greatest need. If we take no action the graph will get worse in terms of the gap.

Q: How will you improve GP services?

A: We are working with all practices to improve access to same day appointments through an incentive scheme.

Q: Will they be open longer including Saturday morning?

A: Practices have extended their opening hours, ie earlier in the mornings or later in the evenings as well as Saturday mornings, but this is variable.

Q: My surgery does not offer Saturday morning appointments?

A: Practices already open extended hours, but this is variable. We want to improve the answering of telephones and ensuring practices do not close at lunchtimes.

Q: So, are you working efficiently?

A: There is always scope for improvement and a number of practices are involved in an initiative called Productive Practice in order to become more efficient.

Q: I agree that we should do all we can to prevent older people being unnecessarily admitted to hospital and would strongly support more community support. The proposal suggests moving services to the RUH rather than the community, why?

A: This is a very interesting point and we do want to support the frail elderly as much as possible in the community. However, the majority of patients who use the GP-led Health services are between 20 and 29 years of age. We want to use resources released to reinvest in community services. All agencies that provide urgent care work together and with the voluntary sector. This provides comprehensive services to patients. We need to make sure resources are in place for people in need and we need money directed to the right place for the future.

Q: I understand the increasing demand, but how will you increase GP appointments?

A: We need to understand how best we can work in primary care and this is what the incentive scheme is all about. Some GPs take calls from patients and can get to the root of the problem quickly and others operate a walk-in and wait service.

Q: What happens if you close the service before you are sure?

A: The service would not relocate until March 2014.

Q: Will there be the same number of GPs?

A: Yes.

Q: What do you mean by duplication of services?

A: The GP out-of-hours service presently operates from the RUH on Saturdays and Sundays which duplicates with GP-Led Health Centre also open at weekends. The GP-led Health Centre also duplicates what practices provide and are already funded to provide.

Comment: I have to wait three weeks for an appointment at my own GP practice. Am I supposed to be psychic when I will next get sick? I get same day treatment at the Walk-In centre.

A: I'm sorry one of my patients had to wait a long time for an appointment. My practice is one of the closest to the GP-led health Centre and demand and activity need to be better managed. There is a need to have primary care stepping up to improve access.

Q: It sounds like it is a done deal and based on cost. People come to us who cannot get appointments elsewhere. You seem to have made your mind up. Who makes the decision? Is the public involvement now over?

A: There are further public meetings, as well as the questionnaire for people to give their views. Following this a report on the findings as well as an impact assessment will be presented to the Wellbeing Policy Development & Scrutiny Panel.

Q: What is the date of this meeting?

A: The Scrutiny Panel is taking place on 16th November 2012.

Q: What about parking at the RUH?

A: Parking has improved. There is now a direct Park & Ride service to the RUH. With regard to the cost of parking, this is in line with other Trusts in the South West. Parking for disabled and renal patients is free. Volunteers pay £1 per day. The area where the pathology block is located will become a car park.

Q: What about the frail and elderly?

A: Yes, this is an issue and there are local transport schemes as well as the non-emergency patient transport service.

Q: Should we convert more GP surgeries into Walk-in Centres?

A: The CCG cannot make practices do this. However, some practices do offer a walk in and wait service, but locally we do hope the incentive scheme will influence practices approach to offering same day appointments and improved telephone access.

Q: What about people visiting Bath?

A: Visitors and tourists can temporarily register with any practice in B&NES as the practices are already funded to do this. There are a number within one mile of the GP-led Health Centre. Prior to the GP-led Health Centre, people were directed to local practices for any medical treatment so we would expect this to happen.

Comment: My surgery is Grosvenor. I am a shift worker and cannot fit an appointment into my day. The bus service is not frequent enough. There is better access in a central location.

A: There is a very clear message regarding access to GPs, but we need to use the resources we have effectively given there will no additional money for the foreseeable future. We need to prioritise those with the greatest need.

Q: Will this increase the pressure on the RUH?

A: No we do not believe it will as our aim is that most of the people who visit the GP-Led Health Centre will go back to their practice.

Q: Why don't you educate people?

A: Evidence suggests that general education about how to use services has no impact. For most people, using the urgent care system is a rare occurrence – on average once every six years for the out-of-hours service and once every three years for the Emergency Department.

Q: What is the cost of someone attending the GP-led Health Centre versus a GP versus the RUH?

A: The pricing structures are different. The A&E tariff is an average of £100. There is no national tariff for GPs visits. However, it works out at approximately £16 per GP consultation. Nationally, walk-in centres are three to four times more expensive than visiting a GP.

Comment: We are being asked to take a lot of this on trust and I'm not convinced.

A: Demand is increasing for example there has been a 5% increase in ambulance activity. Of the 30,000 contacts at the GP-led Health Centre around 10,000 are from outside the area.

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Q: Have you considered another hybrid model such as having a GP service in A&E and keep the Walk-In service in the city centre?

A: Difficult choices have to be made. There is a risk of continuing to pay twice and therefore not being affordable. However, there have been some very good points made about finance and the savings assumptions.

Q: What about the RUH?

A: The out-of-hours service is already based at the RUH. If you were starting with a blank canvas the obvious choice would be to locate this at the RUH. The view seems to be that the GP-led Health Centre is a safety valve for poor GP access.

Q: I work for an organisation where people visit us in Bath – people would have to go to the RUH?

A: Prior to the opening of the Centre, practices had an arrangement to accept temporary registrations and we want to promote this.

Q: The service works now so why change it?

A: Yes, we don't disagree the service is high quality and very valued, but we do have to allocate resources based on need.

Q: Why not try the new model before you close the Walk-in Centre?

A: We have 18 months before the changes would happen.

Q: The Walk-In Centre was determined as being the best way forward when it was set up. What has happened to change this?

A: The Darzi review led to the development of GP Led Health Centres and the PCT was required to commission such a centre. We are now in a very different financial climate and so we need to consider how we use our resources given that we will not receive any increase.

Q: It is popular – why get rid of it? Is it a done deal?

A: We would ask that people complete the questionnaire either tonight or later or on-line so that we take account of comments and views. A final report will be produced setting out what we have heard.

Q: I would feel more comfortable if I could send my questionnaire directly to the Scrutiny Panel as I don't feel I can trust you?

A: All questionnaires do need to come back to Corinne Edwards as it is not appropriate to send them to the Scrutiny Panel. A full report setting out the findings of the questionnaire will be made publically available and presented to the Panel. Members of the public have to make a request to the Council if they wish to make a statement in advance of the Panel meeting.

Urgent Care Public Engagement Event
The Carter Room, Fry's Keynsham
Tuesday 9th October 2012, 6.30 pm to 8.30 pm

Present:
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Shanil Mantri, Learning Disabilities Lead, B&NES CCG
Dr Jim Hampton, Planned Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Joel Hirst, Associate Director Medicines Management, NHS B&NES
Andrea Morland, Associate Director for Mental Health Services, NHS B&NES

Comment: The CCG has no local Keynsham GP membership.
A: The GP Cluster Lead, Dr Shanil Mantri, was introduced.

Comment: Bristol CCG is not currently involved in the redesign process even though many Keynsham residents use Bristol based services.
A: Agreed that longer term engagement with Bristol would take place. A representative from Bristol PCT had attended the Urgent Care Network and the proposal had been shared.

Comment: BEMS had reduced the pressure on the Emergency Department
A: Agreed, which is why we would like to strengthen the GP presence at the front door of the RUH.

Q: How do you know that the GP Led Health Centre has not reduced pressure on the ED? Is there a case that actually the early intervention prevents escalation of a condition in the longer term and therefore attendance at ED?
A: There is national data to which suggests that activity has not reduced at Emergency Departments despite the development of walk-in services. A report produced by the Primary Care Foundation called "Breaking the Mould without Breaking the System," provides evidence and information that has been used to help inform local thinking.

Q: Is there is a revolving door with the GP-led Health Centre for people with long term conditions.
A: The main reasons for attending the GP-led Heath Centre include tonsillitis, earache, viral illnesses, etc which are routinely seen in primary care.

Q: What was the history of the set-up of the Walk-in Centre?
A: The evolution of the Nurse-Led Walk-In Centre to the GP-Led Health Centre was explained. It was noted that the PCT was required to commission it, although did not have a local need in terms of GP access. We are now in a position to do something different as a result of the GP-led Health Centre and GP out-of-hours contracts ending in March 2014.

Q: What is the reason for the DNA rate?

A: There are various reasons for people not attending their appointments and this is an area that needs to improve as this wasted capacity which is paid for.

Comment: Aren't we actually pushing people up to the RUH and therefore increasing the risk of high cost interventions? Isn't the Walk-In Centre saving this? If not and the issue is to actually get people accessing their GP and that is what they are using the Walk-In Centre for, we need to be clear about what GPs will offer and that variability in response needs to be addressed.

Comment: The psychology of the local population needs to be taken into account - the Walk-In Centre provides people with security.

Q: In the new model, will you still be able to walk-in?

A: Yes.

Comment: It should be made clearer that Paulton MIU will still exist as well as above. It is not clear enough.

Q: Walk in services don't exist for the people of Keynsham? Do they use Hengrove?

A: The use of Bristol hospitals was explained and also the role of the Urgent Care network.

Q: An attendee expressed concern about the 9,000 non-B&NES patients who use the GP-Led Health Centre including visitors and people working in Bath. Is there the capacity in the Bath practices to do this?

A: GPs will need to be flexible and get access working better. There will still be a Walk-in facility at the RUH. We are working with practices on an incentive scheme to improve access.

Q: What patient involvement is there for the CCG?

A: There will be a Patient and Public Involvement Group and we want to try to find a way to better engage with the public. The current confusion regarding redesign etc was acknowledged and also the need to get positive outcomes being key.

Comment: It was noted that the physical accessibility of the RUH is not great for people with disabilities or mental health problems. They often use other facilities because they feel safer. Therefore this move may not meet people's needs. William Hubbard noted that A&E are the part of the health service that never says no - if we had GPs in that location it might greatly improve the quality of service.

Q: Could the Mineral Hospital be used? Another attendee noted access to the Min was very difficult so this wouldn't make sense.

Comment: Parking at the RUH is an issue for people.

A: Parking had improved over the past few years. Charging was introduced some years ago, partly as it was believed that some people were parking at the RUH for and working/shopping in Bath). Also moved staff parking to an outlying area and

now charge them too. A new car park will be built on the area where the pathology labs are based as they are being re-built.

Q: Why not charge for DNAs?

A: This is a difficult one not only as it would involve a huge administrative infrastructure to implement it. Even the administrative burden of ringing people is huge. Texting does not work for everyone and sometimes does not work. However, we need to think about how we do reduce the DNA rate.

Q: If there are some people that are known to be non-attenders could GPs enter into a relationship with Dial-a-ride to ensure they get there?

A: This is an interesting idea so thank you raising.

Q: What weekend cover is provided by the GP-led Health Centre and will this be replicated?

A: There is some duplication currently with the GP out-of-hours service (BEMS) based at the RUH at weekends as well as GPs based at the GP-led Health Centre at weekends. The proposal would mean that there will not be a central location. However, the cover provided by BEMS is all day each day either at the patient's home or at the RUH.

Q: Who answers the phone out-of-hours?

A: Currently this is Wiltshire Medical Services, but from April this will be replaced by NHS 111 the new national number.

Q: Is BEMS good value for money?

A: It is slightly above the national average cost, but its works well as its strength is that it is provided by local GPs.

Q: Will the new Centre be delivered by the RUH?

A: We cannot say who will be the provider of the service as it will be subject to a procurement process.

Urgent Care Public Engagement Event
The Elwin Room, Bath Royal Literary & Scientific Institute
Wednesday 10th October 2012, 6.30 pm to 8.30 pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Dr Ruth Grabham, Clinical Director, B&NES CCG
Dr Jim Hampton, Planned Care Lead, B&NES CCG
Dr William Hubbard, Consultant Cardiologist & Head of Medical Division, RUH
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES

Comment: We need adjacent disabled parking for urgent care at the RUH. The disabled car park at RUH is often full. The door spring to the Diabetic Centre is impossible to push. Parking is expensive.

A: Agreed. When reconfiguring parking at the RUH, emphasis is being put on disabled places being close to the different centres. Parking costs are less than other acute hospitals in the South West. WH will take comments back to the RUH.

Comment: The RUH may be cheap compared with other hospitals, but it is currently free to park in the centre of Bath for the GP-led Health Centre.

Q: How much is parking?

A: Many patients do not pay or have reduced charges e.g. cancer patients pay £1 per day, parking is free for the first 20 minutes and two hours is £2.60. Parking issues will be taken into account as part of this review.

Q: Could the RUH Park & Ride bus run at weekends?

A: Not sure, but may be this can be considered for the future.

Q: How much do both the GP Out-of-Hours and the GP-led Health Centre cost?

A: The GP Out-of-Hours service costs £1.6m per year. The GP-led Health Centre costs £1.3m per year.

Comment: I have used the Walk-In Centre twice. When I rang my GP surgery I was referred by NHS Direct on a Sunday morning. The idea of trekking to the RUH for mild conditions is a concern. Riverside is central and accessible to visitors, those not registered with a B&NES GP and those who will not go to the RUH. The costs are minimal.

A: GPs are working hard and are committed to providing appointments for patients. Practices need to balance patients' needs and preferences for same day appointments versus their preference for longer, booked appointments. We are working with practices to improve access for patients. It is recognised that primary care will need to step up and ensure good urgent access.

Q: When will this happen?

A: We are currently working on this and recognise that this is a difficult situation which we need to approach in different ways. Times are changing and GPs need to face the challenge of ill health and what we are doing to prepare for increasing numbers

of people with very ill health. There may be some inconvenience from these proposals, however, there are several GP practices within one mile of the GP-led Health Centre for patients to go to and we need to focus on using resources to deal with the greatest need.

Comment: When ringing for the Out-of-Hours service the practice answerphone gives the BEMS number for patients to ring. I have never had a problem accessing BEMS. The BEMS service is good with quick access to a GP.

A: That is what BEMS is there for. If patients need a GP out of hours it is also possible that, if appropriate, they receive a home visit by a GP.

Q: I endorse the idea of a Walk-in Centre that is central and friendly, as it is now, with low waiting times. Under the plan who would triage at the RUH front door, a receptionist?

A: No, triage would not be made by a receptionist. It would be by a trained nurse. One of the benefits of the proposed option is that it allows access to specialist resources. If all these resources are in the same place it will simplify the system. As commissioners we will set standards about how quickly patients need to be seen and waiting times. BEMS is a very good service and we would expect the provider of a new service to have the appropriate resources.

Q: Will it put pressure on already pressured staff at the RUH? A patient had a 4 hour wait for a planned appointment (cancer unit).

A: The aim of the urgent care centre would be to help reduce the pressure on the Emergency Department given there has been an 8% increase in attendance. Some patients come to ED who would be better seen in a GP practice.

Comment: The plan is to relocate the service. Patients will still be faced with seven choices for urgent care so the system is not being simplified very much.

A: There would be six choices as one choice would be Emergency Department for Urgent Care.

Q: Will the triage service mean more waiting?

A: Waiting times will be part of the standards set and it is not expected to add a step for patients. It is very important to have an experienced nurse triaging patients.

Q: Will the 30,000 contacts be expected to go up to the Urgent Care Centre?

A: No. We hope that many of these can be diverted back to see their GPs rather than going to the Urgent Care Centre. Some people who currently go to the GP-led Health Centre or Emergency Department (ED) could actually see their GP instead. 30% of the 30,000 Walk-In Centre attendances are not B&NES residents, so we need to work with Somerset and Wiltshire CCGs on how to help these patients access their own GPs. We are working with colleagues in Wiltshire who are facing similar pressures. We need to make the system more sustainable. The proposals for Urgent Care Redesign are a small part of this work.

Q: The current contract runs out in 2014. Does the building lease run out then too?

A: No the lease on the building does not run out then. Other services will stay in Riverside. In terms of space, there is potential to use it for other services, however, we have not fully worked this through at this time. Earlier today the GPs were

discussing the future of diabetic services and that is one possible example of a service where we would want to commission a range of community support closer to patients homes. This is a good example of how we might want to use resources in the future.

Q: Do you have to pay the RUH rent for space for both BEMS and the GP-Led Health Centre?

A: There is currently no rental charge for BEMS who are currently on the RUH site. As we go forward rental charges will need to be reviewed.

Q: In terms of projected savings, what about including the costs of appointments that patients do not turn up to? Could there be a clear message to patients that if you don't turn up you are eroding the budget?

A: Yes we need to think best how to do this as this is a very good point.

Q: How will the public be advised of the outcome of the Engagement?

A: If anyone would like to see the report they can let Corinne Edwards know. We will also be doing an impact assessment and a report will be presented to the Scrutiny Panel. All documents will be available to the public.

A: If the service does change it is very important to get the message through, especially to the hard to reach groups. It would be good to get feedback from members of the public on the best way to do this.

Comment: Older people are being presented as a looming burden. We can do prevention work with GPs in order that older people have healthier older lives. We need to ensure older people don't fear going to GPs in case they are perceived as a burden.

A: This is a good point and we need to be sensitive. Prevention is important and it is a community responsibility so we are working closely with the local authority. We need to help people to have meaningful lives whatever their age. This is what we can consider using the savings for example psychological support for people with long term conditions which would have a great impact on their quality of life.

Q: I am concerned about the perception that older people are a burden. A&E does need to respond to older people and is actually also full of the results of binge drinking in younger people.

A: We are not saying that older people are a burden, however, we need to be realistic about the areas of greatest need and we need to use money as best we can. We recognise the concerns about alcohol licensing and the impact this has had.

A: We are passionate about using NHS capacity the best way and not wasting it. 10% of appointments at St Michael's surgery are DNAs and it is a waste of resources. We need to move patients back to the setting they should be treated in. Examples of using the GP-led Health Centre from my practice (Dr Jim Hampton) today are: i) 1 patient was offered an appointment in the morning, lunchtime, in the afternoon, but declined and said she would go to the GP-led Health Centre; ii) GP-led Health Centre referred a patient back for a dressing and the practice booked a 20 minute appointment that the patient did not attend.

Comment: £650,000 is only 0.2% of the CCGs £220 million budget and is not a large amount of money.

A: Although this is a public meeting, I disagree with you; £650,000 is a large amount of money and worth saving. We also need to note that the cost of a consultation at the GP-led Health Centre is double the cost of a consultation in a GP practice. Other areas in the country are reviewing the need for similar services.

Q: Will the additional work for GP practices affect availability for other patients?

A: No. In terms of numbers, even if doing hotel visits for visitors, it will be just one of many visits in a day, for example if doing 10 home visits a day one additional visit is manageable.

Q: Estimates are forecasts and this is only a small percentage of the overall spend and a small amount of money. There is a need for these patients and the Walk-In Centre acts as a safety value for practices. Where will this need be met?

A: We feel that £650,000 is a considerable amount of money. The redesign can offer huge benefits in quality of care, not just in terms of savings. Savings may actually be higher than £650,000, however, it is about the quality of care.

A: There were 28 unused appointments in my practice (Fairfield Park) this week = 280 minutes in just one practice per week. We need to let people know about this. Yes there is a need to provide care for those 30,000 attendances, but the GP-led Health Centre may not be the right place. The right place is often the GP practice and there is capacity there. We are working to make sure appointments are available in GP practices for urgent care.

Q: From Ian Orpen – Who feels that their GP practice does a good job? Show of hands

A: Majority agreed.

Comment: Cllr Katie Hall, Vice-Chair of the Wellbeing Policy Development & Scrutiny Panel explained that the Panel will scrutinise this proposal. I have taken notes of the discussions and have already asked numerous questions of Corinne Edwards and Ian Orpen. We are taking the proposal seriously. The Scrutiny Panel is also holding an Alcohol Reduction Scrutiny Day.

A: The CCG has regular meetings with the Leader of the Council and the Director of Peoples Services and had a recent session on alcohol. It is a very complex issue, the Council has some role, but we also believe that shops and supermarkets have a responsibility to their community. The CCG has a good working relationship with the Council.

Comment: Need to be mindful of not penalising responsible drinkers.

Q: All GPs are working hard. You cannot get capacity from DNAs because you cannot use it unless you know who is not going to attend their appointment. Where will GPs find capacity to see these patients from the Walk-In Centre?

A: This is why we need to work with practices to understand why people DNA to try and reduce the numbers.

Q: I cannot understand the argument that resources are being duplicated. What is the difference between the costs of the Walk-In Centre and a GP practice?

A: It is double because capacity in GP practices for these patients has already been paid for. Therefore we are paying additionally when the GP-led Health Centre is

used for GP practice work. The average cost of a GP appointment is £19/£20 per appointment.

Comment: There is a trend between the rise of GP commissioning and getting rid of Walk-In Centres. GPs do appear to be defending them.

A: This is not GP money, this is health community money. The history of GP-led Health Centres is that PCTs were required to commission them to ensure all communities had the same service to avoid variations. At the time the PCT did not believe it needed such a service as it had no problems with GP access, ie no closed lists or problems recruiting GPs. Such centres had more value in inner city areas where there were problems with GP access. If B&NES had been asked at the time how to spend the money to improve local access this would not have been the way we would have chosen to spend it.

Q: Is there a pot of money for these engagement events and writing the reports?

A: We have to pay for room rental, but the benefits are worth it. PCTs were seen as distant from people and CCGs need to engage with the public so we need to ensure we do this well.

Comment: Savings should not equal a poorer service.

A: This is about improving quality. The experience of co-locating primary and secondary care is good and we have already seen benefits from BEMS being on site at the RUH.

Urgent Care Public Engagement Event
Radstock Methodist Church Hall
Monday 15th October 2012, 7.00 pm to 8.30pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Dr Simon Douglass, Clinical Accountable Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Menna Davies, Communications, NHS B&NES

The meeting had been called by Cllr Eleanor Jackson, in her capacity as B&NES Champion for Adult Health Care.

Q: What about the local area teams that sit beneath the NCB?
A: The diagram had been simplified, but the local area teams are the outposts of the National Commissioning Board.

Comment: I have concerns about the process for the appointment of the Lay member to the CCG. I had asked about it at the meeting at the Centurion in July and was told the details hadn't been agreed, then went on holiday and when I came back it was advertised on 16th August with a closing date of 23rd August, with interviews on 7th September. This left no time for me to apply and I question the validity of this because the process was so quick / short notice. Also I called HR and someone put the phone down on me.
A: The CCG was under tight time pressures but had received 14 applications with three high calibre candidates interviewed.

Q: Are all these paid posts?
A: Yes all posts are remunerated and local rates of pay had been agreed by the PCT in line with national guidance.

Q How do running costs stack up compared to the PCT?
A: PCT £37 per head of population, CCG will be £24 so significantly less. The CCG will receive circa £1,800 per head to spend so it's a relatively small percentage of that spent on health services.

Q: The red line shown on the 'uncomfortable truth' graph isn't real and is just a projection so why use it?
A: This reflects the funding the funding that the PCT would have expected to receive if things had continued before the changes to public sector funding. The NHS has to deliver QIPP efficiency savings to reinvest in services.

Q: How many practices in our area, what about a salary cut for GPs?
A: There are 27 practices plus the GP-led Health Centre which makes the 28. Primary care is also experiencing tough times and is earning the same as seven or eight years ago.

Comment: Will look at this as I don't believe it.

Comment: Radstock has a below average age population and an early death rate in males and high female cancer rates, plus exploding birth rate. Radstock faces particular issues including high incidence of childhood obesity.

Q: Are there national policies and health messages to help take the pressure off health services?

A Yes there are and the messages are very important. Smoking rates locally have dropped from 25 – 19% in last six years.

Q: Given the socio economic aspect what is the CCG going to do locally for Radstock which is a poorer area of B&NES. What are you going to do to make sure we get the right sort of money for the needs of our local population?

A: The CCG is working closely with the Council and that it was recognised that Radstock was an area in need of support. It will be important to work with public health colleagues, who will be moving to the Council, to consider health improvement and healthy lifestyles for areas such as Radstock.

Comment: Pleased to hear that the CCG recognised Radstock as a poorer area.

A: As a GP working in the area for the last 20 years I know absolutely the problems and I have seen a definite improvement in health and longevity locally.

Comment: Obesity and poverty are closely linked.

