BATH AND NORTH EAST SOMERSET

WELLBEING POLICY DEVELOPMENT AND SCRUTINY PANEL

Friday, 17th May, 2013

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

1 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

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

3 APOLOGIES FOR ABSENCE AND SUBSTITUTIONS

Councillor Lisa Brett sent her apology to the Panel.

Councillor Sharon Ball left the meeting at 12noon (after agenda item 10).

Councillor Katie Hall left the meeting at 2.45pm (after agenda item 14).

4 DECLARATIONS OF INTEREST

Councillor Eleanor Jackson declared an ‘other’ interest as a Council representative on Sirona Care and Health Community Interest Company.

Councillor Vic Pritchard declared an ‘other’ interest as a Council representative on Sirona Care and Health Community Interest Company.

Councillor Anthony Clarke declared a ‘disclosable pecuniary interest’ in item 13 on the agenda ‘The future of the Royal National Hospital for Rheumatic Diseases’. Councillor Clarke withdrew from the meeting for the duration of this item.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIRMAN

There was none.

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

The Chairman invited Pamela Galloway (Secretary of the Warm Water Inclusive Swimming and Exercise – WWISE) to address the Panel with her statement.

Pamela Galloway explained that she was speaking on behalf of B&NES residents who, because of disability or short and/or long term health conditions, need access to warm water pools to exercise and swim so they can help, and/or maintain, their health and fitness.

Pamela Galloway described the needs of those residents and the necessity for the adequate facilities in local leisure centres.

Pamela Galloway concluded that the WWISE network applaud the Council's strategy for the provision of leisure facilities for health outcomes, not just for recreation, and welcomed that the draft Health and Wellbeing Strategy placed emphasis on enabling everyone to live healthy and fulfilling lives, reducing health inequalities and improving the health of local people and communities.

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

The Chairman thanked Pamela Galloway for her statement.

The Panel applauded for Ms Galloway's persistence in presenting this issue to various Council bodies and asked if the WWISE network had a support from the Cabinet Member for Neighbourhoods (Councillor David Dixon).

Pamela Galloway replied that the network had the support from Councillor Dixon on this matter.

The Panel asked how far the WWISE network got in terms of the progress on this matter.

Pamela Galloway responded that the aim of the network is to raise the awareness on the need for warm water pools ahead of the redevelopments of leisure centres in Keynsham and Bath.

Some Panel Members questioned if there are health gains in having warm water pools.

Susan Charles (Chair of the Access Bath Group) said that she had spinal injury in the past and one of the main reasons for her being able to overcome that injury is due to use of warm water pools.

The Chairman concluded the debate by thanking everyone who participated in the discussion.

It was **RESOLVED** that the Panel supported the inclusion of warm water pools that are fully accessible to people of all ages and all levels of disability in the current plans for Keynsham and Bath Leisure Centres and any others in B&NES as and when they come due to replacement. The Panel also **RESOLVED** to inform the relevant Cabinet Members on their support for the inclusion of warm water pools.

7 MINUTES 22ND MARCH 2013

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

- Page 9, after paragraph 6 – Councillor Eleanor Jackson left the meeting at this point due to hospital appointment.

The Panel asked the Democratic Services Officer to send a reminder to Jane Shayler for a response on how successful was the usage of the social media and the press by Sirona during the cold snap.

The Chairman informed the Panel that, following a request from senior officer, he agreed to move the report on 'Rough Sleepers' for July meeting of the Panel.

Response from the Secretary of State Office on the Neuro-Rehab services

The Chairman informed the meeting that, in line of the resolution from the last meeting, the Chairman and Vice Chairman sent a letter to the Secretary of State for Health requesting from them to conduct an investigation on the way the Board of the Royal National Hospital for Rheumatic Disease led a process to close the Neuro-rehabilitation services. Letter from the Panel is attached as Appendix 1 to these minutes.

The Chairman informed the meeting that the Panel received a response from the Rt Hon the Earl Howe PC (Parliamentary Under Secretary of State for Quality – Lords). Letter from Rt Hon the Earl Howe PC is attached as Appendix 2 to these minutes.

The Panel felt that the Minister was quite clear that the NHS organisations reporting substantial development and variation of health services must include local Health Overview & Scrutiny Committees (HOSCs) and the Panel **REQUESTED** that the following paragraph, from the letter, be forwarded to all NHS organisations, local and regional:

'With regard to your concerns about NHS organisations reporting substantial development or variation of health services to HOSCs, I should make it clear that the NHS should hold early and ongoing discussions with HOSCs in order to ensure they are fully involved in, and briefed on emerging service models. Before embarking on the process of introducing change to local serviceprovision, NHS orhanisations should have a clear evidence base underpinning the proposed case for change. Clear communication and stakeholder engagement plans are imperativ in promoting the understanding of the case for change. As a minimum, these should cover engagement with all key stakeholders, including staff, patients, the public, MPs, HOSCs and local media. It is for the local HOSC to determine whether this process has been sufficient and effective' - Rt Hon the Earl Howe PC.

Appendix 1

Appendix 2

8 CLINICAL COMMISSIONING GROUP (CCG) 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 3 to these minutes).

Dr Orpen also passed the Power Point slides to the Panel on the Nursing Homes situation in B&NES, which compared the period before and after the GP Local Enhanced Service (LES) was introduced in December 2011.

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

The Chairman commented that Alcohol Liaison Nurses should be invited for the proposed Alcohol Summit in order to have a presentation from them.

The Panel congratulated Dr Orpen and BANES CCG on receiving the authorisation from the NHS England with no conditions.

The Panel asked if the AWP are confident that, should they lose their contract with Bristol, they will still carry on as a secure organisation.

Dr Orpen and Jane Shayler (Deputy Director: Adult, Care, Health and Housing Strategy and Commissioning) replied that they understood that AWP had risk-assessed the impact of losing the Bristol commission and had concluded that AWP would still be a viable organisation without this income stream.

The Panel asked if the parents will get the separate MMR jabs for measles.

