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: Monday, 28th January, 2013

You are invited to attend a meeting of the **Wellbeing Policy Development and Scrutiny Panel**, to be held on **Monday, 28th January, 2013** at **10.00 am** in the **Brunswick Room - Guildhall, Bath.**

The agenda is set out overleaf.

Yours sincerely

Jack Latkovic
for Chief Executive

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

This Agenda and all accompanying reports are printed on recycled paper

NOTES:

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

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

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

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

   Appendices to reports are available for inspection as follows:-

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

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

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

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

6. **Emergency Evacuation Procedure**

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

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

Wellbeing Policy Development and Scrutiny Panel - Monday, 28th January, 2013

at 10.00 am in the Brunswick Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

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

3. APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

4. DECLARATIONS OF INTEREST

   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

   At the time of publication no notifications had been received.

7. MINUTES 16TH NOVEMBER 2012 (Pages 7 - 26)

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

8. CABINET MEMBER UPDATE (15 MINUTES)

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

9. BATH AND NORTH EAST SOMERSET LOCAL INVOLVEMENT NETWORK (LINK) UPDATE (15 MINUTES) (Pages 27 - 28)

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

10. CARE QUALITY COMMISSION (CQC) UPDATE (20 MINUTES) (Pages 29 - 44)

The Panel are asked to consider the presentation from Karen Taylor (CQC Compliance Manager, South Region - Bath and North East Somerset and Wiltshire).

The CQC guidance document on the role and relationship between the CQC and Scrutiny is included as the agenda item 15.

11. WINTERBOURNE VIEW FINDINGS UPDATE (20 MINUTES) (Pages 45 - 68)

The purpose of the report is to provide the Wellbeing PDS Panel with an update following the publication in December 2012 of the Department of Health Review; Final Report – Transforming care: A national response to Winterbourne View Hospital.

The Wellbeing PDS Panel is asked to:

- Note the content of the report; and
- To receive a further update on actions taken to address the recommendations and findings in one year's time.

12. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) - SOCIAL AND ECONOMIC INEQUALITIES (20 MINUTES) (Pages 69 - 76)

This report covers a summary of data held in the Joint Strategic Needs Assessment on the subject of social and economic inequality. This is following an explicit request from the Panel to keep the JSNA as a standing agenda item on a subject-by-subject basis.

The Wellbeing Policy Development & Scrutiny Committee is asked to:

- Note the findings of the briefing
- Consider the broader implications/impacts of these findings on the work of the Panel.

LUNCH AT 11:45 (15 MINUTES)

13. 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.

14. THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES IN BATH UPDATE (45 MINUTES)

The Panel are asked to consider the presentation on the Royal National Hospital for Rheumatic Diseases in Bath.

15. SUBSTANCE MISUSE SERVICES (20 MINUTES) (Pages 77 - 102)

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

- Services in place to support substance misusers to overcome their dependence; to obtain/maintain their tenancy; and to support their families.
- Criminal Justice Services in place to support substance misusers to reduce re-offending.
- Progress being made to support ketamine misusers in B&NES.
- Progress being made in re-commissioning substance misuse services.

16. WORKPLAN (Pages 103 - 110)

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.

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BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 16th November, 2012

Present:- Councillors Vic Pritchard (Chair), Katie Hall (Vice-Chair), Lisa Brett, Eleanor Jackson, Anthony Clarke, Kate Simmons, Sharon Ball, Douglas Nicol and Sally Davis

Also in attendance:

56 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

57 EMERGENCY EVACUATION PROCEDURE

The Chairman drew attention to the emergency evacuation procedure.

58 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Bryan Organ had sent his apology to the Panel. Councillor Sally Davis was a substitute for Councillor Organ.

59 DECLARATIONS OF INTEREST

Councillor Eleanor Jackson declared other interest as she is Council's representative on Sirona Care & Health Community Interest Company.

Councillor Sally Davis declared other interest as she is Council's representative on Sirona Care & Health Community Interest Company.

Councillor Vic Pritchard declared other interest as he is Council's representative on Sirona Care & Health Community Interest Company.

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

60 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

The Chairman used this opportunity to inform the meeting that Connie Wright (BANES LINk member) who had been involved in many of the Health related issues within the area had passed away.

The Panel offered their condolence to Connie's family and friends.

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

The Chairman informed the meeting that Peter Jovcic-Sas will address the Panel now in respect of the NHS & Clinical Commissioning Group Update and also just before item 11 on the agenda (Review of Urgent Care).

The Chairman informed the meeting that Sarah Mitchard will also address the Panel just before item 11 on the agenda (Review of Urgent Care).

Peter Jovcic-Sas said that the Clinical Commissioning Group (CCG) appeared to be too secretive about the role of their Board in terms that their job descriptions are not published. Peter Jovcic-Sas also said that it is unusual that two clinicians are appointed on their Board who have roles of the Chair and Clinical Accountable Officer. Peter Jovcic-Sas asked the Panel to request from the CCG to publish their job descriptions of their senior roles, clarify who is appointed to support Accountable Officer and clarify who is more senior – the Chair or Clinical Accountable Officer.

Councillor Jackson said that speaker made some points that should be answered by the appropriate officers/representatives.

The Chairman said that he would be asking Dr Ian Orpen to provide the answer, if possible, under 'NHS and Clinical Commissioning Group Update' agenda item.

62 MINUTES 21ST SEPTEMBER 2012

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

63 CABINET MEMBER UPDATE (5 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:

Members of the Panel queried why some GP surgeries run out of the flu vaccines.

Dr Ian Orpen replied that this was national issue that will be resolved soon and all surgeries will have enough vaccines.

The Chairman, on behalf of the Panel, complimented the Independent Living Service (commissioned by the Council and provided by Curo Housing) which won the National Housing Federation South West Community Impact Award for Better Health.

The Chairman thanked Councillor Allen for an update.

Appendix 1 - Cabinet Member update

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

Dr Orpen also said that he would be happy to take on board comments made by Peter Jovcic-Sas and make the job descriptions of the CCG Board members available. These job descriptions were created according to the national guidance.

Dr Orpen added that Corinne Edwards leads on Dementia programme we were successful on three bids submitted to the NHS South of England Dementia Challenge Fund (out of five). The Prime Minister's Challenge on Dementia had been published earlier in the year to deliver major improvements in dementia care and research. This initiative became national priority.

The Chairman thanked Dr Orpen for an update and asked that the Panel be informed when the job descriptions for Board members are published.

Appendix 2 CCG update

65 LOCAL INVOLVEMENT NETWORK (LINK) POSITION UPDATE (15 MINUTES)

The Chairman invited Sue Bowen (Funding and Programme Manager) to introduce the report.

The Panel made the following points:

Members of the Panel felt that B&NES Local Involvement Network (LINk) had been put in unfortunate position as the former host service, Scout Enterprises Ltd, went into liquidation on 19th October this year.

Members of the Panel highlighted the value of the work that the LINk did over the past few years and welcomed that the Council was looking to appoint the new host service from 1st December.

It was **RESOLVED** to note the report and instruct the officers to communicate with the Panel the outcome of the procurement for the new host service once it is in place.

66 REVIEW OF URGENT CARE (30 MINUTES)

The Chairman invited Peter Jovcic-Sas to read out his statement.

Peter Jovcic-Sas said that the NHS belongs to us all and BANES CCG has legal duty to involve people who use health service in decisions about those services. The CCG did not make meaningful attempt to engage current users of the walk-in

centre. There is also no information how local GPs will take on the pressure if the walk-in service gets closed nor there was information on how the proposed £500k saving would be invested in services elsewhere. The Equality Impact Assessment did not fully engage with the local representatives or wider communities (i.e. Bath Racial Equality Council). Over 1,000 people signed the petition to keep the centre. Over 70% were concerned about the new model based at the RUH. Peter Jovcic-Sas said that in his view the consultation was too shallow and too basic. The CCG did not provide enough information to allow people to make informed judgement on what they are planning to do. Peter Jovcic-Sas asked the Panel not to support the recommendation and ask the CCG to review their proposal in light of the all the comments on this subject.

The Chairman commented that Peter Jovcic-Sas was quite specific that the CCG haven't been effective in engaging the public and then went on to identify certain representations made through the consultation period. The Chairman said that appears to be conflict in the statement about the engagement process. The Chairman said that there was consultation period where the CCG went out across the authority to engage with the public and get their opinion.

Peter Jovcic-Sas said that there was no enough meaningful engagement with the public. The CCG could do more in terms of the public engagement. The other CCGs across the country take much longer to engage with the public.

Councillor Jackson said that she read in the report about the consultation process and while she thinks that efforts were made to engage with the public the fact is that most of the engagement took place via social media whilst there was no enough information via radio.

The Chairman invited Sarah Mitchard to read out her statement.

Sarah Mitchard thanked the Panel to give her opportunity to speak and also thanked the CCG for their interest in concerns raised and for meeting with Bath Labour Action Team and answer their questions. Sarah Mitchard also welcomed that the CCG worked hard to record the objections and criticism as well as setting out suggestions for how these could be addressed. The overwhelming view that came from the public was that they did not want to lose the GP walk-in service in this form, or from this location. People were worried about the reduction in access to primary care if these proposals went ahead. Therefore, Bath Labour Action team initiated the petition to enable people to express their views. To date 1,100 people signed the petition with 500 of them who left their comments.

Sarah Mitchard said that Wellbeing Scrutiny Panel should consider two main points before making their decision.

Firstly, the proposals in their current form do represent a substantial variation of services. People will lose access to urgent care and everyday primary care in the centre of Bath. The message from people who signed the petition is that they use GP led service at the Riverside when they are unable to access the service they feel they need from their GP. The loss of the GP led walk-in service in Riverside will amount to a reduction or rationing of access to primary care, with the majority of the

30,000 contacts per year expected to go to a GP instead and therefore unable to be seen as quickly or as conveniently as they would have done previously.

Secondly, it is the objection to the availability of financial information. In Sarah Mitchard's opinion there was no clear information how much money would be saved. There was an estimate of potential saving and the public did not have the opportunity to consider if the level of saving would justify to proposal. Sarah Mitchard said that when those questions were asked at the public meeting the CCG did estimate a cost saving of approximately of £500-600k. These savings were based on the expectations that both B&NES Emergency Medical Out of Hours service and proposed GP-led urgent care service at the RUH would be run by the same provider though those services have not been put out to tender yet.

Sarah Mitchard concluded by asking the Panel to reject the plan and instead refer these proposals for a review.

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

Councillor Brett said that she was approached in her Ward by few vulnerable people who were concerned that all services will be closed in the Riverside and asked Sarah Mitchard how did Bath Labour Action Team communicated the proposals to the public, particularly to vulnerable people.

Sarah Mitchard replied that people were told that the other services in the Riverside (dental services, sexual health, etc.) will remain open. The group had no intention to be misleading.

Councillor Hall said that she went to one of the engagement meeting where one of the Labour representatives said that £500k was not a lot of money and asked Sarah Mitchard if she thinks that £500k is not a lot of money.

Sarah Mitchard replied that public were not given a lot of information about financial position on proposal. Sarah Mitchard said that £500k was quite a lot of money and that the above was an unfair question as there was no conversation then about issues that are discussed now. Sarah Mitchard said that this information should have been presented by the CCG to the public at those meetings.

Councillor Hall said that she had those figures through the consultation process and she couldn't understand how the speaker could make the statement that there was no financial information. Those figures were not there at the beginning so Councillor Hall asked for them to be publicised. Those figures were pointing to potential saving of £500-600k out of total budget of £2.9m, which was significant amount of money.

Councillor Jackson asked Sarah Mitchard if she felt that the CCG had established that the sum of £500-600k was the actual saving.

Sarah Mitchard replied that she was under impression that the figure was an estimate and not the final saving.

The Chairman invited Dr Ian Orpen, Corinne Edwards and Tracy Cox to give the presentation.

Dr Orpen, Corinne Edwards (PCT) and Tracy Cox (CCG) highlighted the following points in their presentation (a full copy of the presentation is attached as Appendix 3 to these minutes):

- Rationale for service change
- B&NES demographic change
- Financial pressures
- Engagement Process
- Addressing key concerns
- Risks of doing nothing
- Other key issues considered by CCG
- Next steps
- Questions and comments

The Panel made the following points:

Councillor Brett said that one of the concerns raised during the consultation was about the parking at the RUH and asked what had been done to enable easy access.

Corinne Edwards said that access issues had been one of the main issues during the engagement process. The RUH said that they would be more than happy to work on solutions with the CCG and PCT.

Steve Boxall from the RUH Estates Team said that the RUH would certainly look at ways of improving the access as part of the plans to develop the Urgent Care Centre.

Councillor Clarke commented that the walk-in service was only 3 years in existence and asked if there was any clinical risk involved.

Dr Orpen said that he was quite satisfied that no clinical risk is involved in the proposal.

Councillor Clarke asked if it will be possible to register with two separate practices in future.

Dr Orpen said that is correct. The Government is piloting that scheme currently in London and it will be possible, in near future, to be registered with two separate practices.

Councillor Hall commented that she was pleased with the consultation process. The numbers of concerns were met though there is still some work to be done. Councillor Hall welcomed the financial information as well as information on parking. Potentially there will be better quality of care. Councillor Hall said that she spoke with large number of people, including the users of the centre. Councillor Hall also said that she welcomed the work that was done with students and that she was

pleased that a smartphone app was set for students. Councillor Hall felt that the proposal was positive and that the Panel should have a review on this service change in 6 months if the Panel support the proposal.

The Chairman said that should the Panel decide to support the proposal there will be no opportunity for the decision to be reversed and for the urgent care service to go back to the walk-in centre.

Councillor Jackson thanked the CCG and PCT representatives for coming to Radstock as a part of the consultation process. Councillor Jackson said that there are 30,000 visits per year at Riverside. We are in a consumer led culture when people are expected to have medical attention they need when they need it. Councillor Jackson said that she recently visited Riverside centre because she could get the appointment with her own GP. Councillor Jackson felt that this is a substantial variation of services. It is not only geographical change, it is also cultural change. It will create different way of accessing things. The questions that the Panel should ask is are the benefits outweigh the disadvantages. Councillor Jackson said that until GP surgeries improve their service she is not convinced that this is the right proposal.

Councillor Simmons commented as someone who lives in Keynsham, the RUH is in fact closer than the GP-led Health Centre, but that more and more people don't bother contacting their GP surgery so they use walk-in centres instead.

Corinne Edwards said that the PCT and CCG want to understand why people are wasting that capacity. This had led to the development of the incentive scheme to address telephone and appointment access. She also explained that across the practices in B&NES there was a 3% to 10% do not attend rate for GP and nurse appointments. This is wasted funded capacity and the CCG wants to work with practices on reducing this as part of the incentive scheme

The Chairman commented that walk-in centre had been in existence for short time but it became quite popular to those who use it.

Tracy Cox replied that the PCT and CCG recognise the value of the service and that their intention is to transfer those services. Tracy Cox also said that many of the 30,000 visits are repeat visits by the same people.

The Chairman thanked everyone who took part in the debate.

The Chairman asked the Panel to vote on this proposal.

Voting:

- 7 Panel Members voted in support of the proposal by saying that this service change did not constitute a substantial variation of services.
- 1 Panel Member voted against the proposal by saying that this service change did constitute a substantial variation of services.
- 1 Panel Member abstained.

It was **RESOLVED** that the proposal to relocate the GP-led Health Centre to the Royal United Hospital to create an Urgent Care Centre did not constitute a substantial variation of services and that the Panel agreed with the proposal.

Appendix 3 Urgent Care redesign presentation

67 LOCAL AFFORDABLE WARMTH ACTION GROUP UPDATE (20 MINUTES)

The Chairman informed the meeting that the Panel will consider this item before Medium Term Service & Resource Planning item.

The Chairman invited Chris Mordaunt (Housing Services Manager) and Sarah Scott (Public Health) to introduce the report.

In addition to what was already included in the report and the Action Plan, Chris Mordaunt and Sarah Scott added that the biggest success was promoting home energy efficiency measures and information alongside the flu jab campaign and that 253 improvements took place this year.

The Panel made the following points:

Members of the Panel welcomed the initiative, action plan and measures that were put in place in order to promote affordable warmth to those who are most at risk of dying during the winter months.

It was **RESOLVED** to note and welcome the report and also to note and welcome the action plan.

68 MEDIUM TERM SERVICE & RESOURCE PLANNING - 2013/14-2015/16 - (60 MINUTES)

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

Jane Shayler took the Panel through the report and explained the purpose of each appendix. On a question from the Panel on what P2P means in the report Jane said that is the reference to Procure to Pay (more efficient way to enable people to pay their invoices for the Council).

Jane Shayler highlighted the following key proposals in the service impact statement (for the benefit of the Panel):

There are two separate savings against the Council's contract with Sirona Care & Health. Top of the first page of appendix 3 of the report, Decrease in Sirona contractual values as agreed, is capturing part of the saving that is already incorporated in the contract with Sirona. Jane Shayler reminded the Panel that there is a three party contract for provision of care and health services between the Council, Sirona and the PCT (CCG as of April 2013). On the page 3 of appendix 3 of the report there is more significant saving because that is a new savings target against Council's part of the contract with Sirona. This has not been agreed yet with Sirona so it needs to be worked through in agreement and partnership with Sirona.

One of the areas that need to be explored is relatively recently published national Audit Commission report that looked at the cost in each LA for social care processes which indicates that there are some efficiencies in this area that could be made. Jane Shayler reminded the panel that Sirona delivers a significant portion of adult social care on behalf of the Council.

The Chairman asked what the Audit Commission exactly determined in their report.

Jane Shayler responded that Audit Commission looked at the cost of adult social care processes around the assessment of individual needs, review processes, provision of the advice to individuals (around eligibility for example), but also looked at the other supporting processes. Jane Shayler said that she always thought that we should treat benchmarking reports with the caution because national organisations, like Audit Commission, will be pretty skilful in analysing data though benchmarking does not always compare like for like. Audit Commission report benchmarks cost associated processes prior to the transfer of Sirona. Jane Shayler reminded the Panel that the AWP also manage some services in partnership with the Council. The first saving target against that work is not in the next financial year and there is time to work up the detail of how the saving will be delivered and undertake a full impact assessment, including assessing an equalities impacts.

Jane Shayler also said that one of the things that the Council could consider is whether we would be happy for individuals, who have relatively low level of need, to do something called ‘self-assess’ (i.e. if they need a piece of equipment that doesn't cost very much) to avoid the necessity of a service user going through a lengthy assessment process in order to access a minor aid and/or low-cost (or even freely available) service.

Councillor Jackson said that suggestion about the self-assessment is quite sensible and asked if GPs have any role in pointing people to right services.

Jane Shayler responded said that she was specifically talking about an assessment of need that was undertaken by Sirona and the AWP under the fair access to care services eligibility criteria. It does include role of GPs to identify people's needs.

Jane Shayler informed the Panel that under the savings heading, page 5 of appendix 3, there is significant sum of money in respect of use of the Section 256 funding in total of £1.5m. Jane Shayler explained that £1m of the Section 256 money is currently non-recurring money and levels of funding and associated guidance for using this money is confirmed on an annual basis. However, indications are that s256 funding will continue to be paid by the Department of Health. Jane Shayler said that for next year, 2013/14, some of the money will not go through the CCG but it would come from the National Commissioning Board to Social Services directly.

The Chairman said that s256 compensates for the effectiveness of adult social care with the intention of saving the money for the NHS. The Chairman asked how effective we are in measuring the outcomes resulting from this approach.