A: Yes and the CCG's aim is to narrow the gaps in life expectancy and deprivation.

Q: The JSNA is very thin in parts, particularly regarding mental health. Very little in there about Radstock apart from the fact it's the second highest area for people claiming benefits. How much will the CCG be involved in influencing that? Is it your role as commissioners or is it Public Health as part of the local authority?

A: The mental health commissioning role is a joint appointment between the Council and the CCG. The CCG and the Council will continue to work very closely together building on the partnership between the PCT and the Council. This is a major benefit and quite unusual nationally. The JSNA is not a static document and continues to develop. Comments are very welcome.

Q: What are your plans to deal with diabetes, specifically with regard to the BME population, which has a higher incidence?

A: Specific work has and continues to been done with the BME population.

Q: How is moving the GP-Led Health Centre to the RUH making it more accessible?

A: Although the middle of Bath is accessible for people living in Bath, it is not necessarily that accessible for people who live in North East Somerset. We believe there are wider benefits of bringing the GP-led Health Centre together with the RUH.

Q: How will it affect the Out-of-Hours service at Paulton?

A: It will not affect this service.

Q: Where will this centre be in relation to A&E?

A: It would be in the same place - at the front door of the RUH. You will be able to go to one place to get all you need.

Q: What about access to a consultant at the weekends? They don't work at weekends.

A: Yes they do and all new consultants appointed at the RUH have 7 day week contracts.

Q: Would it affect the hours that GP practices offer now out of hours?

A: No, but we are working with GPs through an incentive scheme to improve access and we would expect to see improvements from next April.

Q: What is happening to the Mineral Hospital?

A: It is a matter of public record that the hospital is in breach of its foundation trust status (one of the smallest foundation trusts). Linkage with the RUH isn't a new idea and is being discussed. The RUH is one of very few hospitals in the country without a rheumatology department.

Q: The FAQs are muddled because there is no detail of where the numbers come from eg numbers of people going to ED increasing. Where do these figures come from?

A: The data comes from the providers. The PCT monitors activity at the RUH and the GP-Led Health Centre as part of the contracts.

Q: What does 30,000 patient contacts mean?

A: Contacts do not mean 30,000 different patients. These are the number of times people visit the GP-Led Health Centre, one patient could visit 10 times which equates to 10 contacts.

Q: What has been done to engage with people who use the Centre?

A: Seeking feedback from those who use the centre through all the public meetings as well as via the questionnaires which have made available at the centre.

Comment: Cllr Jackson said she had seen all the data at the Scrutiny panel but it didn't stack up with her first-hand experience when she attended the centre recently with a sprained shoulder. Only had to wait an hour and observed that everyone there except her was under 40 and included two homeless people, two who looked like they had drug problems, two teenage girls (she thought one might have thought she was pregnant), some Chinese tourists and students. Said that we have a very high teenage pregnancy rate and also a lot of concern about people not registered with a GP. She was told that the centre shuts the door one and a half hours before closing time because it is so busy. Said that sometimes stats don't tell the whole story. In many cases it's for people who may drop-out. Said she was dealt with very well there.

Q: What is the CCG's overall budget?

A: Approximately £220 million.

Comment: £500,000 potential savings is therefore "peanuts".

A: Disagree £500,000 is an awful lot of money and would go a long way to help improve services for people with dementia, diabetes as examples.

Comment: Concerned about accessibility as a lot of people who use the centre would find it hard to get to the RUH. The 20-29 age group are the ones who are likely not to have the bus fare. Said that a lot of homeless people have nothing to do with Julian House at all.

Comment: A weakness of the centre is that it doesn't have access to services like X-rays.

A: This is one of the reasons for wanting to relocate the centre to the RUH as there would be better links and access to other hospital services.

Comment: Of all the NHS reorganisations this has been the most complicated of the lot. Not all treatments cost more; many are simpler and cheaper than in the past. The problem is change in expectations of patients and the treatments being delivered. NHS designed for life-threatening and lifestyle harming conditions but there has been a move in emphasis to stuff that should be done outside the NHS – cosmetic procedures. A lot of expense can be got around by better education to stop people getting into this position. Vast amounts of expense could be saved. Talked about 1/5 of NHS budget 20 years ago spent on homeless people and that today there are millions of empty homes. Said it's a problem of bad governance not money.

A: Agree that although certain treatments are now cheaper there are lot of new treatments and procedures that are expensive which are enabling people to live longer. There have been significant improvements in cancer treatments but they are very costly. There does need to be a much more open debate about funding and the pressures. Getting clinicians more involved and more accountable for the decisions made is one of the key aims of the new policy.

Comment: Have a very dim view of the changes because it means it's not possible to get to see your own doctor.

Urgent Care Public Engagement Event
Radstock Methodist Church Hall
Thursday 25th October 2012, 2.00 pm to 3.30pm

Present:
Dr Ian Orpen, Chair, B&NES CCG
Tracey Cox, Chief Operating Officer (Designate), B&NES CCG
Corinne Edwards, Associate Director for Unplanned Care & Long Term Conditions, NHS B&NES
Menna Davies, Communications, NHS B&NES

Q: How did the elections for CCG appointments happen without public involvement?

A: The Department of Health (DoH) set up a rigorous election process which included a meeting of 150 GPs and Practice Managers (90% turnout in B&NES) who elected an interim group to go forward. This election also included sessional GPs who work in surgeries, hospitals and for the Out of Hours service and make up one third of the B&NES GP workforce. A further election took place in May 2011 when a 98% vote of confidence was achieved for the CCG members with no new nominations being made.

Comment: This is not a true democratic process.

A: This is the process that we have been required to follow by the DoH who, together with the new National Commissioning Board, will continue to check and monitor all CCGs.

Q: What is the Individual Patient Panel?

A: This panel deals with requests for treatments that are not usually covered by NHS funding and are outside the PCT's existing policy. An example of this would be for infertility treatment.

Q: What about conflicts of interest?

A: This is covered in the CCG's constitution and this, together with the CCG's Business Conduct Policy and Register of Interests is available at public meetings and also on the website. Apologies were made regarding the length of the website address which was recognised as being unnecessarily cumbersome due to the requirement for B&NES to be written in full. All at the meeting agreed.

Q: Seeing a GP on the same day is not always possible, what are you going to do to improve access?

A: This concern has been a consistent theme at all these public meetings. Work is on-going with GP practices to address this problem. An incentive scheme is being introduced for the practices in order that they can improve access by answering the phones promptly, staying open at lunchtimes and responding to patients who have 'same day' needs. Another area that requires attention is patients who miss their appointments (DNAs). The DNA rate ranges from 3% - 10%. It was noted that this is time that the GPs are paid for, but is then wasted. All avenues to improve this will be investigated such as texting and phoning patients to remind them of their appointments.

Q: Why pay GPs an Incentive Payment when they are already paid to do the job? The contract with the GPs needs to be changed to make them work more efficiently – we are now in a 24/7 world and they need to adapt.

A: The GPs have a national mandated contract, however, this is currently being reviewed and consultation with the BMA has just commenced.

Q: When monitoring effectiveness, who will monitor the CCGs?

A: The National Commissioning Board will have Local Area Teams (LATs) who will be constantly monitoring CCGs as they continue to develop. GPs are already monitored and this includes both prescribing and referral patterns.

Q: Are these figures available to the public?

A: Yes, via Public Board Reports and Freedom of Information requests.

Q: As a Manager of a Nursing Home I would like to suggest another potential saving. Currently patients are admitted to the RUH if they require intravenous (IV) antibiotics. This could be carried out by qualified nurses in the nursing home and thereby saving an average of three to four days as a hospital in-patient.

A: A new Intravenous service had been commissioned from Sirona Care & Health for District Nurses to be trained to give IV antibiotics to patients in their own homes. There is potential to link this service to support nursing homes.

Q: The loss of the GP-Led Health Centre could be detrimental to the community – my experience of the Out of Hours service was not good, although I acknowledge I should have telephoned in advance. First line of contact with Out of Hours staff at the RUH needs to be improved.

A: The service offered to patients and staff training will be addressed as part of the procurement process. At this time we do not know who will be the provider of the service.

Q: Do GPs have a regular appraisal?

A: Yes, there is currently an appraisal which GPs have to undergo every 5-6 years. A new revalidation system is being implemented from April 2013 which will include both patient and colleague feedback.

It was agreed to ask the PCT's Medical Director, who currently oversees GP appraisals, for a synopsis of the process to be made available on the CCG's website.

Q: Have you considered advising patients of proposed changes to services via videos in waiting rooms? This could also be used to make patients aware of which services they should use for different situations and also of the DNA problems and costs associated with it?

A: Thank you for this suggestion which we will take forward as part of our discussions with practices.

Urgent Care Public Engagement Event
St Luke's Church Hall, Bath
Friday 26th October 2012, 10.00 am to 12.00 pm

Present:
Dr Ian Orpen, Chair, B&NES Clinical Commissioning Group
Dr William Hubbard, Consultant Cardiologist and Head of Medical Division, RUH)
Corinne Edwards, Associate Director of Unplanned Care and Long Term Conditions, NHS B&NES
Joel Hirst, Associate Director of Medicines Management, NHS B&NES
Menna Davies, Communications, NHS B&NES

Q: Where will the CCG operate from?
A: The expectation is that it will operate out of the old PCT offices at St Martin's Hospital, Bath. However, this is a changing situation and may alter in the future as the NHS reforms work through.

Q: How do members of the public express an interest in being involved with the CCG Patient Involvement Group?
A: Please let us know if you are interested. We are looking into the idea of having a promotional leaflet in GP practices. The CCG are really keen to reach out and get people involved in building on the work of the Healthy Conversation events that the PCT ran.

Q: Is there any academic input into the decision making processes in the new design of the NHS?
A: There are 14 clinical networks offering Best Practice being formed e.g. Cardiovascular Disease, Cancer and others. There is also an Academic Science Network promoting innovation and the LETBEs Local Education and Training Boards.

Q: When was the Riverside facility established?
A: In 2001 a Nurse Led Walk-In Centre was opened in Henry Street. In 2004 this relocated to the facility at Riverside. In April 2009 the GP-Led Health Centre was opened at Riverside.

Q: Can we learn things from dental colleagues about reducing missed appointments?
A: GP practices have looked at a number of options. Some practices text patients to remind them about appointments. There is a scheme looking at improving access in GP practices which is being run over the next 18 months and some of these issues will be picked up as part of this scheme.

Q: Is the cost benefit of moving going to be offset to the public who will then have to pay for the additional travel costs to get up to the RUH site?
A: The expectation is that a significant number of the current 30,000 contacts at the GP-Led Health Centre will not go to RUH. It is anticipated that many will go back to their own GP practices. There are lots of Out of Area patients and it is anticipated that they will be redirected to local GP practices, several of which are within one mile of the GP-Led Health Centre, as temporary registered patients.

Q: In a previous era it used to be possible to "sit and wait" for an appointment at the GP surgeries. Why can't we go back to this?

A: Some practices do already offer this service. There is a need for practices to try out different models. The right solution will vary depending on the location of the GP practice, however, we are encouraging GP practices to innovate.

Q: By moving work back to GP surgeries, will this not lead to a cost pressure to GP practices for more nurses and other staff?

A: No extra funding will be available for GP practices. The practices are already funded for this activity. Practices are currently engaging in a programme to review their productivity through reviewing their systems. This may lead to skill mix adjustments in GP practices. There is a large proportion of 20-29 year old users of the GP-Led Health Centre. There is work on-going with the universities to look at supporting the student population to be able to understand how to use the urgent care system including an app for smart phones.

Q: Currently it is easy to get a prescription dispensed after going to the Riverside Centre due to the proximity of the local pharmacy. Moving the Urgent Care Centre would lose good access to medicines.

A: This is an issue which needs to be looked at and considered. Across B&NES there are already 100 hour pharmacies. There are options that could be included in the service specification e.g. having a pharmacy on the RUH site.

Q: Currently there is a strong message to avoid bringing "infected" people onto the RUH site to reduce infection control outbreaks e.g. Norovirus. Surely the move of the Urgent Care Centre onto the RUH site will increase this risk?

A: The issue is about keeping carers and visitors who have symptoms of stomach virus away from the site. The policy has never been to keep "ill" people who need treatment away from the service. Norovirus is a community problem which is not fully understood, but much has been done to minimise its impact.

Q: How will the saving be achieved if other services are going to continue to be run in the Riverside premises?

A: The savings identified are purely related to the benefits of moving the GP-Led Health Centre out. There have not been other savings identified related to the premises. The premises will still be viable for the services staying e.g. Contraception and Sexual Health service, Dental Access services and Specialist Drug and Alcohol Misuse services.

Q: Why not just take the GPs out and leave the nurse-led Walk-In service? Would this give you the savings?

A: The proposed model is assuming that most people can access their GPs. The team believes that the synergies of co-location of the Urgent Care Centre on the RUH site will lead to additional benefits to prevent admissions through access to on-site diagnostics not available at the Riverside.

Q: As a patient it can be very frustrating to get into see the GPs and sometimes GPs clearly are under pressure – we are concerned that this change will put more pressure on the GP system?

A: The reality is that there are significant pressures for the whole health system and the proposed changes are about prioritising patients with the greatest need. The growing

demand from Diabetes, Dementia and changing demographic mean we need to make some difficult decisions now.

Comment: The concerns raised can be summarised into two issues (a) People like the city centre location and find it convenient and (b) There is a fear that the high quality service we get at Riverside will be watered down to a less good service when it moves, due to the diversion of staff into the Emergency Department.

A: The new proposed service will have a clear and separate contract and service specification including key performance indicators that the service will have to deliver. The commissioners are clear that for the model to work there has to be a very different feel to the service at the RUH “front door” and that it is a “primary care” service with all that goes with it. From the work recently seen since the GP out-of-hours service has relocated already demonstrates that there are clear benefits in having a GP-Led service at the front door of the hospital.

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	16th November 2012
TITLE:	Q2 Care Homes Quarterly Performance Report (July - September 2012)
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – Quarter One Performance Report	

1 THE ISSUE

Further to the report to panel of the 18th May 2012 which set out the Quality Assurance Framework for social care services generally, this report is the second in a series of quarterly reports which focuses specifically on the quality of care and performance of residential and nursing homes under contract in Bath & North East Somerset.

2 RECOMMENDATION

The Wellbeing Policy Development & Scrutiny panel is asked to:

2.1 Note the contents of the report.

2.2 Contribute relevant feedback and articulate clearly the role of the panel in relation to the QAF.

3 FINANCIAL IMPLICATIONS

The Council's financial plan for 2012/13 sets out year three targets in relation to residential and nursing care provision for all of the main service user groups including older people, people with learning difficulties, people with mental illness and people with physical and sensory disabilities. The Council's September 2012 revenue forecast for adult social care summarises performance against financial plan targets for 2012/13. The net end of year forecast is on target.

3.1 As stated in the May report,

'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 The quality and performance of care homes can be understood from a range of perspectives for example feedback from those who use services, carers and/or other advocates, from judgements issued by national regulatory body the Care Quality Commission (CQC), from local contractual monitoring/performance management and from the level and type of safeguarding activity recorded. The report provides a high level summary across all these areas and also details progress to date on Council financial targets.

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 EIA 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	*Sarah Shatwell, Associate Director Non-Acute & Social Care*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Care Homes Quarterly Performance Report

July - September 2012

Baseline Data

At the time of writing there were 57 residential and nursing homes under contract in B&NES including those providing services to people with learning disabilities and people with mental illness.

As at 30th September 2012 1161 individuals were recorded as being 'permanently placed' in residential/nursing care, supported living or extra care settings although this figure also includes a number of individuals who are placed out of area i.e. not with a contracted provider in the B&NES local authority area. This compares to a figure of 1139 at the end of the last quarter.

The total weekly cost of the above placements at the time of writing was £760,428 although this figure has not been netted off in respect of income received from NHS B&NES for individuals placed under Continuing Health Care (CHC) arrangements i.e. health funded. This compares to a figure of £743,680 at the end of the last quarter.

Care Quality Commission Data

The Care Quality Commission came into being in April 2009 and required all adult social care and independent health care providers to register by October 2010. Part of the role of CQC is to carry out inspections of care homes and to assess compliance against twenty eight quality standards, known as the 'essential standards'.

Since the last report, in B&NES 11 of the 57 homes under contract have yet to be inspected by CQC although all providers are now registered. Two more homes have been inspected by CQC during the last quarter.

The performance of the 46 homes in B&NES that have been inspected by CQC is summarised in the table below.

All standards met	34 homes (increase of 6 since last report)	↑
One standard requiring improvement	8 homes (same as previous report)	→
Two standards requiring improvement	2 homes (increase of 1 since last report)	↓*
Three standards requiring improvement	1home (decrease of 1 since last report)	↑
Currently under	1 homes (decrease of 5 since last report)	↑

review		

* this includes one home that has moved from three to two compliance issues which is an improvement in the overall position

When one or more essential standards are not met *and* there are serious concerns regarding the quality of care provision in a home, CQC may issue compliance notices which require providers to respond within specific timescales, after which follow up inspections take place. At the time of writing 1 home in B&NES were under compliance action which is a reduction of 1 since the last report.

All other homes with outstanding compliance issues are required to produce action plans setting out how, and in what timescales full compliance will be achieved. More often than not, compliance actions tend to be minor issues such as ensuring that there is liquid hand soap in individual bedrooms and should therefore not be used to gauge the overall quality of care in a particular home.

A report published by Age UK on 28th June 2012 suggested that around 73% of adult social care provision is fully compliant with CQC standards and this figure is corroborated by the analysis above which indicates that 73.9% of homes inspected in B&NES are fully complaint.

Service User & Stakeholder Feedback

Information regarding the quality of care homes is collected at each individual service user review and collated on a 'feedback database' by commissioners. The database is also used to store 'adverse incident' reports received from health colleagues. During the period July to September 2012 concerns relating to 5 care homes were received via the feedback database, these are summarised in the table below.

Nursing home #1	Concern regarding general quality of care
Nursing home#2	Concern regarding clinical care, referred under safeguarding Concern regarding domestic care
Nursing home #3	Concern regarding general quality of care Concern regarding clinical care, referred under safeguarding
Nursing home #4	Concerns regarding general quality of care
Residential home #1	Concern regarding heating/hot water

All concerns are addressed directly with the provider at the time they arise, escalated via safeguarding, included in contract review or discussed with CQC at bi-monthly liaison meetings.

Commissioning & Contracts Review

Commissioning & Contracts Officers have reviewed 9 homes during the last quarter and the schedule of reviews is revised bi-monthly following regular CQC

liaison meetings. Reviews are also prioritised or brought forward if indicated by concerns received. The Contracts & Commissioning team is still operating at 1 FTE below capacity.

Safeguarding Alerts & Investigations

At the time of this report information on the number of individual safeguarding referrals is available for April and August 2012 only. During this period there have been 203 new safeguarding alerts of which 59 service users in receipt of residential care and 16 are for service users in receipt of nursing care i.e. 37% (75) of all safeguarding alerts during April and August were in relation to residents in care home settings. For 2011/12 36% of cases were referred for residents in care homes; the figures are consistent.

The data reports (including those submitted to the Department of Health Information Centre) do not currently break down the outcome of terminated cases by setting, they focus on whether the outcome was substantiated or not and what the outcome for the service user and (alleged) perpetrator was. A request for a detailed breakdown of this has been made and will be available for the next report.

Analysis for this report on outcomes of safeguarding referrals is limited to care homes where more than one alert has been received; for the period April to August 2012, 17 care homes had more than one safeguarding referral and in these 17 care homes a total of 51 referrals were made.

Of the 51 referrals made 42 referrals were for service users in receipt of residential care (40 of these are alleged to have taken place in the residential setting, one is alleged to have occurred in a public place and is ongoing and the other location is not known however no further action is being taken) and nine referrals were for residents in receipt of nursing care (eight of these are alleged to have taken place in the nursing setting and the location for the other referral is currently not known and at the time of the report, the case was ongoing).

The table below sets out the alleged perpetrator at the time of referral and the outcome for those cases that occurred in the care home setting (it does not include the three that allegedly took place elsewhere). The table shows that at the time of the report none of the referrals of alleged abuse by care home staff were substantiated, however eight cases were ongoing. Out of the 27 cases that were concluded 15% (four cases) were substantiated or partly substantiated. Three of which are cases where one vulnerable adult either physically, sexually or emotionally abuses another vulnerable resident.

(Alleged) Perpetrator	Substan -tiated	Not Substan -tiated	Partly substan-tiated	No case to answer / NFA	On going	Total
Care home staff	0	5	0	6	8	**19**
Other vulnerable	2	0	1	6	9	**18**

adult						
Not known	0	0	0	2	1	**3**
Partner	0	0	0	1	1	**2**
Other family member	0	0	0	1	1	**2**
Neighbour /friend	0	0	0	0	1	**1**
Other	1	0	0	2	0	**3**
Total	**3**	**5**	**1**	**18**	**21**	**48**

Homes under Embargo

During this reporting period two homes have been embargoed for placements by B&NES due to quality and/or safeguarding concerns. The embargo on one home was lifted during the quarter following significant improvements being made and this has been further substantiated through CQC inspection and Commissioning & Contract Officer review.

Financial Monitoring

Cross authority work has been completed to establish a regional cost model for care homes based on locally collated data covering six main cost drivers including:

- Nursing/care staff costs
- Other staff costs
- Capital costs/rent
- Fixtures/fittings
- Food/laundry
- Utilities/rates

The weekly rates for residential and nursing home placements currently operational in B&NES have been set using the regional cost model and prices within each individual cost driver can be reviewed separately under these arrangements.

It is estimated that the Council manages to make 85% of all residential and nursing home placements within these weekly rates however a significant (and growing) number of complex nursing, end of life care and dementia care placements cannot be secured within these margins.

The Council's August 2012 revenue forecast for adult social care summarises performance against financial plan targets for 2012/13. The net end of year forecast is on target, however there is still significant pressure on Residential, Nursing and Community based packages of care showing an overspend position of £0.5m. This is currently mitigated by the use of Section 256 monies to offset pressures arising from demographic growth as agreed with the PCT.

Section 256 funding is allocated by the Department of Health in response to increased demand for health and social care services arising from

demographic growth and “winter pressures” and its use to subject to nationally set criteria. In agreement with the Primary Care Trust, the Council has targeted a proportion of this money at funding additional capacity in social care services in response to increases in demand from demographic growth. The appropriate distribution of this funding between the different commissioning budgets will be determined later in the financial year.

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Bath & North East Somerset Council		
MEETING:	Wellbeing Policy Development & Scrutiny Panel	
MEETING DATE:	16 November 2012	**AGENDA ITEM NUMBER**
TITLE:	Medium Term Service & Resource Planning – 2013/14-2015/16	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: ANNEX 1 – Draft Adult Social Care & Housing Medium Term Service & Resources Plan 2013/14-2015/16 with appendices 1 - 6		

THE ISSUE

The draft Adult Social Care & Housing Medium Term Service & Resource Plan (MTSRP) is presented for consideration by the Panel:

(1) To ensure all members of the Panel are aware of the context for Service Action Planning

(2) To enable comment on the strategic choices inherent in the medium term plan

(3) To enable issues to be referred to the relevant Portfolio holder at an early stage in the service planning and budget process

RECOMMENDATION

The Panel is asked to:

(1) Comment on the medium term plan for Adult Social Care & Housing

(2) Identify any issues requiring further consideration and highlighting as part of the budget process for 2013/14

(3) Identify any issues arising from the draft plan it wishes to refer to the relevant portfolio holder for further consideration

FINANCIAL IMPLICATIONS

This report sets the framework for the service planning and budget processes relevant to this Panel for the next 3 years. The financial implications are set out in the enclosed annexes.

The overall financial background for the Council is set out in Appendix 5.

THE REPORT

This report forms part of the service and resource planning process. As set out in the enclosed medium term plan (Annex 1), the next steps include:

(1) Panel comments considered by Portfolio Holders

(2) PDS Resources meeting in January to take overview of comments from Panels and progress on budget setting plus equalities issues.

(3) February Cabinet budget recommendations to Council

(4) February Council approval of budget and Council Tax setting.

The draft Medium Term Service & Resource Plan for Adult Social Care & Housing is attached as Annex 1, and includes its own appendices.