Dr Orpen responded that the separate MMR jabs are not on offer and Public Health could explain this issue in more details. A statement from a public figure created a huge frustration and anxiety between people though the message is clear – the MMR is absolutely safe and everyone should have it.

The Chairman thanked Dr Ian Orpen for an update.

Appendix 3

9 NEW HEALTH COMMISSIONING ARRANGEMENTS (30 MINUTES)

The Chairman invited Dr Ian Orpen to address the Panel.

Dr Orpen gave a presentation where he highlighted the following points:

- Diagram of the new NHS Landscape
- New funding arrangements
- Regulating and monitoring the Quality of Services
- Role of the NHS England
- NHS England outcomes
- NHS England - Facts and Figures
- NHS England Structure
- NHS England – South: Additional responsibilities
- Bath, Gloucestershire, Swindon and Wiltshire (BGSW)
- BGSW Area Team
- The Local Structure
- What are CCGs responsible for?

A full copy of the presentation from Dr Ian Orpen is attached as Appendix 4 to these minutes.

The Panel thanked Dr Orpen for such a detailed description of the new NHS landscape.

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

Appendix 4

10 NHS 111 SERVICE (30 MINUTES)

The Chairman invited Tracey Cox (CCG Chief Operating Officer), Dr Elizabeth Hersch (NHS 111 B&NES and Wiltshire Clinical Governance Lead) and Dr Russell Kelsey (Regional Medical Director – Harmoni) to give the presentation.

The following points were highlighted in the presentation:

- Service Overview
- Service Aims
- Local Implementation – Timeline
- Soft Launch – Key Issues
- Intense Six Week Period of Rectification – Key Highlights
- Current Performance
- Patient Quality & Safety Processes

A full copy of the presentation is attached as Appendix 5 to these minutes.

The Panel made the following points:

Tracey Cox drew Panel's attention to factual accuracy in the report. At page 27, under paragraph 3.5.1, there were 5 serious incidents reported, across B&NES and

Wiltshire, at the time this report was written. Since that time there were further analysis on those 5 incidents, which are now downgraded to 1-2 serious incidents.

The Panel asked what the definition for serious incident is.

Dr Kelsey explained that serious incident in this context is a technical term that the National Patient Safety Agency developed. There are series of criteria that apply to incident that occur when applied medical services are far and above the usual medical provision.

The Chairman asked how come that serious incidents are downgraded from 5 to 1-2.

Dr Kelsey explained that when something goes wrong, it is then brought to the attention of commissioners or Harmoni with the intention to make an immediate assessment on whether there is a case of serious incident. Sometimes it is obvious that there is service failure, which can lead to a patient's death, but it is not always clear. In this case, 4 out of 5 incidents did not fulfil any of national criteria that would normally be associated to serious incidents.

The Panel asked about the significant service failure in the first three months.

Dr Kelsey replied that there were a number of assumptions made by Harmoni before the launch of the process. Some of these assumptions were right though some others were wrong. This was a very complex process that has never been done before on this scale in England. There were a number of pilot sites which were done on a much smaller scale. Harmoni thought they learned lessons through these pilot sites. When the implementation of services on a much larger scale started, the complexity of the staffing combined with the volume of calls was more than the Harmoni thought it would be. Effectively, Harmoni was understaffed to deliver the service required.

The Chairman asked if the figures displayed in the presentation are Harmoni's figures or from the CCG.

Dr Kelsey replied that the figures are produced from Harmoni's computer system and presented to the Department of Health. Harmoni's IT systems are checked and there is no way for those figures to be manipulated. There is an agreement with commissioners not to hide anything in this process. The commissioners are allowed to share Harmoni's raw data.

The Panel asked why is it that the service here is so much worse than in other areas. Why is it that the Minister particularly singled out the South West as an area with very poor 111 services. The Panel commented that when Harmoni did the trial they must have known, as highly paid professionals in this field that it was going to be very difficult to train people to use something so complex. The fact that Harmoni didn't realise that it would take a long time to train people to use it, even though they did a trial before the soft launch, seems to be an unacceptable failure.

Dr Kelsey agreed that the initial service was not acceptable. South West 111 service was singled out because it was very poor when it was launched. It was one of the worst launches in the UK. Harmoni did not have the experience on such a large

scale service. It was the worst service though it is much better now though the performance is not as good as it should be.

The Panel asked what the current view from the Wiltshire CCG is.

Tracey Cox replied that B&NES CCG works closely with the Wiltshire CCG and they are in similar position in terms of their concerns for commencement of the service.

The Panel said that the official from the Department of Health commented that this was a commissioner and provider failure.

Dr Hersch responded as a local commissioner the CCG went through all Department of Health gateways though there are still a lot of lessons to learn.

The Panel noted that one of the points in the six week period of rectification was that Harmoni committed more management resources to the Bristol Call Centre and asked what led to the decision to have more managers.

Dr Kelsey replied that it meant more supervision in the call centre for the health advisors and an improved management for the workforce on the floor.

The Panel asked how the call to 111 services is put through – is it held in the queue or dealt with in some other ways.

Dr Kelsey responded that the caller would get an answer to wait, in case the service is busy. That is the national specification – standard message that says 'You are in the queue'. Dr Kelsey said that at this stage people are not told how many other people are in the queue before them and how long they are likely to wait before their call is answered. This question was raised and the Harmoni are happy to change their telephony system to use this facility. Harmoni contacted the Department of Health if they would be happy for the Harmoni to change their telephony system but they haven't given that permission yet.

The Panel asked if the Harmoni would offer an apology to the Panel Members, as representatives of the residents who suffered under the introduction of the 111 scheme. The Panel felt that it is important that the residents understand that Harmoni is sorry for what had happened.

Dr Kelsey, on behalf of Harmoni, gave sincere apology to anyone, whether individual or family, who experienced distress and difficulties in getting through the 111 service. Harmoni acknowledged they made mistakes that had an effect on people.