Jane Shayler said that one of the challenges is to find robust evidence on what you have prevented. Ideally, the s256 money would prevent people ever needing health

services. One of the proxy measures used locally is delayed transfer of care from the RUH. Some of the s256 money is used to fund extended research pilots.

Jane Shayler said to the Panel that the report before them is a 3 year plan. It does at the moment assume that the £1million s256 money is not carried forward for 2014/15. Savings targets in 2014/15-2015/16are significantly greater than for 2013/14. Jane Shayler said that the Council is proposing to take the report to the Clinical Commissioning Committee in December, although that is not agreed yet, to seek agreement in principle for use of s256 funding in 2013/14, subject to confirmation of the allocation by the Department of Health. Clinical Commissioning Committee will not be in position to make the decision until they have their own allocation of funding confirmed.

Jane Shayler said that the next significant saving is around reducing the number of people who are admitted to residential care by preventing those admissions. BANES and South West benchmarked relatively high number of older people who were admitted to residential care as oppose to people who are held in the community. If we bring the number of admissions in residential care more in line with the national benchmark then we could deliver savings. The majority of people would prefer to remain in their homes rather to be in residential care. One of the things that we need to pay more attention to is more effective advice to people who self-funding for their social care services. We know that some people who are paying for their own services are admitting themselves to private residential care homes at an earlier time than their assessments suggests. They are spending their own money and they spend their money quite quickly and then they come to social services and become eligible via social services to fund their stay. One of the things we are proposing is for people who are self funded to have access to good advice and information from the Council to enable them to make informed choices about what sort of care services they use their money to fund.

Jane Shayler that the last saving proposal is significant saving proposal against Supporting People and Communities funding. Jane Shayler said that this was the best way of achieving challenging savings targets and that she cannot offer the alternative, or better, proposal to achieve the same savings targets and have less impacts on service users. The proposal around Supporting People and Communities saving is to reduce the overall amount of funding and focus the funding on those with higher levels of need. The Supporting people Programme was designed to meet the low level of need. In time, across the country, Supporting People funding has increasingly focused on meeting higher levels of need and supporting mainstream social services objectives, rather than the original aims of the Supporting People Programme.

The Chairman said that he fully understands that Jane Shayler was asked to save the money within the Adult Social Care and Housing but he felt that the current Administration has the opportunity to consider what they consider low priority elsewhere and direct it to where it is most needed. There are some areas of the Council that perhaps could cease in operation and it wouldn't be any great loss. The Chairman also said that there is little that the Panel could do and that there should be more support from the Council for funding services for vulnerable people rather than some other things that the Council funds.

Councillor Allen said that there are very difficult decisions to be made and suggested that political groups might want to discuss these matters outside the PDS Panels. Councillor Allen agreed with the point made by the Chairman though he added that some of the savings are result of the cuts in the funding from the Government.

The Chairman commented that the unfortunate thing is that by the time of the Council Budget meeting it will be too late to do anything.

Councillor Jackson asked if it is not within the scope of the Panel to ask the Cabinet to have another look at this budget.

The Chairman said that the Panel could say that they are not comfortable with the proposed budget. The Panel could also ask to be presented with the budget proposals for the next year at very much earlier date.

Councillor Brett agreed with the Chairman that the Panel should expressed their concerns on the proposal and be presented at much earlier date the budget proposals for the next year and enable all Panels to look at the entire Medium Term Service & Resource Plan for the Council so that the Panels could make recommendations on areas of spend that should be prioritised and those areas of spend that should be considered by the Council not to be a priority.

Samantha Jones (Equalities Manager) reminded the Panel that Council and Elected Members have due regard to the need to eliminate discrimination; advance equality of opportunity; and foster good relations – when making decisions and setting policies. To do this, it is necessary for the organisation to understand the potential effects of its activities on different people. Where these are not immediately apparent, it may be necessary to carry out some form of assessment or analysis, in order to understand them. Samantha Jones reminded the Panel that 2 Councils were taken to the court, one of which failed to consider equality effect of the decision they made. One of the judges in court said 'please prove when making the decision you had demonstrate to me that you had no other financial room to maneuver'.
The Chairman thanked everyone who participated in this debate.

It was **RESOLVED** that:

1) The Panel requested that the budget for Adult Social Services and Housing should be more protected and that savings should be considered within other areas of the Council;
2) The Panel requested that next year's budget be presented at a much earlier date to the Panel (latest at September 2013);
3) The Panel felt that it is essential that the Council protect frontline services for vulnerable people; and
4) The Panel felt that all Officers and every Member of the Council should be aware that they have due regard to the need to eliminate discrimination; advance equality of opportunity; and foster good relations – when making decisions and setting policies, as per the advice of Equalities Manager.

69 IMPACT ASSESSMENT ON THE PROPOSED RELOCATION OF PAEDIATRIC AUDIOLOGY (15 MINUTES)

The Chairman invited Janet Rowse (Sirona Chief Executive) to introduce the report.

The Panel made the following points:

Members of the Panel debated the transport issues for the service users. The Panel felt that clinical opportunities and space at the new location at St Martin's site outweigh travel implications. The proposed changes to Sirona Paediatric Audiology Service are improvements to the current provision.

It was **RESOLVED** that the proposal to relocate the Paediatric Audiology Service from the RUH to the St Martin's Hospital site did not constitute a substantial variation or development.

70 CARE HOMES QUARTERLY PERFORMANCE REPORT JULY - SEPTEMBER 2012 (15 MINUTES)

The Chairman invited Jane Shayler to introduce the report.

The Panel made the following points:

Members of the Panel asked for the rationale of having the Care Homes Quarterly Performance Report.

Jane Shayler explained that 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 report captures the outcomes of the judgements issues by the Care Quality Commission (CQC), activities by the Commissioning and Contracts Team in relation to the quality and performance of care homes and, lastly, the level and type of safeguarding activity recorded.

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

71 WORKPLAN

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

- 6 monthly update/review on Urgent Care Re-design
- Alcohol Harm Reduction Scrutiny Inquiry Day to be moved to 22nd March 2013

The meeting ended at 2.45 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

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

Wellbeing Policy Development & Scrutiny Panel – November 2012

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1. PUBLIC ISSUES

Services for Adults with Autism

Representatives from The National Autistic Society (NAS) along with adults with autism, their families and carers, and some professionals last week attended a consultation event in late September on how the Adult Autism Strategy can be implemented effectively.

The event offered the opportunity for people to find out more about the Council's Fulfilling and Rewarding Lives Autism Strategy and put forward comments and suggestions they had on how to improve services and support for adults with autism in the area. People were able to share their experiences and help influence the way that people with autism access vital diagnosis, support, employment, education and housing services in the community.

Diana Elliott, Branch Officer of the NAS Avon Branch, said: "This meeting was a real opportunity for parents, carers and people with autism to make an impact on the Bath & North East Somerset adult autism strategy. It was a great turn out and we hope that the Council will take forward the views expressed to help shape the future of autism services in the area. If the right help and support is not available, it can have a profound and sometimes devastating effect on people with autism."

Martin Hedley, a local singer-songwriter who has Asperger syndrome, spoke at the event about his personal perspective and said: "I suffered a breakdown last year as a direct result of a lack of appropriate support, even after I had established myself within my local community by setting up an arts community project and was about to go self employed as a musician and campaigner"

Anyone who was not able to attend the event but who would like to see details of the draft Strategy can contact Diana Elliott, email: avon@nas.org.uk or mob: 07825 227026. Alternatively the Strategy can be accessed via the Council's public consultation page: www.bathnes.gov.uk/services/adult-social-care-and-health.

2. PERFORMANCE

Independent Living Service National Award

The Independent Living Service (ILS) commissioned by the Council and provided by Curo Housing has won the National Housing Federation South West Community Impact Award for Better Health.

Curo was also overall winner for the South West beating the winners of all the other categories (improving neighbourhoods, safer streets & building futures) and now goes forward to the national awards – which will be judged in January 2013.

Substance Misuse Services

The National Treatment Agency (NTA) has acknowledged the significant improvement in substance misuse treatment services in Bath & North East Somerset. In particular, as part of its review of performance the NTA has commented: *"…this is a rebalanced, recovery orientated system that could enter the top quartile performance range in 12 months if this progress continues."*

3. SERVICE DEVELOPMENT UPDATES

Dementia Challenge Fund

NHS South of England announced the successful bids against the Dementia Challenge Fund. Three out of the five submitted by B&NES were successful amounting to £455k. These include the RUH, Sirona Care & Health and Curo. The PCT has agreed to fund the other two unsuccessful bids from Age UK B&NES and The Carers' Centre (joint) and AWP on a 12 month non-recurring basis as they were felt to be integral to improving services for people with dementia.

Wellbeing Policy Development and Scrutiny Panel
16.11.12
Key issues briefing note

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

B&NES Clinical Commissioning Group (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

B&NES CCG is in the process of appointing its executive nurse and secondary care consultant. Following a recruitment process the post of executive nurse has been offered and accepted. Details are now being finalised. Meanwhile we are currently short-listing for the post of secondary care consultant.

The structures of the CCG have now been approved and recruitment to these posts is proceeding.

Appointments to date:

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

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

Authorisation

Before CCGs become legally constituted bodies they must go through a rigorous and extensive assessment process called authorisation. A team of 10-strong including Andrea Young, Chief Operating Officer NHS South of England and Tim kelsey, National Director for Patients and Information at the NHS Commissioning Board (NHS CB) held an authorisation site visit in Bath on Friday November 9. The aim of the site visit was to asses B&NES CCG's technical submission which covers 119

criteria across six domains. This submission is an important element towards B&NES CCG achieving its status as a legally constituted body from April 1 2013.

The panel was suitably impressed by the progress in B&NES. Of the 119 criteria assessed, B&NES CCG received 106 greens. The CCG is confident of achieving full authorisation with no conditions.

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 November.

Central Southern Commissioning Support Unit appointments

Central Southern Commissioning Support Unit has appointed John Wilderspin as its Managing Director. John has a distinguished track record in the NHS having worked as National Director for Health and Wellbeing Board Implementation at the Department of Health as well as holding the post of CEO at both acute trust and at primary care trust. Four of the six posts within the senior team have been appointed and the structures which sit below are also being appointed too.

Primary care trust

Ed Macalister-Smith retired last month (October) and Jenny Howells is acting Chief Executive.

Summary prepared by Craig MacFarlane

Bath & North East Somerset Council

NHS Bath & North East Somerset Clinical Commissioning Group

Redesigning Urgent Care – the Case for Creating an Urgent Care Centre

Date: 16/11/2012

Healthier, Stronger, Together

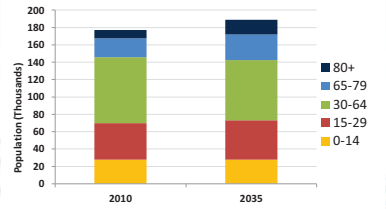
Rationale for service change

- An ageing population
- Increasing demand & expectations
- People living longer with long term conditions
- Finite resources & inequitable use
- Support of local clinicians
- Right treatment, right place & right time
- Clinical evidence & best practice
- Health & Social Care Summit – 14th November

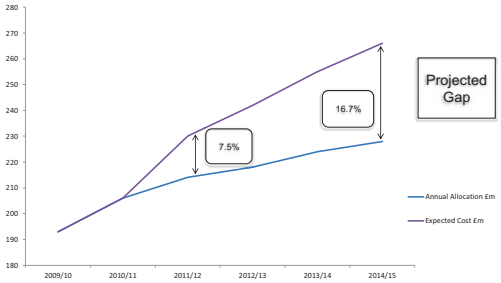
NHS Bath & North East Somerset Clinical Commissioning Group

B&NES demographic change

- ONS projects population increase from 176,000 to 198,800 by 2026 – 12% increase
- 80+ population projected to increase by 40% - 9,900 in 2010 to 13,900 in 2026



The uncomfortable truth



Engagement process

- 25th September 2012 to 31st October 2012
- Media briefings
- 7 public meetings – 120 people attended
- 208 questionnaires completed
- Staff meeting
- Health & equalities impact assessment

NHS Bath & North East Somerset Clinical Commissioning Group

Addressing key concerns

- GP access
- Vulnerable people, eg homeless
- Visitors & tourists to the city
- Parking & charges at the RUH
- Getting to the RUH
- Convenience
- Quality & customer focussed
- Financial assumptions

NHS Bath & North East Somerset Clinical Commissioning Group

Risks of doing nothing

- Wider impact on local population
- Loss of opportunity
- Demand versus capacity
- Fragmented system with poor governance
- Erosion of general practice
- Long term conditions not integrated

NHS Bath & North East Somerset Clinical Commissioning Group

Other key issues considered by CCG

- Re-commissioning services in isolation
- Not an essential service
- GP practices have open lists
- Inequitable funding not based on need
- Emergency department & ambulance service well recognised
- NHS 111
- Not urgent care
- Evidence base

NHS Bath & North East Somerset Clinical Commissioning Group

Next steps

Subject to outcome of Scrutiny Panel:

- Report to Clinical Commissioning Committee – 22nd November
- Recommendation to proceed to PCT Board – 28th November
- Development of specification via Urgent Care Network
- Visits to other Urgent Care Centre sites
- Procurement to begin in February 2013

NHS Bath & North East Somerset Clinical Commissioning Group

Questions & comments

NHS Bath & North East Somerset Clinical Commissioning Group

OUR COMMUNITY, OUR HEALTH, OUR SOCIAL CARE

BANES LINk Report to the BANES Wellbeing Policy Development and Scrutiny Panel meeting on 18th January 2013

The Care Forum will be supporting the BANES LINk as their host organisation from December 2012 – March 2013.

The BANES LINk committee has put together a work programme**:**

1. Autism – Jayne Pye to update with commissioners on the BANES Autism Strtaegy
2. Continue LINk Committee meetings – Jan 15th 2013 (MH Commissioning) / February 12th 2013 (SWANO re Neurological Alliance) / March 12th 2013 (CCG PPI Strategy).
3. Produce LINk E-Bulletins for membership and public - publication as monthly.
4. Annual Report: April 2012 – March 2013 to be produced . Meet on 10th January 2013 to plan.
5. Long Term Conditions – Jayne Pye to monitor and review
6. Care home visits – Jill Tompkin to discuss with Sarah Shatwell
7. Representation to continue, mainly through Members, with other ongoing commitments, such as AWP Stakeholder group on 18th February 2013, and representing the LINk on strategic matters, such as development of Health & Wellbeing Board, Clinical Commissioning Group, Diana Hall Hall attended a CCG meeting on 19th Dec 2012 and the development of the Local HealthWatch.
8. Meet with South West Assoc of Neurological Organisations on 14th January re a public meeting to be held before the end of February
9. Invite Ian Orpen CCG to share their Patient and Public Involvement Strategy at the committee meeting on 12th March 2013
10. Meet with Karen Taylor CQC 24th January 2012

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A guide for overview and scrutiny committees for health and social care

How your committee can work with the Care Quality Commission

September 2011

Contents

Published September 2011

1. Introduction

This is a guide for locally elected councillors and local authority officers involved in the scrutiny of health and social care who want to know more about how their scrutiny committee can work with the Care Quality Commission (CQC). We are the independent regulator of health and adult social care services in England. This guide tells you more about CQC and what we do. It explains what your scrutiny committee can expect from us as we work together locally to improve care. It explains what information you can share with us to help us check on services, and how you can use the information we hold to help your scrutiny committee.

The guide has been written by CQC with support from the Centre for Public Scrutiny, and some local authority officers and councillors working together. We would like to thank those involved for their effort and enthusiasm. Examples from their work have been used in the guide.

We will carry on working with all scrutiny committees in England during 2011/2012, building stronger working relationships with more committees and exploring how to work with elected councillors under new scrutiny arrangements that may develop.

We would like to hear from more scrutiny committees and to use more of the information councillors hold about people's views and experiences of their care. We are especially interested to hear about people's experiences of social care services as well as health care. We hope the examples in this guide encourage all scrutiny committees to share information with CQC to help us work together to improve care.

For more information about our work with scrutiny committees, please go to www.cqc.org.uk/localvoices. For information about HealthWatch go to: www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/healthwatch.cfm

You can also read *A guide for local councillors: Working with the Care Quality Commission* available at www.cqc.org.uk/localvoices

2. About the Care Quality Commission

We are the Care Quality Commission, the independent regulator of healthcare and adult social care services in England. We check whether care services meet essential standards of quality and safety, and we also protect the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.

Find out more about us at www.cqc.org.uk

Which services do we check?

We check on these types of services:

- Providers of medical treatment to people of all ages, including treatment provided in hospitals, by ambulance services and by mental health services.
- Providers of care homes for people over 18 who need help to maintain their independence and wellbeing. This includes nursing homes. Care homes can provide residential care for the following:
    - People with long- or short-term health conditions
    - Disabled people and people with learning disabilities
    - Older people
    - People with drug or alcohol problems.
- Agencies that provide care, treatment and support to people living in their own homes to help them maintain their independence and wellbeing.
- Providers of services for people whose rights are restricted under the Mental Health Act.
- We started to register and check on dental services (in the community) and independent ambulance services from April 2011. We will register GP out-of-hours services from April 2012. Subject to Parliament, we will now register primary medical services including walk-in centres and GP services from April 2013.

What standards do we check on?

The Health and Social Care Act 2008 requires providers of all regulated care services to meet government standards of quality and safety – the standards the government says anyone should expect whenever or wherever they receive care. These standards cover things like cleanliness, dignity, safety and staffing.

We register providers if they meet the standards, we check whether or not they continue to do so and we take action if standards aren't being met. Our assessments are based on people's experiences of care and the impact it has on their health and wellbeing, as well as on whether or not the right systems and processes are in place.

We put the views, experiences, health and wellbeing of people who use services at the centre of our work.

You can read our guidance about the essential standards and full details of the outcomes we look for at www.cqcguidanceaboutcompliance.org.uk and at www.cqc.org.uk/_db/_documents/Quick_guide_to_the_essential_standards.doc

We have also produced guides for the public explaining what you can expect from your care which can be found at:
www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm

You can expect any of the health or social care services we check on to meet the following essential standards:

You can expect to be involved and told what's happening at every stage of your care

- You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
- You will be given opportunities, encouragement and support to help you live as independently as possible.
- Before you receive any examination, care treatment or support you will be asked whether or not you agree to it.

You can expect care, treatment and support that meets your needs

- Your personal needs will be assessed to make sure you get safe and appropriate care that supports your rights.
- You get the treatment that you and your health or care professional agree will make a difference to your health and wellbeing.
- You will get the food and drink you need to meet your dietary needs.
- If you have more than one care provider, or if you are moved between services, you will get coordinated care.

You can also expect your needs to be met in relation to:

- Your cultural background and the language you speak
- Your sex (gender)
- Your disability
- Your age
- Your sexual orientation (whether you are a lesbian, gay, bisexual or heterosexual person)
- Your religion or belief
- Your gender identity, if you are a transsexual person
- Your needs if you are pregnant or have recently had a baby.

You can expect to be safe

- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.

- You will get the medicines you need, when you need them, and in a safe way.
- You will be cared for in a safe and accessible place.
- You will not be harmed by unsafe or unsuitable equipment.
- You will be cared for in a clean environment where you are protected from infection.

You can expect to be cared for by qualified staff with the right skills to do their jobs properly

- Your health and welfare needs are met by staff who have the knowledge, skills and experience needed.
- There will always be enough members of staff available to keep you safe and meet your needs.
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.

You can expect your care provider to routinely check the quality of its services

- Your care provider will monitor the quality of its services to make sure you are safe.
- Your personal records, including medical records, will be accurate and kept safe and confidential.
- You, or someone acting on your behalf, can complain and will be listened to. Your complaint will be acted upon properly.