The Panel needs to consider the implications of this medium term plan and make recommendations to the relevant portfolio holder(s) and Cabinet. Where the panel wishes to either increase expenditure or reduce savings targets alternatives should be proposed.

The Panel should concentrate only on the parts of the plan relevant to its own remit as the PDS Resources meeting in January will be taking an overview.

RISK MANAGEMENT

A risk assessment will be completed as part of the final budget papers and inform the Council's reserves strategy. The main risks relate in the next financial year to:

(1) The robustness of the savings estimates.

(2) The potential for some service levels to deteriorate as a result of the savings, some savings are from service reductions but most savings are directed at efficiencies.

(3) The implications for staff arising from savings albeit that the costs of severance will be budgeted for corporately and unions are being consulted together with the affected staff.

(4) The need to maintain a planned and phased approach to savings at a time when pressures are starting to require substantial and immediate cuts.

(5) Equalities impacts of the savings.

EQUALITIES

1.2 Service Action plans will be developed for management purposes and will be subject to Equalities Impact Assessments as they are completed.

1.3 Equalities issues will be considered in more detail as the budget is prepared. The PDS Resources meeting in January will take an overview of progress.

CONSULTATION

1.4 The corporate implications of this report have been considered by Strategic Management Team (SMT) including the *Section 151 Finance Officer; Chief Executive & Monitoring Officer*

1.5 Further consultation has taken place as part of developing the revised Corporate Plan. Budget fairs took place on 6th and 7th November and feedback from these has helped inform the draft plan.

ISSUES TO CONSIDER IN REACHING THE DECISION

1.6 All the following issues are relevant to service and resource planning: *Social Inclusion; Customer Focus; Sustainability; Human Resources; Property; Young People; Human Rights; Corporate; Health & Safety; Impact on Staff; Legal Considerations*

ADVICE SOUGHT

1.7 The Council's Monitoring Officer (Council Solicitor) and Section 151 Officer (Finance Director) have had the opportunity to input to this report.

Contact person	*Jane Shayler, Tel: 01225 396120*
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Adult Social Services & Housing - Analysis of Headline Numbers

	2011-12 Budget		2012-13 Budget			2013-14 Budget							2014-15 Budget							2015-16 Budget						
	Gross £'000	Net £'000	Gross £'000	Net £'000	Staff FTEs	Budget Pressures £'000	Savings £'000	One off changes £'000	Gross £'000	Net £'000	FTE changes	Staff FTEs	Budget Pressures £'000	Savings £'000	One off changes £'000	Gross £'000	Net £'000	FTE changes	Staff FTEs	Budget Pressures £'000	Savings £'000	One off changes £'000	Gross £'000	Net £'000	FTE changes	Staff FTEs
Housing Operations	1,576	1,544	1,447	1,445			(20)		1,427	1,425		0				1,427	1,425		0				1,427	1,425		0
Homelessness Prevention	502	259	514	151					514	151		0		(25)		489	126		0				489	126		0
Housing Services	68	30	41	1	39.59	8	(39)		10	(30)	-2.3	37.29	8	(65)		(47)	(88)	-2.8	34.49	8			(39)	(80)		34.49
Housing	2,146	1,832	2,002	1,597	39.59	8	(59)		1,951	1,546	- 2.30	37.29	8	(90)		1,868	1,463	- 2.80	34.49	8			1,876	1,471	-	34.49
Drug Action	2,789	546	2,729	519	2.6	2	(50)		2,681	471		2.6	2			2,683	474		2.6	2			2,686	476		2.6
Adults Mental Health	2,589	2,154	2,226	1,742					2,226	1,742		0		(16)		2,210	1,726		0		(16)		2,194	1,710		0
Mental Health Commissioning - Other	89	44																								
Mental Health Older People Purchasing	5,481	3,797	6,172	4,046		223			6,396	4,269		0	229	(44)		6,580	4,454		0	216	(44)		6,752	4,626		0
Mental Health Social Services Staff	921	725	1,061	820	30.92	40			1,101	860		30.92				1,101	860		30.92				1,101	860		30.92
Adults & Older People-Mental Health Commissioning	9,080	6,720	9,459	6,608	30.92	263			9,722	6,871	-	30.92	229	(60)		9,890	7,039	-	30.92	216	(60)		10,047	7,196	-	30.92
Non Acute & Social Care Commissioning Staff	258	258	259	259	8.67	6	(15)		250	250		8.67	6			256	256		8.67	6			261	261		8.67
Non Acute & Social Care Commissioning	5,843	5,622	6,134	5,581		63	(152)		6,045	5,492		0	65	(786)		5,325	4,771		0	68			5,392	4,839		0
Supporting People & Communities Commissioning	6,101	5,879	6,393	5,840	8.67	69	(167)		6,295	5,742	-	8.67	71	(786)		5,580	5,027	-	8.67	73			5,654	5,100	-	8.67
Dir Mgmt	148	148																								
Commissioning Staffing & Support Services	360	360	1,085	1,081					1,085	1,081		0				1,085	1,081		0				1,085	1,081		0
Commissioning & Contracts Management	6	6																								
Commissioning Management	474	474	372	342	18.72	27			399	370		18.72	27			426	397		18.72	27			453	424		18.72
Section 256 Social Care Monies			2,501	2,601		1,000	(1,500)		2,001	2,101		0			1,000	3,001	3,101		0				3,001	3,101		0
Adult Care Commissioning	988	988	3,958	4,025	18.72	1,027	(1,500)		3,485	3,552	-	18.72	27		1,000	4,512	4,579	-	18.72	27			4,539	4,606	-	18.72
Older People Purchasing	23,962	8,923	23,965	8,044		665			24,630	8,710		0	679	(172)		25,138	9,217		0	626	(252)		25,512	9,592		0
Fairer Charging Income		(1,667)		(1,865)		(4)	(60)		(64)	(1,929)		0	(4)	(60)		(129)	(1,994)		0	(5)			(133)	(1,998)		0
LD Commissioning	43	43	43	43	1.54				43	43		1.54				43	43		1.54				43	43		1.54
LD Purchasing	16,608	7,674	16,586	7,858		882			17,469	8,741		0	892	(119)		18,242	9,514		0	903	(119)		19,026	10,298		0
Learning Difficulties Commissioning	16,651	7,717	16,629	7,902	1.54	882			17,512	8,784	-	1.54	892	(119)		18,285	9,558	-	1.54	903	(119)		19,069	10,342	-	1.54
Physically Disabled Purchasing	2,362	2,185	2,571	2,388		131			2,702	2,519		0	131	(24)		2,809	2,625		0	110	(24)		2,895	2,711		0
Hearing & Vision Purchasing	664	553	839	725		55			894	780		0	57			950	837		0	59			1,009	895		0
Physical Disability, Hearing & Vision	3,025	2,738	3,410	3,113		186			3,596	3,299	-	-	188	(24)		3,759	3,462	-	-	169	(24)		3,903	3,606	-	-
Bsm Locality	974	957										0							0							0
Equipment Service	182	(63)										0							0							0
Integrated Access Team	1,490	1,403										0							0							0
NES Locality	931	914										0							0							0
Specialist Services-Hearing & Vision	203	203										0							0							0
Training	393	359										0							0							0
Finance & Resources	191	112										0							0							0
Service Delivery Management	(84)	(144)										0							0							0
Employment Development	148	148										0							0							0
Residential	3,379	3,309										0							0							0
Commissioning Staffing & Support Services	343	343										0							0							0
Extra Care Services	1,829	1,829										0							0							0
LD Provider	5,391	5,379										0							0							0
Mental Health Service Delivery	802	604										0							0							0
Sirona Care & Health	449	244	18,343	18,343		48			18,391	18,391		0		(868)		17,523	17,523		0		(871)		16,652	16,652		0
Sirona Care & Health	16,620	15,597	18,343	18,343		48			18,391	18,391	-	-		(868)		17,523	17,523	-	-		(871)		16,652	16,652	-	-
GRAND TOTAL OF CASHLIMITS	81,363	49,274	86,887	54,125	102.04	3,147	(1,836)		88,198	55,436	- 2.30	99.74	2,092	(2,179)	1,000	89,111	56,348	- 2.80	96.94	2,020	(1,326)		89,805	57,042	-	96.94

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Draft Capital Programme - 2013/14 - 2017/18								
		Costs			Funding			
Project Title		2013/14	2014/15 Onwards	5 Year Total	Borrowing / Capital Receipts	Grants / External Funding	RIF / Development Funding	Comments
		£'000	£'000	£'000	£'000	£'000	£'000	
People & Communities								
Adult & Housing Services								
Full Approval								
Supported Housing Development		77	-	77	-	77		
Provisional Approval								
Disabled Facilities Grant		1,000	4,000	5000	-	5,000		2013/14 proposed for full approval - detailed project plan required annually for 2014/15 onwards
Affordable Housing		700	-	700	700	-		Business Case & detailed project plan required
Gypsy & Traveller Sites		775	775	1550	1,550	-		Business Case & detailed project plan required
Total - Adult & Housing Services		**2,552**	**4,775**	**7,327**	**2,250**	**5,077**	**-**	

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MEDIUM TERM SERVICE & RESOURCE PLAN – SERVICE IMPACT STATEMENT – ASHLEY AYRE - ADULTS

Growth and Saving Items

1. PROPOSED REDUCTIONS TO BALANCE BUDGETS

(A) Change Programme Savings

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
	293	296	H	None	None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Decrease in Sirona contractual values as agreed.		Already accommodated in service planning			

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
39	39	0	M	2.6 fte	None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Savings identified from the customer services workstream which looks at redesigning the customer pathway making better use of IT systems and implementing streamlined processes (including family information)		Yet to be determined. Service will transfer work to the customer service equivalent to this reduction			

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
15			M	0.75 fte	None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
P2P Efficiency savings		Restructure of administration in relation to Invoice payment and purchase orders			
54	**332**	**296**	**Sub Total – Change Programme Savings**		

(B) Other Cashable Efficiency Savings

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
50			M	1.0 FTE	None

How saving to be achieved	Impact to Service Delivery	Additional Information (Inc. PDSP Feedback)
Savings in commissioning substance misuse services to be achieved primarily through reduced commissioning staff capacity with a small saving to be achieved by reducing spend on residential treatment by “holding” people in community treatment services, which are now achieving significantly improved outcomes following pathway redesign.	Limited service impact as there is less need to fund out of area residential treatment as a consequence of improvements to the care pathway and effectiveness of community treatment. The treatment system is dependent on national performance related funding. Further reductions in service from council or NHS locally will put performance and therefore treatment system investment at risk. Lack of effective substance misuse services can adversely impact on the community, including escalation of drug and alcohol related crime and anti-social behaviour. Loss of commissioning capacity will increase workload pressures.	

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
	575	575	M	TBC (Primarily Sirona)	None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
In partnership with Sirona Care & Health further efficiency savings from the contract with 'Sirona' Care & Health. This would be in addition to the £9.0m savings already built into the five year contract between Sirona, the Council and the Primary Care Trust. A recently published Audit Commission report "*Reducing the cost of assessments and reviews"* based on 2010/11 benchmarking information, which pre-dates the establishment of Sirona, suggests that efficiencies from social care processes could be achieved in the medium term. Target is based on bringing B&NES costs closer to the national benchmark. Delivery of the saving would need to be supported by: i) improved access to signposting, provision of advice and information (including to self-funders); ii) policy and process redesign, including increases in self-assessment; and iii) pathway redesign, culture change and skill-mix review.		Any service impacts would need to be assessed in light of the detailed savings plans, to be developed and agreed during 2013/14. The Audit Commission report suggests that savings can be made without adversely impacting on quality. If implemented in the right way, this change could impact positively on service users as a) some service users would self-assess or be signposted to services with no requirement for an assessment; and b) people who 'self-fund' their care services would be able to access advice (particularly financial advice) and, also a 'brokerage' service that would enable them to choose the provider of their service in light of up to date, accurate information on value for money, quality etc.		Change will require short-term investment in change management and investment in targeted advice and information, including to self-funders.	
50	**575**	**575**	**Sub Total – Other Cashable Efficiency Savings**		

(C) Additional Income

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
20	0	0	L	None	None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Additional income from administration of Homesearch.		None. Additional income from Curo and other Registered Providers to fund advertising of social rented properties via the Homesearch Scheme.			

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
60	60		M		None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
The Fairer Contributions policy, which is based on national guidance and determines individuals' personal contribution to the costs of their community based personal care services. The policy requires that individuals are left with basic minimum income thresholds, which are nationally prescribed. Further protection is provided by a nationally prescribed 25% "buffer", which in B&NES is set above the required minimum at 30%. A very small amount of additional income could be generated by reducing this buffer back down to the statutory 25%.		Impact on the income of service users subject to the Fairer Contributions Policy, though these service users would continue to receive the income protection prescribed through national guidance. Some impact on commissioning and finance capacity to implement change.			

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
1,000	-1,000		L		
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Utilise s256 12/13 carry forward to delay recurring impact (one off). In line with Department of Health Guidance, it has been agreed by the Council and Primary Care Trust (to become the Clinical Commissioning Group (CCG) in April 2013) that a proportion of s256 funding can be utilised to offset demand-led pressures in adult social care purchasing budgets (including funding of Personal Budgets).					

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
500			L		
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Utilise s256 funding to meet pressures on adult social care purchasing budgets arising from demographic growth – particularly in placements, packages and Personal Budgets for older people and people with mental health needs, including dementia.					
1,580	**-940**	**0**	**Sub Total – Additional Income**		

(D) Reduced Service Levels

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
0	51	0	H	1.5 FTE	None

How saving to be achieved	Impact to Service Delivery	Additional Information (Inc. PDSP Feedback)
£25k saving from ceasing the voluntary Accreditation Scheme for private rented accommodation. £26k saving from a reduction in staffing capacity in Housing Services.	We are changing our approach to ensuring quality standards in HMOs – this is currently being consulted on. The Accreditation Scheme provides landlords & tenants with reassurance that a property meets minimum standards. Proposed additional HMO licensing areas cover a significant proportion of the accreditation properties. – as a result, the voluntary scheme will be stopped. Reduction in staffing capacity is likely to result in increased waiting times for some housing services.	

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
0	375	455	H	None	None
How saving to be achieved		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
A planned reduction of spend on purchasing the provision of personal care and support for older people, including those with dementia, adults with mental health needs, adults with learning difficulties and disabled adults, including those with sensory impairment. Primarily achieved by reducing admissions to residential care, particularly for older people, including those with dementia, by improving access to preventative and early intervention and also, by ensuring that signposting, access to universal services and advice to all, including self-funders, is effective. This saving aligns with investment plans to develop preventative services.		Some service users and their families/carers view admission to residential or nursing care as the "safe" (low-risk) option. Our staff will work to ensure that any concerns about community-based alternatives are addressed effectively. In order to reduce such concerns and mitigate any risks, it would be critical to ensure strong, effective preventative and early intervention services, pathway redesign, and improved signposting and access (including to self- funders) to financial advice. Further investment of Section 256 funding as well as a strategic shift in the investment of a proportion of Supporting People & Communities Funding would be appropriate in supporting the further development of this approach, which is in line with current national and local health and social care strategies. Proposal will increase pressures on Commissioning Team and will require culture change programme for practitioners.		Proposals made in light of high- level review by IPC, which suggests that savings could be achieved by further reductions in admissions to residential care. IPC review makes it clear that these savings can only be realised if part of a strategic shift, including pathway redesign, improved access to preventative services and culture change – see also comment against savings in relation to assessment & care management.	
0	**426**	**455**	**Sub Total – Reduced Service Levels**		

(E) Discontinued Services

2013-14 Saving £000	2014-15 Saving £000	2015-16 Saving £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
152	786	0	M	None	None

How saving to be achieved	Impact to Service Delivery	Additional Information (Inc. PDSP Feedback)
Over the coming years, the Council will focus the money it has available on care for the most vulnerable adults to support their independence. As a result of this focus, there will be a reduction in the level of services which are not directly discharging defined statutory duties under Community Care legislation. Detailed proposals for 2014/15 will be worked up during 2013/14 and the estimated savings by "sector" set out below should, therefore, be treated with caution. Detailed proposals to be worked up during 2013/14 will enable consideration of: a) alignment with the Council's priorities; b) service performance, utilisation and value for money; c) engagement with providers, including views on how they might help deliver savings by for example working together more effectively to avoid duplication; d) the overall picture including how targeted investment is made to mitigate the impact of delivering the savings and,	Proposals represent a shift in the focus of Supporting People & Communities funding away from lower level support and towards delivery of more mainstream adult social care objectives. There will be an impact on the people who currently use these specific services, such as older people, people who need support to enter or re-enter the workplace, people who need support to avoid/prevent homelessness, people who are socially excluded because of multiple/complex vulnerabilities such as mental ill health, disability, poverty, poor educational achievement & poor housing. There will be an impact on a range of services which community organisations, as well as independent sector organisations, provide on our behalf. However, as we continue to target our services towards more vulnerable people, there will still be an important part for the independent/ community sector to play in	

indeed, help deliver the savings; and e) work with other partners including the CCG to join up commissioning intentions and take a whole-system view including along care pathways. It is proposed that £500k be reinvested in order to mitigate the impact of proposals and enable the development of targeted services to realise savings from a) assessment/care management; & b) further reductions in admissions to residential care. Estimated savings, by discontinuing or reducing services by "sector", taking account of the application of £500k reinvestment/ mitigation are as follows: • Older people support, including 'sheltered' housing, estimated saving £449k - • Mental Health support, estimated saving £77k • Learning Difficulties support £20k • Physical & Sensory Impairment support £11k • Young People estimated saving £61k • Ex-offenders/substance misuse estimated saving £42k • Generic (not age/client group specific) estimated saving £160k. • Advice & information estimated saving £118k,. Total saving £938k.	respect of delivering some of the £500k reinvestment in targeted advice/information; preventative services; and "pump-priming" third-sector organisations to recruit and support volunteers. Managing the de-commissioning of services represents a significant challenge to commissioning capacity. Officers will continue to examine this area of spend and the various contracts in place to seek to bring forward settings into 2013-14 if possible.	
152	**786**	**0**	**Sub Total – Discontinued Services**
1,836	**1,179**	**1,326**	**TOTAL SAVINGS**

2. PROPOSED Growth (Including Inflation)

(A) General (Including Inflation)

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
43	43	43	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
1% inflation on salary budgets		None			

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
941	975	1,009	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
For adult social care purchasing of packages and placements, non-pay inflation provision of 1.75% has been made, which is approximately half current RPI. Very few provider contracts include guaranteed inflationary uplifts and consultation/ negotiation with providers is undertaken on an annual basis. Negotiation of "best price" for an individual care package is also undertaken as appropriate and those making placements have received training in undertaking such negotiations.		Subject to an assessment of need and relevant eligibility criteria, the Council has a statutory obligation to meet an individual's assessed needs and, therefore, does need to be able to secure services from the market. Ultimately, the effect of not allowing for the impact of inflation on the purchasing budgets will be overspends in those budgets through an upward creep of fee levels above the agreed rate in order to secure placements/ packages. Also, Local Authorities that have not undertaken appropriate consultation with providers before determining annual inflationary uplifts have been subject to formal challenges			

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
-44	-44	-44	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Increased income from inflationary increase on service user contributions in line with government increases in benefits.		None		None	

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
48			L		
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Increase in 2013/14 based on agreed contractual values.					
988	**974**	**1,008**	**Sub Total - General**		

(B) New Legislation/Government Initiatives

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
0	**0**	**0**	**Sub Total – New Legislation / Government Initiatives**		

(C) Increase in Service Volumes

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
131	131	110	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Demographic Growth in Adults of working age i.e. 16 – 64 years old		Projections of the impact of demographic growth on adult social care purchasing budgets are based on ONS (Office of National Statistics) projections for Bath & North East Somerset, based on the actual B&NES resident population as at April 2010 of 186,927. 2012/13 purchasing budgets are showing the effects of demographic pressures with an increase in both activity levels and the acuity/ complexity of need. Ultimately, the effect of not allowing for the impact of demographic growth on the purchasing budgets will be overspends in those budgets as, subject to the appropriate assessment of eligibility and need, the Council has a statutory responsibility to secure services.		None	

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
388	388	303	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Demographic Growth in Older People 65+ years (including dementia)		Projections of the impact of demographic growth on adult social care purchasing budgets are based on ONS (Office of National Statistics) projections for Bath & North East Somerset, based on the actual B&NES resident population as at April 2010 of 186,927. 2012/13 purchasing budgets are showing the effects of demographic pressures with an increase in both activity levels and the acuity/ complexity of need, with a direct relationship between the complexity/acuity of need and the cost of the package/placement to meet that need. Ultimately, the effect of not allowing for the impact of demographic growth on the purchasing budgets will be overspends in those budgets as, subject to the appropriate assessment of eligibility and need, the Council has a statutory responsibility to secure services.		None	

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
600	600	600	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Learning Disabilities – Transitions from Children services to Adults		Forecast growth based on the known population of young people who will transition from children's services to adult social care (with a corresponding transfer of costs). The forecast does not fully take account of any "unknown" adults with learning difficulties, not currently in receipt of services who may move to B&NES and/or need services as a result of a breakdown in the provision of care by often elderly carers. However, such cases are relatively small in number and forecasts include some assumptions based on historic trends (ie commissioners anticipate that there will be a small number of such cases each year).		None	
1,119	**1,119**	**1,013**	**Sub Total – Increases in Service Volumes**		

(D) Other

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
40	0	0	H	1 FTE increase	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
Approved Mental Health Practitioner (AMHP) Capacity		To ensure enough capacity to meet the Council's statutory and legal functions and requirements, particularly in respect of Mental Health Act assessments. In the 5-year period 2007-11, the number of Mental Health Act assessments undertaken increased from 205 to 279. There has been no corresponding increase in AMHP capacity during this period and there is now a significant shortfall in capacity, which has resulted in some use of agency staff, which is neither sustainable nor desirable on cost and quality grounds.		None	

2013-14 Growth £000	2014-15 Growth £000	2015-16 Growth £000	Risk to Delivery	Impact on staff	Impact on Assets and Property
1,000	0	0	L	None	None
Description of Growth (including driver)		**Impact to Service Delivery**		**Additional Information (Inc. PDSP Feedback)**	
One-off funding required to meet the funding gap in the 2012/13 budget that was temporarily met by slippage from 2011/12 in Section 256 funding.		2012/13 Council Approved Budget included a one-off saving from Section 256 funding (Dept of Health funding designed to address demographic growth pressures in the adult social care and health system and to invest in services designed to prevent hospital admission and facilitate discharge from hospital). The £1m non-recurring underspend arose from a combination of achieving greater than planned efficiency savings from the purchasing of social care packages and placements and, also, the slower than planned implementation of some early intervention, reablement and preventative services compared to the original joint health & social care programme.		None	
1,040	**0**	**0**	**Sub Total - Other**		
3,147	**2,093**	**2,021**	**TOTAL GROWTH**		

Bath and North East Somerset JSNA – 2012 – Executive Summary

- **Overview & Trends**
  - **Population**
  - **Mortality and life expectancy**
  - **Disability and Long Term Conditions (LTCs)**
  - **Mental Health**

Background

Increase in population over time (primarily students), 50/50 men women, population just under 180,000 in 2010, and low levels of ethnic diversity

Increase in births (more mothers over 30), expected increases in some young people ranges and older people.