The Panel said that they acknowledged that both commissioners and providers are working on service improvement and asked for a further report/update for the September meeting of the Panel. The Panel also commented that residents are asked too many questions once they got through to health advisor. The Panel felt that Harmoni should monitor what the average summation of the call is. Some Members of the Panel said that boat dwellers and travellers have great difficulty accessing services and felt that people who are not in standard housing should be treated like the rest.

Dr Kelsey replied that the average handling time per caller is 8 minutes. Initially it was much longer, around 20 minutes, but that was when the service was new. There is a process of what questions have to be asked during the call in order to assure non-clinical staff that person is safe and also for the staff to understand what is going on.

The Panel asked about the NHS Pathways system.

Dr Kelsey responded that the NHS Pathways is a system of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. The system is used by non-clinical staff. It has been used for 3-4 years and very well tested. It also has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required.

The Chairman noted that the Harmoni is now in extended soft launch period of the 111 services which is now 3 months behind the schedule from the proper launch date. The Chairman read out from the report that Harmoni is commissioned for 5 years and asked when the 5 year period starts. The Chairman also asked if the current provision is at the cost of Harmoni.

Dr Kelsey responded that he is not familiar with financial details though, as far as he is aware, services are provided at Harmoni's cost at the moment.

The Chairman thanked everyone who participated in this debate.

It was **RESOLVED** that:

1) The Panel noted the current performance and the actions agreed with Harmoni to improve performance in line with both national and local service specification requirements;
2) The Panel are disappointed in the poor quality of the 111 service in the first three months;
3) The Panel appreciated the apology from Dr Russell Kelsey, on behalf of Harmoni, to anyone, whether individual or family, who experienced distress and difficulties in getting through the 111 service; and
4) The Panel requested a further update on the progress of the local services for September 2012 meeting as a separate stand-alone item.

Appendix 5

11 CABINET MEMBER UPDATE (15 MINUTES)

The Chairman invited Councillor Simon Allen (Cabinet Member for Wellbeing) to give an update to the Panel (attached as Appendix 6 to these minutes).

The Panel made the following points:

The Panel welcomed the Health and Wellbeing Strategy and felt that, around the rest of the key areas in the Strategy, the action on reducing social isolation and loneliness is a particularly important issue to be addressed through the Strategy.

Some Panel Members suggested that the Council could look at the Bristol Light Box Happiness Project (provides supportive environment for socially isolated people) as one of ways to tackle loneliness. Councillor Allen welcomed the suggestion.

Members of the Panel suggested to the Chairman to include Public Health Update for every meeting of the Panel. The Chairman welcomed the suggestion.

The Panel congratulated Lesley Hutchinson and her team on achieving an Audit Rating Level 5 (Excellent) following an internal audit undertaken by the Council's Audit & Risk Team for the overall framework of control for Adult Safeguarding.

The Chairman thanked Councillor Allen for the update.

Appendix 6

12 HEALTHWATCH UPDATE (15 MINUTES)

The Chairman invited Pat Foster (Healthwatch B&NES) to introduce the report.

Pat Foster took the Panel through the report, as printed, and asked the Panel how often they want for the Healthwatch to report in future.

The Panel welcomed the report and said that they wanted to hear from the Healthwatch at every meeting of the Panel.

The Panel asked about volunteer involvement in the Healthwatch and if the Healthwatch works together with the 'One Stop Shops'.

Pat Foster replied that one of the ways to include volunteers in the Healthwatch is via Healthy Conversations sessions. Volunteers are expected to voice the opinions of the community groups that they represent. Pat Foster also said that the Healthwatch will get in touch with the 'One Stop Shops' soon.

It was **RESOLVED** to note the report and to invite the Healthwatch to present regular updates to the Panel.

13 THE FUTURE OF THE ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES-UPDATE (30 MINUTES)

The Chairman invited Kirsty Matthews (Chief Executive - Royal National Hospital for Rheumatic Disease - RNHRD) to introduce the report.

The Panel made the following points:

The Panel asked if there is any other organisation, apart from the RUH, that the RNHRD could get involved with in terms of the acquisition.

Kirsty Matthews replied that as the RNHRD is a Foundation Trust (FT) it can only be acquired by the FT. The Board of the RNHRD have found it very challenging now that the RUH application for the FT status had been delayed but it is for the RNHRD, as the FT, to operate under the legal framework and under the relevant Act provision/s.

The Panel commented that the NHS might lose £7-8million before the RNHRD is acquitted and felt that money could be spent better.

The Chairman asked if the directive from Monitor effectively gave a lifeline to the RNHRD. When the Panel learnt that the RUH will not get the Foundation Trust status the immediate thought was what will happen with the RNHRD now. The RNHRD is now in a period of suspension and losing £10k per day on average. The Chairman acknowledged that the RNHRD is delivering an exemplary service and it is well loved and well respected in the area, delivering exactly what patients and users want.

The Chairman said that back in March 2012 an announcement was made that the closure of the RNHRD was imminent and it would merge with the RUH. That was meant to happen by the end of the last financial year but due to recent events it didn't happen.

The Chairman added that the Panel was very critical on the way the RNHRD Board handled the closure of the Neuro-rehab services, and certainly the response from the Secretary of State suggests that any NHS organisation are obliged to engage at an early stage with the Health Overview and Scrutiny Committee. The Chairman acknowledged that the RNHRD is engaging now over the problems of the financial imposition and some of the commissioners may be able to help the RNHRD. The Chairman asked Kirsty Matthews if there is any organisation that the Council can lobby in order to gain extra financial support.

The Chairman said that he learnt recently that Weston Super Mare hospital is looking for outside bids of support. There are thirteen contenders, so it is not an impossible aspiration.

Kirsty Matthews responded that the RNHRD Board are fortunate to work closely with Monitor over the period of the significant breach in status for 4.5 years. Monitor has been quite supportive and the relationship is quite good. The reason why the RNHRD continue to work towards the acquisition by the RUH is that, as an organisation, the RNHRD believes that it is in the best interest of the patients. The other reason is the close clinical relationship between the two organisations. Kirsty Matthews also mentioned the research and development partnership with the RUH and suggested that the Panel might want to ask one of the Clinicians, or Medical Director, to attend a future meeting to explain how closely the RNHRD works with the RUH.