How we carry out our checks

Under new proposals, we will inspect all adult social care, independent healthcare services, and most NHS hospitals at least once a year. (By NHS hospitals we mean all NHS acute hospitals and all NHS ambulance trusts. We inspect at least one type of service in all other trusts). We will inspect dental services at least once every two years. We check on services more frequently where there are concerns that people may be getting poor care. We identify these concerns by sharing information with a wide variety of organisations, by listening to the public, local groups, care staff and whistleblowers, and by monitoring data. We build a profile of each service that is updated whenever new information arrives. This helps our inspectors to decide where there is a risk that people could be experiencing poor care. The information comes from different sources, including:

- People who use services, families and carers
- LINks (local involvement networks)
- Overview and scrutiny committees for health and/or social care
- Foundation trust councils of governors
- Other voluntary and community groups
- Other regulatory organisations and the NHS Information Centre

- Other organisations such as commissioners of care (like councils) and the health and local government ombudsman
- Staff and other professionals
- CQC inspectors.

Feedback from people who use services is very important to us. We treat it as seriously as we do other forms of information.

When we decide that there is a risk of poor care, we assess whether or not the service is failing to meet one or more of the essential standards. We review the information we hold and we ask the people running the service to prove that it is meeting the standards. We may conduct further visits to the service to observe how care is delivered, talk to the people who use the service and to staff, and to check the provider's records if necessary.

If we judge that services are not meeting essential standards we use our powers to require improvements. We follow up to make sure the improvements are made and we hold services to account if they don't do so. If we judge that people's health, wellbeing and safety are at risk we take swift action to protect them.

Once we have reviewed a service we publish our findings as quickly as possible. Our information can help people choose a service or tell them about standards of care at a local service. We update our website when there are changes to report about checks, improvements or concerns.

What we do if a service doesn't meet the essential standards

If standards aren't being met, we require improvements within a set timescale. The service must then send us an action plan telling us how it will make these improvements.

If the service does not improve, or we have serious concerns about the health and safety of people who use it, we have a range of enforcement powers we can use including fines, warnings, restrictions to the way the service is provided, suspension or cancellation of its licence to operate, and prosecution of those providing the service.

When we propose to use our enforcement powers, the service has 28 days to challenge us before we can make our decision public. However, if we believe there is a serious, immediate threat to people's health and safety, we can act immediately to restrict, suspend or stop the service from being provided and we can make our decision public as soon as we do so.

3. What your scrutiny committee can expect from CQC?

This section sets out how our staff aim to work with all scrutiny committees for health and social care across the country. If the relationship between CQC and your scrutiny committee is still developing, we will gradually introduce the steps set out below.

Regular contact with CQC staff

Your scrutiny committee chair and lead officer (if you have one) can expect to be given a named local CQC contact person and to be informed if this person changes. You will have contact with your local CQC manager or inspector every three months either by phone, email or a meeting. We may have more frequent contact than this if you have shared information with us about local services and we need to discuss this with your committee. When we make contact with your committee, CQC staff can:

- Explain how we check on services and promote the essential standards of quality and safety to your committee.
- Share with your chair, our confidential programme of reviews over the coming six months (without dates), and any current improvement or enforcement actions we are taking that can be made public. **If your chair or committee prefers, we will only share information that is already in the public domain.**
- Find out about your committee's latest work programme and any responses you are making to NHS consultations.
- Hear from your committee about the issues/concerns local people are raising about the health and social care services in the area. These may come from your scrutiny reviews, public meetings, feedback from your members and so on.
- Give you feedback about how we have used any of the information your committee has already shared with us.

How we work with your committee during a review of a service

At the start of a CQC service review we check our records to see whether your committee has recently submitted information to us about the service at any of its locations. We may then contact the committee chair and lead officer (if there is one) by phone or email to let you know about the review and the timescale. We will usually do this where:

- Your committee has raised concerns about the service provider, or
- The service provider is included in your work programme, or
- There are gaps in our knowledge about people's views and experiences of the service provider, that your committee may help us fill.

We will invite your committee to give us any new information about the service. We may encourage you to make contact with neighbouring scrutiny committees if you need to coordinate providing information for CQC.

At each contact/meeting with your committee, we will identify with you any actions you intend to take as a result of our reviews. For example, further evidence-gathering

about particular service providers or requests for information. This will help us coordinate our activities better.

How we work with your committee when we take enforcement action

We will aim to let your scrutiny committee know about an enforcement action we have taken as soon as it is made public. This is when the representations and appeals process that service providers can use is also ended. For example, we will aim to share press releases with you as soon as we can. We understand that this is particularly important where your committee has also been seeking local improvements to services from the provider concerned.

We will be interested to know whether your committee plans to take action as a result of our enforcement action, and will work with you to coordinate this with further CQC activity.

How we give feedback to your committee

We will let you know we have received any information that your committee sends us between our regular contacts or meetings. If your committee sends information to us via the CQC webform, you will receive an automatic acknowledgement (see page 11). At our regular meetings/contact with you, we will aim to:

- Give you verbal feedback about how we have used any information you have shared with us.
- Highlight the findings and outcomes of relevant reviews of providers.
- Make sure your committee has a copy of the relevant compliance reports.

Our approach to sharing information that is not yet public or is confidential

We can tell your chair and lead officer (if you have one) about the programme of reviews of services we expect to carry out over the coming six months. We will not tell you the dates for these reviews or whether we will be visiting a service as part of the review. It is very important that we keep our programme of unannounced visits confidential. The public have told us that this is one of the most important things we do. We expect committee chairs and lead officers to respect this information and not to share it with service providers or other groups who may make it public. **If your chair or committee does not wish CQC to share this information with you, please discuss this with your local CQC contact.**

We are unable to share enforcement action we are taking while a service provider has the chance to appeal against this action. Once the appeal period is over, the enforcement action can be made public and shared with the committee.

CQC will not share confidential personal information with scrutiny committees. Similarly, we would not expect a committee to share information with us that identifies individuals or their families, unless this information comes from the individual themselves, someone has agreed that their information can be shared with CQC or someone has asked a committee to pass the information to CQC.

4. Sharing information with CQC about local services

We hope your scrutiny committee will share information with us about people's views and experiences of local services, and let us know what you are doing to improve care in your area. It will help us if you can:

- Keep in contact with our local CQC staff.
- Share any information with us if you think it helps us check on the essential standards.
- Share information with us about any of the services we check on – adult social care, health services, dentists and so on.
- Let us know if the committee chair or contact officer changes so that we contact the right person.

Your committee can provide information it already holds, such as:

- Formal reports/reviews of local health or social care services.
- Information gathered to inform a review.
- Your committee's workplan.
- Comments gathered at public events about local health or social care services.
- Contact from members of the public.
- Information on local concerns or emerging issues.
- Local surveys and so on.

You may also wish to gather additional information for one of our reviews of a service provider. For example:

- Inviting scrutiny members to contribute information directly to the committee chair to be shared with CQC.
- Holding a meeting or using an existing committee or public meeting to gather information about a service.

How to share your information with CQC

You can share information with CQC in three ways:

1. Through our website, where there is an online feedback form for scrutiny committees, LINks and other groups at www.cqc.org.uk/localvoices. You can complete the form in your own words and you can also attach your reports to the form. It helps to highlight which sections of the report tell us about the quality or safety of care.
2. Through your local CQC contact. You can share information with them by email, phone or face-to-face when you meet them. It is helpful to copy information that you send through the webform to your local CQC contact so they know this information is available to them straight away.
3. Through our enquiries contact centre at 03000 616161 or enquiries@cqc.org.uk

Top tips about the information you share with CQC

1. If in doubt, share your information with us. We would rather have the chance to read about your concerns and decide what action to take, than not know about them. If you have concerns about the care provided, then it is likely that your information will help us check on services.
2. Try to name the health or adult social care service or services you are describing in all your comments or reports. This is especially important when you are giving us information about several different services.
3. Focus on giving us information that tells us about what you have found out or heard about a service providing care, rather than details of how your committee works.
4. Provide the evidence for your conclusions and comments and any dates whenever possible, and explain what sort of evidence you have (it may be a small number of concerning stories or evidence from a survey or meeting with many more people).
5. Try to match your information to our CQC essential standards of quality and safety. You can relate your information to as many standards as you like.
6. Please let us know whether you are giving us information that is positive or negative about how care is provided. Both positive and negative comments about a service are important in helping us judge whether a service continues to meet our standards.

What we do with your information?

Relevant information from your committee becomes part of our 'quality and risk profile', which we hold for every health and adult social care organisation. The information you share with us will:

- Help us spot problems or concerns in local services that we need to act upon.
- Help in our assessments and reviews of different types of organisations.
- Allow us to look at how well a service provider meets essential standards of quality and safety. This will help us decide if the service provider can continue to register with us and provide its services to local people.
- Help us decide if we need to ask a service provider to make improvements in some areas of its care, to show us that it will meet all these standards in future.

We match your information with our essential standards of quality and safety if we can, and decide whether it is positive or negative. Then we weigh up whether it is clear and whether it is about people's experience of care. For example, does it tell us something that has an impact on a person using the service and does it represent the views of someone using the service (or groups of people using the service)?

We will give your information a score. The higher the score, the more likely it will make a difference to our judgements about the care provided by a service. If your information does not relate to our essential standards we may use it as background information about that service, or we may not be able to use it at all.

Scrutiny committee review reports can be particularly useful in helping us decide which services to review or what to look for when we visit a service.

What to do if you are concerned about someone's safety?

We want people who use care services to be safe, especially if they are in vulnerable circumstances, and may find it difficult to speak for themselves. If you have urgent concerns about the wellbeing of a child or vulnerable adult, your committee should contact your local authority children's or adult social care department. This might be evidence of physical, sexual, psychological abuse, neglect and acts of omission including ignoring medical or physical care needs or discriminatory abuse.

CQC does not deal with these individual cases of safeguarding, but we work closely with local authority safeguarding staff and can use the information in our judgements about services. We can follow up a service where concerns have been raised, and this may lead us to take enforcement action against the service if we find it does not meet essential standards of quality and safety.

If you share information with your local safeguarding team, we hope you will also let your local CQC contact know – in case we also need to act swiftly. Please remember that you can share urgent concerns with us at any time.

5. Where to go for more information

For more information about CQC go to www.cqc.org.uk or ring 03000 616161

To talk to us about our work with scrutiny committees, email: involvement.edhr@cqc.org.uk

For information about the development of HealthWatch England, please go to our website: www.cqc.org.uk/aboutcqc/whatwedo/improvinghealthandsocialcare/healthwatch.cfm

You can get involved in HealthWatch England developments by sending an email to enquiries@nunwood.com

You may want to talk to some of the scrutiny committees involved in developing this guide. They are:

- Torbay Health Scrutiny Committee
- Joint Health Overview and Scrutiny Committee Pennine Acute NHS Trust
- Leicestershire County Council Joint Health Scrutiny Committee
- Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee
- Cambridgeshire County Council Health and Adult Social Care Scrutiny Committee
- Isles of Scilly Health Overview and Scrutiny Committee
- Ealing Health Scrutiny Panel

6. Examples of working together

Information from scrutiny committees is already helping CQC check on a range of health and social care services. Scrutiny committee review reports and the findings from these have been particularly useful. In some areas, information from scrutiny committees has helped us focus on which aspects of a service to look at in one of our reviews, and which locations to visit.

In this section, we provide examples of how some scrutiny committees have been working with CQC and how information is being shared between us. Each committee works in a different way but these examples show what can be achieved by working together.

Ealing Health Scrutiny Panel

Ealing Scrutiny Committee has worked with CQC during its review of access and quality of care for Ealing patients after hospital or other clinical treatment. The review has identified the main care pathways and service providers involved in aftercare in Ealing, and examined access to and quality standards of aftercare, and the causes of any poor performance. It has examined the initiatives underway to address any concerns and lessons learnt from services elsewhere.

It has focused on hospital admission and discharge, transfers of care, specialist rehabilitation and end of life care.

Isles of Scilly Health Overview and Scrutiny Board

Isles of Scilly Health Overview and Scrutiny Committee has regular contact, by email and phone, with CQC through the Committee chair and the vice chair. The compliance manager addressed the committee, explaining CQC's role and its relationship with scrutiny committees. This has helped the Committee develop the questions for commissioners, providers, patients and carers as part of its review of stroke aftercare services. It has also made use of the CQC's national review of stroke services. The Committee is sharing the findings with CQC and discussing the implications of their final report. Commissioners and providers are aware of the committee's relationship with CQC.

> "The role of health overview and scrutiny committees is evolving and up until recently some members didn't realise the importance of the relationship between CQC and health overview and scrutiny committees. I think we need to further develop our relationship with CQC as the scrutiny function of health overview and scrutiny committees will increase."
> (Chair of the Isles of Scilly Health Overview and Scrutiny Committee)

Torbay Health Scrutiny Board

Torbay Health Scrutiny Board has been building its local relationship with CQC and held a workshop with elected members and CQC, which has been very positively received. The Committee communicates with CQC whenever necessary by phone and email and regular meetings are scheduled between CQC and the Scrutiny Committee chair. CQC is also attending Scrutiny Committee meetings as an observer in the public gallery.

The Committee aspires to the four principles set out by the Centre for Public Scrutiny:

> "critical friend challenge to decision-makers; enable the voice and concerns of the public and its communities; be 'independent minded governors' who lead and own the scrutiny process and drive improvement in public services."

The Committee has improved its understanding of CQC's role. CQC has shared information about all the 153 service providers in Torbay and the details of the CQC inspectors responsible for these providers. CQC has also shared its confidential programme of reviews planned over the coming months in Torbay, and a list of the essential standards of quality and safety. The Committee receives email alerts and links to publications of any CQC review reports on local providers. As a result, a councillor has already raised an issue about a service provider to the Committee which is being followed up with the provider and the primary care trust (PCT) initially, and the Committee will then update CQC.

The Committee shares its work programme, the minutes of its meetings and forthcoming agendas with CQC. It has also raised a concern about the procedure for safeguarding at one provider which has been followed up.

In future, the Committee will be considering a more formal agreement or protocol between CQC and the Committee. Formal meetings are also scheduled between the scrutiny committee chair, CQC and the LINk/HealthWatch chair to exchange information and work programmes.

Leicestershire County Council Overview and Scrutiny Committee

The Committee has met with CQC locally and developed a working relationship. A meeting was held between the assistant director of strategy and commissioning and the scrutiny officer to discuss how the relationship with CQC might work locally. It was agreed to organise a briefing for all elected members in the county on CQC and its work. The assistant director, scrutiny officer and CQC's local compliance manager met and planned the briefing workshop for councillors about CQC. The scrutiny officer is developing a local guide for CQC and overview and scrutiny committees working together.

Cambridgeshire County Council Health and Adult Social Care Scrutiny Committee

The Committee was invited to contribute to a CQC review of an out-of-hours GP service provided in part of the county in 2010. Through dialogue with CQC, the Committee was able to feed its views and concerns into the review, based on its experience of scrutinising local services, on the information it had picked up from the local community and concerns raised by individual councillors. As a result, it was able to use CQC's findings from the review to inform its response to the PCT's consultation on future provision of the out-of-hours services. The Committee found this very helpful.

The Committee has established an ongoing relationship with CQC, including holding a seminar for all councillors, not just those involved in health scrutiny. The seminar was an opportunity to discuss how individual councillors can contribute information to CQC, as well as the scrutiny committee. Fifteen councillors attended and all considered it was very useful in developing a relationship between the council and CQC.

Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee

The Committee has established local contact with CQC and learnt more about CQC's role. It has shared information about its review of dementia care services.

At the end of every Health Scrutiny Committee meeting in Nottingham City, councillors consider the issues that they have discussed and whether there are any issues that should be referred to CQC, which they do using the CQC webform.

> "We realised that the public nature of scrutiny means that overview and scrutiny committees can provide useful information to the CQC. The committee decided it is important to have a good relationship with our local CQC contacts and to provide CQC with ongoing information as a result of our scrutiny work." (Scrutiny officer, Nottingham County Council)

Joint Health Overview and Scrutiny Committee Pennine Acute NHS Trust

The officer for the Joint Health Overview and Scrutiny Committee and the officer for the Joint Scrutiny Committee for the Pennine Acute NHS Trust now meet regularly with their CQC inspector. The Committee submitted its review of hospital nutrition to CQC, which then inspected nutrition within the Pennine Acute NHS Trust, as part of its national inspection. Recent CQC inspections, following a documentary about the Trust have been discussed with the Committee's officer. Future work by the Committee will focus on the patient experience, and will be shared with CQC.

How to contact us

Phone: 03000 616161
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103–105 Bunhill Row
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We have also produced an easy read version of this guide, which can be found at **www.cqc.org.uk**. Please contact us if you would like a summary of this document in other formats or languages.

CQC-172-2500-STE-092011

Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development & Scrutiny Panel
MEETING DATE:	18TH January 2013
TITLE:	Winterbourne View Findings Update
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: Appendix 1 – "Winterbourne View Update – Final Report and Findings" **Appendix 2 – Draft Action Plan**	

1 THE ISSUE

1.1 To provide the Wellbeing PDS Panel with an update following the publication in December 2012 of the Department of Health Review; Final Report – Transforming care: A national response to Winterbourne View Hospital

2 RECOMMENDATION

The Wellbeing PDS Panel is asked to:

2.1 Note the content of the report; and

2.2 To receive a further update on actions taken to address the recommendations and findings in one years time.

3 FINANCIAL IMPLICATIONS

3.1 There are no specific financial impacts.

4 THE REPORT

4.1 This paper provides an update following the publication in December 2012 of the Department of Health Review; Final Report – Transforming care: A national response to Winterbourne View Hospital

4.2 This paper summarises the key findings highlighted within the DH review, the Programme of Action identified with key actions, and also contains a draft action plan to address the recommendations and the findings of the review locally within Bath and North East Somerset.

5 RISK MANAGEMENT

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

6 EQUALITIES

An EqIA has not been completed because this report is provided for information and there are no direct equalities issues.

7 CONSULTATION

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

8 ISSUES TO CONSIDER IN REACHING THE DECISION

8.1 Customer Focus; Health & Safety; Other Legal Considerations

9 ADVICE SOUGHT

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

Contact person	Jane Shayler, Telephone: 01225 396120 Mike MacCallam, Telephone: 01225 396054
Background papers	
Please contact the report author if you need to access this report in an alternative format	

Appendix 1

Winterbourne View Final report and recommendations

1 Summary

The physical and verbal abuse of patients with learning disabilities at Winterbourne View has been extensively reported on previously, following the original Panorama broadcast on 31st May 2011.

This paper provides an update following the publication in December 2012 of the Department of Health Review Final Report: **Transforming care: A national response to Winterbourne View Hospital**

This report follows earlier publications which have been previously been reported:

- DH Review; Winterbourne View Hospital – Interim report
- NHS review of commissioning of care and treatment at Winterbourne View
- South Gloucestershire Safeguarding Adults Board Winterbourne View – A Serious Case Review
- Care Quality Commission – Internal Management review of the regulation of Winterbourne View
- Care Quality Commission – Learning Disability Services Inspection Programme, National Overview

2 Key Findings – beyond Winterbourne View

The collated findings of all reports as highlighted in these reports is summarised below:-

- All too often, people were being wrongly placed in hospital settings and there was a failure to design, commission and provide services which give people the support they need, and which are in line with well established best practice.

- Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals. There was a lack of focus of promoting rehabilitation back to a home setting. The DH Final report notes this as a **serious failure of commissioning.**

- The result is that far too many people are in hospital when they should not be, and they are staying there for too long – in many cases for years.