7% have physical disability, 12% sensory impairment, 1% autism, 16% mental health

Assets

- Low rates of long term conditions, and key disorder
- Vaccination rates for people with LTCs are high
- Emergency bed days, smoking levels are low amongst people with Long Term Conditions
- SEN pupils are achieving well
- Prevalence of mental health conditions are generally lower or in line with national rates
- Suicide rates are low

Needs

- Conditions of the heart, cancer, lungs and diseases of the digestive system are the most common forms of death (in line with national)
- Cancer incidence increasing
- High rates of asthma amongst young people
- Excess winter mortality is high, but this is not down to an increase in winter deaths
- Self-harm and depression prevalence high (1000 more depression cases than expected)
- Dementia highlighted as a concern by Healthy Conversation
- BME population identified as at risk of mental health problems

- **Service Use & Quality**
- **Safeguarding**
- **Carers**

Assets

- Low rates of outpatient attendances, planned & unplanned admissions, low weighted prescribing costs, death rates in RUH low
- 11% of population self-define as a carer, and evidence of carer satisfaction with services
- High user satisfaction with social services
- Over 700 voluntary sector agencies, delivering a wide range of service

Needs

- Ambulance service quality recorded as weak by CQC
- Referrals into children's services increasing, Child Protection Plans increasing (increasing complexity in cases), but may relate to increased awareness following Baby P.
- Year on year increase in adult safeguarding, national evidence of under-reporting and demographic trends suggest this increase will continue
- 11 care institutions measured by CQC have improvement notices (out of 500 within 20 miles of Bath.)
- Evidence of internal pressures across health and care system

Costs

- Older people's social care has low spend compared to comparable areas
- Schools, child welfare and children's service all have low levels of spend.
- Total NHS spend per head is higher than other areas and expenditure has increased by 34% since 06/07
- Adult care costs are comparably high

- **Health Improvement and Protection**
- **Health Determinants**

Assets

- Low rates of infectious diseases
- Lower level admissions for injuries than nationally
- Reducing no. road traffic collisions
- Low no. abortions, increase in contraceptive prescribing
- Child health & immunisation uptake is generally good
- 84% of adults know how much exercise they should be doing, (4% cycle to work, 19% walk)
- No. of adults registered with GP as obese is low.
- High fruit & veg consumption
- Smoking rates are low, 56% would like to quit and evidence of cessation effectiveness
- Rates of alcohol attributable hospital admissions are low compared to other areas but rising
- Illicit drug use is stable and acquisitive crime is low, hospital admissions for CYP substance misuse is also low

Needs

- Chlamydia screening uptake increasing, but lower than national, % positive is lower than national
- Increasing births placing strain on education places,
- Increase in respiratory tract infections in <1 year olds
- Significant GP practice variation in MMR
- Significantly higher rate of overweight amongst children starting school, childhood obesity rate is still increasing – but this is in line with national and regional rates.
- Between 74-90% adults not taking enough exercise – Cost and time main barrier to organised events, driver behaviour & road safety main reasons for not cycling more
- Smoking a significant cause of death and higher in some groups than others
- Alcohol specific admissions in U18s are higher than national, but most admissions still occur in over 25's. For men the highest rate of admissions is in 40-49yr olds.
- Significant crime and disorder impacts of alcohol, and significant determinant of mental health problems
- Proportion of drug users completing treatment low but rising

- **Social Determinants & Natural Environment**

Assets

- High levels of education achievement, bullying in line with national levels, absence low
- No. benefits claimants and no. NEET are low
- Highly skilled residential workforce
- Overall child poverty levels are low
- Historically low levels of crime an d adult and youth reoffending levels are reducing
- Evidence of untapped social capital
- 53% of those in care feel they have good community connections
- Interventions which boost individual social functioning have been highlighted as an opportunity by the care forum
- Good access to natural environment
- Reducing no. calls with regards environmental issues

Needs

- 1/3 of pupils do not feel their school deals effectively with bullying
- Benefit claimants and NEETs increasing over time, teenage mothers and those with learning difficulties are highly represented.
- Older people and those with mental health conditions likely to be affected by disability benefit changes
- Significant evidence of under-reporting of Domestic Violence (78% victims recorded as women).
- House prices and affordability is a significant challenge and benefit changes will increase pressure. High % of people aged 65+ are residents of nursing and care homes
- Different approaches to social capital required in different areas.
- Poor air quality in some areas which has been linked to poor health outcomes
- Severe weather risk, fuel and utility price increases linked to climate change – 30,000 houses (over 40%) currently improperly insulated.

Data is accurate as provided to JSNA team at 22/03/12

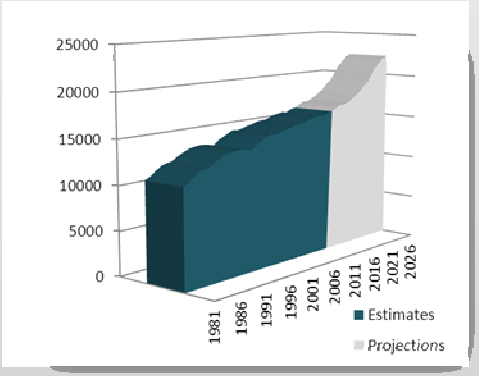
- **Cross-cutting Themes**
  - Complex Families
  - Aging Population
  - People with multiple conditions or needs (co-morbidity)
  - Social and Economic Differences
  - Rural Areas

Complex families

- The Government estimates that there are 220 families in Bath and North East Somerset experiencing a range of needs and who are costing services between £250k and £330k each per year.
- Early work has identified 500 individuals in B&NES who are within a complex family
- There are notable geographical concentrations of these families

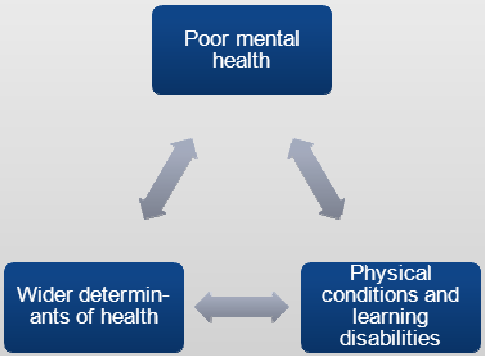
Aging Population

- Increases in life expectancy will change the local population



- 7% of the population 75+ in 1981, increasing to 11% in 2026, (3% - 7%, 80+)
- Changes to disease profile and causes of death. For example, 85% of 85+ have moderate or severe hearing loss. Older people with LTC felt less confident in managing health
- Pressure on care provision (over 4700 elderly carers by 2026) and suitable accommodation (including affordable warmth)
- Strong desire to play more of a role in managing own health, care forum highlights need for activities to support independence

People with multiple conditions or needs (co-morbidity)



- There is a strong relationship between conditions.
- 46% of people with mental health problems have a long term condition and 30% of those with long term conditions have a mental health problem.
- Further relationships with sensory impairment and dementia.
- Higher rates of poverty and unemployment (and at risk of benefits changes) and people with mental health problems considered a particular risk group.
- 80% of homeless people have physical health conditions and 70% have mental health conditions
- Relationship between alcohol misuse and mental health conditions and also with a range of criminal behaviour, both as victims and offenders

Rural Areas

- Certain rural areas have been identified as specifically high risk for fuel poverty and impacts of severe weather
- A number of complex families live in rural areas, and care forum consultation has raised accessing clients in rural areas as a barrier to service provision.
- Rural communities have been identified as possessing a greater than average level of social capital.

Social and Economic Differences

- 20% of the population live in certain communities where there is:
  - Shorter life expectancy, increased prevalence of long-term conditions.
  - Poorer general health, lower breastfeeding levels, higher admissions for self-harm and poisoning
  - Poor dental health, higher rates of smoking and more than four times as likely to be admitted to hospital for alcohol specific conditions.
  - Significant relationship between unemployment, offending and education achievement.
  - Strong relationship between lower levels of social capital and inequality, however small area studies have shown strong willingness to be more involved.

Appendix 5

MEDIUM TERM SERVICE & RESOURCE PLANS – 2013/14 to 2015/2016

FINANCIAL PLANNING ASSUMPTIONS

1. Context – The Financial Challenge

The Council's Budget for 2013/2014 will present a full and detailed Medium Term Service and Resource Plan for the three-year period from 2013/2014 through to 2015/2016. This will enable the Council to take a planned and structured approach to meet the significant financial challenge facing the Council.

2013/2014 represents the third year of financial planning prepared in the context of the Government's Comprehensive Spending Review (CSR) announced in October 2010. This CSR included a deficit reduction programme with 28% cuts to local authority spending spread over the four year period from 2011/2012 to 2014/2015.

However as we approach the next Comprehensive Spending Review in 2013 it is clear that the reductions set out in the previous CSR will not be sufficient to meet the Government targets to reduce the fiscal deficit as, the on-going impact of economic uncertainty both across Europe and indeed worldwide, means the UK economy continues to fall short of previous expectations.

The financial implications for the Council will not be clear until the Provisional Local Government Financial Settlement which is not expected until mid December 2012 and the overall position will be impacted by a range of significant changes affecting local Government Finance as set out below.

- The needs based Formula Grant funding system (the Four Block Model) for local government will come to an end and be replaced a combination of localised Business Rates and (where appropriate) a top up grant to be know as Revenue Support Grant.

- The new Localised Business Rates (National Non Domestic Rates) will provide for the Council to retain 50% of local business rates going forwards to further incentivise growth. The Council will also share in the cost of non-payment, business cessation and NNDR appeals. There will be a safety net where business rates decrease by 10% or more. This system will be reset from time to time to allow an element of rebalancing – the first such reset being scheduled for 2020 or later.

- The new Revenue Support Grant will use a baseline needs assessment for 2013/2014 and will be set broadly at a level to cover the gap between funding need and the initial 50% share of local business rates. The RSG will then be reduced to reflect Government savings requirements from 2013/2014 onwards.

- Responsibility for setting Council Tax Benefit passes to local authorities from 2013/2014 in the form of the new Local Council Tax Support Scheme. At the same time the funding from Government will be reduced by over 10% resulting in a shortfall of around £1.5M, which is proposed to be met from adjustments to the new scheme. The elderly and most vulnerable claimants will be protected.

- Anticipated reforms to the Planning System to provide for full cost recovery did not progress as expected. Some fee increases are being permitted but this falls far short of the levels that had already been factored into budgets for 2012/2013.

- Public health responsibility and related services will pass to the Council from April 2013, together with an appropriate budget transfer from the PCT. It is assumed the grant received will fully cover all related costs of this service.

- The full implementation of planned changes to Government Funding for LEA and Academies through the Local Authority Central Spend Equivalent Grant (LACSEG) will go ahead in 2013/14. Whilst some recognitions of local authority concerns has been made by the Dept. for Education, the Council will still face reductions in funding well in excess of current levels of spending. This will become increasingly challenging as more schools move to become Academies.

- Early years funding for 2 year olds will move from the LEA into the Dedicated Schools Grant which is primarily a technical change however the remaining funding for Early Years within LEA's will be reduced nationally. The exact local implications of this will not be clear until the Settlement is announced.

These issues are reflected within the Medium Term Service and Resource Planning process for 2013/2014 to 2015/2016 to the extent the impacts can be reasonably anticipated.

There are also a range of service specific cost pressures that need to be addressed including impacts of national policy changes. The most significant of these include:

- Rising elderly population placing significant demands on Adult Social Care and Health services.
- Increased demand for Children's care services.
- Contractual inflationary costs particularly for care placements and external service contracts.
- Local impacts of the economic downturn and increasing competition e.g. car parking income.

It should be particularly highlighted that the scale of changes impacting in 2013/2014 makes the financial implications for the Council extremely difficult to predict and the Provisional Local Government Finance Settlement may vary from the assumptions we have made. However taking account of the anticipated reductions in government grant funding and the pressures outlined above suggests that around £30m of budget savings will be required over the period 2013/2014 to 2015/2016.

2. Summary of Budget approach for 2013/2014 – 2015/2016

The sound financial management of the Council over the years means it is in a better position than many other councils to face the continuing financial challenges arising as a result of the national economic situation.

The Council Budget currently being developed will cover the period from 2013/14 to 2015/2016, recognising the very difficult financial challenge now facing the whole of the public sector and the increasing need to prioritise resources. The following principles have been used to support this:

- Investing in economic growth
- Keeping Council Tax bills as low as possible
- Making every effort to protect essential frontline services for local people.

There are no longer the available resources to deliver the full range of services that have been provided in the past. New legislation and demographic changes similarly demand clear prioritisation and new approaches. This increasingly means difficult choices.

The development of the Budget has moved away from setting targets and budget top slices based on historic spending, to an approach more focussed on prioritisation supported where appropriate by zero based budgeting. This approach has included: -

- Ensuring only essential cost pressures are taken into consideration, challenging all proposals for inflationary increases and additional spending.
- A continued focus on achieving efficiency savings within and across service areas.
- Maximising savings achieved through the continued development of the Change Programme with projects like Customer Services and Procure to Pay.
- Seeking to increase income from new and existing sources. Developing and investing in a diversified income base to help protect the Council from reductions in Government funding.
- Minimising costs of borrowing utilising Council cash flow balances where appropriate to provide funding for capital projects.
- Exploring opportunities to support Communities to enable them to be more resilient and self-sustaining.
- Making better use of Council Assets, particularly council land and property, to reduce running costs and provide capital receipts.
- *Where Government is cutting its grants to local authorities, or other external sources of funding are being reduced, these savings requirements may need to be passed on to the relevant service.*

The scale of the projected savings required over the next three years, is such that the Council will need to prioritise services and whilst every effort will be made to protect essential frontline services for local people, this will inevitably lead to proposed reductions in service areas which are considered a lower priority.

The proposals put forward in the Medium Term Service and Resource Plans provide for a balanced budget in 2013/2014 and 2014/2015 subject to government funding announcements. 2015/2016 will be significantly dependant upon improvements to

the global and national economy and whilst these MTSRP's proposals go some way to addressing the financial challenge in this year, it is likely that further savings will be required.

3. Council Tax

Council tax levels have now been frozen since 2010/2011, supported by Council Tax Support Grants from the Government. These grants are time limited and create a funding pressure when they are discontinued. The Council Tax Support Grant for 2011/12 is payable until 2014/2015, whereas the Council Tax Support Grant for 2012/2013 was a one off grant. Each of these grants was conditional on a Council Tax freeze in the respective financial year.

On 8th October 2012 the Government announced the provision of grant funding to support councils who freeze their Council Tax for next year (2013/2014) at the current level (i.e. a zero increase). The grant is equivalent to a 1% increase in Council Tax (approximately £700K) and has been confirmed as payable for two years at present i.e. for 2013/14 and 2014/15.

This announcement also indicated that Council Tax increases over 2% would trigger the legislative requirements for a local referendum on the proposed Council Tax increase. This is subject to confirmation in the Provisional Local Government Finance Settlement.

The Cabinet currently expect to be in a position to make recommendations on Council Tax levels to Council in February 2013 as part of the 2013/2014 budget setting process.

The figures in this plan assume no increase in Council Tax and the administration will take into account the Government's settlement (grants to local authorities to be announced in December), together with the results of consultation, in deciding the level of Council Tax to be recommended.

4. Government Grants

The Council currently receives approximately £41m in formula grant from the Government which is distributed using a complex needs based formula known as the Four Block Model. This formula includes significant weightings attached to deprivation based indicators across a range of specific service blocks

The Council has historically lost significant funding (around £2.5m per annum) from its formula grant settlement through the application of the damping system or, in layman's language, the protection by Government of other authorities who should be getting less on a needs basis than they currently are. For 2012/2013 the level of damping was £2.3M.

This needs based formula is being replaced from 2013/2014 as part of the Local Government Resource Review. This formula is currently being updated in order to arrive at a baseline funding level for local authorities. This will be used as the starting point for the new system – beyond this point funding needs will only be considered on a periodic basis to reset funding for local authorities. The first such reset will not be until 2020.

The main element of the new system will provide for 50% of Business Rates (National Non Domestic Rates) to be retained locally. This will provide an added incentive to local authorities to stimulate and encourage business growth in their area with 50% of this effectively being retained by the Council. However the Council will also share in the risk of non-payment, business rate appeals and most significantly business closure or failure. A national safety net will be put in place to provide some protection although this will only operate once business rates have reduced by over 10%.

In the case of most councils, including BANES, it will be necessary for the Government to top up the retained business rates to the initial baseline funding level. This will be done by way of a top-up grant to be known as Revenue Support Grant (RSG). As already indicated, once this RSG is set in line with the initial baseline it will not be reassessed every year for changes in need. It will however be reduced each year in line with the reductions the Government wishes to make to local authority funding. It is therefore likely that for many Councils, including BANES, RSG may disappear altogether within the next 10 years.

Given these changes it is therefore very difficult to predict with any degree of certainty the overall level of funding the Council will receive going forwards. Based on the Government's technical consultation on the proposed changes received over the summer period, it is possible to model the potential funding outcomes. Indeed this consultation identified up to a 13% reduction in 2013/2014 although some of this reduction reflected potential changes to the funding for New Homes Bonus. Taking this into account an overall reduction in funding of up to 6% has been assumed for 2013/14 and approximately 5% in each of the years 2014/2015 and 2015/16.

The new arrangements for a localised 50% share of Business Rates provides the potential to produce some additional funding going forwards if new growth is achieved. However it should be recognised that the future planned closure of the MOD Sites will present an initial challenge as these business rates are lost. Based on modelling work a prudent assumption has been made for an initial ½% increase in Business rates income although this is reduced to a neutral position for 2015/2016 to reflect the aforementioned risk.

New Homes Bonus has been assumed to increase in line with experience to date – providing an additional £700K per annum. This income has been assumed to support the Revenue Budget to help minimise the impact of budget reductions on priority frontline services. This income will peak in 2016/2017 as New Homes Bonus is only payable for a 6 year period.

Whilst some small further reductions have been factored into specific service areas within the Medium Term Service and Resource Plans, the assumption for financial planning purposes will be for any further cuts in specific grants to be contained within the relevant service areas.

The Provisional Local Government Finance Settlement expected in mid December 2012 will provide further details of baseline funding allocations for 2013/2014. Future years funding will be dependant upon the outcome of the next Spending Review due in 2013 (CSR2013). The announcements will inevitable vary from the assumptions made above and may potentially require variations to be made to the proposals set out in these Medium Term Service and Resource Plans.

5. Medium Term Service and Resource Plans

The Medium Term Service and Resource Plans cover the financial planning period from 2013/2014 through to 2015/2016 and have been prepared by each service area to reflect the details of the specific proposed savings to ensure the Council is in a position to consider a balanced Budget proposal.

As set out in Section 2, the process was based on prioritisation of savings in order to meet the projected need to find £30M of spending reductions over the next three years.

All proposals are subject to on-going scrutiny and consultation with final proposals being put forward by the Cabinet to the Council in February 2013.

6. Reserves

The budget for the current financial year 2012/2013 provides for the Council's General Fund Balances to be maintained at their risk assessed minimum level of £10.5m. There are no assumptions to change this position going forwards and the risk assessed levels will be reviewed as part of the final Budget proposal in Feb 2013.

A range of Earmarked Reserves are maintained by the Council for specific purposes. The likely commitments against each of these reserves will reviewed as part of the ongoing development of the Budget for 2013/2014.

The Council's reserves position remains relatively strong and will provide some flexibility to support the Budget over the Medium Term Service and Resource Planning period, particularly to facilitate timing and implementation of recurring savings.

Any proposed use of reserves will recognise that they can only be used once, and will take account of the overarching principle of not using reserves to provide support for recurring budget pressures.

7. Pensions

The most recent actuarial review as at 31 March 2010 concluded a number of positive factors which did not require any significant variation in the Council's employers contribution level overall. These factors included:-

- The Avon Pension Fund investments have performed relatively well albeit since that review investments generally have been volatile and affected by poor stock market performance.
- The Government has switched the rate for future pensions increases from the Retail Price Index (RPI) to the historically lower measure of the Consumer Price Index (CPI).
- A national review of public sector pensions schemes is being undertaken by the Government (the Hutton Review).

The outcome of the actuarial review has factored into the Budget plans and whilst no change was provided for in terms of the overall contribution level for the Council, the implications of a reducing workforce may require a further adjustment by the Council to maintain this neutral cash position going forwards.

Work is currently commencing to consider the potential impacts of the next actuarial review due as at 31 March 2013. The implications of this review may lead to changes in contribution rates from 2014/2015. This valuation will take into account the national changes to the Local Government Pension Scheme from 1 April 2014 reflecting changes to employee contribution rates and benefits including a move away from Final Salary to a Career Average scheme.

8. Pay Awards

Discussions are currently taking place nationally between the Employee and Employer representatives regarding the potential pay award offer for 2013.

Provision has been made within the MTSRP for a small increase (1%) in line with previous national government expectations for a public sector pay in 2013/2014. Similar provisions have been made for 2014/15 and 2015/16.

9. Other Assumptions

Some of the other key assumptions being used in the development of the medium term plans include:

- Contractual inflation of 2% has been provided for each year throughout the period where it is deemed essential, except in the case of Adult Social Care costs where the provision for inflation has been set at 1.75%. No further inflation has been provided for general supplies and services.
- Balanced budgets are delivered for 2012/2013 - there is no provision for overspending.
- Interest earnings on the Council's cash balances are based on a 1% return – this will be reviewed in line with the Council's Treasury Management Strategy.

10. The Local Government Finance Settlement 2013/2014

The Provisional Local Government Finance Settlement is now expected in mid-December 2012 following the Government's Autumn Budget Statement, which is scheduled for 5th December 2012.

This Settlement will provide the detailed position for the Council in terms of exactly what Government funding it will receive for the year ahead – 2013/2014. We expect this to include confirmation of the baseline position for the Localised Business Rates scheme, new homes bonus funding, and to also reflect the recently announced 2013/14 Council Tax Freeze Grant provisions

The Settlement should also confirm the limits on Council Tax increases above which a local Council Tax Referendum would be required.

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Local Government Association

Funding outlook for councils from 2010/11 to 2019/20:

Preliminary modelling

www.local.gov.uk

Executive summary

Councils were cut earlier and harder than the rest of the public sector as the government began to implement its deficit reduction policy. If the same pattern of cuts to the public spending is replicated in the next Spending Review, councils will not be able to deliver the existing service offer by the end of this decade. Fundamental change is needed to one or both of:

- the way local services are funded and organised
- statutory and citizen expectations of what councils will provide.

The Local Government Association (LGA) has modelled all future sources of council revenue, including grants, local taxes, fees and charges, investment income and reserves drawdown to the end of this decade on assumptions that offset grant cuts against the potential for growth in other revenue sources. Our income forecast is optimistic.

We have also modelled future service spending demand, assuming that efficiencies could make it possible to reduce spending in real terms over the whole decade. Our demand forecasts err on the side of caution.

On these assumptions, our model shows a likely funding gap of £16.5 billion a year by 2019/20, or a 29 per cent shortfall between revenue and spending pressures.

We have also modelled the funding available for individual services within the projected resource constraint. On the assumption that demand in social care and waste are fully-funded, other services face cash cuts of more than 66 per cent by the end of the decade. Assuming that capital financing and concessionary fares are also funded in full, the modelled cash cut for remaining services rises to over 90 per cent.

We need to face up to what that means. Local government is the most efficient part of the public sector and will maintain that record, but efficiency is not enough. Without money and reform, there is no solution. Future sustainability starts with social care funding reform, allowing a genuinely free conversation between councils and local residents about how much tax they want to pay and what services they want to receive in return, and rethinking the structures of local public services as a whole.

Preliminary analysis of the funding outlook for councils

1. Introduction

The LGA has set out to identify the level of service provision that councils could be expected to be able to sustain if their revenue base were to be constrained within the spending levels first set out by the Chancellor in the Autumn Statement in November 2011 and subsequently confirmed in the Budget on 21 March 2012. This paper describes the preliminary model we have constructed.