Kirsty Matthews added that the RNHRD have had to wait for a long time for the process to be secured and she agreed with the frustrations around the legal

framework that the RNHRD needs to work within. The RNHRD is now working with Monitor to secure central funding for the year 2013/14 to get to the point where the RNHRD services can be acquired by the RUH.

The Chairman asked why the hospital is losing £10k per day currently.

Kirsty Matthews replied that there are number of factors contributing to it. Partly it is that the income base is reducing and it is difficult for the hospital to reduce their fixed cost base in terms of the building cost, level of support to run the hospital, etc. It is a number of factors – partly to do with reducing tariffs (less income now though the same level of service provided) and partly to do with cost pressures, imbalance between the income and cost.

Kirsty Matthews added that it would not be the case of 'passing the buck' to the RUH. The RUH would need to go through their own due diligence and risk assessment process in terms of choosing to acquire services that the RNHRD provides. There is a benefit that comes through the acquisition that allows reduction of the cost base, such as not having the RNHRD Board (overhead cost base).

The Panel commented that one of the issues could be a failure to adapt to a changing culture. There was no evidence that the RNHRD was selling their services and asked if the hospital engaged in the heavy marketing policy.

Kirsty Matthews replied that one of the main challenges for the RNHRD is that most of the NHS provider organisations have their patients coming in through the A&E. There are no patients in the RNHRD that just turn up; they are there as a result of the RNHRD excellent marketing. The RNHRD have seen an increase every year in the number of referrals into rheumatology services. What hit the RNHRD the hardest was that despite the fact that the hospital attracted significant increases in their rheumatology patients, they were paid 12% less in one year. So, the income for those patients was cut by 12%. Kirsty Matthews also said that there was an increase in complex pain patients. The hospital also launched two new services that absolutely sit within the description of the RNHRD but the hospital has to work with a 12% reduction in tariff.

The Chairman said that there must be a way to fund the hospital which provides an exemplary service to their patients and asked if there is anyone that the Council can lobby on the RNHRD's behalf to help financially.

Kirsty Matthews thanked the Chairman for suggestion and replied that it would be more appropriate if she writes formally and ask that question.
The Chairman suggested that Kirsty Matthews should write a letter to the Chairman of this Panel, Councillor Paul Crossley (Leader of the Council) and Jo Farrar (Chief Executive of the Council) asking if there is anyone that the Council can lobby on the RNHRD's behalf to help the hospital financially.

The Panel agreed with this suggestion.

It was **RESOLVED** to:

1) Note the report;

2) Ask Kirsty Matthews to write a formal letter to the Chairman of this Panel, Councillor Paul Crossley (Leader of the Council) and Jo Farrar (Chief Executive of the Council) asking if there is anyone that the Council can lobby on the RNHRD's behalf to help the hospital financially; and
3) Receive a further update at November 2013 meeting.

14 THE ROYAL UNITED HOSPITAL BATH STATUS - PRESENTATION (30 MINUTES)

The Chairman invited Francesca Thompson (Chief Operating Officer – RUH) to give the presentation to the Panel.

The Chairman also welcomed Jacqueline Sullivan (CQC Inspector) to the meeting.

Francesca Thompson highlighted the following points in her presentation:

- Care Quality Commission job
- RUH Compliance
- CQC Inspection (February 2013)
- Monitor Outcome
- Black Escalation Jan, Feb and Mar 2013
- ED Attendances and Non-Elective Admissions – Trend
- ED Attendances by Time of Day
- ED Attendances and Non-Elective Admissions – by PCT
- Hospital Flow: Open Beds, Occupancy, Outliers and Green To Go Patients
- 4 hour Performance
- RUH Focus
- Solutions

A full copy of the presentation is attached as Appendix 7 to these minutes.

The Panel made the following points:

The Chairman thanked Francesca Thompson for the presentation.

The Chairman said that it was the worst winter on record for the RUH but not weather wise for the area. The Chairman also commented that when the CQC make an unannounced visit they just decide themselves what to inspect.

Jacqueline Sullivan (CQC Inspector) said that all comments from the CQC are in the report, including the recommendations. The CQC had a lot of intelligence from the wider community via CQC's website, which started to raise their concerns about the discharge of patients. People were concerned that when they were leaving the hospital it wasn't in safe and organised manner.

The Panel welcomed the presentation and welcomed the transparency. This was not only the RUH's problem but the problem for the whole local health and social

care community. One of the ways to overcome these issues is for everyone to get together and work together – all South West HOSCs, Health and Wellbeing Boards, MPs and NHS bodies. The Panel asked what plans are in place to work in a more strategic fashion.

Francesca Thompson replied that one of the slides shows that the RUH invited the Intensive Support Team (IST). They were invited just at the right time and they helped the RUH to look at what is needed internally but the IST also identified that they wanted to work with the whole community. There will be a diagnostic session within the next 4-6 weeks for the whole community to have a debate on this matter. Prior to that, the RUH set up the Urgent Care Task & Finish Group which is driven by the commissioners (Chaired by Dr Simon Douglass). This is for Wiltshire and BANES, not yet for Somerset, though on operational level Somerset is involved. The Urgent Care Task & Finish Group has met on a number of occasions and the group was very clear on immediate actions that have to be taken.

The Panel asked for an explanation on the Monitor Outcome slide.

Joss Foster (RUH Commercial Director) replied that the application process for the Foundation Trust status is to submit the application to Monitor. The application was made in October 2012. The RUH went through the process with Monitor who made the decision in March 2013 to defer the verdict up to 12 months so the RUH go back and sort out the issues that were highlighted in the CQC report.

The Chairman asked if there is any opportunity to release the verdict from the CQC if the RUH becomes compliant earlier than anticipated.

Jacqueline Sullivan replied that the CQC always ask for an action plan when there is an issue about the compliance. In this instance the RUH said that they will complete their action plan by 31st May 2013. The CQC will then re-inspect after that date for compliance. If the CQC is satisfied with the compliance then the verdict is released.