- Many people are sent a long way from their home and families.

- Many Hospitals and care homes are not offering the quality of care that people have a right to expect.

- This model of care goes against government policy and has no place in the 21st century.

- People should have access to the support and services they need locally – near to family and friends – so they can live fulfilling lives within the community.

- Winterbourne View was an extreme example of abuse, but multiple examples were found of poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people.

- Adult safeguarding systems failed to link together the information (from Winterbourne View). The NHS South of England review highlighted the absence of processes for commissioners to be told about safeguarding alerts, and failures to follow up concerns when commissioners became aware of them

- All parts of the system – those who commission care, those who provide care and individual staff, the regulators and government – have a duty to drive up standards. There should be zero tolerance of abuse.

- People with challenging behaviours can be, and have a right to be, offered the support and care that they need in a community-based setting, as near as possible to family and other connections.

3 Next steps – Concordat: Programme of Action

To accompany the final report the DH has published a Concordat; Programme of Action, that commits to a 'programme of change to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities and autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them':

And further states that;

'we will safeguard people's dignity and rights through a commitment to the development of personalised, local, high quality services alongside the closure of large scale inpatient services and by ensuring that failures when they do occur are dealt with quickly and decisively through improved safeguarding arrangements.

The Government's Mandate to the NHS Commissioning Board sets out that

"The NHS Commissioning Board's objective is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people'

The key actions from the Final Report and the Concordat; Programme of Action are:

i). Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014:

- The NHS Commissioning Board (NHSCB) will: Ensure that all Primary Care Trusts develop registers of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care as soon as possible and certainly no later than 1 April 2013;

- Make clear to Clinical Commissioning Groups (CCGs) in their handover and legacy arrangements what is expected of them, including:
    - Maintaining the local register from 1 April 2013; and
    - Reviewing individuals' care with the Local Authority and identifying who should be the first point of contact for each individual.

ii). Health and care commissioners will review all current hospital placements and support everyone inappropriately placed in hospital to move to community-based support as quickly as possible and no later than 1 June 2014:

Health and Care Commissioners will:

- By 1 June 2013, working together and with service providers, people who use services and families, review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual, based on their and their families' needs and agreed outcomes;

- Put these plans into action as soon as possible, so that all individuals receive personalised care and support in appropriate community settings no later than 1 June 2014;

- Ensure that all individuals have the information, advice and advocacy support they need to understand and have the opportunity to express their views. This support will include self-advocacy and independent advocacy where appropriate for the person and their family.

iii). Every area will put in place a locally agreed joint plan for high quality care and support services for people of all ages with challenging behaviour, that accords with the model of good care.

- By April 2014, CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area.
- This joint plan will be part of the Joint Health and Well-Being Strategy and Joint Strategic Needs Assessment
- The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements

iv). Evidence best practice

- By Summer 2015 NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability

- By Summer 2016 NICE will publish quality standards and clinical guidelines on mental health and learning disability

v). Prioritising children and young people's services

For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education.

- DH will work with the Department for Education (DfE) through the Children and Families Bill to introduce from 2014, a new single assessment process for every child and young person up to age 25 with special education needs or a disability, with an Education, Health and Care Plan (subject to parliamentary approval).

- DH and DfE will work with the independent experts on the Children and Young People's Health Outcomes Forum to consider how to prioritise improvement outcomes for children and young people with challenging behaviour and how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013.

- From June 2013 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England

vi). National Leadership Supporting Local Change

To provide national leadership and support to the transformation of services locally, the Local Government Association and NHSCB will develop an improvement programme.

- This will involve key partners including the Department of Health (DH), the Association of Directors of Adult Social Services (ADASS) and Association of Directors of Children's Services (ADCS) and the Care Quality Commission (CQC) and will closely involve service providers, people with learning disabilities and autism and their families in their work

- At a national level, from December 2012, the cross-government Learning Disability Programme Board chaired by the Minister of State for Care and Support will lead delivery of the programme of change by measuring progress against milestones, monitoring risks to delivery, and challenging external delivery partners to deliver to plan, publishing regular updates.

- By March 2012 the NHSCB and ADASS will develop service specifications to support CCG's in commissioning specialist services for children, young people and adults with challenging behaviour.

- The Department of Health will publish a follow-up report one year on by December 2013 and again as soon as possible following 1 June 2014, to ensure that the steps, set out in the Concordat, are achieved.

vii). Improving quality and safety

Ensuring that commissioners are commissioning the right services, that organisations are properly accountable, and that regulation is most effective, underpins many of the systemic problems revealed by Winterbourne View. However, the Programme of Action also places emphasis on strengthening safeguarding adults board arrangements, applying protections of the Mental Health Act and the Mental Capacity Act, addressing the use of medication and improving access to advice and advocacy services.

- Safeguarding Adults Boards will be put on a statutory footing; local authorities will be empowered to make safeguarding enquiries, and Boards will have a responsibility to carry out safeguarding adults reviews

- The Safeguarding Adults Board will publish an annual report on the exercise of its functions and its success in achieving its strategic plan

- The DH will work with CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions and will report by Spring 2014

- During 2014 the DH will update the Mental Health Act Code of Practice taking account of findings form the DH review

- The DH will publish by the end of 2013 guidance on best practice on positive behaviour support to minimise the use of physical restraint and never use to punish or humiliate

- The DH and Royal College of Psychiatrists will commission, by Summer 2013, a review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour

- The DH will drive up the quality of independent advocacy through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.

4 Bath and North East Somerset – Local response and action plan

The NHS Bath and North East Somerset/NHS Wiltshire Cluster has appointed an independent Project Manager on a short term contract to develop a local action plan to address the findings and recommendations of all of the reports identified above on behalf of both PCT's. This is attached as Appendix 1 to this report.

It is accepted that the organisational structures and current commissioning arrangements differ between NHS Wiltshire and NHS BANES, and the respective local authorities. Therefore the draft action plan has been modified in two ways

i) To reflect B&NES own circumstances
ii) To incorporate the additional actions published in the DH Final Report

5 Recommendations

The Wellbeing Policy Development and Scrutiny Panel is recommended to note the content of this report and to receive an update on the implementation of the action plan within twelve months

Mike MacCallam
Associate Director – Learning Disabilities and PSI

Winterbourne View - Bath and North East Somerset local action plan January 2013

Standard	no	Requirements	Recommendations	Actions/Comments	BANES specifics	BANES Action	By When
There is an effective commissioning process in place for services for people with LD	1	There is a single commissioning strategy, based on an integrated commissioning approach		Review current commitment to joint commissioning Establish joint commissioning arrangements and develop single agreed strategy	Integrated commissioning already in place. Need to articulate a commissioning strategy that reflects existing practice – see 3 below	Confirm commissioning strategy/intentions for supporting people with challenging behaviours	Sept 2013
	2	There is an agreed service model based on person centred, best practice principles	35,99	Review current provision/model against Mansell Report 2007, and DOH Interim Report 2012 Agree new service based on the above, linked to resource levels	BANES has a service specification for challenging behaviour services	Review existing model and revise as necessary	June 2013
	3	The commissioning strategy and service model should a) Be based on the JSNA and should aim to meet the needs of the whole population within the local area b) Seek to reduce the number of people using the in-patient A&T units c) Aim to meet the needs of people whose behaviour challenges within the community wherever possible	46,47 111,44 94,29,31 32,42,97 33,16,81	Engage with Public Health over the adequacy of JSNA over identifying needs of whole population Incorporate into commission strategy		Refresh JSNA	On-going
				Review current approach to managing people with challenging behaviour and identify options for improving capacity to manage people within the community		Set up short life group with Sirona and other partner providers and articulate within Comm Strategy	Set up group by April 2013

		d) Ensure the generic mental health service support people with LD and autism to be supported in their own communities and familiar localities e) Risk stratify services within the model f) Explicitly seek to reduce the inequalities experienced by LD people g) Commit to reducing the use of anti-psychotic medication h) Make available effective advocacy services to patients, users and their families		Draw up pathway and criteria for use of A&T placements	This is already in place with AWP	Clarify model for 2013/14 Share with Sirona Complex Health needs service	March 2013 March 2013
				Draw up options/development plan for increasing capacity for residential provision for people who challenge within the County			
				Draw up criteria for risk stratification of services	Number of systems already in place – risk register with Sirona CHNS; Commissioner contract review framework	Review existing systems and revise criteria for risk stratification of services	Sept 2013
				Define and agree targets for reduction in inequalities for people with LD: incorporate into commissioning strategy			
				Review use of anti-psychotic medication for people with LD/autism, and set targets for reduction.		Agree with Sirona CHNS	June 2013
				Review current advocacy services should be reviews especially lined to non-compliant services	BANES commissions independent advocacy.	QA against Advocacy Performance Mark	Sept 2013

	4	The roles and responsibilities of the commissioning bodies are clearly defined and agreed	78,87,43	Agree lead commissioning arrangements between NHS Wiltshire/CCG/Wiltshire Council, and draw up formal agreement	S75 agreement in place for CCG & LA in BANES	Revise S75 agreement to include people with Autism	Dec 2013
	5	The roles on responsibilities of commissioners and care co-ordinators are clearly defined and agreed, including the specific communication processes between the two	12,21	Review current roles and responsibilities Identify optimal arrangements in line with best practice and the interests of users Draw up formal agreement outlining these that is agreed between all partners. To include a formal schedule d over the communication process	Could/need to include in contract variation with Sirona	Agree revised documentation for care co. reviews – already in hand Include specific requirements for reviewing CB services	Mar 2013
	6	There is a specific exercise to follow-up all previous Winterbourne patients a) To ensure the impact of any abuse experienced or witnessed is minimised b) Who remain in hospital with a view to return them to their own communities	2,88	Review current arrangements/care plans for all ex - Winterbourne service users	Previously completed for 2 BANES service users	Agree fresh review of ex patients of WV and current hospital placements with Sirona CHNS. DIschage plans to be in place	June 2013
There is an effective contracting process in place for services for people with LD	7	A standard contract is used for all spot placements and provider services which includes appropriate quality and safety measures	3	Review current contracts use for placements and identify changes needed in line with requirements 8-13 Initiate negotiations with providers over changes to contracts	agreed	Review current contract and specifications including use of NHS contract for CHC funded placements Implement in line with new National Service specification yet to be published	October 2013

Page 56	8	The contract requires the provider to provide evidence of a) Effective governance within the provider b) Service provision is in line with the Statement of Purpose for the Service Provider c) They are engaged in activities that they are registered to provide d) How they are discharging their responsibilities under the MHS (1983) e) There is unimpeded access to the complaints by patients, users and families f) Provision of the right environment and skilled staff to meet the needs of patients and users g) An effective reporting mechanism for staff who have concerns over service provision, including a whistleblowing process h)	24,93,45 57,59,58 27,66,89 90	See requirement 18 There is a compelling case to include a requirement to demonstrate effective governance by Board members, including mandatory visits	8-13 Need to be clear – is this for ALL social care & health contracts?	As 7 above Engagement with providers to agree revised contract and reporting mechanisms Agree role of Sirona and individual case managers to monitor through reviews	July 2013 July 2013
There is an effective contracting process in place for services for people with LD	9	The contract requires the provider to report as agreed on a) Requirement to report adverse/serious untoward incidents b) Incidents of absconding c) Police attendance in the interests of patient/user safety d) Criminal investigations e) Safeguarding investigations f) DOLS applications and renewals g) Lengths of stay	3,6,7 8,9,10 11,17,30 41	See requirement 18 This may require an agreement to report generally on incidents for whole service	8-13 Need to be clear – is this for ALL social care & health contracts?	As 7 above	

		h) Levels and outcomes of complaints i) Detention status of patients at point of discharge j) To identify if a discharge is to be a facility within the same company/associated company/NHS trust					
There is an effective contracting process in place for services for people with LD	10	The contract requires the provider to demonstrate that staff meet minimum requirements with regard to a) Signing up to appropriate codes of conduct b) Induction and training standards c) Meeting the needs of people who challenge d) Access and use of appropriate supervision e) Understanding and application of DOLS standards f) Training and application of restraint and seclusion in line with agreed policy	25,30 115,27	See requirement 18 SCR recommends "encouragement" re code of conduct requirement			
	11	The contract requires the provider to a) Use the Care Programme Approach where appropriate, with a clear focus on discharge planning b) Undertake care planning and activities are in line with best practice including • Based on personalisation principles • Involve and are owned by the individual • Work to agreed outcomes • Are in appropriate and	17,30, 113a,92 114,72 106,19 35,40	See requirement 18			

		accessible formats c) Have effective systems of clinical supervision in place d) Have an adequate complaints process in place e) Provide access to adequate advocacy services f) Access by visitors to agreed and defined standards g) Have an adequate restraint and seclusion policy that meets commissioners requirements					
	12	The contract requires the provider to provide evidence in regard to the Registered Manager a) On their qualifications an continued professional development b) That their normal place of work promotes ready access by all patients/service users and staff within the service c) Actions being taken to replace them as required	60,113 61	See requirement 18 This is a boarder issue for CQC, but reflects the central role the Registered Manager has in delivering high standards within a service	8-13 Need to be clear – is this for ALL social care & health contracts?		
	13	The contract requires the provider to allow access by commissioning and operational staff undertaking inspection, monitoring and casework to all areas of the provider service at all times	70			Recruit to additional Contract support officer post to enhance contract monitoring and contract compliance	May 2013
	14	Commissioners will have agreed methodology for determining value-for-money for provision, based on outcome data, which will be applied to placements	38,39,22	Commissioners work with Operational staff to review how outcomes are currently incorporated into the care planning process, with particular emphasis on placements to A&T	B&NES/Sirona is already introducing new documentation to improve assessment and review processes	Agree and implement revised assessment and review documentation with Sirona from April 2013	April 2013

There is an effective contracting process in place for services for people with LD				services. To agree changes to care planning processes to ensure outcomes are clearly defined. Commissioners to • Identify how outcomes can be collated to help support the future use of placements • Define a VFM methodology that can be used in agreeing placements	B&NES operates a Single Panel process to assure VFM.	Ensure that this includes enhanced review/monitoring for people with complex needs/challenging behaviours – build into contract monitoring with Sirona	April 2013
	15	There is an agreed process for commissioners a) To agree new providers prior to a placement being made b) To agree new placements to a provider that is currently or has been previously used	83	To review what criteria are currently used to agree the use of providers To agree what criteria are to be used for agreeing the use of a provider, and to set up a clear process for applying these to providers. To ensure that there are adequate information systems in place to allow this process to operate effectively. These would be additional checks made beyond the checks made by CQC	a) Covered by accreditation framework b) Covered by panel processes	Review current accreditation processes and specification for enhanced services	June 2013
There is an effective system of inspecting and monitoring services	16	There is an agreed process for assessing the performance of providers against their contract	4,5,69 20	Review current review processes Draw up and agree processes that meet the standards covered in requirements 17-27	Already covered with contract review framework	Continue with existing contract review framework	Ongoing

	17	The monitoring process includes inspection processes that directly review the provision of care and support	62	Review current arrangements for reviewing services Agree what would be required to ensure that there is direct inspection of service provision, and who is responsible for undertaking this work – this needs to be linked with requirement 5	Covered in contract review framework – programme of visits already in place	Continue with existing contract review framework	Ongoing
	18	There is a set of standards defined for the requirements set out in the contract	5,6,6,8 9,10,11 17,30,41 45,57,58 59,60,113 113a,115 92,114	Undertake an exercise with commissioners, operational staff, users and families and providers to draw up standards for the contractual elements covered in 8-13 Agree the standards and incorporate into contracts and monitoring processes	These are already in the contract review framework	As per 8 above	July 2013
	19	The monitoring process has processes for a) Care co-ordinators within operational services to provide feedback on placements, including safeguarding concerns and alerts b) Families, self and peer advocates to feedback on the quality of service provision	15,21,84	Review current processes/practices Draw up processes to ensure this requirement is met	a) Already in place b) Not sure	Draw up processed to ensure this requirement is met	Sept 2013
	20	The monitoring process is aligned to the risk stratification of providers	46	Determine the level of monitoring required generally for each level of risk. It should be recognised that this approach should not be used rigidly, and that levels of monitoring	Need to clarify		

				may need to be increased in response to concerns regardless of the risk stratification			
	21	The monitoring process reviews providers at unit and corporate level	47,53	Commissioners to have process for monitoring placements at unit and organisational level, including collating key information sets	BANES uses a contract review framework and programme to review providers, + accreditation framework	Continue with existing arrangements	On-going
There is an effective system of inspecting and monitoring services	22	The monitoring process includes capacity to access services at any time as required	70	Review the current working arrangements of staff who could be involved in review work (link to requirement 26) Identify any changes required to ensure there is capacity to meet this requirement, and draw up action plan to make required changes. Build requirements and processes for out-of-hours reviews/inspections of overall review process (requirements 16 and 26)	System already in place to allow for unscheduled contract reviews Links to safeguarding and whole homes review process	As above	On-going
	23	Service reviews include pharmacy led review of medication regimes/usage	26,68	Commissioners to identify criteria and process for when this would be required	Joint work with medicines mgmt. over this	Liaise with Medicine management – draw up schedule of reviews linked to contract review programme	Sept 2013
	24	The monitoring process is undertaken by staff who can demonstrate relevant competency to undertake this work. This may include the use of “experts by experience”	63,64	Review the competencies required to undertake the agreed review process (requirement 16) Review the current competencies and capacity of staff involved in	Experts by experience – programme agreed with Your Say	Agree programme with Your Say for programme of visits across Health and Social Care	June 2013

				review work (link to requirement 5) Identify actions required to ensure there is sufficient capacity to meet this requirement including a) Capacity to review competency on an on-going basis b) Training and development requirements for staff			
	25	There is an agreed protocol and procedure for information sharing over safeguarding alerts and concerns between operational services, commissioners, regulators and providers	23,53,77	Review current agreements and identify and changes required in regard to • Current protocols and processes • Current implementation of protocols and processes		Develop and implement 'trigger protocol'	October 2013
There is an effective system of inspecting and monitoring services	26	There is an agreed structured process for working with providers who are not meeting contractual requirements including a process for ending contracts and decommissioning services	69	Review current practice in regard to providers who are not meeting contractual standards and/or there are concerns over quality of care and support Agree a clear process for all agencies to follow in order to meet this requirement: link to requirement 36 in regard to CQC role There will need to be agreement over the principles around working with providers, including the extent to which	Default and breach process already in place as part of contract	Review and refresh as necessary	October 2013

				agencies will support contracted providers to improve and meet required standards			
	27	There is an effective process for monitoring the quality and effectiveness of advocacy services	29	Undertake review	Contract monitoring already in place for commissioned advocacy service	Undertake quality performance audit using national toolkit – Action for Advocacy	Dec 2013
There is an agreed process in place for reviewing the effectiveness of inspection and monitoring processes	28	This is not specifically identified in the recommendations, but the overall criticism of regulatory and review processes would indicate that there needs to be a robust review process on an on-going basis that ensures processes are effective					
	29	See requirement 5			See 5		
There is a clear process for managing individual placements	30	The case management process will a) Use CPA will be used where appropriate b) Have a clear focus on discharge planning c) Monitor length of stay d) Ensures that MCA and DOLS requirements are being met appropriately e) Ensure that people with LD or autism who are not subject to the MHA (1983) are not subject to the same restrictions as people who are f) Ensure that the requirements of the MHA (1983) are being met appropriately g) Will ensure that plans to	17,18,34 67,79,80 86,82,107	Review current arrangements for case managing placements Draw up agreed process and standards for case management process This will include how requirements 31-33 will be met	30-33 Agreed – need to agree with Sirona Already in place via the Sirona CHNS	Meet with Sirona to review agreed processes	April 2013

		move a person between units run by the same provider are in the person's best interest					
	31	Expectations over communication between care coordinators and families will be clearly defined	13				
	32	Availability of clinical expertise to care-co-ordinators will be defined and agreed	14			Review with Sirona	April 2013
	33	There is an agreed process for pharmacy led reviews of placements where required	26		Joint work with medicines mgmt. over this	As 23 above	June 2013
	34	There will be a specific review of current placements within A&T units to ensure there are clear plans for discharge	28	Specific exercise required to review current placements	No current placements	No action necessary	
	35	There will be a periodic review of the case management process to assess if it's meeting best practice standards	55	Draw up process of jointly reviewing case management processes between the relevant agencies	Already covered in contract with Sirona and role of safeguarding teams to audit	Review though contract review meetings with Sirona at organisational and individual commissioner level	On-going