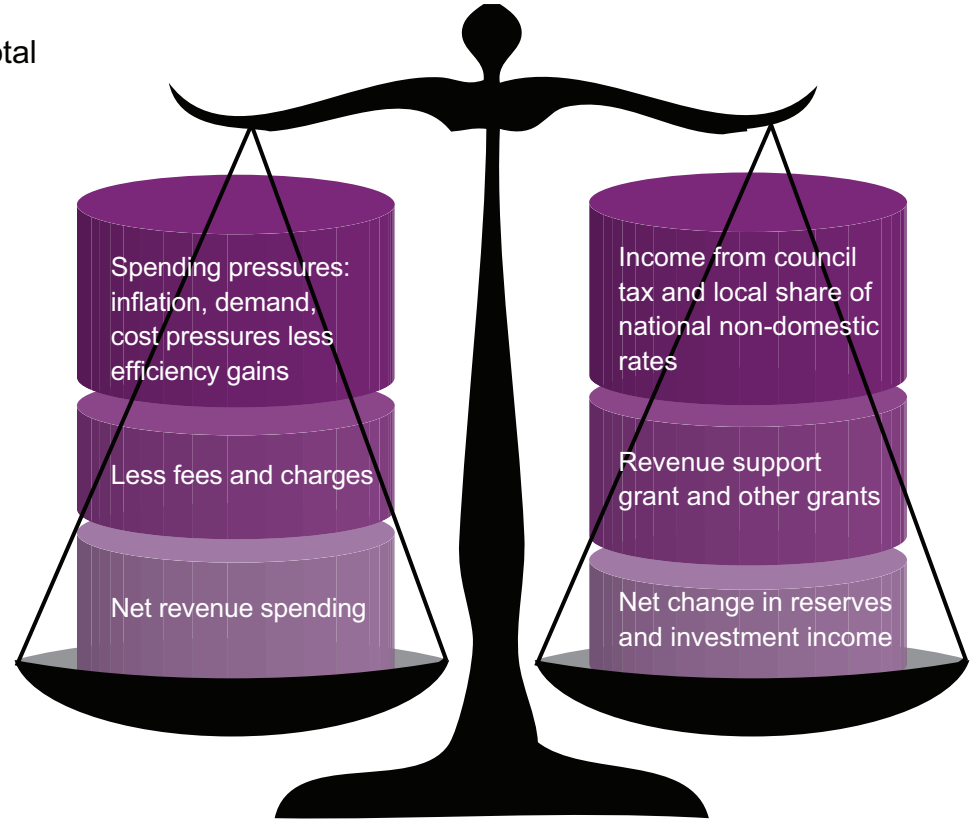
We have sought to present a credible analysis that recognises the reality beneath a headline account of council cuts based on only formula grant and simplistic assumptions about spending pressures.

Our model recognises that total council income rests on a number of sources, including non-negligible changes from year to year in fee income and reserve levels, and that councils are actively taking steps to mitigate cost pressures by reforming the way they deliver services.

Our analysis is built on:

- projections of council tax, national non-domestic rates (NNDR), grant and other income streams over the period 2010/11 to 2019/20
- projections of total annual net revenue spending in nine principal service blocks within council budgets over that same period.

The model works as follows:



2. The path of council income

The model projects the likely path of council revenue, based on a number of assumptions:

- **Council tax:** We have assumed that council tax will be frozen until 2014/15 and will thereafter grow by 2 per cent per year. This may be optimistic.
- **National Non-domestic Rates:** We have assumed future NNDR growth at 3.5 per cent, which assumes 2.9 per cent growth in retail price index (RPI), in line with the Office for Budget Responsibility's (OBR) forecast, and 0.6 per cent of growth above RPI to reflect future growth in the tax base. We have also assumed that councils will retain 50 per cent of total NNDR yield as the "local share" from 2013/14 when the new rates retention scheme comes in and that the share will remain constant throughout the period, in accordance with the intentions published by the Government in May 2012.
- **Government grants:** Detailed information on the Government's plans for grants to local government is not expected to be available until summer 2012. For the purposes of the model, we have derived current levels of grant funding from published sources up to 2012/13. For 2013/14 onwards, we have assumed that the central share will be returned to local government through grants, and that for 2013/14 and 2014/15 other grant will be allocated in line with the total funding for local government set in the 2010 Spending Review. For periods beyond 2014/15, we have assumed that the total funding for local government will be reduced in a broadly similar manner to that set in the 2010 Spending Review, which reflects the future path for Departmental Expenditure Limits set out in the Chancellor's 2012 Budget. Overall, in the 2010 Spending Review, central government funding for local government was cut from £29.7bn in 2010/11 to £24.2bn in 2014/15. The assumption made in the model is that there could be a further reduction in funding to around £17.6bn by 2020.
- **Investment income:** Future investment income is assumed to be responsive to changes in interest rates, although we have not modelled changes to the amount that councils invest. The level of investment income will obviously be linked to future levels of reserves.
- **Transfers to and from reserves:** We have assumed reserves will be drawn down through 2013/14 in line with councils' returns to the Government but gradually rebuilt as the new business rates retention scheme and localisation of council tax support will require authorities to manage an unprecedented level of volatility at the local level. We expect that the effect of these changes will be an inclination to build up reserves as a safeguard.
- **Sales, fees and charges:** We assumed that income from sales, fees and charges would be sensitive to prevailing economic conditions for market-facing services such as parking and planning but that care fees would increase in line with the CPI. Fees and charges are an adjustment to net spending rather than being treated as a revenue item.

The revenue lines are adjusted to remove income attributable to authorities whose spending is not modelled (see section 3).

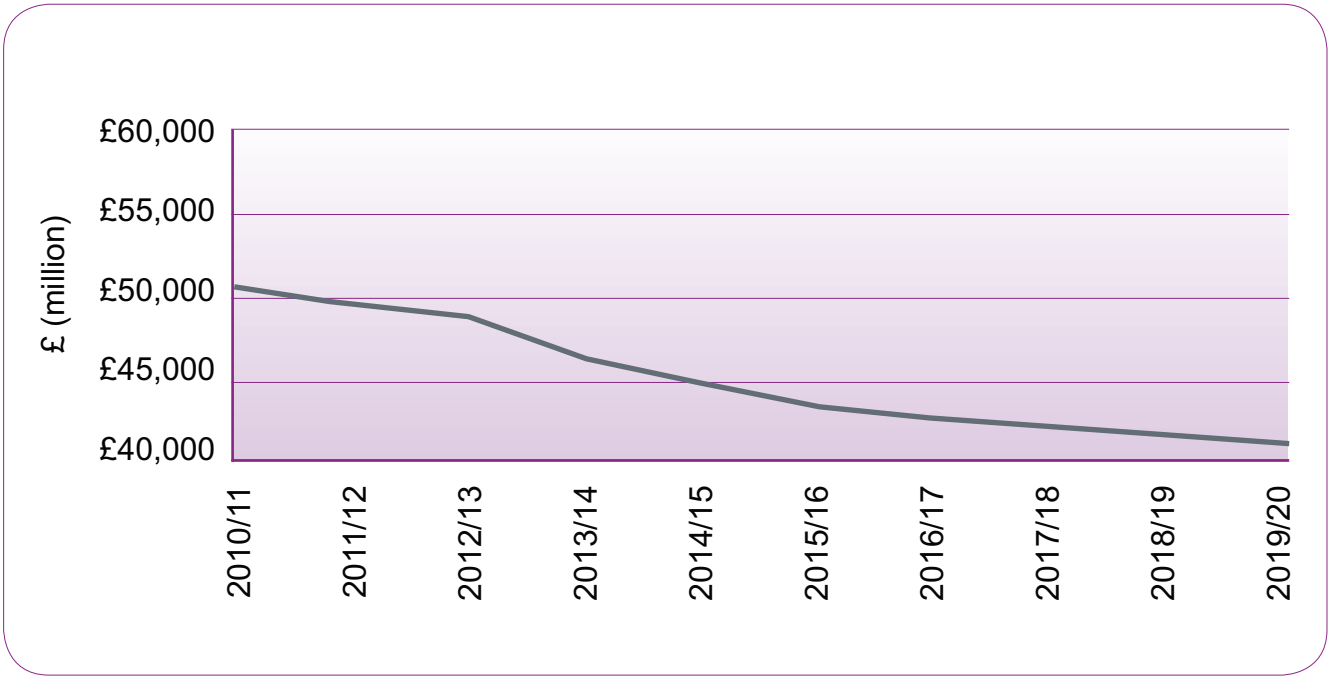
The following graph shows that total council income falls by £9.5 billlion in cash terms between 2010/11 and 2019/20. Over the period, income falls by 19 per cent in cash terms, or 23 per cent in real terms.

It should be noted that the model has not attempted to take account of volatility in income streams, particularly business rates. The model assumes that business rates grow at a uniform pace year-on-year; in reality, it is much more difficult to predict business rates yield from year to year. Some councils that are starting with a smaller tax base may find it a challenge to grow business rates at a rate that will keep pace with their spending pressures. Rates yield can go down as well as up and it is a near-certainty that some councils will face shocks from that source. Under the current system, that volatility has been smoothed out at the national level.

When the new rates retention system comes in to effect in April 2013, councils will have to manage the impacts of changes to their business rates income within their own budgets. The localisation of council tax benefit will also introduce a new source of volatility. The uncertainty is making it very difficult for councils to plan medium term financial strategies and many councils that are in a position to are considering adding to their reserves at levels beyond what has been assumed in this model as a safeguard against future volatility.

More detail on the revenue projections is set out in Annex A.

Chart 1 Projected income



3. The path of council spending

The funding model then projects the path of council spending between 2011/12 and 2019/20 in nine major service blocks:

- education (excluding the Dedicated Schools Grant)
- children's social care
- adult social care
- highways, roads and transport
- housing (not including housing revenue account (HRA) or housing benefit)
- culture, recreation and sport
- environment including waste
- planning and development
- central services.

Spending has been excluded on Fire (as a group of single-service authorities with their own precept), Police (for the same reason, as well as reflecting the likelihood that they will continue to receive differential treatment in the Spending Review and future council tax frameworks), HRA and housing benefit spending (as self- or separately-funded areas), and schools spending funded by the Dedicated Schools Grant and pupil premium. Spending has also been modelled on an assumption that council responsibilities remain unchanged from 2012/13 (so public health, which will transfer with corresponding revenue funding in 2013/14 is not included in this version of the model; nor is the outward transfer of schools support for academies).

For each service area, baseline spending has been set using 2011/12 Revenue Account data (and 2012-13 budget) and projected using the major drivers of cost for those services.

Drivers essentially break down into two categories:

- drivers of unit cost (eg inflation or efficiencies)
- drivers of service usage (eg population change).

The cost of servicing capital financing costs has also been included as an expenditure item and assumed to stay relatively flat throughout the period. This may be an underestimate since borrowing costs can be expected to return to higher levels over the decade. Although the Office for Budget Responsibility does forecast a 1 per cent increase in market gilt rates, higher interest rates will only apply to a small proportion of total local authority borrowing and the resulting cost pressures are not expected to have a material impact on expenditure for councils at a national level.

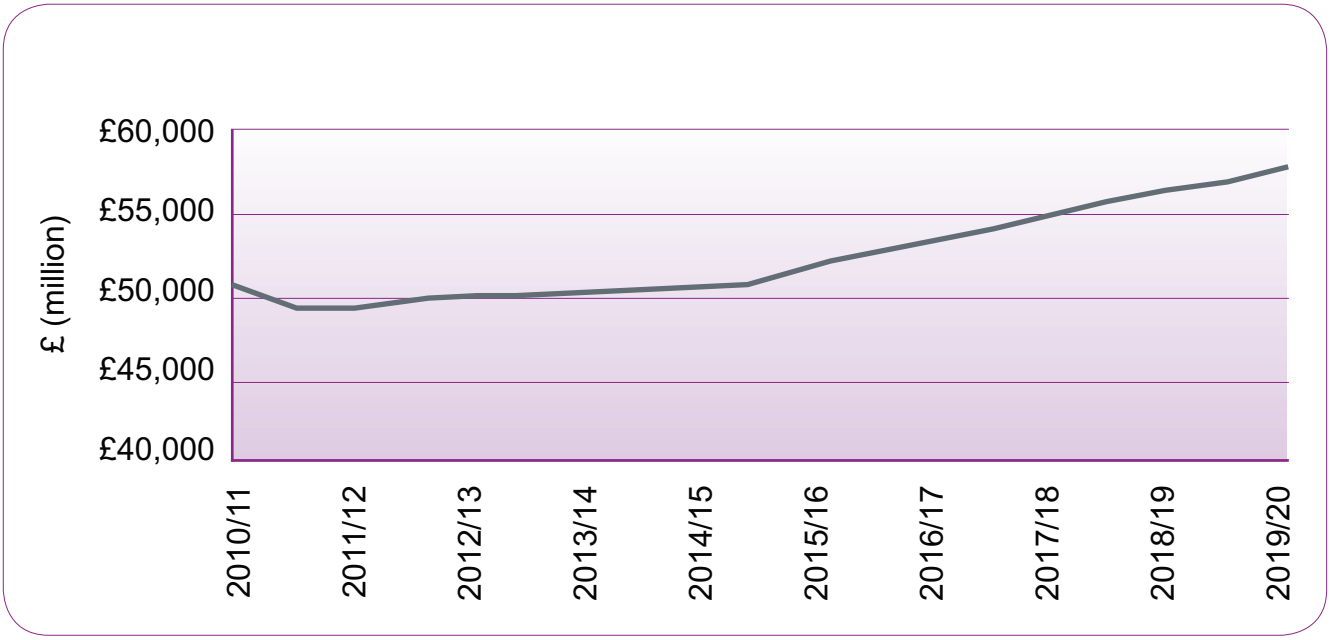
Cost drivers have only been included in the model where credible quantifiable data has been available, which means that in many instances the future expenditure on a service is likely to be higher than the estimate. Councils we have consulted on our figures have been unanimous that our estimates err on the cautious side compared to what they are expecting in their councils, in some cases significantly so. Annex B describes the block-by-block assumptions in more detail. We will be undertaking further work with councils to develop these.

The model also builds in efficiency assumptions. In this version of the model, the assumption is uniform for most services: councils start by achieving 2 per cent annual efficiency savings which tapers to 1 per cent by the end of the period.

It is sensible to assume diminishing returns from efficiency: nearly two-thirds of councils are already engaging in shared service arrangements and over 200,000 jobs have been shed since 2010. More detailed analysis will be required to estimate the scope for further efficiencies in each service block (eg savings from further outsourcing, different models of provision, sharing services, etc.)

The overall result for council spending pressures is shown in the graph below. The model shows that, thanks to assumptions about rising fees and charges and sustained efficiency increases, there is a very modest rise in expenditure demand throughout the period, with total predicted expenditure demand up in cash by only some £7 billion, or 14 per cent, by the end of the decade. This represents a historically-unprecedented real-terms fall of 6 per cent, with real terms cuts in every year for the first half of the decade and annual real increases below 1 per cent in the second. Many will question the plausibility of such a projection of success in containing spending pressures.

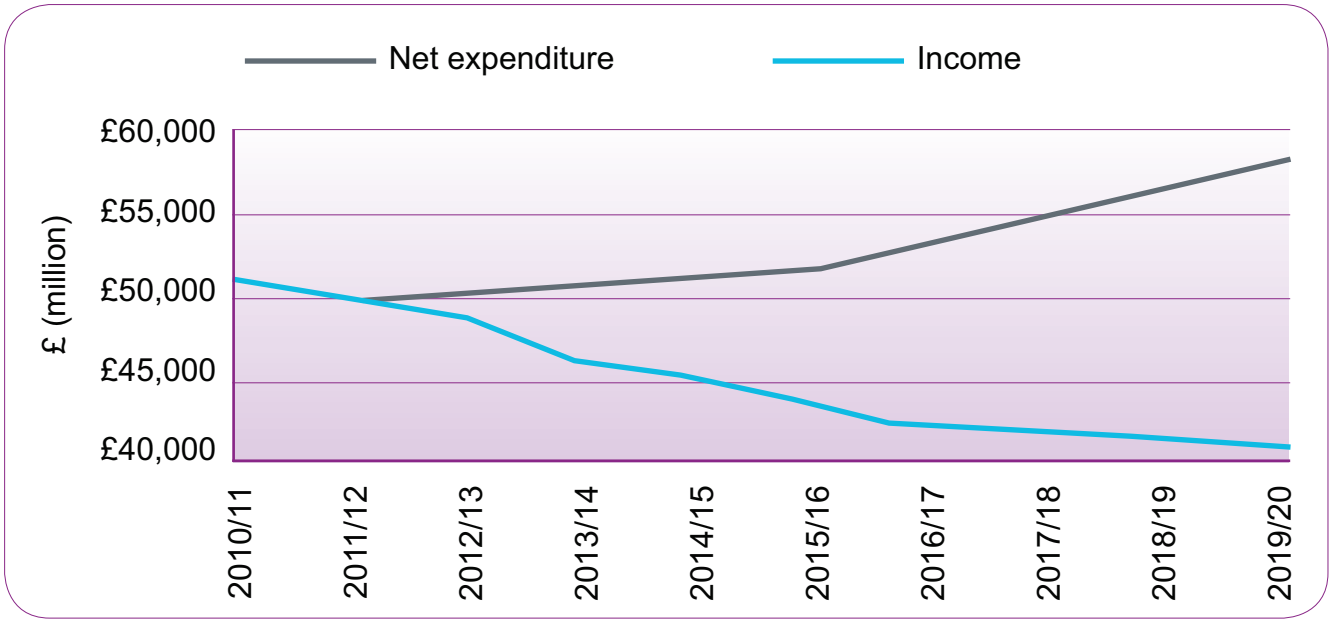
Chart 2 Projected net expenditure



4. Mapping income against spending

Our analysis then balanced projected spending against projected revenue to 2019/20. A gap opens out in 2012/13 and then continues to widen every year through to 2019/20. The overall funding gap starts at about £1.4 billion in 2013/14 in cash and amounts to over £16.5 billion in 2019/20.

Chart 3 Income vs Expenditure



In former times, such an analysis would have begun a conversation with central government about an increased path for grant income. The Government has, however, already made its broad intentions for public expenditure beyond 2015 clear. The question, therefore, is what those intentions mean for services.

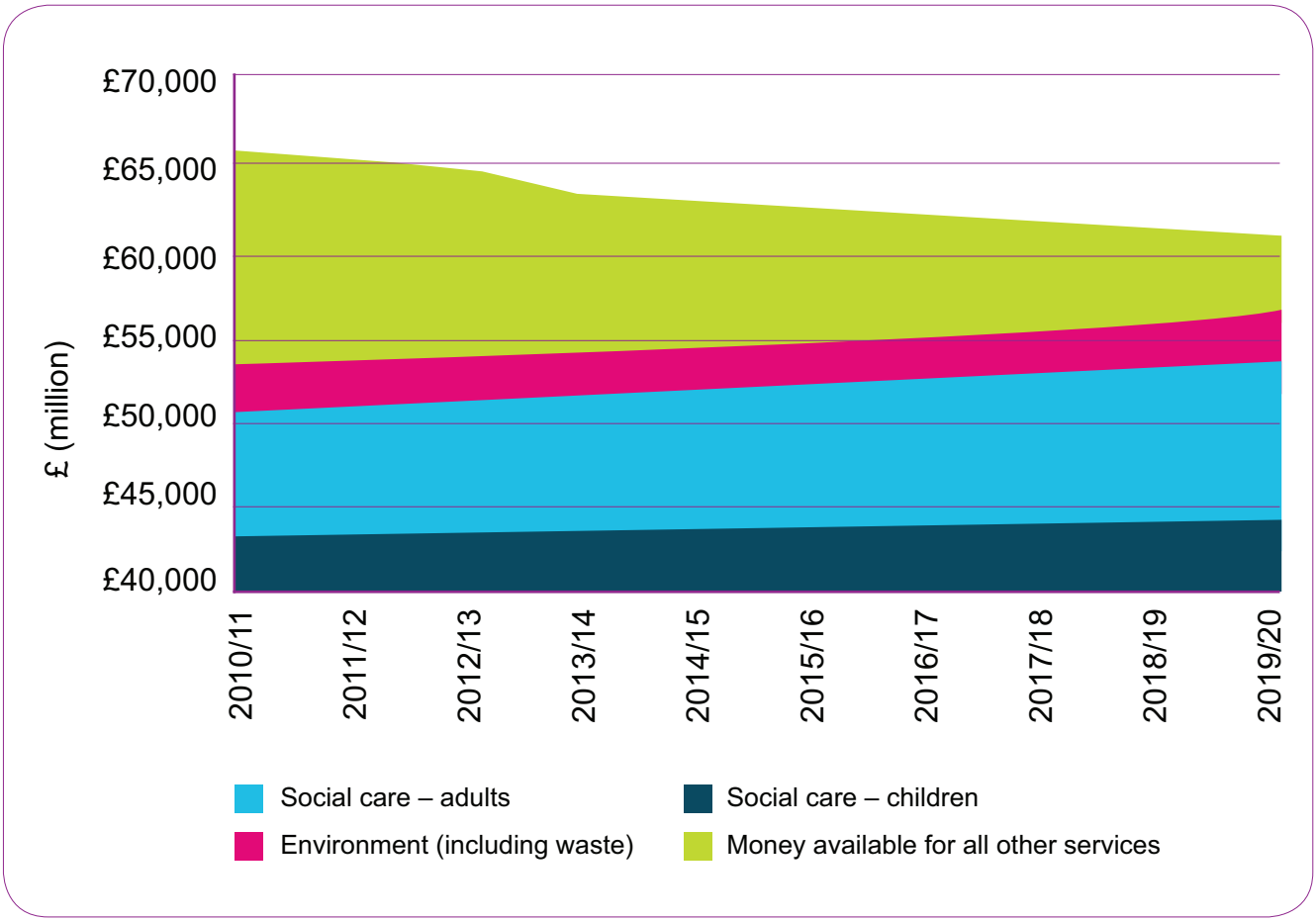
5. Funding for all council services

The model provides an opportunity to test councils' ability to deliver their unavoidable statutory obligations within the available resource envelope.

At this stage, we have made a very simplistic definition of "unavoidable statutory obligations" and deemed it to cover social care and environment/waste only. The model does, however, allow us to approach this in a more sophisticated way and we look forward to doing so.

The result, on this version of the model, is this graph:

Chart 4 Social care and waste spending within the overall funding envelope



With social care and waste spending absorbing a rising proportion of the resources available to councils, funding for other council spending drops by 66 per cent in cash by the end of the decade, from £24.5 billion in 2010/11 to £8.4 billion in 2019/20. This is the equivalent of an 80 per cent real terms cut.

If capital financing costs, worth about £4 billion a year in 2019/20, are also assumed to be an unavoidable cost, the resources available for other services drops to just under £4.4 billion by the end of the period, an 82 per cent cash cut.

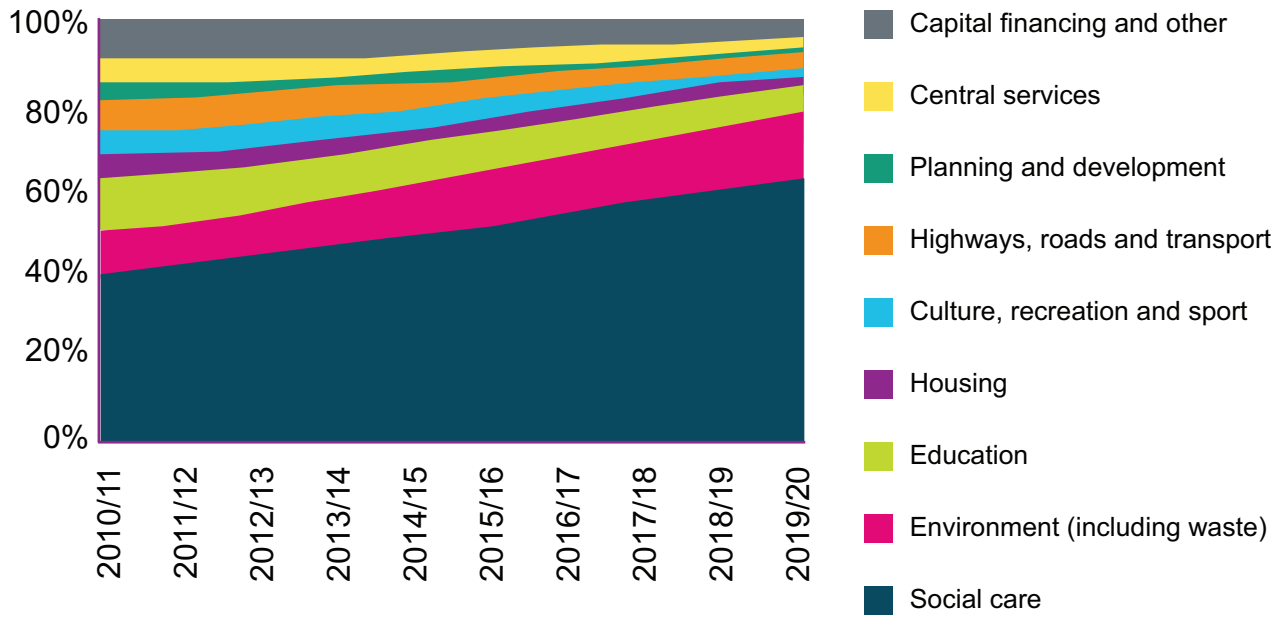
Our projections show that spending on public transportation alone, driven largely by concessionary travel – another largely unavoidable statutory obligation – is likely to amount to about £2 billion by 2019/20.