Jacqueline Sullivan also said that it is up to Monitor to make the final decision on when, and if, they will approve the Foundation Trust status application from the RUH.

The Chairman said that the Panel would want to help the RUH to gain Foundation Trust status though the Panel is aware that the RUH catchment area is beyond BANES. The Chairman said that it would be useful if the data from the RUH could be broken down for each authority that is within the RUH catchment area.

It was **RESOLVED** to:

1) Note the presentation
2) Request from the CQC to share compliance findings with the Panel once they are ready; and
3) Invite the RUH representatives to give a further update on the Foundation Trust application status at one of the future Panel meetings.

Appendix 7

15 WORKPLAN

The Panel **RESOLVED** to note the workplan with the following additions/amendments:

- Adult Safeguarding Annual Report for September 2013
- Regular Public Health updates
- Regular Healthwatch updates
- NHS 111 update – September 2013
- Update on the future of the RNHRD – November 2013
- The RUH status update – to be confirmed

The meeting ended at 3.00 pm

Chair(person) .....

Date Confirmed and Signed .....

Prepared by Democratic Services

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

28th March 2013

Dear Mr Hunt

Re. Closure of the Neuro-Rehabilitation Unit, Royal National Hospital for Rheumatic Disease (RNHRD), Bath from 31st March 2013

We are writing to you as the Chairman and Vice-Chairman of the Wellbeing Policy Development and Scrutiny (PDS) Panel at Bath & North East Somerset Council. The Panel has taken a proactive interest in the proposal by the Board of the RNHRD to close the Unit. There has been significant public interest.

We have concerns about the way in which the Board have engaged with both the public and the Council in its Health Scrutiny role.

This page is intentionally left blank

What are our concerns?

At our public meeting on January 28th 2013, the PDS Panel were officially informed of the decision by the RNHRD Board to close the Neuro-Rehabilitation Unit.

Prior to this meeting, Local Involvement Network representatives informed us they had insufficient opportunity to comment on the proposal. RNHRD Governors also expressed their concerns about the plans in respect of maintaining an appropriate service for the Unit's current patients elsewhere. We also discovered that the staff team at the Unit had been given notices.

It was not until 22nd March 2013 when the Panel received a report upon our request from the Specialised Commissioning Team for the South West about the re-provision of specialised neuro-rehabilitation services and further presentations from the NHS Clinical Commissioning Group and the RNHRD about this important aspect of the decision.

Why does this matter?

Elected representatives acting on behalf of their local communities must have an adequate amount of time to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area.

By the 28th January 2013, it was clear that the RNHRD Board had already made a decision to close the Unit without operating within the spirit of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 – part 4 (Health Scrutiny by Local Authority), Section 23 – Consultation by responsible persons.

We had no opportunity to meaningfully feedback on the proposal, nor did the RNHRD Board have proper time to act on any comment from us. The consultation that did take place was post-hoc and the assessment of the impact on current patients was reported just 9 days before the closure.

If the duties of Local Authorities as set out in statute are to have any impact we'd expect decisions, such as those proposed by the RNHRD Board, to be reported to us at a much earlier stage.

What would we like you to do?

We feel it is important that the Coalition Government stands strongly behind its own legislation and backs Local Authorities to do an effective job of scrutinising local health decision-making. We would like you to:

- Investigate this matter and consider the points we have made about this case;
- Offer some guidance about your expectations in relation to health bodies reporting substantial developments of the health service in the area of a Local Authority, or for a substantial variation in the provision of service – particularly in respect of the timing of reporting.

Finally, we would like to put on record the excellent clinical service provided by the Neuro-Rehabilitation Unit.

We thank you for your time in considering this issue.

Yours sincerely,

Councillor Vic Pritchard and Councillor Katie Hall
Chairman and Vice Chairman
Wellbeing Policy Development and Scrutiny Panel
Democratic Services
Guildhall
Bath
Bath and North East Somerset Council
BA1 5AW

Tel: 01225 394452 Email: democratic_services@bathnes.gov.uk

From the Rt Hon the Earl Howe PC
Parliamentary Under Secretary of State for Quality (Lords)

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

PO00000772547

Councillors Vic Pritchard and Katie Hall
Chairman and Vice Chairman
Wellbeing Policy Development and Scrutiny Panel
Bath and North East Somerset Council
Democratic Services
Guildhall
Bath BA1 5AW

26 APR 2013

Dear Councillor Pritchard and Councillor Hall,

Thank you for your letter of 28 March to Jeremy Hunt about the closure of the neurological rehabilitation unit at the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust in Bath.

As I am sure you are aware, it would not be appropriate for ministers to investigate individual local service changes or the re-provision of clinical services. The Independent Reconfiguration Panel (IRP) was set up in 2003 to advise the Secretary of State for Health on proposals for changes to the health service in England referred to him by local authority health overview and scrutiny committees (HOSCs). The Secretary of State considers each referral on its own merit, before taking a final decision.

However, in light of your concerns, Departmental officials have made enquiries about the matter you have raised. I understand the Trust's Board took the decision to close the neurological rehabilitation unit on 20 December 2012 because the unit has experienced a change in commissioning patterns over the last two years, and the number of referrals to the unit has therefore reduced.

As you have stated in your letter, the Bath and North East Somerset Wellbeing Policy Development and Scrutiny Panel (PDS) was subsequently formally notified of the Trust's decision on 28 January to close the unit.

I am advised that the South of England Specialised Commissioning Group (SCG) and NHS Bath and North East Somerset (which has now been dissolved) undertook a public consultation on the alternative provision of the services

during March. This involved public meetings, an online survey, an impact assessment, a travel time survey and meetings with clinicians. I understand the report of the public consultation was presented to the PDS in March.