There are effective safeguarding processes in place across all agencies	36	The local safeguarding processes and procedures included a) Processes to ensure people in individual placements have Unimpeded access to the complaints process Ready, private access to independent professionals. This will include people subject to DOLs, MHA detention, restraint and seclusion, or who are making complaints b) Processes for care coordinators to inform commissioners of relevant safeguarding concerns (see requirement 18) c) Processes for care co-ordinators, commissioners and CQC inspectors to work together in regard to safeguarding alerts d) Processes in place to respond to providers who are failing to meet required standards (see requirement 25)	19,109 48,49,50 73,100 56,110	The local safeguarding team should be involved in the overall action plan to ensure that is requirement is met in terms of - Defining roles and responsibilities (requirement 5) - Establishing required contractual arrangements (requirement 7-13) - Establishing effective reviewing and case management processes (requirements 16 & 30)		Review and refresh existing policies and procedures –make explicit - Joint working with Sirona and Safeguarding team	October 2013
	37	There are local processes in place to undertake analysis of safeguarding information including a) Monitoring of trends across providers b) Analysis of A&E data c) Whistleblowing activity	51,108 105,36 54,65	Review current processes for - Collecting and collating safeguarding data - Analysing data - Using and disseminating analysis, and the impact it has in the experience of users and families of services	Discuss with Associate Director for Safeguarding	Conduct detailed review with Safeguarding team	July 2013

	38	The LSAB a) Has reviewed the findings from the Winterbourne SCRb b) Has an agreed process for reviewing safeguarding activity, including SCRs, and other serious incidents c) Has an agreed process for reviewing the effectiveness of local safeguarding processes	85,104 102	Undertake specific Winterbourne review Review lead role in regard to oversight of safeguarding processes	Discuss with Associate Director for Safeguarding	LSAB to report back	Mar 2013
ADDITIONAL ACTIONS FROM DH FINAL REVIEW	39	The NHS Commissioning Board (NHSCB) will: Ensure that all Primary Care Trusts develop registers of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care as soon as possible and certainly no later than 1 April 2013;			Registers of pwld already in place	Work wth Sirona to: Refresh GP registers Update to include people with autism Ensure that registers identify people with MH or challenging behaviour	April 2013
	40	DH will work with the Department for Education (DfE) through the Children and Families Bill to introduce from 2014, a new single assessment process for every child and young person up to age 25 with special education needs			This is already in hand	Meet with Divisional Director for childrens services to disseminate DH final review	Feb 2013

		or a disability, with an Education, Health and Care Plan (subject to parliamentary approval).				Agree local strategy for implementing single EHC plan Develop commissioning intentions for supporting young people into adulthood into formal strategy, esp those with complex needs/challenging behaviour Review operational processes for ensuring safeguarding is built into transition planning processes	Dec 2013 October 2013 Feb 2013

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Bath & North East Somerset Council	
MEETING:	Wellbeing Policy Development and Scrutiny Panel
MEETING DATE:	18/01/2013
TITLE:	Joint Strategic Needs Assessment (JSNA) – Social and Economic Inequalities
WARD:	ALL
AN OPEN PUBLIC ITEM	
List of attachments to this report: JSNA Topic Summary : Social and Economic Inequality	

1 THE ISSUE

1.1 This report covers a summary of data held in the Joint Strategic Needs Assessment on the subject of social and economic inequality. This is following an explicit request from HWPD&S members to keep the JSNA as a standing agenda item on a subject-by-subject basis

2 RECOMMENDATION

The Health and Wellbeing Policy Development & Scrutiny Committee is asked to:

2.1 Note the findings of the briefing

2.2 Consider the broader implications/impacts of these findings on the work of the panel

3 FINANCIAL IMPLICATIONS

3.1 The JSNA has been produced by re-tasking existing council and NHS resources.

3.2 The JSNA underpins the Clinical Commissioning Group's Plan and the emerging Health and Wellbeing Strategy which will both have an impact on long term budget setting and prioritisation. Findings will also be used to support the Equalities Impact Assessment of council service and financial plans.

4 THE REPORT

Background

4.1 The requirement to conduct a Joint Strategic Needs Assessment has been placed on local authorities under the Health and Social Care Act 2012, however the requirements on exactly what a Joint Strategic Needs Assessment is are quite broad. As a result, a local approach has tried to take best practice from elsewhere and take the local audience into account. As a result it is not a static, many-page document, but instead a process covering a range of topics, issues and is available in a range of documents.

4.2 At the HWPD&S meeting on 27 July 2012 a request was made for more in-depth presentations on JSNA data to be made to the panel to support their policy development and scrutiny role. This is the third presentation to be made to the panel.

Content

4.3 The JSNA contains a wide range of local statistical data gathered from national sources and local databases; local opinions gathered from existing consultations and engagement exercises and also data gathered from performance management systems. It is designed to highlight positive features of the area as well as more traditional medical 'needs'.

4.4 The summary document provided as Appendix 1 covers the current JSNA content on the subject of dementia and includes input from local commissioners.

4.5 Full JSNA documents and underlying materials are currently available through the council web-site at www.bathnes.gov.uk/jsna

4.6 The JSNA is an ongoing project and we are always looking for new intelligence about our communities, if you feel we should be told about anything, please contact research@bathnes.gov.uk

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

Socio-economic inequality is an important aspect of the local approach to Equalities. An understanding of the distinct needs of this part of the community will assist decision makers in addressing needs for the whole population.

For many of the data sources used in the JSNA data is not available with regards other equalities characteristics, particularly ethnicity.

A more comprehensive appendix detailing the equalities findings of the JSNA is available on the Council web-site at www.bathnes.gov.uk/jsna

CONSULTATION

6.1 Cabinet Member; Staff; Other B&NES Services; Stakeholders/Partners; Other Public Sector Bodies; Section 151 Finance Officer; Monitoring Officer.

6.2 All information contained in this report has already been approved by the Health and Wellbeing Board and the JSNA steering group as an accurate reflection of local needs.

6.3 Information gathered from public engagement is a critical element to the JSNA, and the new Healthwatch engagement member will have a statutory responsibility to input. As the JSNA process develops we will be investigating more ways of getting existing public engagement information fed into the process. In addition, an aim of the web-portal is to ensure that local information can reach the communities who have need of it.

7 ISSUES TO CONSIDER IN REACHING THE DECISION

7.1 Social Inclusion; Human Rights; Corporate; Other Legal Considerations; Wellbeing

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	Jon Poole, Research & Intelligence Manager Helen Tapson, Public Health Intelligence Analyst
Background papers	www.bathnes.gov.uk/jsna
Please contact the report author if you need to access this report in an alternative format	

Introduction: What do we mean by Socio-Economic inequalities?

However you define health, there tend to be systematic Inequalities in health experience between different geographical areas, genders, ethnic communities, and different social and economic groups. Inequalities in health experience between different geographical areas, genders, ethnic communities, and different social and economic groups.

- Health Development Agency, 2005, p1

A report examining the impact of different health outcomes by gender, ethnic grouping etc. can be found at:
http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/research-library/35364

This report focuses specifically on socio-economic inequality, as measured through the Income Deprivation domain of the Indices of Multiple Deprivation 2010.

In 2007 an independent commission chaired by Sir Michael Marmot was asked to propose evidence based strategies for reducing health inequalities, some of its key findings are below:

- *There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.*

- *Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.*

- *Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.*

Adapted from Marmot, Atkinson et.al. 2010 p9

Find out more about the Marmot review at http://www.instituteofhealthequity.org/

The Marmot review concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

And reducing health inequalities is an emerging priority of the Health & Wellbeing Board.

Local Evidence

Despite relatively low levels of social inequality in Bath and North East Somerset as a whole, there are small geographical areas with notable issues. These areas are largely comprised of social housing estates. Overall, five areas are within the most notable 20% of the country across a range of data: Twerton West, Whiteway, Twerton, Fox Hill North, and Whiteway West.

Social inequality has a significant relationship with a wide range of health and social care needs. When talking about social inequality we look at the difference between the 20% of the district experiencing the greatest level of inequality compared to the 20% who experience the least inequality based on a combined measure used by the government to allow national comparisons between areas.

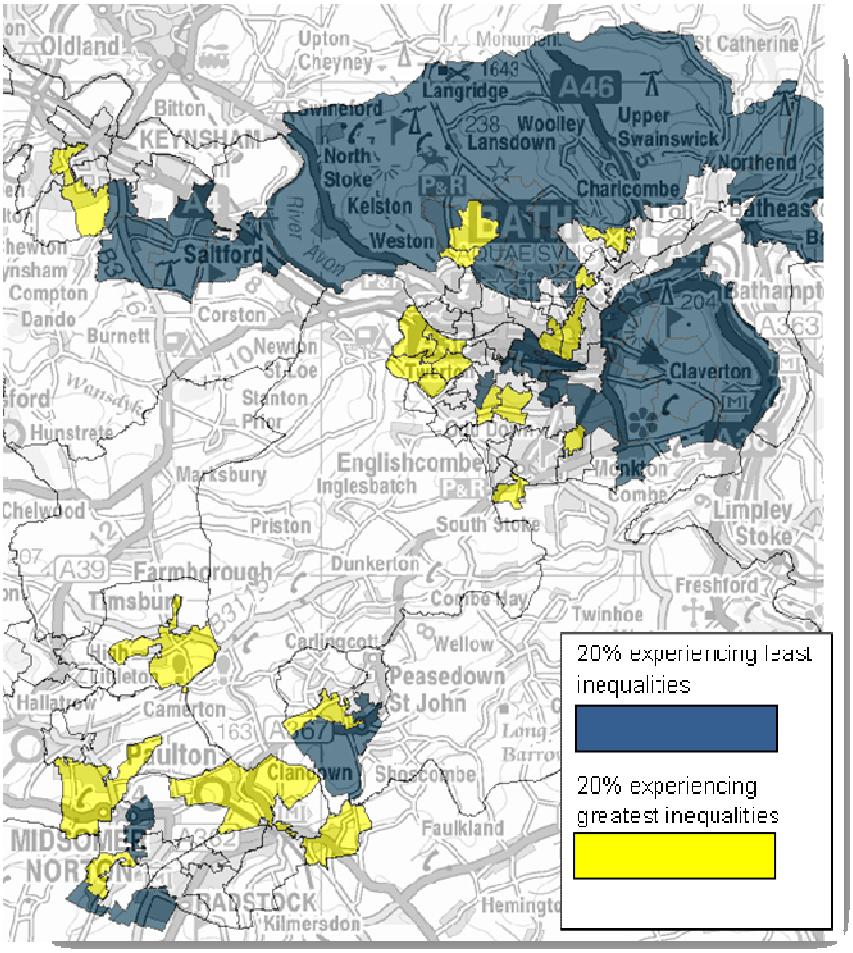

Fig 1: Inequality mapped in Bath and North East Somerset (20% least deprived and 20% most deprived – adapted from the Indices of Multiple Deprivation 2010

Life expectancy, mortality & long term conditions

People living in some of these areas live significantly shorter lives compared to other areas. In B&NES, a man born in one of the communities marked in blue can expect to die 6.3 years younger than a man born in the 20% experiencing the least inequality. For women the gap is smaller, though there is still a difference of 3.5 years. A greater rate of people die in these communities compared to those experiencing the least inequality.

If everyone in B&NES had a similar health experience to those who suffer the least inequalities, then it may be possible to prevent 40% of premature deaths in males and 9% of premature deaths in females (over 220 deaths over a three year period).

This group also have a 60% higher prevalence of long term conditions and 60% higher severity of conditions than those people living in areas suffering least inequalities and as such are more likely to be users of health and social care services.

Engagement with practitioners working in Twerton and Southdown (two wards which have areas experiencing notable social inequalities) has suggested that alcohol misuse and mental health are significant factors for this group. Cost and physical access to services were identified as important

Health and lifestyle determinants

This cohort has been identified as being at particular risk of a wide range of health and lifestyle issues. Premature births are high and breastfeeding initiation and continuation rates are significantly lower. Babies born to mothers in this group are more likely to have lower birth weight linked to maternal factors.

Self-harm hospital admissions are 3x higher for these communities.

There is poor dental health in wards experiencing greater social inequalities, particular with regards decayed, missing or filled teeth. There is a notable variation in dietary habits linked to social inequalities at a national level.

There are greater levels of smoking in these areas, and those areas experiencing greater social inequality have some of the lowest levels of successful quit rates through smoking cessation services.

People living in these areas were also over four times more likely to be admitted to hospital for alcohol specific conditions and over twice as likely to be admitted for alcohol attributable conditions; there is also a strong relationship with emergency admissions for poisoning.

Social and environmental factors

This cohort has been identified as a particular priority for education and significant improvements have been seen amongst children in this group following targeted activities.

As of May 2011, Twerton West, Twerton and Fox Hill North had over 20% of their resident working age population claiming out of work benefits, significantly greater than the B&NES population as a whole, the South West and national rates. There is a significant relationship between the proportion of a small area that is defined as NEET (Not in Education, Employment or Training) and social inequality.

There is a relationship between all major crime types and social inequality, when the night-time economy is excluded as a factor.

Climate change will affect the poorest and most vulnerable residents; increased energy costs will affect all those on lower incomes. However those in energy inefficient homes are not always in the areas of more traditional inequality.

There is limited engagement with traditional art and cultural activities from residents in these communities.

Community capacity (the ability of a community to do things for itself), is strongly linked to social inequality, with less natural capacity being observed in this cohort. There is some emerging evidence of effectiveness surrounding targeted engagement activity designed to build social capital. A study in one small area of B&NES has suggested that a substantial proportion of residents in these areas want to be more involved in their local area, but do not feel they have a say at the moment – however these perceptions can vary on a street-by-street basis.

www.bathnes.gov.uk/jsna
research@bathnes.gov.uk

References:

(2012) Bath and North East Somerset Council, JSNA: 15 Page Summary, Bath and North East Somerset Council http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/research-library/35324 (Accessed 03/01/12)

(2005) Coppell & Ray Introduction to Health Inequalities Health Protection Agency, http://www.nice.org.uk/nicemedia/documents/thi_introduction.pdf (Accessed 03/01/12)

(2010) Marmot, Atkinson et. Al Fair Society, Healthy Lives:The Marmot Review Executive Summary http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-executive-summary.pdf (Accessed 03/01/12)

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Bath & North East Somerset Council		
MEETING	Wellbeing Policy Development and Scrutiny Panel	
MEETING DATE:	18th January 2013	**AGENDA ITEM NUMBER**
TITLE:	**Substance Misuse Services**	
WARD:	ALL	
AN OPEN PUBLIC ITEM		
List of attachments to this report: Appendix 1 – DAAT Income Appendix 2 – B&NES Substance Misuse Performance Charts Appendix 3 – Ketamine Health Symptoms Information for GP/Health Professionals Appendix 4 – Ketamine PUF Patient Assessment Questionnaire (Pelvic Pain, Urgency and Frequency) Appendix 5 – Ketamine Service User Leaflet Appendix 6 – Ketamine Support Group: Loss and Bereavement Art Exhibition		

1. THE ISSUE

1.1 This paper details the substance misuse services commissioned and delivered in B&NES with particular reference to the needs of people using ketamine; to younger drug and alcohol users (those under 25); and to younger service users who have insecure accommodation.

1.2 This report also gives an update on the re-commissioning of existing substance misuse services.

1.3 The function of the Drug and Alcohol Team (DAAT) is to commission a wide range of services and interventions for adult substance misusers (aged over 18) throughout B&NES (for drug and alcohol services). Services are provided by Avon and Wiltshire Partnership's Specialist Drug and Alcohol Services (SDAS) and Developing Health and Independence (DHI). Young People's services are commissioned by CYPS and delivered by DHI's Project 28.

2. RECOMMENDATION

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

2.1 Services in place to support substance misusers to overcome their dependence; to obtain/maintain their tenancy; and to support their families.

2.2 Criminal Justice Services in place to support substance misusers to reduce re-offending.

2.3 Progress being made to support ketamine misusers in B&NES.

2.4 Progress being made in re-commissioning substance misuse services.

3. FINANCIAL IMPLICATIONS

Substance misuse services in B&NES are funded via a pooled treatment budget of £2.8m (see attached Appendix 1) with all finances contributing to an integrated treatment pathway. The National Treatment Agency (NTA) is the biggest contributor to the pool. NTA funding is, in part, performance related and therefore volatile and reliant upon efficient, effectively resourced and delivered services.

4. THE REPORT – SUBSTANCE MISUSE SERVICES

4.1 Background

- Three years ago the performance of the substance misuse services was very poor, with B&NES being the worst performing DAAT in the South West and amongst the worst in the country. Since then there has been a vast improvement in service performance, quality, activity,value for money and service user outcomes. The NTA have been very involved in monitoring this process and have commended our approach and the resultant improvements (see attached Appendix 2 performance charts which show measurable quantitative and qualitative service improvements against NTA specific key performance indicators). It is the NTA's opinion that within the next 12 months B&NES substance misuse services are likely to be in the top quartile in the country.

- When a strategic decision 20 months ago to move from 3 to 2 providers also brought efficiencies it was agreed, following a business case, that these efficiencies should be used to build alcohol service capacity in response to the needs identified by the Council and its partner organisations – B&NES PCT, Avon and Somerset Probation Service and Avon and Somerset Police. This has been supported by the B&NES Alcohol Strategy identifying that tackling substance misuse, including alcohol-related crime and harm, is a key priority for

partners [B&NES Community Safety Partnership and its successor the Responsible Authorities Group, and the Probation Service].

- This strategic intent is supported by evidence from the Probation Service's assessment in 2008-09 identified that 63% (312) of offenders in B&NES report having a problem with alcohol (the highest % in their area), compared with 25% (124) for drugs. (The highest age groups reporting an alcohol misuse problem are the 18-20 and 21-24 year olds.) In addition, of those offenders convicted of a violence offence, 66% reported a problem with alcohol.

- Whilst tackling alcohol misuse is not the primary purpose of the NTA funding to date – which remains focused on drug misuse – it is a significant problem in B&NES and we have, therefore, committed ourselves to working together to better meet our local needs within existing resources.

4.2 Drug Specific Services

- As shown in the attached performance charts (Appendix 2), at Quarter 2 of 2012-13 there were 762 adult drug misusers in treatment addressing their problematic drug use. Over the last 2 years the number of adult drug misusers accessing treatment has risen considerably, from 642 (Q1 2010-11) to the present 762. This shows both an increased need for these services and increased efficiency in delivering services within existing resources.

- A very high level of these adults in treatment (599) use opiates (i.e. heroin) and/or crack cocaine and these users cause the highest harm to themselves and to their communities.