To fit within the envelope left after social care, waste, concessionary travel, and capital financing costs are taken into account, the spending projections in other service blocks would have to be cut by over 90 per cent in cash terms – which, in real terms, leaves practically no funding for them at all.

Reductions on this scale would be highly likely to leave councils vulnerable to legal challenge. Many of these service blocks have statutory elements which may not necessarily be prescriptive but have already proven to be highly-contested, such as spending on libraries and road maintenance.

It should be noted that the national picture masks a wide variation in the positions of councils within each type; this is particularly true for shire districts and unitary councils. These outliers face a number of risks which are likely to manifest themselves earlier than the end of the decade.

Chart 5 Service spending as proportions of overall budget



We also tested the assertion that sufficient savings can be achieved by sharing back office functions, or cutting senior management posts to avoid the need for frontline service reductions. The following graph shows the budgets available for each service within the modelled revenue constraint. It is clear that, with the best will in the world, cuts to central services spending could not make enough money available to protect frontline services from drastic reductions.

It is also worth considering the impact of 66 per cent cash reductions in service spending on electors and other residents. Even in the starting position, the largest amount of council spending is on the fewest people, as shown in the following charts:

Chart 6 Spending by service area

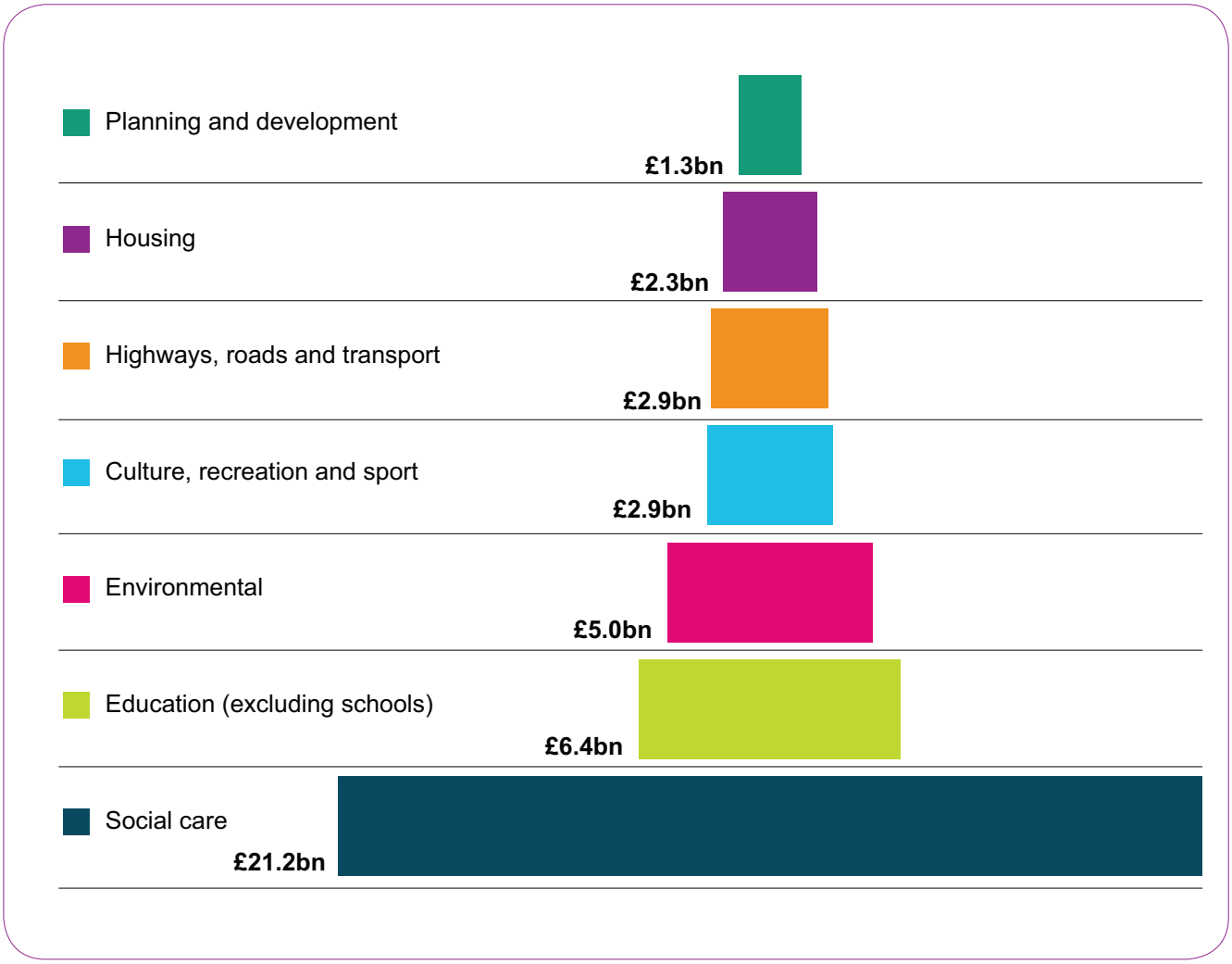
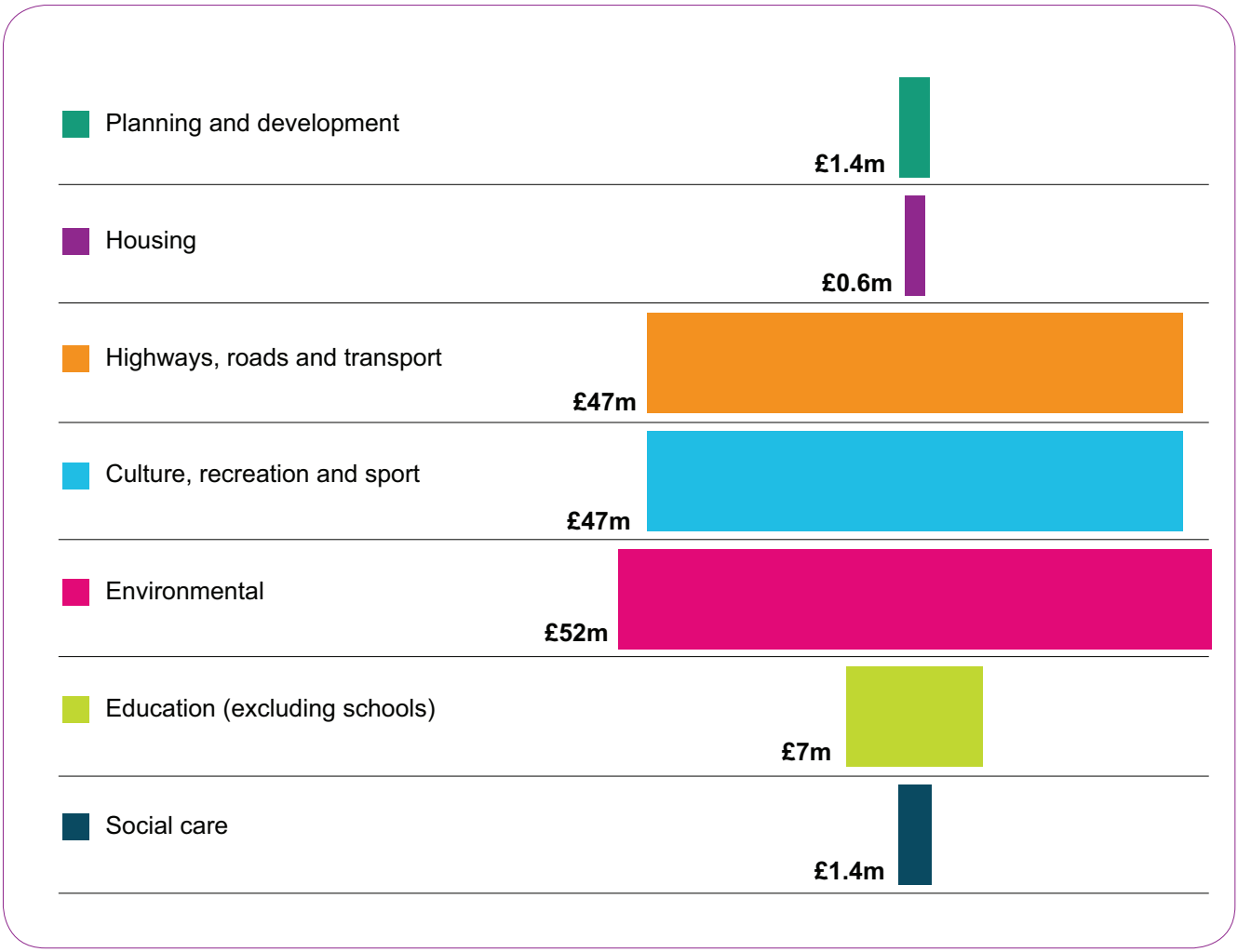


Chart 7 Numbers of service users by service area



It should be noted that chart 7 reflects only the number of care users for whom councils commission or directly provide care, which does not take into account how many people look to their council for support in this area. The majority of those receiving social care actually fund their own care, and councils have important responsibilities for market development and for ensuring the continuity and stability of care for local people. Nevertheless, there is a mismatch between where the bulk of council spending goes and the number of people who access those services. This mismatch risks being even further entrenched given the growth in social care demand that is expected by the end of the decade and beyond.

In the absence of fundamental reform to the way public services are funded and delivered in a local area, it would appear that either the statutory framework or citizen expectations for the mix of services that councils provide or commission will have to change – or, more likely, both. Our funding projections suggest that conflict between statutory duties as they currently stand may be unavoidable, leaving little room for funding of non-statutory services. This may, in turn, require a renegotiation of public expectations of services and central government expectations that councils can continue to deliver national policy outcomes that reflect less austere times. Simply put, the 'business as usual' service offer appears not to be possible for the end of the decade.

6. What does this mean for the future of council services?

This paper has modelled an extremely conservative account of the future spending pressures councils face, and a possible path for future revenue that errs on the optimistic side. All the councils with which we have discussed this work agree in telling us that their demand pressures are more acute than described here. The model shows that, even on that doubly benign scenario, councils will not be able to deliver their existing service offer and that radical change to existing policies for those services will be needed within the next few years.

Decentralising the politically difficult only works for a while

Councils were cut earlier and harder than the rest of the public sector as the government began to implement its deficit reduction policy. They have faced tougher spending cuts than most central government budgets.

It is precisely not the case that councils took the brunt of the cuts because they were perceived to be inefficient or overfunded to start with: indeed, the Prime Minister said that councils were "the most efficient part of the public sector" even as his government cut them harder than Whitehall. However, the government is fortunate that councils, with their greater local and public accountability and democratic immediacy, have shown over many years that they can manage tight budgets and take very difficult decisions. It was Ministers' easiest course to rely on councils to keep on taking those difficult decisions in a way that central government remains unable to.

The financial analysis in this paper shows, however, that the government cannot continue decentralising the politically difficult.

Magnifying the spending protection problem

The difficult choices that councils have already faced and the financial outlook described in this paper are a direct consequence of the Government's decisions about how to allocate public spending in the last Spending Review.

Government grants to councils were cut by 28 per cent while central government's own budgets were only cut by 8 per cent. But many central government budgets faced cuts of far more than 8 per cent. That is because the Spending Review prioritised spending strongly: demand-led budgets such as welfare benefits and interest payments received automatic protection; the NHS and schools were protected in real terms, and overseas aid as a share of GDP. Between them, those budgets account for three-quarters of all public spending, which means that almost the entire pressure of cuts has been brought to bear on the remaining quarter (which includes grants to councils).

What this paper has shown, however, is that council spending itself includes budgets that must be protected. That gears up and magnifies the effect of the spending protection in central government's budgeting. The 66 per cent cash cuts to non-waste, non-care budgets modelled in this paper is a residual of a residual – they are what is left behind after central government's budgets have been prioritised to protect schools and hospitals, pensioners and bondholders, leaving council grants at the bottom of the priority list, and after council budgets have then in turn been prioritised to fund care.

As a result, spending on services such as planning and road maintenance have had to take a bigger hit – a perverse consequence, when one considers that it is councils' ability to invest in the services that help to generate economic growth that is being hampered.

There is no particular logic to this position. It is largely a by-product of how Spending Reviews are run and how the budget lines Ministers consider are labelled. We can speculate that if Ministers had considered future spending using categories based on the service being delivered, rather than on departmental labels, they would not have regarded care of the elderly as being in the lowest-priority bracket and eligible for the highest proportion of cuts.

Efficiency is not enough

Councils have now shed 200,000 jobs in this decade. With two years of the current spending review period still to go, this number will increase significantly before the next Spending Review period. Pay has been frozen for three years in a row in local government, senior salaries are on a downward slope; and local government remains the only part of the public sector that has managed to negotiate a deal with both trade unions and central government to ensure the future stability and affordability of their pension scheme. As this paper shows, the money spent on corporate and back-office functions only came to less than £3 billion at the start of the decade: the cuts to non-care and waste services required by the end of the decade are worth more than five times that.

It is simply the case that the financial outlook for councils will not pay for the services they currently provide by the later years of the decade.

Both central and local government need to face up to what that means.

Councils cannot, unaided, change the legal or institutional framework that dictates their service responsibilities, limits their scope to do things differently, and constrains their revenue base. Councils cannot repeal the statute law that requires care must be provided, library service provision must be comprehensive and efficient, roads must be maintained, equality must be promoted, or – even – that local newspapers must be provided with copies of papers for council meetings. Unlike the Exchequer, councils cannot borrow their way out of trouble or raise new taxes. At present, impact assessments on narrow policy changes are conducted by individual departments without considering the cumulative impact on councils and the demands they place on their funding. Central government and Parliament can no longer delegate their part of the responsibility for making hard choices about local services. The next wave of decision-making will require a more explicit partnership between local and central government.

Options: Reform of adult social care

Future sustainability starts with social care funding reform. The conservative model in this paper makes it clear that care spending will continue to grow strongly while councils' revenues will fall and then stagnate. In fact, the situation is even more challenging for individual councils whose demographic profile is most heavily characterised by an ageing population. We are aware of councils which are modelling social care demand growing at twice the rate of the assumptions in our model.

As the model shows, the financial future of the local government sector is driven by care spending, It will pass 45 per cent of council spending in 2019-20, eating up other budgets as it does so.

We believe that reform must involve a number of components:

- Fairer funding: a fairer funding system with clarity about what the public and the state is expected to contribute towards care costs
- Simplification: a simpler legal framework for care and support to make the system easier to understand and navigate
- Integration: progress on making the right links with health, public health and housing to improve services for the individual and efficiency for the tax payer
- Increased funding: adequate resource for the system and recognition that structural reform and increased funding must go hand in hand

However, as fundamental reform of the system will take some years to legislate for and implement, let alone to take financial effect, the immediate funding issue needs to be urgently addressed. The Treasury has to recognise that it has a strategic misallocation of spending on its hands and correct that with an injection of Exchequer funding into social care to deal with the immediate problem, alongside implementing reforms to reduce long-term public sector costs. Independent analysis by the King's Fund points to a £1.2 billion gap in social care funding by 2014/15. On the scale of Treasury spending decisions, this is modest, a third of 1 per cent of total departmental expenditure limits, and is considerably less than the best estimate of the amount by which the Barnett Formula over-provides for Scottish public spending.

It may seem that transferring responsibility for social care to a better-funded part of government might solve councils' funding problem. But it would not solve the nation's problem and would, we believe, significantly worsen the prospect of keeping spending under control in the long term. If there is one lesson from the last 20 years it is that spending on care has been better controlled, better targeted, and better focussed on the user as a result of local control than it would have been under national management. When care was last nationally funded prior to 1993, the budget was wildly out of control and if there is a problem now it is arguably because councils have managed an underfunded system too well and the lid has consequently remained on for too long.

Local government can act as an integrated commissioner bringing health, housing, transport, leisure, training and other local services to support those with care needs and care providers in a way that no other public body would be able to match. Councils have already demonstrated that they are able to develop dynamic markets with a diversity of care providers to meet care and support needs along the whole spectrum.

We believe that social care reform along the lines that we have proposed can go a long way towards securing councils the headroom they need to maintain their current service offer in future.

Options: local public services should work together better

A number of councils have now gone well beyond shared back offices and brought service delivery together in shared organisations that answer to councillors representing more than one area.

South Oxfordshire and Vale of White Horse district councils created a shared management structure in the last Spending Review period. The West London councils of Hammersmith and Fulham, Westminster and Kensington and Chelsea have developed tri-borough arrangements for social care and public libraries, while East Lindsey and South Holland Districts have an integrated delivery structure for a wide range of services. The Greater Manchester Authorities have established a formal Integrated Authority to deliver economic development and transport services on behalf of the whole conurbation. Such initiatives are already spreading widely – although it would be mistaken to think these measures can do more than make a contribution to the overall need for savings: one recent estimate suggested they might contribute £2 billion, or one-tenth of the reduction in prospect for services apart from care and waste.

Much more significant savings are potentially available from reengineering the local public sector as a whole. The costliest and most intractable public service issues are almost without exception a responsibility shared among a number of local agencies, but those agencies in general share little else: neither budgets, staff, plans, objectives, or customer information. Hospitals spend huge sums of money maintaining elderly patients in acute beds while councils firefight within the care system, while joint arrangements to commission preventive work to keep people out of hospital are rare and riddled with bureaucratic barriers.

Intuitively, bringing more services of this kind together at local level with a collective budget and strategy would save money, both now and in the future, through focussing on reducing demand.

The evidence now available to show how this is possible is growing and improving in quality. The current Whole-Place Community Budget pilots are attempting to set the evidence from their places out in a compelling business case for radical change. Should they succeed, the economic and social arguments for seeking short- and long-term savings from integrating local services and commissioning will be compelling.

At the same time, councils in other places are working with other local public sector organisations to improve their collective effectiveness and efficiency. From the partnerships developing a single caseworker approach to Troubled Families, to the Creative Councils pilots, to the Capital and Asset Pathfinders, further evidence and more developed models of collective working are emerging to feed the business case for whole-place public sector management. Over the coming months, the LGA will be working to bring that, sometimes disparate, body of work together into a coherent picture of what the future local public sector might look like and how it might work.

Options: proper dialogue with residents about the local taxes they pay

A further option to buttress the future financial stability of councils is to give them greater ability to self-fund expenditure through local taxation, agreed and voted on by local residents. This might involve removing the continuing barriers to setting council tax levels without Ministerial interference, a more thoroughgoing localisation of the business rate than is currently on the table, the transfer of a buoyant national tax to local control – many countries have local sales taxes, for example, which could be replicated in this country by hypothecating a proportion of VAT

revenue – or allowing councils the discretion to raise their own supplementary local taxes from a predetermined menu of options. Allowing a genuinely free conversation with local residents about how much tax they want to pay and what services they want to receive in return is not only in the close spirit of localism, it is also fully consistent with the government's ambitions not to add further to public borrowing. The importance of this local democratic conversation with taxpayers has been highlighted in the recent work of the House of Commons Political and Constitutional Reform Select Committee on a Code for independent local government, and the LGA is pursuing it in its response to the Committee.

Options: cutting services out, not back

Finally, councils and the government will inevitably need to consider how to frame an effective conversation with electors and other residents about a service offer that is simply reduced from its current level.

The most direct option is to change the law. Parliament could repeal a proportion of councils' 1300 statutory duties and councils would cease to fulfil them. When the Government consulted on a review of councils' statutory duties in March 2011, the exercise proved to be controversial, difficult and painful. It was clear that the public is not ready to consider a significant change in the scope of what they have come to expect from the state. However, if public spending is to be constrained in the next Spending Review on the scale the Government is intending, central government must surely recognise that it will have to undertake a realistic review of the duties of the state.

In line with the government's commitment to transparency and localism, such a review would ensure that accountability rested in the right place: Parliament cannot expect to vote through spending limits that are inconsistent with the laws it itself has made.

A variation on this approach would be to exploit legal ambiguities to stretch the boundaries of what fulfilling a statutory service obligation involves. Councils could work with their communities to develop a shared and reduced set of expectations about what a park should look like or what the condition of a well-maintained road should be. As the latter example illustrates, though, providing "thinner" rather than fewer services carries legal and moral risks, as well as political ones.

Another option, though, is to reduce the scope of what councils do by transferring responsibilities to a better-funded part of government. Services which might be considered for transfer in this way might include regulatory services with a uniform statutory framework such as trading standards or animal welfare: but the sums of money at stake here are very small compared to the scale of the problem.

The need for a debate

Local government is the most efficient part of the public sector and will maintain that record. Its approach to overheads, shared services, senior salaries and procurement put central government's record in the shade.

It is also the most trusted part of government and the place where genuine and lively democratic debate with citizens about the public service offer can best be conducted. But now that the basic statutory service offer can no longer be reconciled with the funding outlook to the end of the decade, we need a debate about how to solve the problem in which local electors and councils, but also Ministers and central government, need to take a full and responsible part.

The last Spending Review decentralised the politically difficult. Over the second half of this decade, the challenge will be to prevent the consequences of that becoming politically impossible for councils and government alike. Without money and reform, there is no solution. We do not believe that this or any government would deliberately choose to do without filling potholes, funding the voluntary sector, commissioning public libraries, or planning for economic development. But planning future spending without planning the changes those spending plans require is to make that choice by inadvertence. The lines on the charts in this paper are the converging train tracks that will carry the most immediate and popular public services into history unless the passengers – government, councils and the voters – draw a new map for organising and funding local public service, and draw it now.

Annex A
Income assumptions

The model projects the likely path of council revenue, based on a number of assumptions:

- **Council tax:** We have assumed that council tax will be frozen until 2014/15 and will thereafter grow by 2 per cent per year. We have also assumed a very modest growth in the tax base of 0.50 per cent a year from 2013/14.
- **Formula grant:** We have used the Revenue Outturn (RO) returns for 2010/11; Revenue Account (RA) returns for 2011/12 and the 2012/13 Department for Communities and Local Government (DCLG) Local Government Finance Settlement for NNDR and revenue support grant (RSG) figures.
- **National Non-Domestic Rates:** The business rates system is set to undergo massive reform in 2013/14 but very little of the operational detail is publicly available. We have tried take into account how the new system is expected to work from the information that is in the public domain, particularly the Statements of Intent released on 17 May 2012. We have assumed future NNDR growth at 3.5 per cent (equivalent to 2.9 per cent in RPI, in line with the OBR's forecast, and 0.6 per cent in growth above RPI to reflect growth in the tax base, which is roughly on trend). To project income from 2013/14 when the new rates retention scheme comes in, we have assumed that councils will retain 50 per cent of total NNDR yield as the "local share" and that the share will remain constant throughout the period as set out in the Statement of intent on central and local shares published by DCLG.
- **Revenue Support Grant and other grants:** Detail on the use of the centrally retained share of business rates income and funding of grants is not yet available, although the Government's Statement of Intent indicated that in future very substantial amounts of grant that are currently funded separately would in future come within the scope of being funded from the business rates central share. More detail is expected to be published for consultation in summer 2012. For the purposes of the model, we have derived current levels of grant funding from published sources, including the DCLG RO returns for 2010/11; RA returns for 2011/12 and the 2012/13 DCLG Local Government Finance Settlement information. For 2013/14 onwards, we have assumed that the central share will be returned to local government through grants, and that for 2013/14 and 2014/15 other grant will be allocated in line with the total funding for local government set in the 2010 Spending Review. For periods beyond 2014/15, we have assumed that the total funding for local government will be reduced in a broadly similar manner to that set in the 2010 Spending Review. For 2015/16 and 2016/17, the trajectory modelled for grant funding is consistent with the assumptions set out in the 2012 Budget Statement on the likely overall level of Resource Expenditure. It is further assumed that, beyond 2016/17, the total level of government funding for local government continues to fall. Overall, in the 2010 Spending Review, central government funding for local government was cut from £29.7 billion in 2010/11 to

£24.2 billion in 2014/15. The assumption made in the model is that there could be a further reduction in funding to around £17.6 billion by 2020

- **Investment income:** We have used the RO returns for 2010/11, RA returns for 2011/12 and thereafter assumed that yield will be responsive to the changes in the market gilt rate, although we have not included any assumptions about changes to the levels of investment.
- **Transfers to and from reserves:** We have used the RO returns for 2010/11, RA returns for 2011/12 and data from DCLG on councils' planned reserves for 2012/13. We have assumed reserves will be drawn down through 2013/14 but gradually rebuilt as the new business rates retention scheme and localisation of council tax support will require authorities to manage an unprecedented level of volatility at the local level. We expect that the effect of these changes will be an inclination to build up reserves as a safeguard.
- **Sales, fees and charges:** The RA data that forms the baseline for this model does not include data on fees and charges, so we used 2010/11 RO data on the proportion of expenditure in service blocks that come from fees and charges and applied these splits to 2011/12 RA data. We assumed that income from sales, fees and charges would be sensitive to prevailing economic conditions and applied a multiplier derived by calculating the difference between consumer price index (CPI) and the output gap to market-facing services. Then we applied the additional income from sales, fees and charges against expenditure rather than income.