With regard to your concerns about NHS organisations reporting substantial development or variation of health services to HOSCs, I should make it clear that the NHS should hold early and ongoing discussions with HOSCs in order to ensure they are fully involved in, and briefed on emerging service models. Before embarking on the process of introducing change to local service provision, NHS organisations should have a clear evidence base underpinning the proposed case for change. Clear communication and stakeholder engagement plans are imperative in promoting the understanding of the case for change. As a minimum, these should cover engagement with all key stakeholders, including, staff, patients, the public, MPs, HOSCs and local media. It is for the local HOSC to determine whether this process has been sufficient and effective.

I hope this reply is helpful.

Yours sincerely,

Earl Howe

EARL HOWE

Bath and North East Somerset Clinical Commissioning Group
Update, May 2013

CCG Authorisation

Bath and North East Somerset Clinical Commissioning Group (CCG) assumed responsibility for commissioning health care in BaNES on April 1. We were delighted to receive our authorisation from NHS England with no conditions. Out of 211 CCGs across England, we were one of only 106 who received unconditional authorisation.

Emergency pressures

Emergency pressures have lessened since the last briefing, both throughout the NHS and at the RUH, with waiting times at the RUH Emergency Department improving. However, NHS England have recently written to CCGs setting out an A&E improvement plan requesting that CCGs work with their Area Team to develop local improvement plans to address the urgent care pressures. In response BaNES CCG has produced a draft plan with partners which will be finalised by the end of May. B&NES CCG continues to lead the Bath Health Community Urgent Care Network where the plan will be reviewed and monitored to ensure that services cope better next winter with the seasonal increase in demand.

Urgent care centre

The tender advert for the new Urgent Care Centre, which will be based at the front door of the RUH's emergency department, plus associated services, was placed on Supply 2 Health on 8th May. The UCC will be staffed by experienced emergency nurse practitioners and GPs as well as other healthcare and administrative staff. It will be the first point of contact for all patients who 'self-present' (ie not those who arrive by ambulance etc) at the ED and will be open 24 hours a day, 365 days a year.

The UCC will assess patients when they arrive and either treat them, send them to ED or refer them to their own GP, community pharmacist or dentist. It will help ensure that more patients receive the treatment they need, when they need it, and relieve pressures on ED by providing urgent, non-emergency care on the spot.

Bristol CCG's decision to recommission mental health services

Some people will have seen the recent press article reporting on the decision by Bristol CCG to recommission its mental health services, which are currently provided by Avon and Wiltshire Partnership NHS Mental Health Trust (AWP). We would like to reassure everyone that patients and services in BaNES will not be affected by this decision, whatever the outcome when the new contract is awarded in 2014.

BaNES CCG is not planning to recommission mental health services, and neither are our neighbours in Wiltshire and North Somerset. However, as part of our commitment

to ensuring high-quality mental health services for everyone who needs them, we are working very closely with AWP on a range of improved services including:

- Enhanced Talking Therapies through primary care
- Developing the Early Intervention in Psychosis service and
- Carrying out improvement work on inpatient facilities.

Measles

We are working with colleagues in public health, locally and nationally, to develop a plan of action to protect our population against measles. This is a precautionary measure, as to date there have been NO confirmed cases in BaNES.

However, with small numbers of cases in surrounding areas (Wiltshire, Gloucestershire and Bristol), there is clearly a need here as elsewhere in the country to take all the necessary steps to protect the local population.

At the heart of our plan is a national MMR catch-up campaign which will be led by local GP practices and will involve practices contacting the families of unvaccinated or partially vaccinated children between 10 and 16 years of age, inviting them to come in and be vaccinated. This is the age group which, nationally, is less likely to have taken up the MMR vaccination. Vaccinations will be given in two stages one month apart.

We are confident that local GP practices will be happy to do this. In addition, we are asking them to respond positively to requests for vaccination from unvaccinated or partially vaccinated people outside the 10-16 age group.

(Those born before 1970 are likely to be immune to measles).

The GP letters will be backed up with local and national communications in the local newspapers, radio and TV. They will be sent out over the next three months, with the aim of having secured 95% immunisation in the target group of 10-16-year-olds by the end of the school holidays. This is the level considered to represent ‘herd immunity’, which lessens the risk to those in our population (unvaccinated pregnant women, some people with cancer) who cannot now be vaccinated and for whom catching measles would pose a serious health risk.

MMR vaccination is very successful in preventing measles, and patients are completely immune after they have received the second (‘booster’) vaccination, which can be given a month after the first.

We are working very closely with our public health colleagues to monitor this situation. If a case is confirmed in our area, we will be informed immediately by the Health Protection Agency (now ‘Public Health England’). We will then consider what further steps may be necessary.

Commissioning for quality
BaNES CCG is committed to putting quality and patient safety at the heart of everything it does. From the very outset, we aim to ensure that patients' wellbeing is strongly represented in our decision-making, and have appointed Dawn Clarke (Director of Nursing) and Dr Ruth Grabham (Clinical Director), to ensure a clear clinical voice on our CCG Board.

One of our aims as an organisation is to improve the experience of local residents, patients and their carers by making sure that health services are provided promptly, safely and effectively. We will continue to ensure the quality of healthcare services is maintained by monitoring the quality of that care and by building quality measures into our contracts with healthcare providers. We have identified a range of measures that address safety of services, effectiveness and patients' experience that are written into these contracts. These range from reducing hospital acquired infections, improving communication between primary and secondary care, improving adult and children's safeguarding arrangements and improving learning from the experience of patients.

Additionally, the CQUIN payment framework enables commissioners to reward excellence by linking a proportion of our healthcare providers' income to the achievement of local quality improvement goals. The CQUINS for 2013-2014 were developed through a collaborative partnership between the CCG and the providers and include, amongst others, 'Transforming Patient Services', improving end of life care, improving continence care and implementing the 'Fifteen Steps Challenge' which encourages patients and staff to identify potential improvements with a view to enhancing the patient experience and increasing patient confidence.

Alcohol Liaison Nurses
The CCG is investing £153,000 in an enhanced Alcohol Liaison Service based at the RUH. Alcohol-related hospital admissions cost £5 million a year, ranging from bones broken in falls to serious, long-term illnesses such as liver cirrhosis. One in every five people admitted due to alcohol is readmitted.