- Over the last 20 months there has been an increase in people identifying a need for support for other drug misuse (e.g. ketamine use). Since January 2012, **688** triage assessments have been carried out, with previous ketamine use identified in **107** of these triages, with **18** people reporting problematic ketamine use. Eight of these 18 people are experiencing physical health issues, with 2 people's symptoms severe enough to require referral on to secondary urological services.

- To minimise the harm to the service users, their families and B&NES communities, and to support service users to address and recover from their substance misuse, an intensive range of substance misuse treatment and prevention services are currently delivered as described below:

  A range of interventions to address drug addiction:
  - community detoxification and rehabilitation;
  - opiate substitute prescribing services;
  - psychiatry,
  - psychology and
  - psycho-social interventions (i.e. counselling; cognitive behavioural therapy etc.);
  - outreach;
  - education, training and work programmes;
  - re-settlement and housing/tenancy support to obtain/maintain tenancy;

- peer support; and
- relapse prevention activities to support service users to promote recovery and sustained abstinence.

- Through efficiencies and service re-design, stretch targets were agreed with providers in 2011-12 (as part of contract negotiation) with the aim of having capacity to meet the needs of 700 drug clients. The providers were asked to be innovative in engaging drug users in structured treatment programmes. Through effectively working together the providers have exceeded this stretch target and are working at 10% above commissioned capacity (currently at 762 drug misusers in treatment) without additional resources. **Importantly, in the last year significantly more service users exited treatment successfully 'drug-free' (up from 77 in 2010-11 to 124 in 2011-12), and were supported to maintain their recovery**.

- Needle and syringe exchange services are delivered from treatment centres in Bath and Midsomer Norton, and pharmacies throughout B&NES to reduce the risk of blood borne viruses; reduce drug litter; and deliver harm reduction advice to service users on over-dose prevention, safer sex and reducing risk-taking behaviour.

- 'Save a life' overdose prevention training to service users and their families delivered throughout B&NES (monthly to approximately 8-10 people per month). This is also included as part of a wider training programme of support to health, social care, criminal justice and other Council staff.

4.3 Reducing Re-offending: Criminal Justice (Drug and Alcohol) Services

- Criminal justice specific services were enhanced (through efficiency savings) to increase the capacity and range of services. The service has capacity to work with 100 service users per annum to reduce re-offending through a range of services as follows:
  - 7 day per week drug and alcohol arrest referral service in the police custody suite (increased from 5 days per week) and in Bath magistrates court;
  - Drug Rehabilitation Requirement (DRR) services for up to 10 DRR service users at any one time (statutory order for between 6-18 months in length). One of the DRR service users is addressing ketamine misuse;
  - Alcohol Treatment Requirement (ATR) service – capacity has been increased to work with 30 service users per year (Court order for 6 months). The service is fully delivered within existing resources, has excellent compliance and service user outcomes (reducing/ceasing offending and reducing/ceasing alcohol consumption). This service has been so successful (with referrals from Magistrates) that 27 people have already commenced in service this year, with an expected surge in referrals early in the new year;
  - Drug Intervention Programme services tracking, co-ordinating, key-working, counselling and re-settlement services to support up to 70 service users in the community and on release from prison;
  - To reduce domestic violence (DV) linked to alcohol use, a Reducing Substance and Violence Programme (RSVP) counselling service works

with 10 DV perpetrators (at any one time) to address issues of aggression, violence and controlling behaviour.

4.4 Alcohol Specific Services

- As well as the alcohol services within the criminal justice service, treatment services are in place to enable people to over-come alcohol misuse and dependence through the delivery of evidence based treatment (e.g. NICE CG115) to reduce harmful drinking and alcohol dependence, with capacity to work with 400 service users per year delivering:
  - community detoxification and rehabilitation;
  - one-to-one counselling;
  - psychiatry;
  - psychology;
  - psycho-social intervention and group work programmes to address addiction;
  - education training and work programmes;
  - re-settlement and housing/tenancy support to obtain/maintain tenancy;
  - peer support;
  - relapse prevention activities to support alcohol misusers to become and maintain abstinence.

- Alcohol hospital (RUH) liaison service to reduce alcohol-related attendance and admissions to hospital by providing:
  - alcohol-related advice and support around controlled drinking;
  - facilitated referrals into structured treatment.

  This service also supports and trains primary care professionals including GPs, nurses and other hospital staff, pharmacists, occupational health departments and social care professionals. The aim is to enable early identification of harmful drinkers and support staff to provide advice and facilitate early referrals to treatment.

4.5 Transition Support

- Effective support for Children and Young People's Services (CYPS) staff, and Young People's substance misuse providers by having appropriate joint arrangements in place with young people's substance misuse services to ensure:
  - there are clear care pathways and transition for young people moving into adult treatment services
  - there is effective liaison support with CYPS to discuss cases of parental substance misuse
  - drug awareness training is delivered to social workers/CYPS staff within B&NES.

4.6 Family Services

- Family and carers services that supports carers and families, and enables them to support service users through recovery. Current services provided:
  - 2 groups per week (one in Bath and one in Midsomer Norton);
  - A range of one-to-one counselling, couple's therapy, and group interventions to at least 50 family/carers per annum to support families

and carers, and to enable them to support service users in their recovery from substance misuse;

- Loss and Bereavement Group in Norton Radstock supporting family and friends following the death of a young man in the area linked to ketamine use. Approximately 15-20 people access this support. The group held an art exhibition from 14th-22nd December at the Radstock Church Tea Rooms, with a pre-exhibition event on the evening of 13th December attended by approximately 60 people (Appendix 6).

4.7 Re-Commissioning

- AWP and DHI's contracts were extended by 2 years to provide time to stabilise services and to get the improvement we needed prior to re-commissioning.

- We were explicit that services would be re-commissioned during 2012-13 when the 2-year extension came to an end. An open, well understood (by service users and providers) and accepted re-tendering process has been followed. Two services were commissioned for adult services (Complex and Recovery services) and one Young People's service was re-commissioned at the same time.

- As the Council hold the pooled treatment budget it was decided to use the Council's procurement team for the re-tender along the whole substance misuse pathway with the Young People's service. The Council's procurement team provided advice and support.

- Pre-Qualifying Questionnaires (PQQ) were evaluated. Successful PQQ bidders were invited to submit Invitation to Tender (ITT) submissions in early November 2012 with interviews during late November, and decisions made prior to 25th December 2012 regarding the award of contract(s).

- Contracts were awarded to Avon and Wiltshire Partnership (Specialist Drug and Alcohol Services) for the Adult Complex service; Developing Health and Independence (DHI) for the Adult Recovery service and DHI for the Young People's service. New contracts will commence on 1st April 2013 with any necessary adjustments made in light of grant allocations received.

4.8 Younger People in Treatment

- **97** of **762** drug misusers in treatment services are between 18-24 years of age (more than 1 in 8 of adults in treatment). 22 of these 97 people declared themselves to have no fixed abode (NFA) - almost 25% of the 18-24 age range (one of whom is from the Norton Radstock area).

- Project 28 works with young people around substance misuse either at their base in Bath, or via outreach.

- 104 young people accessed treatment with Project 28 between July and September 2012.

- 145 young people accessed therapeutic activities with Project 28 between July and September 2012

- Project 28 made contact with 339 young people between July and September 2012.

- Due to funding constraints outreach has reduced from 2 nights per week to one night. However the team proactively changed their evening from Wednesday to Friday night, when there are more young people around, in order to increase engagement. During outreach the team covers alcohol and drug awareness; sexual health; and harm reduction advice. The outreach team is in Midsomer Norton either on a fortnightly or once every 3 weeks basis. Between May and mid-October the outreach team saw 260 young people in Norton Radstock area during 9 outreach sessions (average of almost 30 young people per session). The young people are aware of ketamine and its impact; none of them use it, and they had all had a negative attitude towards the drug.

- DHI offer a tenancy support service providing re-settlement and housing/tenancy support to help to support vulnerably housed or homeless clients to obtain, or maintain, their tenancy. They also deliver housing floating support and provide or signpost service users to debt advice and benefits support.

- Alcohol service performance monitoring is not as robust as drug treatment monitoring and it is difficult to state currently the size of the alcohol and housing needs of this group.

4.9 Ketamine Need and Response

- Through local, regional and national intelligence we are aware of Ketamine and its use as a club or party drug (primarily) amongst younger people, with reports of use in the Norton Radstock area of B&NES and in Bristol. We have sought to increase our knowledge of this drug (and particularly of its health implications and how it is being used) and to cascade this knowledge appropriately as well as to identify local use and support needs. We have done so in the following ways:

    - A Steering group was set up which meets quarterly at the Hub in Midsomer Norton. It is chaired by Dr Fiona Carroll from SDAS with input from the urology consultant Mr John McFarlane, and attendance by SDAS clinician; DHI practitioner who works from the Hub; Project 28 Outreach worker; and the Substance Misuse Commissioning manager.

- In order to better understand the need, triage forms were adapted in January 2012 to specifically ask a question around ketamine use. From 688 triages completed, 107 answered 'Yes' to previous ketamine use. 18 of the 107 disclosed problematic ketamine use (the rest were recreational users, with most of them stating they had tried ketamine only once or twice). All ketamine users were under 25 years of age.

- A patient assessment questionnaire was implemented to screen, where appropriate, for any urological health symptoms related to ketamine use (pelvic pain/urgency and frequency – called the 'PUF' Questionnaire - see Appendix 4) with an assessment care pathway agreed direct to the Urologist. 8 PUF questionnaires have been completed resulting in 2 Urology referrals. One person, post-surgery, is making a good recovery, one person is being supported and encouraged to access the Urology service.

- The Providers went to last year's National Urology Conference to learn more about the medical health implications of ketamine use.

- The DAAT and providers have raised awareness with GPs around ketamine health implications (followed up with Appendix 3 – Ketamine Health Symptoms Information leaflet) and have encouraged them to ask young people who present with urinary tract infections (UTI) about ketamine use.

- Two sessions of Ketamine training were delivered to GPs and health professionals – one session Bath wide and one at St Chads surgery. Other GP practices in the Norton Radstock and Paulton area have been contacted and offered ketamine specific training. They are all agreeable and this will be delivered shortly.

- A training programme for GPs, Pharmacists, health and social care professionals and carers was rolled out in 2012-13 to inform and raise awareness of the harms caused by ketamine. Another evening training event is being held in Bath on 27th February 2013.

- The DAAT and substance misuse treatment providers have been asked (and agreed) to input into the GP training day on addiction for Registrars at the RUH Postgraduate Centre on 30th January 2013 (oversee workshops and give presentations). This training will be on the management of alcohol, opiate and ketamine addiction and will explore how to support patients exhibiting addictive behaviour to engage and induce change.

- DHI are linking in with the sector inspector at Radstock police and, as part of this, DHI and SDAS have offered to attend PCSO team meetings to provide condensed ketamine awareness training, and advice on treatment services at the Hub in Midsomer Norton. At the same time we will seek to get one PCSO to act as 'champion' and invite them to the longer training event on 27th February 2013.

- The DAAT is working with the Young People's Substance Misuse Commissioning Manager and Young People's Training Officer to offer training on drug and alcohol awareness (including ketamine awareness) to the Young People's workforce (including youth services). The DAAT and providers have agreed to run workshops with CYPS as part of the Celebrating Fatherhood programme.

- The Shared Care Monitoring Group has been part of the discussions around ketamine. Dr Jones from St Chad's surgery sits on the group has offered to have his registrar link with the Ketamine Steering group and carry out a ketamine audit of their surgery.

- The providers have developed a Ketamine service user leaflet (Appendix 5) and are seeking innovative ways to deliver ketamine awareness and harm reduction messages to 'recreational users' via social media: twitter and facebook, and through peer mentors.

- As stated in 4.6 above there is a support group at Midsomer Norton for previous ketamine users and family members, set up following the death (linked to ketamine use) of a young man in the area.

- As stated in 4.8 above, the Project 28 outreach team seek to proactively engage young people. They go to Youth Clubs and 'hot spots' based on intelligence from young people, the police and the Anti-Social Behaviour team. However, ketamine is a party/club drug and is used in the 'party/club' scene, and where there is access to veterinary medicines. It is used at parties, or in the home and street outreach is not effective at engaging ketamine users.

- There is a lot of development work in B&NES to identify the scale of use and need and following discussion with the National Treatment Agency their advice is that Ketamine use in B&NES is not unexpected. Ketamine is not localised to Midsomer Norton nor to the south west. The nature of ketamine use is 'recreational' and their view is that having ketamine users accessing B&NES services is a positive sign, showing we have outward facing accessible services that service users have confidence in. We are aware of the need; we have engaged with stakeholders to raise awareness of ketamine (and other substances); we have been proactive in having services in place to meet the needs of all substance misusers in B&NES (not only opiate and crack cocaine users) and this is a strength of our system.

5. RISK MANAGEMENT

Risks in relation to re-commissioning are being effectively managed through advice and support from the Council's Procurement Team.

6. EQUALITIES

Equality Impact assessments have formed part of the re-commissioning of services and are not applicable to this update.

7. CONSULTATION

7.1 AWP, DHI, Project 28, and the NTA's Deputy Regional Manager were consulted in connection with the Ketamine services detailed in this report.

7.2 Consultation on the re-commissioning has followed the Council's processes:

- Service users, providers; stakeholders including the NTA were consulted on the draft specification. Feedback, including that from the NTA, was favourable.
- Service users, providers and all stakeholders were consulted on as part of the needs assessment and were part of the Expert Group.
- Service users were actively involved in the tender evaluation and decision making process.

8. ISSUES TO CONSIDER IN REACHING THE DECISION

This report is for the Scrutiny Panel's information.

9. ADVICE SOUGHT

The Council's Director for People and Communities, the Section 151 Officer and the Monitoring Officer have had opportunity to review and comment on this report. In addition, the Associate Director Mental Health and Substance Misuse Commissioning and the Programme Director for Non-Acute Health, Social Care and Housing, have had the opportunity to input to this report and have cleared it for publication.

Contact person	Carol Stanaway, Substance Misuse Commissioning Manager 01225 477971
Background papers	• Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery • The Government's Alcohol Strategy 2012 • Refreshed Alcohol Harm Reduction Strategy for Bath and North East Somerset 2012 • National Drug Treatment Monitoring System (NDTMS) Green (Performance) Reports
Please contact the report author if you need to access this report in an alternative format	

Drug and Alcohol Team (DAAT) Finances 2012-13

The DAAT income comes from a range of sources and is **pooled into a pooled treatment budget (PTB)** with all finances contributing to an integrated pathway. Income sources are as follows:

Income	**£**
B&NES Council	541777
National Treatment Agency	1273744
PCT	703699
PCT (Choosing Health – Public Health)	80000
Probation	18822
Criminal Justice funding (NTA DIP)	82148
Home Office DIP (going to PCC 1/4/13)	43744
Home Office DAT Partnership Grant	56604
TOTAL INCOME	**2800538**

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B&NES SUBSTANCE MISUSE PERFORMANCE 2010-12

Chart 1

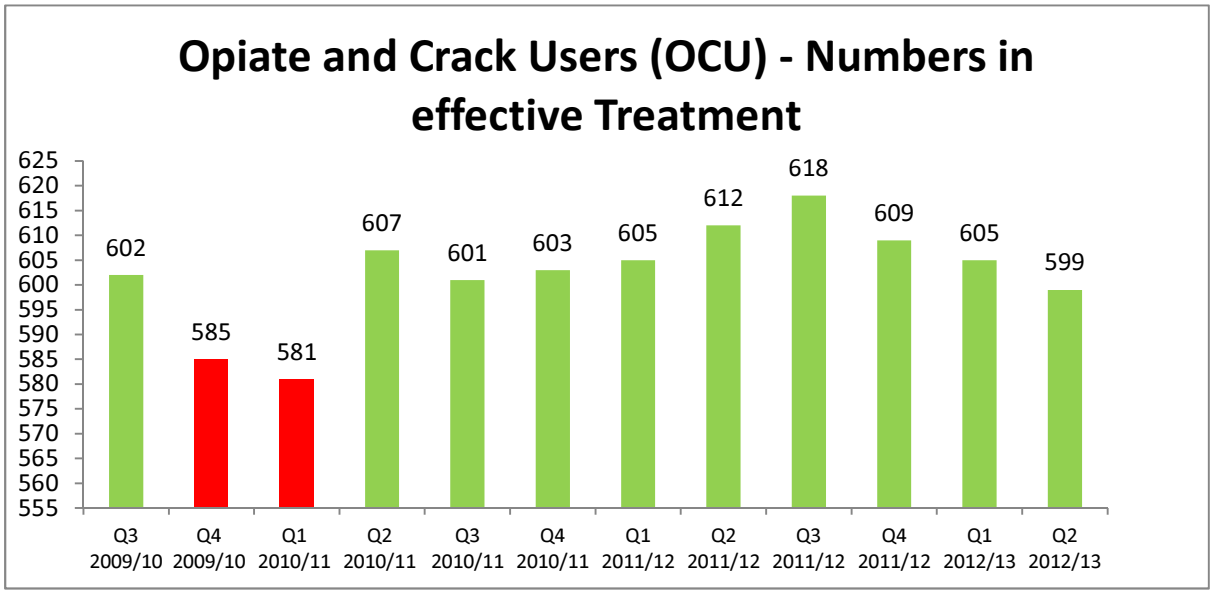


Chart 2 – shows increasing numbers of people are engaging in treatment

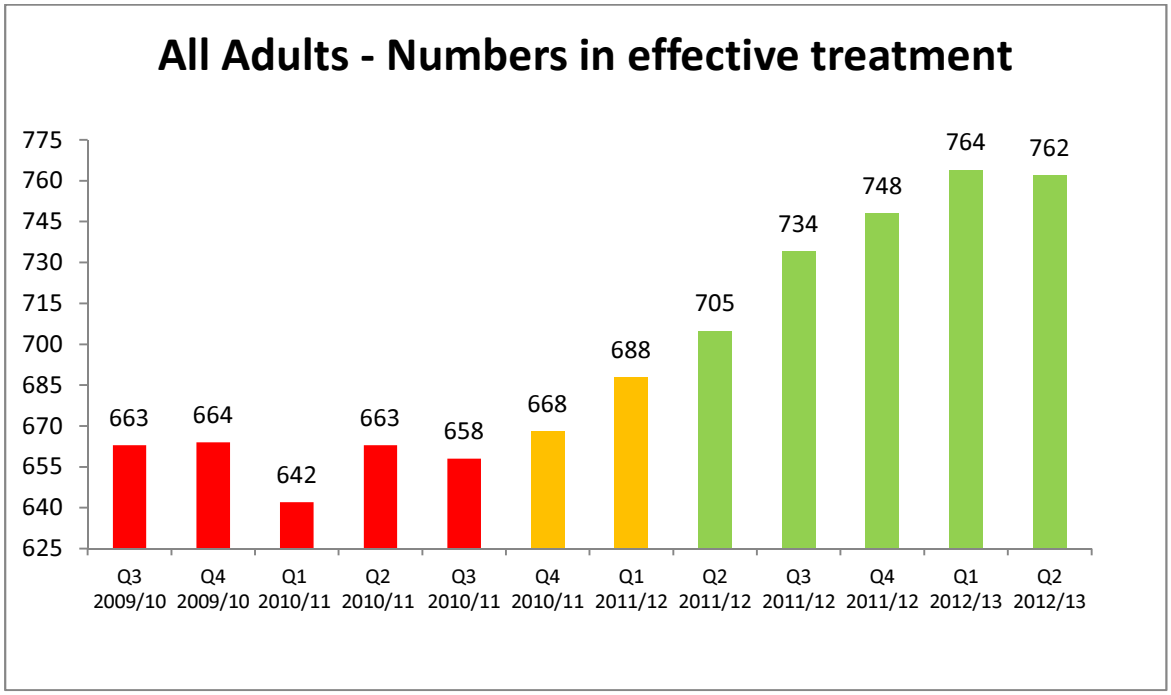


Chart 3 – shows an increasing % and number of people who do not use opiates/crack cocaine engaging in treatment to address their substance misuse