The revenue lines are adjusted to remove income attributable to authorities whose spending is not modelled (see section 3).

Annex B
Cost drivers in service areas

This section sets out the primary cost drivers that have been applied to each service area and identifies other factors which are likely to drive costs but which we have not been able to quantify.

Education

- Expenditure excludes services funded by Dedicated Schools Grant, Pupil Premium, and Further Education Funding.
- Inflation and the Office for National Statistics (ONS) projections for child population were applied as cost drivers in the model.
- Child population numbers were used rather than pupil numbers because education-related services that are funded from outside the Dedicated Schools grant have a user base that extends beyond pupils.
- The impact of central government policy decisions such as increased number of academies and knock-on effects of any future changes to the schools funding formula are not reflected in the model.

Children's social care

Inflation, the change in child population, and changes in the numbers of looked after children (LAC) are applied as cost drivers.

- The increase in the numbers of LAC are derived from the historic ratio of LAC to child population.
- The model assumes that pressures on LAC increase at the beginning of the period, reflecting the trend since the Baby Peter case in 2008, but it also assumes that these pressures will start to abate by 2014/15.
- It seems highly likely that projections in this service block underestimate future spending pressures since reliable data was not available for key cost drivers such as changes to the length of time spent in care, increase in referrals, use of agency staff, complexity of care needs, etc.
- The Children and Family Court Advisory and Support Service also report that there has been a sustained increase in the number of councils applying to the courts for Care Order since the Baby P case, but the numbers are still too volatile for a trend to be predicted and the average costs for councils leading up to a court application have not been accurately determined.
- Of cost drivers that have not been applied to the model due to the unavailability of reliable data, changes to the numbers of referrals and the type of care that is provided are considered by far the weightiest cost drivers and sector advisers suggest may even outweigh the three cost drivers that have been quantified in the model.

Adult social care

- We relied entirely on the 2011 projections of the London School of Economics Personal Social Services Research Unit projections about the growth in demand in both areas (driven by changes to changes to population over 65 and changes to population of adults aged 18-64 with learning disabilities).
- We split this area into two, projecting spending on older people and other adults with care needs.
- The model assumes that post-2015 social care staff pay will increase by 2 per cent per year in real terms.

- The impact of changes to the types of care that people receive, Dilnot proposals/ government changes to funding of ASC, changes to NHS spending on reablement and other services, and the impact of shortfalls in Disabled Facilities Grant funding have not been applied to the model.

Highways, roads and transport

- We split this area into two: concessionary fares and all other spending.
- For concessionary fares, we applied inflation but have made a highly ambitious assumption that demographic pressures due to increased numbers of pensioners will be offset by reductions to the discretionary element of spending, which amounted to about 18 per cent.
- However, this is likely to be optimistic as several of the key cost drivers in concessionary fares are in the hands of commercial bus operators and are factors over which councils have limited influence, eg commercial bus fares and the operating costs of bus companies.
- For other transport spending, we applied inflation and vehicle miles based on the Department for Transport's (DfT) 2011 Road Traffic Forecasts.

Housing

- We factored in inflation and changes in the number of households.
- The model does not include any estimates of the impact of housing benefit changes or the economic downturn on demand for housing advice, applications for homelessness, demand for Disabled Facilities Grant, etc.

Culture, recreation and sport

- We split this area into two: libraries and all other spending.
- For libraries, in addition to factors that increase costs such as CPI and population change, the model also takes account of deflationary pressures such as reduced library usage.
- We were not able to quantify aggregate savings from the four major reform models that libraries are using.
- Currently 50 per cent of culture and sport services are outsourced to social enterprises, charitable trusts or the private sector. This is especially so in London and big towns. We can expect this to increase although at the moment there is limited interest from most large cities.
- We also assumed that councils would be able to find a further 2 per cent a year efficiency savings either in their own operations or from contracts with other providers in the last four years of this period.

Environment

- We split this into two: waste management and all other environmental services.
- We applied the cost of landfill as a driver by multiplying estimates of household waste from Department for Environment, Food and Rural Affairs (Defra) statistics by the cost of the landfill tax.
- Figures are based on the assumption that the percentage decrease in the amount of waste landfilled will be 6.31per cent until 2014/15, based on the historic trend.
- In 2014/15 landfill tax will reach £80 per tonne. As the Government has not announced plans to increase the landfill tax further after this date, it is anticipated that the rate at which landfilling decreases

will slow because increases in landfill tax have been key in encouraging increased recycling.

- From 2015 onwards we have predicted that the percentage decrease year on year for landfill will be half the rate of previous years.
- It also will be harder to reduce the amount sent to landfill once certain levels of recycling have been reached.
- We also applied values for increases to collection costs based on the average percentage increase in the cost of waste collection from 2006/07 to 2010/11 (applied forward 2011/12 until 2019/20) and the projections for growth in households.
- On the whole, it is likely that waste management costs are underestimated as, apart from landfill tax, cost drivers associated with disposal such as volatility in the recyclates market have not been able to be factored in.
- For other environmental services, we factored in inflation and population change.

Planning and development

- The model factors in inflation and population change.
- It also projects that the number of planning applications will stay constant to 2013/14 but will thereafter increase by 5 per cent a year as a result of economic recovery and will climb gradually back to the levels received by councils at the start of the last decade.

Central services

- The model assumes that councils will continue to target corporate and back office functions to achieve maximum savings, but will reach a point about midway through the decade when they start to see diminishing returns, given the high levels of efficiency savings from these functions they have already realised.
- It is highly optimistic to assume that councils will be achieve savings that exceed their Gershon targets in this area.

Capital financing

- The Office of Budgetary Responsibility forecasts market gilt rates up to 2016/17. While methodologically it may be feasible to make an estimate of what these changes could mean for capital financing costs there are too many unknown factors for such estimates to be meaningful.
- The forecast interest rates would only apply to new borrowing that is undertaken between now and 2020. It is so far unclear what impact budget cuts will have on the level of prudential borrowing undertaken by local authorities. One outcome could be that councils borrow more to compensate from a loss of capital grant. However, it is equally plausible that councils rein in borrowing as a result of pressures on their revenue budgets.
- As it is not possible to forecast what future borrowing levels will be, it is also not possible to forecast the relationship between new borrowing and amortisation of historic debt. These unknown and unpredictable variables mean that any estimate of future financing costs that includes future interest rate changes would not be sufficiently robust.

- New borrowing was on average 7.3 per cent of the total amount of historic debt each year between 2005/6 and 2010/11, and it would optimistic to assume that borrowing levels will continue to be this high. The OBR's forecasts see interest rates changing by 1 per cent between now and 2016/17. Applying this 1 per cent fluctuation to somewhere between 5-10 per cent (based on historic trend) of borrowing would not be expected to yield a difference in funding pressure that is significant at a national level.
- As any changes that result from including future interest rate changes would be marginal, we believe that assuming that capital financing costs stay flat will not have a material impact on the outcomes of the model.

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L12-449

MEDIUM TERM SERVICE & RESOURCE PLAN
PEOPLE & COMMUNITIES (Adult Social Care & Housing)
2013-14 until 2015-16

ANNEX 1

1. Introduction

This plan shows the changes that are already taking place and proposals for the future in response to the key influences and challenges facing the People & Communities Department and, in particular adult social care and housing.

This plan is one of a series of plans that make up the Council's Medium Term Service & Resource Plan:

- Resources
- People & Communities
    - Children's
    - Adult Social Care & Housing (this plan)
- Place
    - Service Delivery (Planning, Transport, Waste, Highways, Libraries, Tourism Leisure & Culture)
- Regeneration, Skills & Major Projects

The overall context is rising demand for services alongside reductions in public expenditure that are unparalleled since the Second World War. In the short term this Council's reserves and commercial sources of income, together with its long term financial plans and efficiencies, put it in a strong position. However, the situation is now radically changing with the need for a shift towards substantial reductions in service provision to supplement efficiencies.

The external and corporate influences on this plan can be summarised as follows:

- Reductions in public expenditure and reduced Council budgets – this is the third year of the 2010 Government Comprehensive Spending Review (CSR) which covers the four years to 2014/2015 – the savings are very challenging and are set to continue well beyond 2013 – CSR 2010 took 28% out of local government funding (for the first 3 years of this settlement) and additional reductions are now coming in.
- There is a key demographic change with a projected 40% increase in the older population by 2026 creating a significant additional financial pressure and an increase of the entire population of 12% by the same date.
- Increases in Council Tax will in future be supplemented by 6 years of new homes bonus. These changes are helping to offset the reductions but only have a relatively marginal impact.

- Business rates growth (or decline) will from April 2013 become the responsibility of local government (as at least 50% will be retained or lost locally) and a level of growth below 1% p.a. is expected - with 90% of growth occurring as a result of growth in the enterprise area in Bath.
- No end is yet in sight for the review of funding of social care – following the Dilnot Commission - the increasing costs of care run the risk of making Council budgets unviable over the next decade, although there have been suggestions there may be some announcements as part of CSR 2013 to help mitigate this.
- The Government estimates that there are 220 families in Bath and North East Somerset experiencing a range of needs and who are costing services between £250K and £300K p.a. per family. Joining up services between agencies supporting such families is becoming a national and local priority.
- Schools continue to self-fund (through the Direct School Grant ring fenced budgets) but those that become Academies, which is the majority of secondary schools, are independent of the Council and its support. This creates diseconomies that have to be absorbed as the local education authority role diminishes.
- Government expects that councils will continue to deliver further efficiencies and minimise Council Tax increases – Government guidance says increases are to be below 2% in 2013 to avoid triggering a local referendum and offers a 1% grant (for 2 years) to temporarily reward Councils for a 2013/14 Council Tax freeze.
- Changes in Government legislation, regulations and guidance - there are some simplifications and some new scope for local decision making but at the same time radical and demanding changes such as:

    - Localism, Planning Reform, new grant funding to support local government (less money and less types of grant),
    - Return of a share of Business Rates and related growth to local government, new Benefits system (Universal Credits and Council Tax Benefits – the latter now called Council Tax Support),
    - Incentives for growth (new homes bonus, regional growth fund, Business Rates growth, Local Enterprise Partnerships, more discretion over Council Tax discounts such as for empty homes and a second homes premium).
    - The Council will also be taking on significant statutory functions for Health and Wellbeing in the area and the connected strategies and Boards.

The Council published a new corporate plan in 2012 which outlined a new vision and objectives. The Council Change Programme remains a key driver for internal efficiencies and improvements in services to customers. Note: A summary from the latest Joint Strategic Needs Assessment – the source of some of the above needs-related statistics - is attached as Appendix 4 (more detail is also available on the Council's website).

2. Existing Staff Resources & Finances

On 1st October 2011 700 social care staff and 1000 health staff providing integrated Community Health & Social Care Services transferred to the newly established Sirona Care & Health CIC (Community Interest Company). The relatively small retained staffing resource, sitting in the new People & Communities Department, undertakes the integrated commissioning of health, social care and housing and, also, the delivery of housing services, which did not transfer to Sirona.

The functions incorporated in this plan are listed below. Changes start with this as the base position (September 2012).

	Gross £'000	Net £'000
Mental Health Commissioning – Adults of Working Age and Older People	9,459	6,608
Older People Commissioning	23,965	8,044
Physical Disability & Sensory Impairment Commissioning	3,410	3,113
Learning Difficulties Commissioning	16,629	7,902
Supporting People & Communities Commissioning	6,393	5,840
Adult Care Commissioning – Other	3,958	4,025
Adult Substance Misuse (DAT)	2,729	519
Housing Services	2,002	1,597
Sirona Care & Health	18,343	18,343
Fairer Contributions Income		(1,865)
Total 2012/13 budget at October 2011	**86,888**	**54,125**

A more detailed analysis of planned revenue and capital expenditure is contained in Appendices 1 and 2.

3. Key Proposed Changes – Years 1 to 3 – 2013/14 to 2015/16

Many of our proposed changes are intended to address the increasing local demographic pressure faced by the Council. In three years, the local increase in the number of people aged over-65 is projected to be 5.6% and for people over-85 the figure is 5.8%. This compares with an overall increase of 0.5% in population over the same period.

Providing more people, who are also living much longer, with health and social care will be very expensive with costs locally increasing from £18.2 million (in 2010) to potentially £34.6 million by 2035. This is the local manifestation of a national challenge which national government has to address.

This combination of demographic pressure and underlying budgetary pressure requires a multi-stranded approach: -

- Investment – the Council has within its budget earmarked an extra £3.251 million over the next three years
- Efficiency measures
- Service reductions

- Re-prioritisation of significant parts of our budget to focus on the wellbeing of the most vulnerable adults and placing an emphasis on maintaining the independence of older people in their own homes.

The scale of the challenge means that there is a need to take a structured approach to the next 3 years. A 3-year programme is proposed - involving the community as far as possible and being mindful of impacts on specific groups within our local community.

2012/13 represented the third and final year of a programme set out in the Adult Social Care & Housing MTSRP 2010/11-2012-13, aimed at bringing the unit cost of placements and packages in line with the South-West average and also at reducing the number of residential and nursing care placements made, so that we could focus a greater proportion of our spend on supporting people to be cared for in the setting that they want – usually their own home.

An ambitious work programme designed to deliver a reduction in both the unit cost of residential and nursing care placements and a reduction in the number of placements being made in residential and nursing care has been in place during this period.

Key elements of the work programme are as summarised below:

- **Single Panel** – has been in place since March 2011, replacing client-group specific panels for agreeing placement/package funding. The change is designed to ensure consistency, equity and value-for-money for all individual placements and packages of care and also to identify pricing differentials between different providers for comparable placements and packages.
- **Placements & Packages Policy** – sets out for health and social care managers and other case managers the overall approach and policy framework for setting up placements and packages of care and support in B&NES, including guidelines on resource allocation and specific areas of practice. Was formally adopted, following consultation, in April 2011.
- **Investment in community-based options** - including re-ablement, rehabilitation, prevention and early intervention where the evidence supports these approaches as sustaining people in their own homes;
- **Market Shaping** - greater focus to procurement; contract negotiation and management. Targeted negotiations with providers informed by benchmarking and pricing structure breakdown were undertaken and delivered efficiency savings each year in the period 2010/11 to 2012/13. Focused re-commissioning of some learning difficulties and mental health services delivered improvements in quality and value-for-money.

The key risks and challenges associated with delivering savings through this approach include:

- Savings were modelled on benchmarking the number and unit cost of existing placements in residential and nursing care. Delivery of savings from these existing placements depends on a change in the placement/care package and/or a reduction in the care home fee. Provided assessments and support plans are quality assured, changes in individuals needs resulting in a reduction in placement/care package costs are unlikely for the majority of existing service users;
- Capacity and capability to undertake contract negotiations and achieve real fee reductions, particularly as a significant proportion of placements and packages are procured on a “spot” (individual) rather than “block” basis, with an increasing number purchased through a Personal Budget. Some additional, non-recurring resource had a positive impact on progressing this work whilst also supporting learning and personal development across the commissioning team but this continues to be a challenge;
- Although B&NES unit costs for residential and nursing care placements benchmark higher than average across the South West, B&NES fees benchmark as average in the sub-region (South Gloucester/Bristol/ North Somerset). A real reduction in fees against this more local benchmark may make it more difficult to compete in the market and secure individual placements; and
- Delivering an efficiency saving from providers of residential care should not directly impact on service users, however, 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. Commissioners continue to closely monitor both the quality and safety of residential care services, including staffing levels and skill-mix, training and management arrangements.

The deliverability of further efficiency savings from the purchasing of placements and packages of care over the next three year period does need to be considered in the context of the preceding three-year efficiency programme. It is also important to recognise that purchasing budgets (funding a wide range of commissioned independent and third sector services, including nursing, residential and home care as well as Personal Budgets) represent approximately 90% of the Commissioning budget with the remaining 10% funding delivery of housing services and the commissioning team, including the Director of Adult Social Services role, adult safeguarding and quality assurance.

As in previous years, we have adopted the following approach in developing the proposals for achieving long-term, sustainable financial balance in the context of the reductions in public expenditure and reduced Council budgets set out earlier in this report:-

- **Productivity & Efficiency** - prioritise those areas where either our knowledge of the market and/or benchmarking of our performance and/or spend indicates that there are still efficiency gains to be made through: effective procurement and contract negotiation; and streamlining or tightening systems and processes.
- **Service Redesign** – making improvements to care pathways to improve outcomes for individuals; and shifting investment in line with our strategy.
- **Changing the Offer** - in the context of demographic pressures and reduced public sector finances, it will be necessary to limit access to services and increase income from charging for services.

The most recent national benchmarking information indicates that there is further work to be done in reducing the number of residential and nursing care placements made in line with the overall service strategy, which is to sustain greater numbers of people in community settings by:

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

Despite the scope for realising further savings from residential and nursing care placements, the scale of the financial challenge is such that it is necessary also to limit access to services. It is proposed that this be done by targeting investment in services that sustain people with relatively high levels of need in their community and reduce the need for residential care and hospital admission. However, this does mean that there will be reduced funding of untargeted universal services, particularly those where there is little evidence of good quality outcomes for people in need and/or where those services are currently primarily accessed by people with lower levels of need.

4. Finances & Service Impacts

The service impacts of the changes are set out in the attached impact analysis at Appendix 3 and summarised below.

The following savings targets have been set for the next three years:

- 2013/14 £1,836m
- 2014/15 £1,179m
- 2015/16 £1,326m

Pay has been assumed to increase by only 1%. The unavoidable growth in 2012/13 is itemised in Appendix 3 and is mainly associated with contract inflation, pay increments and demographic growth. This means the real savings in each year will need to be in the region of 5% of gross spend.

The proposals to meet the three year targets can be categorised as follows:

» Cashable Efficiencies £1.882m
» Additional Income £0.640m
» Reduced Service Levels £0.881m
» Reduced/Discontinued Services £0.938m

Savings proposals totalling **£4.341m** set out in Appendix 3 can be summarised as follows:

- **Sirona Care & Health Contract** – In partnership with Sirona Care and Health reopen contract negotiations with an additional savings target of £1.15 million to be achieved through efficiencies in social care processes. A recently published Audit Commission report indicates that there is scope to achieve such efficiencies. However, there are challenges associated with the delivery of this additional target (a total £9m saving is already incorporated into the 5-year contract between Sirona, the Council and the Primary Care Trust). To deliver this level of savings from efficiencies, Sirona and the Council will need to work together to redesign the system and agree associated policy changes. The system includes the Council's one-stop-shop, which would need to provide effective sign-posting and advice aimed at diverting people from mainstream social services. Development and agreement of detailed proposals, including system-redesign and policy changes will need to be undertaken during 2013/14 for implementation in 2014/15.

- **Refocusing part of our spend on residential/ nursing care to preventative services** – deliver an efficiency saving of £830k by supporting people to live in the community through commissioning highly targeted and effective preventative services. In tandem with this ensuring access to signposting to universal services and provision of advice, including financial advice to self-funders, thus reducing spend on registered residential and nursing care provision. This impacts on all service user groups, older people, including those with dementia; people with a learning disability, mental health need or physical disability. A key challenge associated with delivery of this saving is the current level of capacity in preventative services to effectively support and sustain people in community settings with small, low-cost packages – particularly in light of other savings targets against Supporting People & Communities services commissioning. There is also a risk that delivery of this efficiency saving impacts on commissioned services quality. Steps will need to be taken to ensure that there is a timely response to adult safeguarding concerns with associated increased pressure on commissioning capacity to respond to and take action in respect of these concerns.

- **Reduction in spend on Supporting People & Communities (SP&C) commissioning** – Over the coming years, the Council will focus the money it has available on care for the most vulnerable adults to support their independence. As such, we propose to deliver a saving of £1.438m with targeted reinvestment of £500k bringing the net saving to £938k. There will be an impact on a range of services which community organisations, as well as independent sector organisations, provide on our behalf. There will be an impact on the people who currently use these specific services, such as older people, people who need support to enter or re-enter the workplace, people who need support to avoid/prevent homelessness, people who are socially excluded because of multiple/complex vulnerabilities such as mental ill health, disability, poverty, poor educational achievement and poor housing. It is proposed that £500k re-investment is made in targeted services designed to mitigate the impact of the funding reductions and also to realise savings from a) assessment/care management (as set out above); and b) reduced admissions to residential care services.

- **Use of Section 256 Funding** – in order to off-set demand pressures arising from demographic changes, it is proposed that £500k of the Department of Health reablement and “winter-pressures” funding transferred by the PCT/CCG to the Council under a Section 256 agreement along with a further 1-year carry-forward of £1m from 2011/12, be used to fund growth in the adult social care purchasing budgets for placements/packages/Personal Budgets (PB). However, there is the risk that this funding, which is currently allocated on an annual (ie non-recurrent) basis is not confirmed for future years and/or is confirmed at a lower level than in previous years.

- **Change Programme Savings -** The Council’s internal Change Programme is now in the third year of a five year work programme. It is aimed to deliver a range of service improvements for local people and make significant financial efficiencies. A total of £634k of savings within this plan forms part of the programme. £541k of savings is built into the Sirona contract (this is separate from the additional savings highlighted above), £78k efficiencies expected from the “customer services reconfiguration” project and £15k from the “Procure to Pay” project.

5. National and local Performance Frameworks

There have been significant changes in the national performance regime in the last 18 months. An initial reduction in the national performance framework has been replaced by a number of service specific requirements in Adult Health & Social Care and Public Health. National inspection frameworks in Adult and Children's Services (CQC and OFSTED) are continuing.

Further national performance frameworks are anticipated to emerge in the future. The Local Government Association (LGA) has introduced a new national Peer Challenge scheme. Most local authorities are expected to participate in this scheme which replaces the Audit Commission's Corporate Peer Assessment (CPA). This will allow local authorities to identify their own strengths and areas for improvement. It is anticipated that Bath & North East Somerset Council will undergo a peer assessment in 2013.

The Council has developed a new performance framework which meets service specific national requirements and also provides local performance information to support effective decision making. This incorporates value for money (VFM) and benchmarking where information is available and a corporate VFM judgement continues to form part of the annual audit of accounts.

Currently, it is not possible for councils to compare their relative overall performance as this information is now not gathered nationally. However, continuing local monitoring indicates that levels of performance have been broadly sustained and we are currently reviewing how we can actively demonstrate this using the new LGA mechanisms.

6. Longer Term Options – Years 4 to 10

The longer term solutions are more speculative and will in part be driven by the wider agenda for local government, city regions, Local Enterprise Partnerships, demand pressures on social care (with an aging population), climate change issues but also perhaps the growth and economic prosperity opportunities arising from an expanding population.

The proposed changes in the next 3 years are radical and will set the agenda for some years to come. Public expenditure reductions will also continue for some years to come. The slow recovery of the economy and public sector finances at a national level is a major concern and threat to local government.

The Council's role as an enabler and community leader is crucial to the changes described here so that local people have access to the right services. The changes in schools and health and social care alone will radically take this agenda forward over the next 3 years.

The fundamental issue remains the funding of social care. The increasing demands and associated costs are linked to the demographic change affecting all Councils as people are living longer and the population of people in care continues to grow. This runs the risk of making Council budgets unviable if a new approach and national funding system is not introduced. Councils will not be able to support their other priorities in the medium term if this issue remains unresolved.

A graph showing the potential effect of social care funding in the medium term is attached as Appendix 6. The analysis has been provided by the Local Government Association.