The Alcohol Liaison Service employs 2.5 staff (two nurses and an alcohol support worker) to talk to people about their drinking (if alcohol is known to have played a part in their admission) while they are in hospital. It can also start services such as detox while patients are on the ward, to be continued at home afterwards. This approach is shown to pay dividends as people are much more likely to cut down on their drinking after an 'intervention'.

At the same time, we continue to support efforts through the BaNES Health and Wellbeing Board to encourage people in the area to keep their drinking to levels that will not cause harm. One of the ways this is done is through 'Developing Health and Independence', a single, confidential phone number for advice, referrals and support aimed at those who are worried about their drinking, and their families.

This page is intentionally left blank

Bath & North East Somerset Council

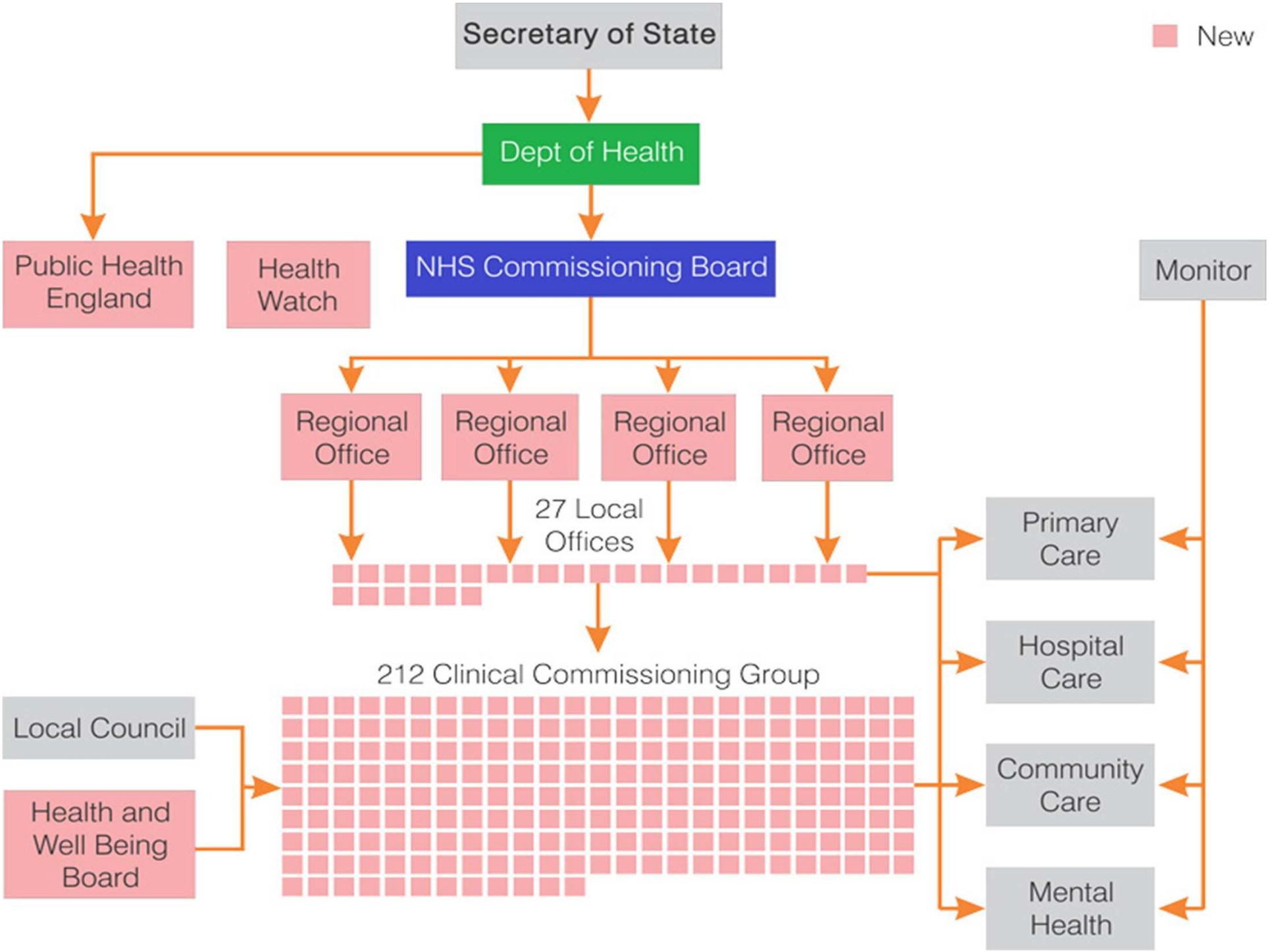
NHS
Bath and North East Somerset Clinical Commissioning Group