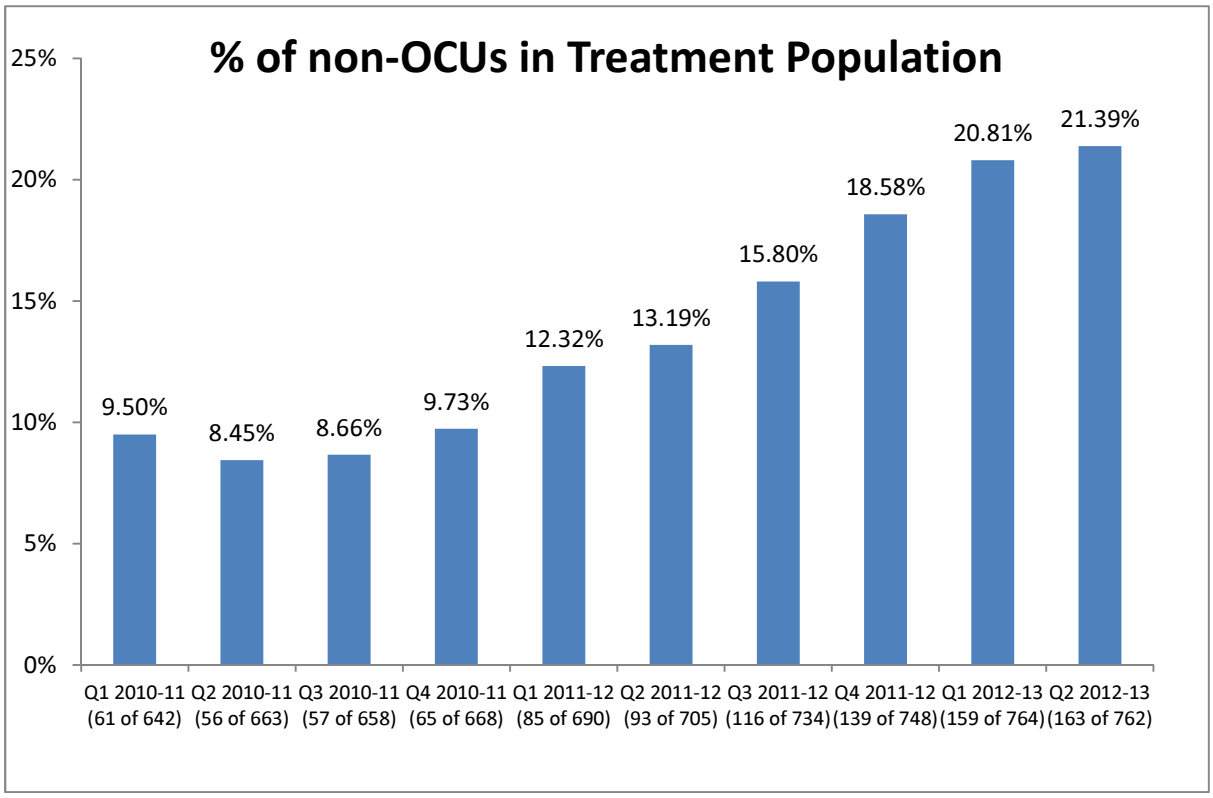


Chart 4 – shows improved outcomes with increasing numbers of people successfully exiting treatment abstinent (drug free)

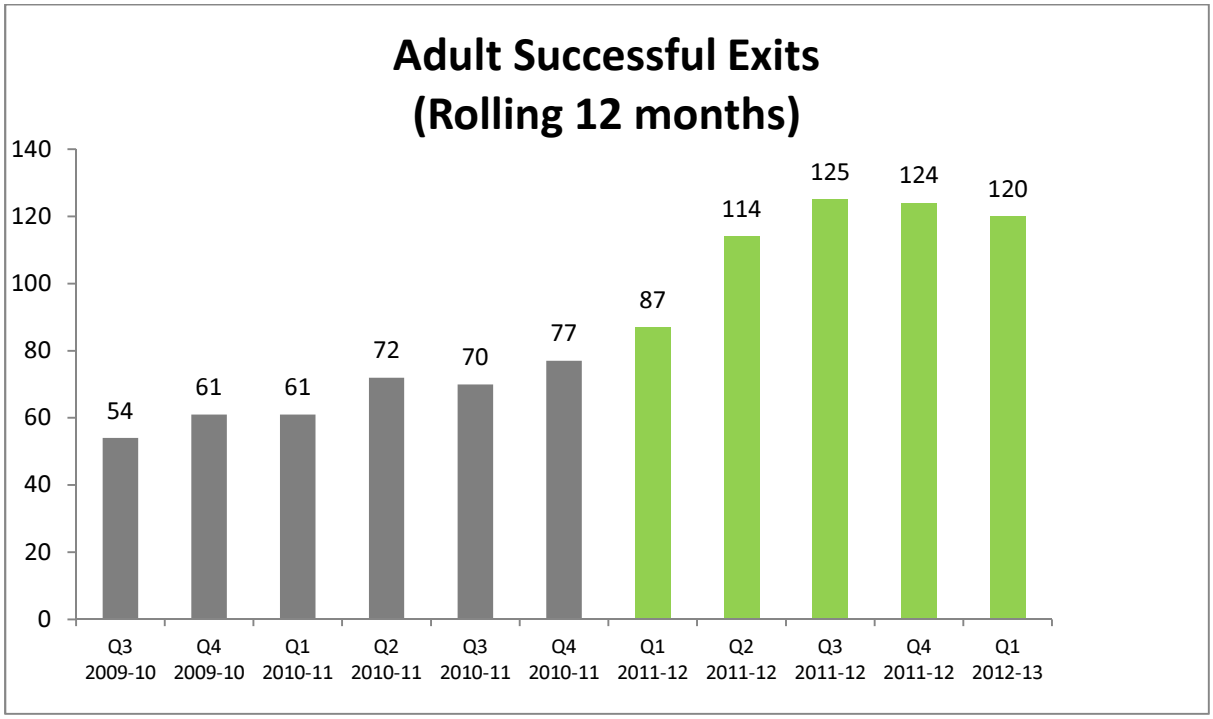


Chart 5 – whilst national waiting times are 3 weeks, B&NES providers work to 5-day waiting times

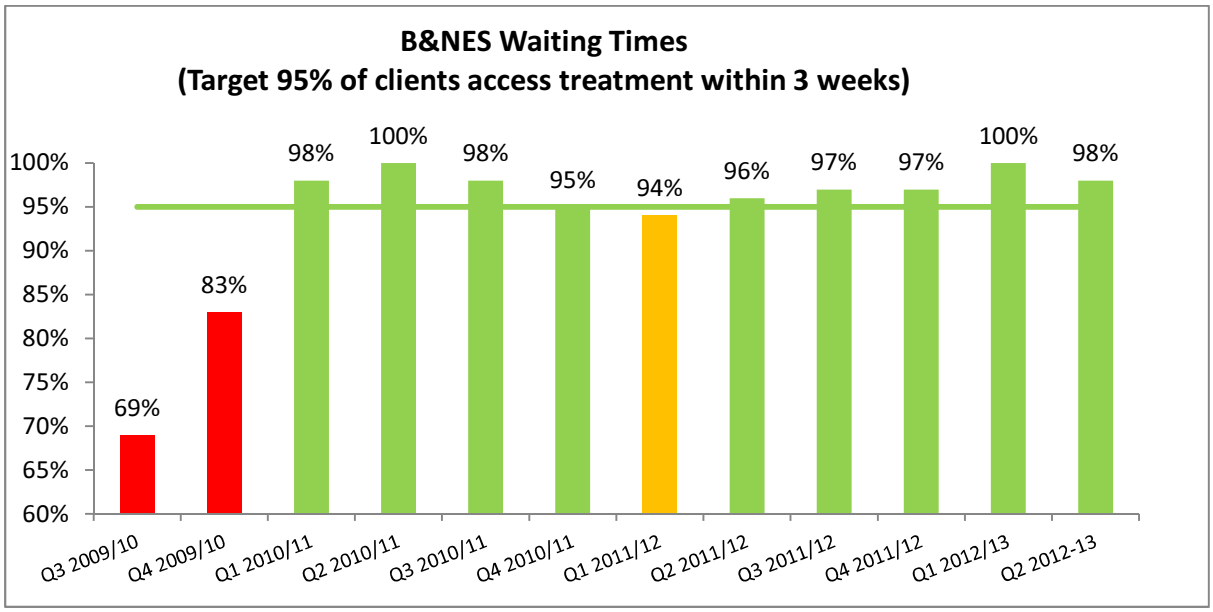


Chart 6

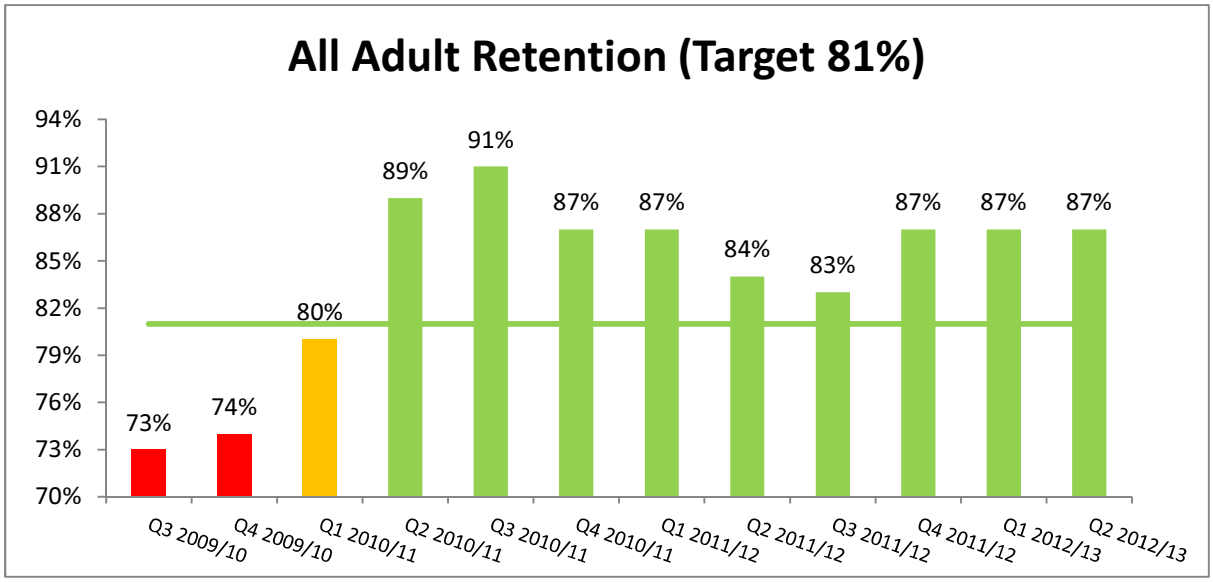


Chart 7

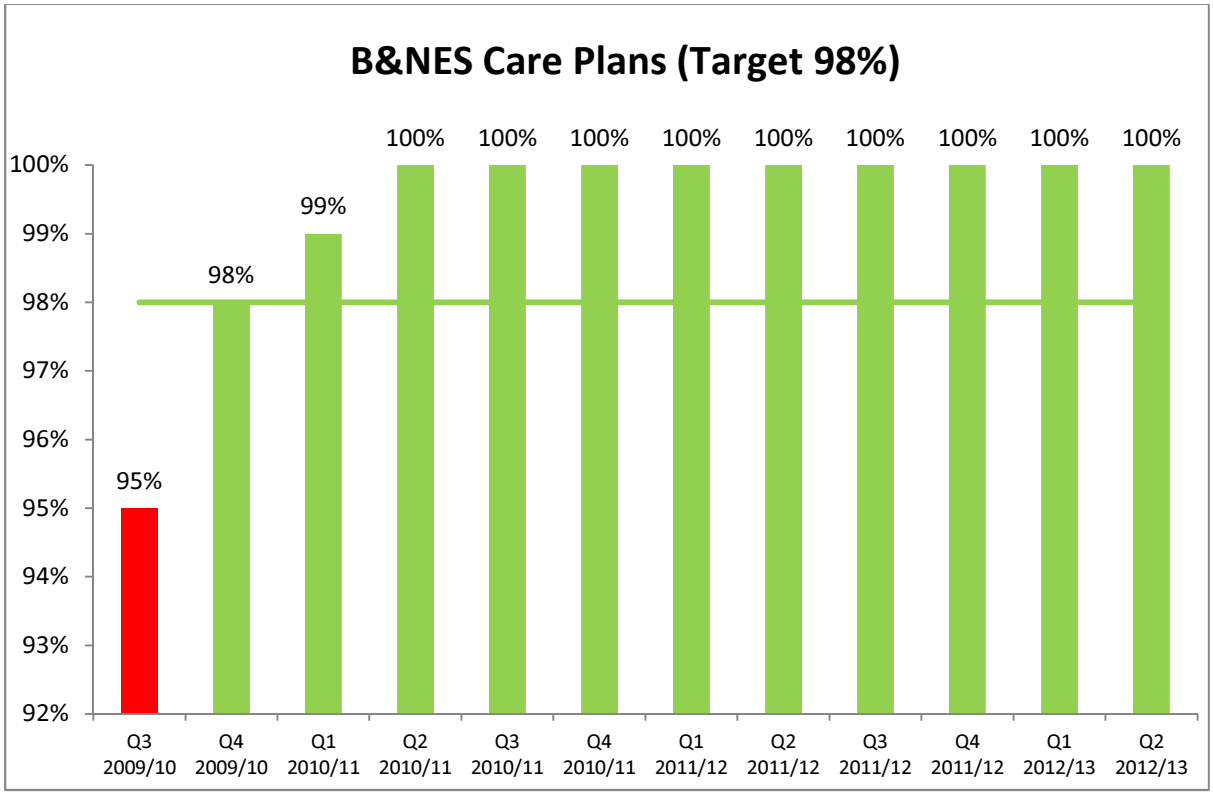


Chart 8

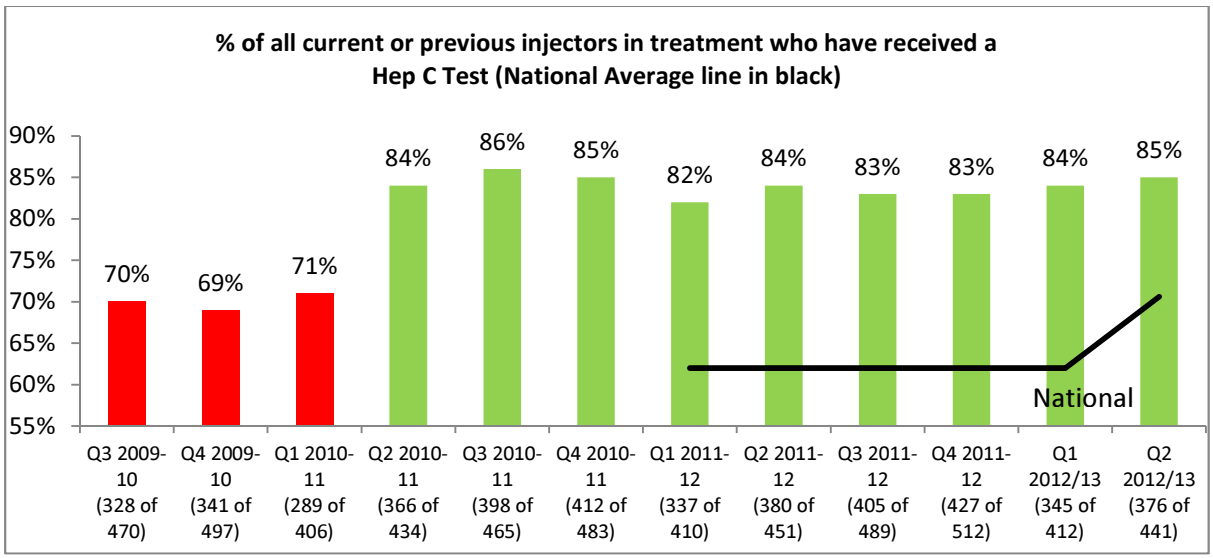


Chart 9

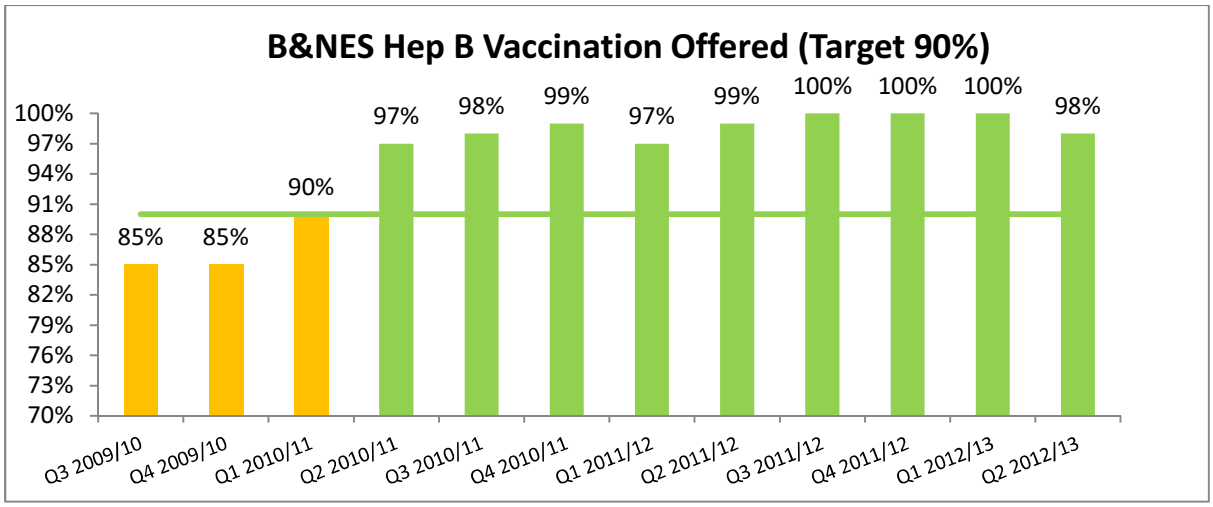
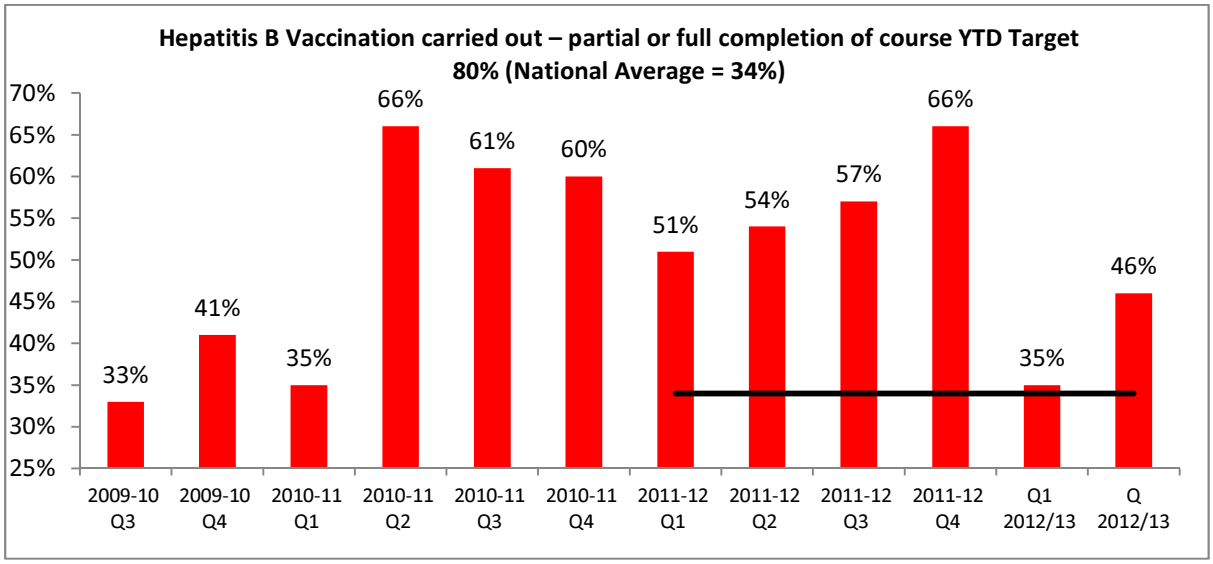


Chart 10 - very challenging target currently being reviewed nationally due to difficulty in achieving compliance. The target counts "all new entrants to treatment year to date" (not only opiate and crack users). B&NES performs considerably above national target.