7. Approval of this plan

This plan is to be considered by the Wellbeing Policy Development & Scrutiny Panel in November 2012.

The Cabinet Member for Wellbeing will then review it again so that any changes can be incorporated into a final version of the plan for approval alongside the overall budget in February 2013.

Appendices

Appendix 1 – Adult Social Care & Housing – Analysis of Headline Numbers
Appendix 2 - Adult Social Care & Housing - Capital programme
Appendix 3 – Adult Social Care & Housing - Impact of proposed budget changes
Appendix 4 - Joint Strategic Needs Assessment Summary
Appendix 5 - Council's financial context
Appendix 6 – LGA Report – Funding Outlook for Councils from 2010/11 to 2019/20

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REPORT TO HEALTH OVERVIEW AND SCRUTINY COMMITTEE AT BATH & NORTH EAST SOMERSET COUNCIL

PROPOSED CHANGES TO: Sirona Paediatric Audiology Service

Prepared by: Martha Cox

Date: August 2012

DECISIONS REQUESTED

The Overview and Scrutiny Committee (OSC) is requested to determine whether the proposal to relocate the Paediatric Audiology Service from the RUH to the St Martins Hospital site constitutes a substantial variation or development.

PART ONE – Description of proposed service changes

1. The current service

Children's Hearing Services – a community based service to assess hearing in children aged 6 months to 16 years at one of 15 venues across the Bath Clinical Area (B&NES, West and North Wiltshire and the Mendip area of Somerset), referred by GPs and health visitors in the main, but also from paediatricians and speech therapists. Approx 2500 new cases are seen each year. Many children suspected of hearing loss are shown to have normal hearing or a temporary loss due to glue ear. Children with permanent hearing impairment are seen in specialist clinics, and babies diagnosed with hearing loss following newborn hearing screening are closely monitored. The clinical team includes audiometricians (health workers trained and experienced in assessing children's hearing) and paediatric doctors, and is headed by a Consultant Paediatrician qualified in Audiological Medicine. The service follows protocols published by the British Society of Audiology. The service also delivers the newborn hearing screening service to approx 5000 babies born in the Clinical Area, and the school hearing screening programme for approx 5000 school entrants.

2 What are the proposed service changes

The proposed service changes are to relocate the Paediatric Audiology Service from its current location at the RUH to the St Martin's site.

Context

"Transforming Services for Children with Hearing Difficulty and their Families" – DH August 2008 is a Good Practice Guide which sets out the challenge facing children's hearing services and a vision of quality improvement. One specified key element is the provision of appropriate testing facilities for assessing children. The paediatric audiology facilities at the Royal United Hospital, Bath currently fall short of the expected standards within that Guide.

The single largest shortfall is the lack of a reliable method for assessing hearing in each ear for children under age 4 years and especially under 2½ years (the latter age group representing up to 20% of referrals dealt with by audiology service). The technically superior and accepted method of testing this age group is by Visual Reinforcement Audiometry (VRA). The technique requires delicate and sensitive equipment to be left *in-situ* and is performed in a sound treated environment (below 20dB background noise). This can only be achieved in dedicated paediatric audiology rooms where it has proven to be robust, reliable and great fun for the children themselves.

Additionally, the current service does not conform to standards associated with trying to assess children aged between 2½ and 4½ years who require play audiometry; they too require sound treated rooms for assessment which are not available in Bath & North East Somerset (nor in Wiltshire). This group represents 36% of referrals.

3 Why are these changes being proposed?
The effects of the above is that 50% of hearing assessments carry unacceptable risk of not picking up hearing difficulties which could lead to permanent loss of hearing.

The room specification at the Royal United Hospital Children's Centre (where the only sound proofed room is located) has been highlighted as unsatisfactory in the National Quality Assurance Report on Bath Newborn Hearing Screening and Audiology Programme (NHSP) in three consecutive reports. In addition there are capacity issues due to restricted clinic room usage at certain times. There have also been a number of recent patient safety incidents within these clinics due to the restrictive space available.

4 Rationale
BANES is an outlier in not having a suitable facility for VRA and for older children requiring hearing aids. Most areas around the UK have at least 1 facility with Swindon having 2 and Salisbury 1, both of which are smaller providers than B&NES.

5 Summary of involvement outcomes
This proposal has been discussed with a number of staff, parents and local organisations affected including:

- Consultant Paediatric Audiologist Adrian Dighe
- Wiltshire Teachers of the Deaf
- Somerset Teachers of the Deaf
- Educational Audiologist, Sensory Support Service – Westbury-on-Trym
- Sirona Head of Adult Audiology – Mel Ward
- Sirona Head of Children's Services – Chrissie Hardman
- Manager of the Newborn Hearing Screening Programme
- Audiometrician
- Assistant manager of Sirona Hearing and Vision Service
- Team Manager of Disabled Children, BANES
- Team Manager of Disabled Children, Somerset
- Equalities Manager, BANES Council
- Bath LINKs
- Parent representatives – Bath and Somerset
- Early Support Health Visitor

6 Timescales
It is proposed that the relocation of Paediatric Audiology takes place in the Spring 2013

7 Additional information

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

Sirona considers this proposal to be a substantial variation as the service is changing locations.

Benefits of the proposed service changes	• A bespoke new state of the art facility will give us a significant advantage over other areas as we will be able to provide high quality neonatal screening. • Moves facility closer to special school. • Co-locates with Adult Audiology, therefore transitioning to that service will be easier. • Easier (and free) to park than RUH • Close to Park and Ride • Close to a large number of Sirona's other community services eg Children's Learning Difficulties Nursing, Health Visitors, School Nursing
Any disbenefits, including how you think these could be managed	• Perception of dislocating from RUH • May be concern about bringing children into an adult facility but children will have a separate waiting area and the clinic will be staffed by a Paediatric Nurse. • Issues about travelling, parking, public transport. Will need to talk to local bus companies, Sirona parking service and Sainsburys about accessible travel and number of parking spaces.
Any issues for patients/carers/families in accessing the new service particularly if a change of location has been suggested	• Travelling to the new location will be more difficult for some and easier for others.
How do you think the proposed changes will affect the quality of the service	• Clinically there will only be positive impact as the current facilities are not fit for purpose
Impact of the proposed changes on health inequalities	See Equalities Impact Assessment
Any other comments	
If you are a representative of an organisation, such as LINKs, please indicate how you have drawn on the views of others from your group	The LINKs committee met to discuss the proposal on the 21st August 2012 and unanimously supported the relocation of the service.

PART THREE – Impacts at a glance

Impacts	Sirona View	***Patient/carer/public representatives' view***
Impact on patients	🟢	🟠
Impact on carers	🟢	🟠
Impact on health inequalities	🟢	🟠

Impact on local health community	●	●

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

GLOSSARY

- list definitions of any technical terms, acronyms etc

Name and role of officers completing the EqIA	Martha Cox - Service User Involvement Facilitator, Sirona Samantha Jones – Corporate Policy Manager – Equality and Diversity, B&NES Council
Topic	Relocation of Paediatric Audiology Service from RUH to St Martins Hospital
Name of Directorate and Service	Sirona Care and Health
Date of Assessment	July 2012

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

It is intended that this is used as a working document throughout the EqIA process, with a final version including the action plan section being published on Sirona, B&NES Council and/or NHS B&NES' websites.

Identify the scope of the subject / topic or plan

	Key questions	Answers / Notes
1.1	Briefly describe the aims of the subject/topic/plan	To move the Paediatric Audiology Unit from Royal United Hospital to St Martins Hospital.

		To improve the service and to ensure the service becomes compliant with the recommendations of the National Quality Assurance Report on Bath Newborn Hearing Screening &Audiology Programme. To increase the capacity of the unit. To create a child –orientated facility.
1.2	Provide brief details of the scope of the subject/topic/plan being reviewed, for example: • Is it a national or legislative requirement?	The current facility is not compliant with legislative requirements. There is no option to increase the size or capacity of the unit in its present situation. The current facility is a rented space – moving to St Martins will enable us to improve the facility and to delete rental costs.
1.3	Does its aims conflict with any other plan or service activity of Sirona or its partners?	No
1.4	What steps have you taken to ensure this does not *inadvertently* affect another service?	The written business case taken to PCT Commissioners (February 2012) shows that consideration has been taken of this issue and there are no conflicts.

2. Consideration of available data, research and information

	Key questions		**Data, research and information that you can refer to**
2.1	What equality training have those who developed the subject/topic/plan received?	Sirona Care & health have a standard that all employees undertake 3 yearly equality and diversity training. Senior managers involved in the decision making for this proposal are up to date with their training.	Training records.

2.2	What is the equality profile of the employees who will be affected by this? Are there any particular staffing issues? (e.g. high proportion of female workers etc)	91% of employees of the service are female. 9% of employees are aged between 25-29, 9% are aged between 35-39, 18% are aged between 40-44, 9% are aged between 45-49, 18% are aged between 50-54, 28% are aged between 55-59 and 9% are aged between 60-64.	This data comes from the Paediatric Audiology Team equalities profile.
2.3	If there are proposed staffing reductions: what are the potential knock-on effects of this on other service areas including other public services where we collectively serve our citizens?	N/A	
2.4	What is the equality profile of service users who will be affected by this?	**Ethnicity** – 51% are white British; 3% have any other white background; 1% are Asian; 1% have any other mixed background and 43% did not state. **PCT** – 28% come from BANES; 10% from Somerset; 59% from Wiltshire and 3% from other areas. **Age** – 17% are aged 0-4 years; 32% are aged 5-9 years; 33% are aged 10-14 years; 16% are aged 15-19 years and 2% are aged 20+. **Class of hearing loss** – 2% had no loss detected; 19% had mild loss; 47% had moderate loss; 8% had profound loss; 19% had severe loss and 5% had no result recorded. 31% of children had additional	This data comes from the Paediatric Audiology Department deaf children and young people equalities profile as of 25/07/12

		diagnoses of need other than hearing loss.	
2.5	What do you know about service users' needs in relation to this service area? (e.g. results of customer satisfaction surveys, results of previous consultations)	A service user feedback questionnaire was undertaken by the service in Sept 11. The results were largely positive though there was a low response rate. 62% said nothing could be done better. 96% said that yes they would recommend the service to their family and friends.	Organisational Survey 2011 results
2.6	Are there any gaps in the data, research or information that is available? What additional information would assist you in developing your financial plan?	Yes. We need more detailed, accurate data. We acknowledge we have more reliable data on long term / repeat service users; we do not have reliable data yet on new or 'one-off' service users.	
2.7	What consultation have you carried out on this subject/topic/plan?	This proposal has been discussed with a number of staff, parents and other local groups affected including: • Consultant Paediatric Audiologist • Wiltshire Teachers of the Deaf • Sirona Head of Adult Audiology • Sirona Head of Children's Services • Manager of the Newborn Hearing Screening Programme • Audiometrician • Assistant manager of Sirona Hearing and Vision Service • Team Manager of Disabled Children, BANES	

		• Team Manager of Disabled Children, Somerset • Equalities Manager, BANES Council • Bath LINKs • Parent representatives – Bath and Somerset • South West Regional Director of The National Deaf Children's Society (?) • Early Support Health Visitor	

3. Assessment of impact

	Identify the impact/potential impact on	Examples of how the topic promotes equality	Examples of potential negative or adverse impact and what steps have been or could be taken to address this
3.1	**Age** – different age groups	This will be a purpose built screening unit for young people and children which will be designed specifically for this service user group. It will provide a better standard of audiology screening which will comply with best practice. It will enable specialists to identify issues sooner and therefore minimise distress to children, reduce repeat visits and, over time, reduce costs.	None
3.2	**Disability** – Disabled people (ensure consideration	The St Martins site is fully accessible. The new unit will be designed to meet	Public transport to the existing unit at RUH is free from central Bath. There is no facility for

	of a range of impairments including both physical and mental impairments)	the needs of people with hearing impairment, focussing on children, young people and new parents and carers.	free transport to St Martins. We are going to talk to the bus companies to investigate setting up a free service to St Martins from the Park and Ride and also from town.
3.3	**Gender** –women and men	N/A	N/A
3.4	**Gender identity -** transgender people		
3.5	**Race** -black & minority ethnic groups		
3.6	**Religion / belief** –different religious/faith and those with none		
3.7	**Sexual orientation -** lesbian, gay, bisexual & heterosexual people		
3.8	**Rural communities** – people living in rural communities	Some people travelling from Keynsham / Radstock / Wiltshire will benefit from the move as they will be able to avoid travelling through central Bath. Parking at St Martins is free whereas there is a charge at RUH.	Public transport to the existing unit at RUH is free from central Bath. There is no facility for free transport to St Martins. Public transport in B&NES area can be expensive. We are going to talk to the bus companies to investigate setting up a free service to St Martins from the Park and Ride and also from town.
3.9	**Socio-economically disadvantaged** –people who are disadvantaged due to factors like family background, educational attainment, neighbourhood and employment status		
4. Monitoring and review			
4.1	What arrangements have you put in place to monitor the *actual* effect of your subject/topic/plan following its implementation?	Service user feedback is planned to ascertain the effect of the move on service users, once the relocation has taken place.	

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

The outcome of this EqIA will fall into one of four categories:

Please tick which is appropriate:

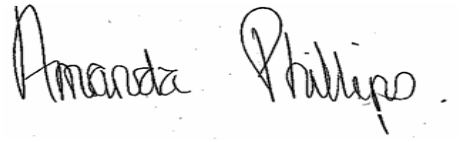
1	No major change required	X
2	Adjustments to remove barriers identified by EqIA or to better promote equality	
3	Continue despite having identified some potential for adverse impact or missed opportunities to promote equality	
4	Stop and rethink	

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

Issues identified	Actions required	Progress milestones	Officer responsible	By when
Consultation	Plan to meet with staff and small scale service user consultation		Martha Cox	Sept 12
Service user monitoring	Set up a formal monitoring and reporting system.	Service user consultation set up three months after the opening of the relocated service	Martha Cox	Summer 13
Public transport	Consider if / how public transport can be provided free of charge as it is for RUH currently	To begin conversation with local bus companies regarding this issue.	Facilities	

5. Sign off and publishing

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

Signed off by: __  _____ (Director) **Date: 25 October 2012**

Print Name: _____Amanda Phillips _____

Registered address:
Sirona Care & Health CIC, St Martin's Hospital, Clara Cross Lane, Bath BA2 5RP
Co Reg. No: 07585003. VAT No: 119273709

Reg Co. No. 07585003

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	**Friday 16th November 2012.**
TITLE:	Local Affordable Warmth Action Group Update 2012
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 Terms of Reference Appendix 2 Action Plan	

1 THE ISSUE

1.1 Affordable Warmth is a key determinate for wellbeing and is particularly significant for vulnerable low income households. The inability to benefit from affordable warmth can be described as fuel poverty and this affects 17% of B&NES residents (House Condition Survey 2011).

1.2 The purpose of the Local Affordable Warmth Action Group (LAWAG) is to coordinate activities to tackle excess winter mortality, fuel poverty and promote affordable warmth. It comprises representatives from across the community, voluntary and statutory sector with and interest in solutions to these issues. The terms of reference for the group are given at Appendix 1.

2 RECOMMENDATION

The Wellbeing Policy Development and Scrutiny Panel is asked to:

2.1 Note and comment on the report.

2.2 Note and comment on the action plan at Appendix 2.

3 FINANCIAL IMPLICATIONS

3.1 There are no financial implications arising directly from this report. However, the Council's approach to Green Deal will impact on take up of affordable warmth schemes and there are financial considerations associated with this and the wider energy efficiency retro fit opportunities it presents.

4 THE REPORT

4.1 Housing Services plan and promote home energy efficiency measures to meet the Councils statutory responsibility under the Home Energy Conservation Act 1996 (HECA) and have done so since the introduction of this legislation. The focus of this work has been affordable warmth for vulnerable groups in Bath and North East Somerset.

4.2 As part of this work the service represented the Council on a regional affordable warmth action group for a number of years to share and identify good practice on promoting home energy efficiency measures. More recently this group concluded that local authority level groups would be a more effective way to promote and organise affordable warmth initiatives.

4.3 In 2009 the local authority health profile identified Bath and North East Somerset (B&NES) as being an outlier for excess winter deaths. The excess winter mortality index (EWMI) for 2004-07, published in 2009 was 21.4 compared to an English average of 17.0. In 2010 the profile revealed that B&NES had the worst levels of excess winter mortality in England, for the period of 2005-08, with a EWMI of 26.3, compared to England's value of 15.6. The EWMI rose to 30.1 in the rolling three year average published this year (2006-09), but is no longer the highest in England.

Figure 1 below compares the annual levels of winter deaths, summer deaths and excess winter mortality index for each year from the winter of 2002/03 to the winter of 2010/11. The graph shows the fluctuation in the levels of winter deaths.

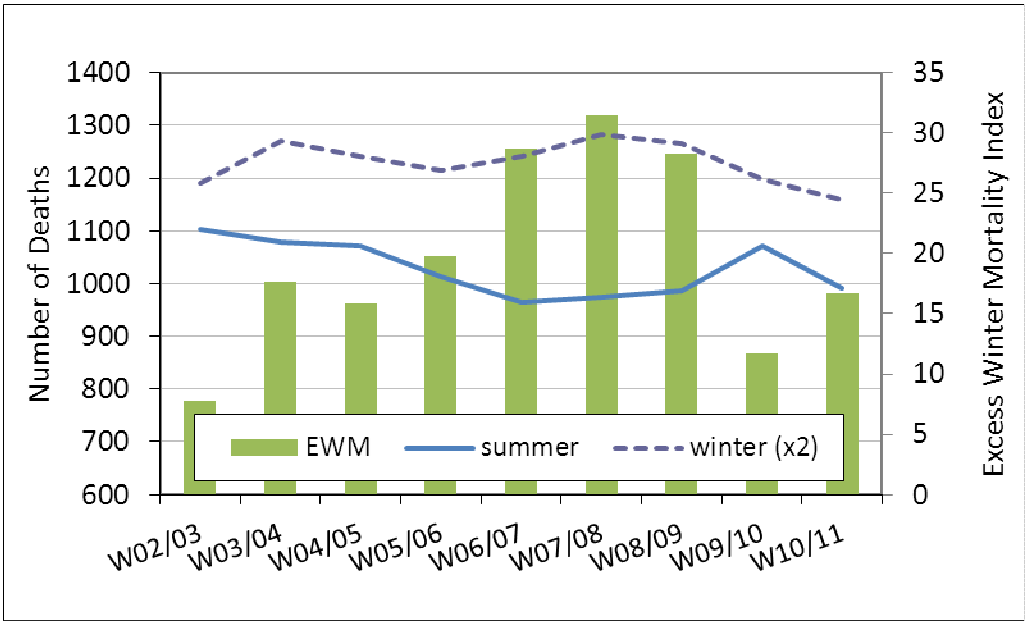
The high EWMI for B&NES stimulated a greater interest in the promotion of energy efficiency and affordable warmth and assisted in the formation of a Local Affordable Warmth Action Group (LAWAG). Following an approach by Housing Services, B&NES Public Health agreed to chair the group and work began on a series of projects aimed at promoting affordable warmth for those most at risk of dying during the winter months.

The Public Health Outcomes Framework published in January this year features the following 2 overarching outcomes that set the overall vision for the whole public health system:

- increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life; and

- reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

Figure 1 Excess Winter Mortality, Deaths in summer and Deaths in winter by year of winter (2002-2011)



Source: Public Health Mortality File

Two Public Health Indicators, namely Fuel Poverty and Excess Winter Deaths are directly relevant to the work of the LAWAG. Progress against these outcome indicators will be monitored by the Health and Wellbeing Board.

4.4 The LAWAG Action Plan to improve home energy efficiency for vulnerable households is shown at Appendix 1. The key theme of the actions is to promote the B&NES Home Energy Efficiency Advice Line which is commissioned by Housing Services and holds details of local and national energy efficiency and heating schemes.

5 RISK MANAGEMENT

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

6 EQUALITIES

6.1 An EqIA has not been completed for this report because there are no policy recommendations arising from this update report. The Warm Streets Energy Efficiency Programme referred to in the action plan has been considered as part of the EqIA completed for the Home Health and Safety Policy.

7 CONSULTATION

7.1 Staff; Other B&NES Services; Community Interest Groups; Stakeholders/Partners; Other Public Sector Bodies.

7.2 The action plan discussed at the LAWAG meetings and developed through discussion with Housing, Public Health and Sustainability colleagues.

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Social Inclusion; Customer Focus; Sustainability; Property; Young People; Corporate; Health & Safety;

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	Chris Mordaunt (Housing Services) 01225 396282 Sarah Scott (Public Health) 01225 831418
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

Appendix 1
Affordable Warmth Action Group – Terms of Reference

1. Purpose

This group will coordinate activities to tackle excess winter mortality, fuel poverty and promote affordable warmth.

2. Objectives

- To oversee the refresh of the affordable warmth action plan
- To implement the action plan
- To monitor progress against the action plan

3. Membership

The group will comprise representatives from organisations with an interest in the solutions to relieve fuel poverty, reducing excess winter mortality and the promotion of affordable warmth. The group will be facilitated by the Local Authority and Health Services Partnership.

4. Governance

The group will be accountable to the Bath and North East Somerset Health and Well-being Board.

5. Frequency of meetings

The meetings will take place quarterly.

6. Review of terms of reference

These Terms of Reference shall be approved by the Affordable Warmth Action Group and will be reviewed annually.

Sarah Scott
23/05/2012

Appendix 2
Local Affordable Warmth Group Action Plan 2012

	Action	Progress at October 2012	Key dates
1.	Warm Streets Loft and Cavity Wall insulation programme	The Warm Streets programme has now ended. This will be replaced by the B&NES Green Deal/ECO offer. ECO Starter project planned for Southdown and Twerton	February 2012
2.	Warm Streets Free for All scheme	Successful run on several occasions including during the run down of Warm Streets	None – review under Green deal
3.	Heatseekers – thermal imaging trial	Opt out scheme in 3 B&NES wards until September 2012	None – review under green deal
4.	Assessment of individual household affordable warmth needs	Existing address level information being collated by Housing Services. Use anticipated for HECA reporting	31st March 2013
5.	Awareness raising for visiting Council, Social Care and Health Staff	20 minute briefing package on Cold homes and Falls hazards being developed by Housing and Public Protection Services. To be offered for team meetings.	5th December 2012 is first trial session
6.	GP / Health Worker Referral Scheme	Referral routes to be offered as part of 5 above	2013
7.	Pharmacy Campaign	Home Energy Advice line promoted last winter and to continue this season	November 2012
8.	Flu jab campaign	Home Energy Advice line promoted last September and repeated this year	September 2012
9.	Promotion of affordable warmth service to BME groups	Housing Services visits to Imam and Policy Community Fair in 2012	Review for 2013
10.	Fire service promotion of Home Energy Advice Line	Energy saving info provided with Christmas cards during Home Fire Safety visits last year	December 2012

Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **16th November 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 29.10.12.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
16th Nov 12						
	Cabinet Member update (5 min)		Cllr Allen			
	NHS/CCG update (15 min)		Dr Ian Orpen			
	LINk update (15 min)		Diana Hall Hall			
	Urgent Care Re-Design Impact Assessment (30 min)		Dr Ian Orpen			
	Quarterly Care Homes update (15 min)		Sarah Shatwell			
	Medium Term Service and Resource Plans (60 min)		Jane Shayler			
	Impact Assessment on the proposed relocation of Paediatric Audiology (15 min)		Martha Cox			
	Local Affordable Warmth Group update (20 min)		Chris Mordaunt			
18th Jan 13						
	JSNA – Social Inequalities		tbc			
	The Royal National Hospital for Rheumatic Diseases in Bath update		Derek Thorne			
	Strategic Transition Board update		tbc			
	Care Quality Commission update (20 min)		Karen Taylor			
	Winterbourne View update (20 min)		Mike			

Last updated 29.10.12.

			MacCallam			
	Substance Misuse in B&NES (20 min)		Andrea Morland			
	Energy Efficiency report		tbc		The Panel on suggestion from Cabinet member	
	Alcohol Harm Reduction SID - recommendations		L Rushen			
22nd Mar 13						
	JSNA – topic ?					
Future items						
	Talking Therapies update		Andrea Morland			
	Dementia Strategy update		Sarah Shatwell?			