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Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

DHI

Dear Doctor or Health Professional

Re: Association of Ketamine with Unexplained Bladder and Abdominal Symptoms

We would like to draw your attention to increased recreational use of ketamine in B&NES. Ketamine use can present a serious risk of damage to bladder, urinary tract and kidneys. The drug's use is most prevalent among younger people, who may be seeking help from GPs without actively disclosing their ketamine use.

Patient profile to look out for: If you have a patient who fits the following profile, we strongly recommend you ask the client directly whether they have ever used ketamine:

1. Any male with symptoms of cystitis.

2. Females with symptoms of cystitis, unresponsive to antibiotics or with negative microbiology.

3. Males or females with unexplained abdominal pains.

These symptoms can be severe enough to require hospitalisation with potential progression to irreversible bladder and renal damage. Cases of bladder carcinoma associated with ketamine use have been identified in the Bristol area in 2010 and 2011. Although commoner among those who use ketamine daily or at high doses, damage can also occur with low dose recreational ketamine use.

Recommended management is primarily preventative:

1. *Establish a link:* Aim to establish a clinical link between the symptoms and use of ketamine – most ketamine users are well aware of this link, so do ask them.

2. *Provide client with information about causes and outcomes:* Explain to the patient the cause of the symptoms (inflammation and ulceration of the bladder), and that if ketamine use continues, it can result in irreversible bladder damage with chronic supra-pubic pain and chronic urinary symptoms (which may require long-term catheterisation or surgical interventions such as removal of the bladder or formation of a new bladder). If urinary symptoms are severe, refer to Mr John McFarlane at the Urology Department at Royal United Hospital services for further advice or investigation.

   Other risks from with ketamine use include vulnerability associated with loss of self awareness and control. Chronic use among males is also linked to erectile dysfunction.

3. *Harm reduction and pain management:* Encouraging the patient to reduce or ideally stop their ketamine use is important. Cystitis-like symptoms will usually resolve if the patient stops using the drug. The patient should be aware that the healing process can take many months. Patients with severe urinary tract symptoms may be reliant on ketamine itself as an analgesic to control the associated pain, so cutting down ketamine use may only be realistic if there is *good alternative pain control.* For mild pain an NSAI and paracetamol is recommended (also consider nefopam). For

moderate pain buprenorphine patches can be used (if opioids required, use modified release preparations) – such as morphine patches.

4. *Seek further help from others regarding treatment strategy and support for your patient:* For further support, please encourage them to seek advice from Project 28 (for those aged 18 and under) – or from Developing Health and Independence (DHI), which is the single point of entry for adult drug services in Bath. Chronic ketamine use often results in anxiety and depression which can get worse during a detox. Success in stopping will depend on active management of these symptoms plus a substantial amount of psychotherapeutic support.

Ketamine is associated with the following physical problems:

i Cystitis like symptoms are caused by ulceration of the bladder. This may progress to chronic problems with a shrunken inflamed bladder and suprapubic pain, dysuria and haematuria, as well as urgency, frequency and incontinence. Ketamine and at least one of its metabolites appears to be toxic to the epithelial lining of the urinary tract system.

ii The renal and urinary systems may become obstructed with a gelatinous precipitate, which is probably sloughed epithelium. This may progress to a narrowed or scarrred urethra with subsequent renal problems.

iii The biliary tree may also become obstructed and dilated (which has been associated with a raised ALT or Alk Phos on liver function). This may be the cause of the severe abdominal pains, well known to ketamine users as 'K Cramps'. These symptoms often occur prior to the development of urinary tract symptoms.

If there are any signs or symptoms of the above evident then referral to the Urology Department at Royal United Hospital is recommended.

Most users snort ketamine, but occasionally Ketamine may be injected (I/M or I/V), in the belief that they will be able to use less, get a better hit and avoid some of the adverse effects. All the usual safer injecting advice should be given, plus advice that injecting is unlikely to avoid urinary tract symptoms or K cramps.

If you are concerned about a patient regarding ketamine dependency then please contact DHI or Project 28. If you are concerned about bladder or urinary tract symptoms advice may also be sought at DHI or a direct GP referral made to the Urology Department. Please see contact details below.

DHI Beehive Beehive Yard Walcot Street BATH BA1 5BD Tel. 01225 329 411	The Recovery Hub High Street Midsomer Norton BA3 2DP Tel. 01761 417 519	Project 28 28 Southgate Street BATH BA1 1TP Tel. 01225 463 344	Department of Urology Royal United Hospital Combe Park Bath BA1 3NG Tel. 01225 825 990

Patient Assessment Questionnaire

For each question below, please circle the answer that best describes how you feel.
The last 2 columns on the right are for your doctor to assess your answers. Please do not mark anything in these columns.

Patient's name: _____ Today's date: _____

	0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1 How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
2 **b.** If you get up at night to go to the bathroom, does it bother you?	Never	Mildly	Moderate	Severe			
3 Are you currently sexually active? **YES** ____ **NO** ____							
a. IF YOU ARE SEXUALLY ACTIVE, do you now or have you ever had pain or symptoms during or after sexual intercourse? 4	Never	Occasionally	Usually	Always			
b. If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
5 Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)?	Never	Occasionally	Usually	Always			
6 Do you have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7 **a.** If you have pain, is it usually...		Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
8 **a.** If you have urgency, is it usually...		Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
						SYMPTOM SCORE (1, 2a, 4a, 5, 6, 7a, 8a) —SUBTOTAL	
						BOTHER SCORE (2b, 4b, 7b, 8b) —SUBTOTAL	
						TOTAL SCORE (Symptom Score + Bother Score) =	

The Pelvic Pain and Urgency/ Frequency (PUF) questionnaire is a simple tool that provides a fast, easy, and noninvasive way to screen for IC. Also available in Spanish.

International prostate symptom score (IPSS)

Name: Date:

	Not at all	Less than 1 time in 5	Less than half the	About half the time	More than half the	Almost always	**Your score**
Incomplete emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?	0	1	2	3	4	5	
Frequency Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5	
Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
Urgency Over the last month, how difficult have you found it to postpone urination?	0	1	2	3	4	5	
Weak stream Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5	
Straining Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5	

	None	1 time	2 times	3 times	4 times	5 times or more	**Your score**
Nocturia Over the past month, many times did you most typically get up to urinate from the time you went to bed until the time you got up in the morning?	0	1	2	3	4	5	

Total IPSS score	

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed – about equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Total score: 0-7 Mildly symptomatic; 8-19 moderately symptomatic; 20-35 severely symptomatic.

Experiencing problems...what can help?

If you have urinary tract symptoms, bladder or kidney pain, talk your GP – you may also need a referral to the Urology Department.

Ask DHI about support with a detox plan.

Ear acupuncture can be really helpful with anxiety, pain and health problems. This is available at the Beehive.

There are also many other activities that can give your life structure and satisfaction, and may be critical to getting off and staying off ketamine. DHI also runs activities such as gardening, fishing and cookery.

DHI can also support you to access other services which can help, with issues such as housing and employment.

Blood borne virus testing and vaccinations are also offered at DHI, from a specialist nurse.

Help & Support

DHI is the initial point of access into Bath & North East Somerset drug and alcohol services.

You can simply walk-in or telephone for an initial assessment.

Tel. 01225 329 411

DHI, The Beehive
Beehive Yard
Walcot Street
Bath BA1 5BD

DHI Midsomer Norton
The Hub, High Street,
Midsomer Norton, BA3 2DP

Project 28 is the Young People's service for people aged 18 or under and can be contacted through DHI on
01225 329 411

Are you experiencing problems?

If you are using Ketamine do you recognise any of the following:

- Pain on passing urine
- Needing to urinate urgently and often
- Depression or increased levels of anxiety on days when not using ketamine.

If so then contact DHI who will be able to help with support and planning around reducing and stopping ketamine use.

Let your GP know if you are having any physical symptoms from ketamine use. You may need a referral to the urology department. Staff in this department are aware of the problems caused by ketamine and can help if need be.

For help and support: call DHI on 01225 329 411

Harm Reduction around Ketamine

Avoid vulnerable situations: when taking ketamine stay in the company of people that you trust.

Don't mix ketamine with other drugs. Mixing with alcohol can induce nausea and vomiting.

K Cramps are a sign that ketamine is likely to be causing damage. Stop using ketamine if you have abdominal cramps. Avoid bathing to soothe cramps as there is a danger of unconsciousness and drowning.

Urinary Tract Symptoms: Stay hydrated with water. If you get pain when passing urine or have to go more often than usual then it is important that you seek medical help.

Avoid Blood borne viruses. Don't share snorting tubes as these can spread viral Hepatitis, including Hepatitis C and Hepatitis B. Injecting significantly increases the risks. If you are injecting then make sure you're getting clean equipment from a pharmacy or needle exchange (available through DHI). These are free services.

Detox Guidelines

Talk to your GP or to DHI – we can help you plan a detox.

Try to cut back gradually, allowing your body to adjust. Try to use less ketamine each time you use and try to take the drug less frequently. Start using later in the day and have days when you do not use at all. Once you have done this select a particular day to stop. It's good to be clear in your determination to stop: it will help you to prevent relapse.

Work on the specific symptoms that you have. Talk to your GP or to a pharmacist about treatment for pain and withdrawal symptoms. Eat well and drink plenty of water.

Anxiety and sleep problems may be treated with complementary therapies . You could discuss these with your GP or DHI.

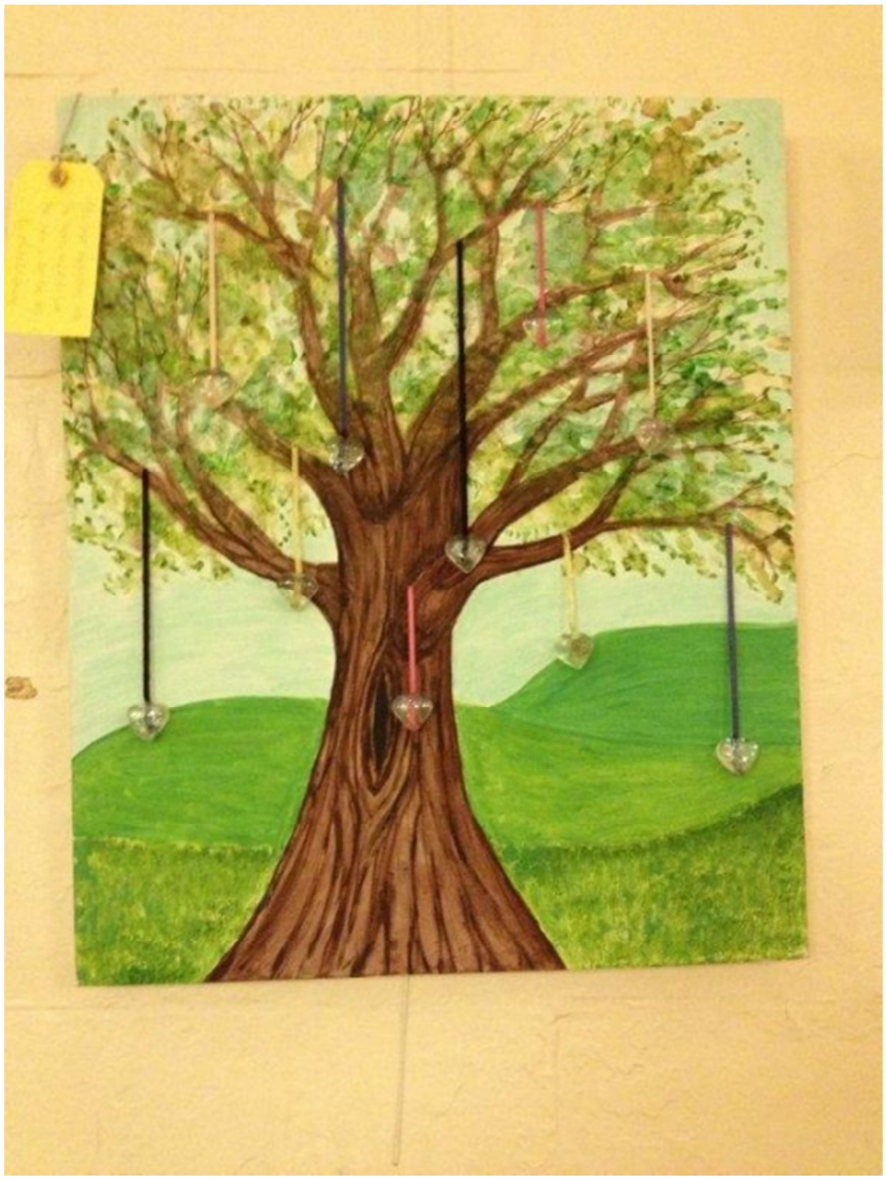
Allow for plenty of time to sleep in the first few days of detox. Re-establish a healthy sleep pattern.

Low motivation and low mood is normal in days after detox. Routine, structure and exercise are very important. The things that you spend your time doing at this stage are an investment in preventing relapse. Contact DHI for help with this.

Plan meaningful and enjoyable activities to stimulate and reinforce positive progress...you are doing well so long as you are not relapsing.

Art Exhibition emerges from Loss and Bereavement Group

14th-22nd December 2012 Radstock Church Tea Rooms.



A TWO WEEK art exhibition is being held in Radstock displaying art created by members of a local Loss and Bereavement group.

DHI clients are contributing to an art exhibition at Radstock Church Tea Rooms called 'Highly Blessed' which runs from 14th–22nd December. The group includes friends and family members who have been affected by loss and bereavement during the past year. The young people's group has been meeting since October and members have been able to use the creative outlet to express a range of issues including loss and bereavement.

The exhibition emerged from an idea by the group members themselves who were keen to share their work with a wider audience. The group has been supported by specialist staff from DHI (Developing Health and Independence), Project28 a young people's service and Avon and Wiltshire Partnership's Specialist Drug and Alcohol Service (SDAS).

Following a suicide, the group was established to address Loss and Bereavement, along with drug related issues, including Ketamine use. The partners are working together to offer services to those who have been affected.

Michelle Emery has been coming along to the group following the death of her brother Jamie, and she says:

> *"Going to the group has been like therapy for me, it's been nice to be around Jamie's friends and it's been good for them too. The group has been something to look forward to every week during what has been a very difficult time. There's been some lovely pieces of art that we've produced and being part of the group has really helped, giving us a way of venting our emotions."*

Helen Bartolini from DHI's centre 'The Hub' in Midsomer Norton adds:

> *"The exhibition was organised as part of a multi agency initiative. There had been a loss and that's why we are running the group, which is a result of bereavement in the community. We are very proud of the works of art the participants have produced. Each piece tells a story and we hope as many people as possible will come along to see the exhibition which runs until the 22nd December. "It's important that in difficult times, families and friends are supported as they experience issues around loss and bereavement. We'd like to thank everyone who took part."*

Rosie Phillips Chief Executive of DHI says:

> *"DHI works hard to support people to overcome complex and often life-threatening issues. We are able to support people to access support locally to maintain their recovery. In our project in Midsomer Norton, individuals can access a wide range of groups and activities, as well as receive support from the dedicated staff at the project. We also provide a wide range of services for family members concerned about their loved ones' substance misuse."*

As part of our work to support families and carers, DHI is holding a two day event in Bath on April 11 and April 12 2013. The theme for the 'Reach Out' conference is 'Shared Voices'. Much of the experience of people affected by someone else's substance misuse is hidden. This event will give an opportunity for family members and carers to speak up and speak out about their experiences, particularly with others in a similar situation together with the professionals who provide their services.

If you would like to find out more about the Reach Out event, please visit http://www.dhi-online.org.uk/news/article/shared-voices-reach-out-conference-2012/

Bath & North East Somerset Council
MEETING: **WELLBEING POLICY DEVELOPMENT & SCRUTINY PANEL** MEETING DATE: **18th January 2013**
TITLE: **WORKPLAN FOR 2013/14**
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 2013/14

3 FINANCIAL IMPLICATIONS

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

4 THE REPORT

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

a) Holding the executive (Cabinet) to account

b) Policy review

c) Policy development

d) External scrutiny.

4.2 The workplan helps the Panel

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

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

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

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

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

(1) public interest/involvement

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

(3) resources (Councillor, officer and financial)

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

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

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

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

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

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

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

4.6 When considering the workplan on a meeting-by-meeting level, Councillors should also bear in mind the management of the meetings - the issues to be addressed will partially determine the timetabling and format of the meetings, and whether, for example, any contributors or additional information is required.

5 RISK MANAGEMENT

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

6 EQUALITIES

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

7 CONSULTATION

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

8 ADVICE SOUGHT

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

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

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Last updated 08.01.13.

Wellbeing Policy Development & Scrutiny Panel Workplan

Meeting Date	Agenda Item	Director	Report Author	Format of Item	Requested By	Notes
18th Jan 13						
	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	Specialist Vascular Surgery at the RUH (20 min)		Tracey Cox (tbc)			
	LINk update (15 min)		Diana Hall Hall			
	The Royal National Hospital for Rheumatic Diseases in Bath update (45 min)		Kirsty Matthews and James Scott			
	JSNA – Social Inequalities (20 min)		Jon Poole and Helen Tapson			
	Strategic Transition Board update (20 min)		Mike MacCallam			
	Care Quality Commission update (20 min)		Karen Taylor (CQC)			
	Winterbourne View findings update (20 min)		Mike MacCallam			
	Substance Misuse Services (20 min)		Andrea Morland			
22nd Mar 13						

	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
	Energy Efficiency report – tbc (20 min)		Chris Mordaunt			
	Provision of Neuro-Rehabilitation at the Royal National Hospital for Rheumatic Diseases		Ian Orpen?			
	Alcohol Harm Reduction SID - recommendations		L Rushen			
17th May 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
	6 monthly review/update on Urgent Care		Ian Orpen (tbc)			
	Mental Health Support Services		Andrea Morland			
26th Jul 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
20th Sep 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					

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22nd Nov 13	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
17th Jan 14	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
21st Mar 14	Cabinet Member Update (15 min)		Cllr Allen			
	CCG update (15 min)		Ian Orpen			
	JSNA – topic ?					
Future items						
	Talking Therapies update		Andrea Morland			
	Dementia Strategy update		Sarah Shatwell?			
	6 monthly review/update on Urgent Care				Panel on Nov 2012 (for May or July 2013)	

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