The New NHS Commissioning Landscape

Dr. Ian Orpen

17th May 2013

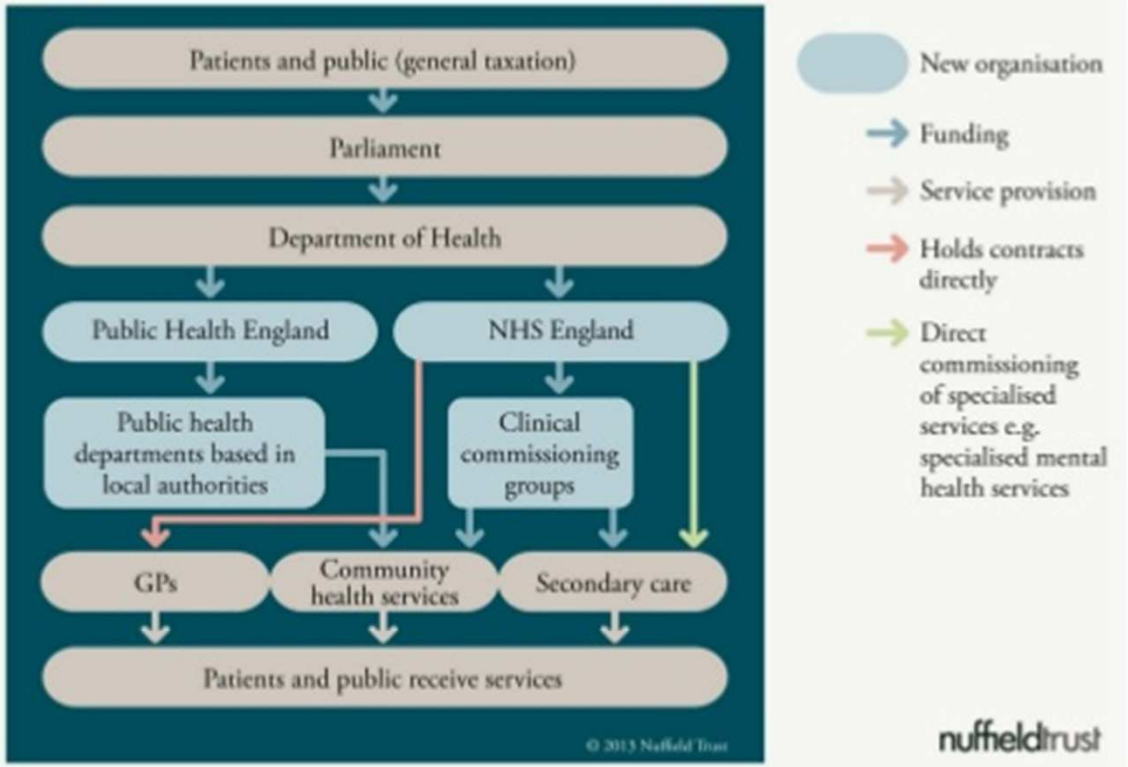
Healthier. Stronger. Together


Secretary of State
New
Dept of Health
Public Health England
Health Watch
NHS Commissioning Board
Monitor
Regional Office
Regional Office
Regional Office
Regional Office
27 Local Offices
Primary Care
Hospital Care
Community Care
Mental Health
212 Clinical Commissioning Group
Local Council
Health and Well Being Board

evidence for better health care

nuffieldtrust

New Funding Arrangements

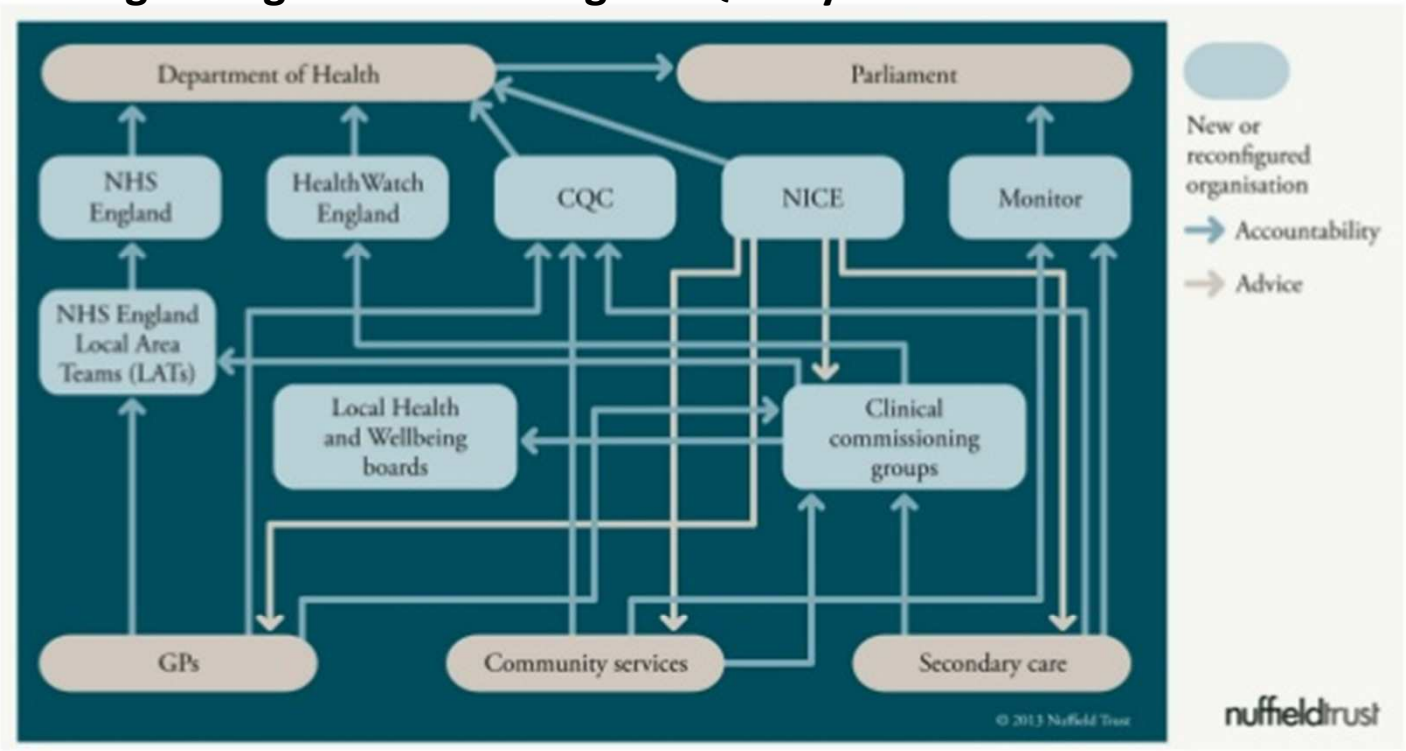


NHS
Bath and North East Somerset
Clinical Commissioning Group

evidence for better health care

nuffieldtrust

Regulating and Monitoring the Quality of Services



NHS
Bath and North East Somerset
Clinical Commissioning Group

Role of NHS England

- To allocate resources to CCGs
  - and support them to commission services on behalf of their patients
- To deliver improved outcomes for patients
- To directly commission
  - primary care
  - military, offender health and
  - specialised services
- To plan for civil emergencies,
- To provide system oversight and leadership

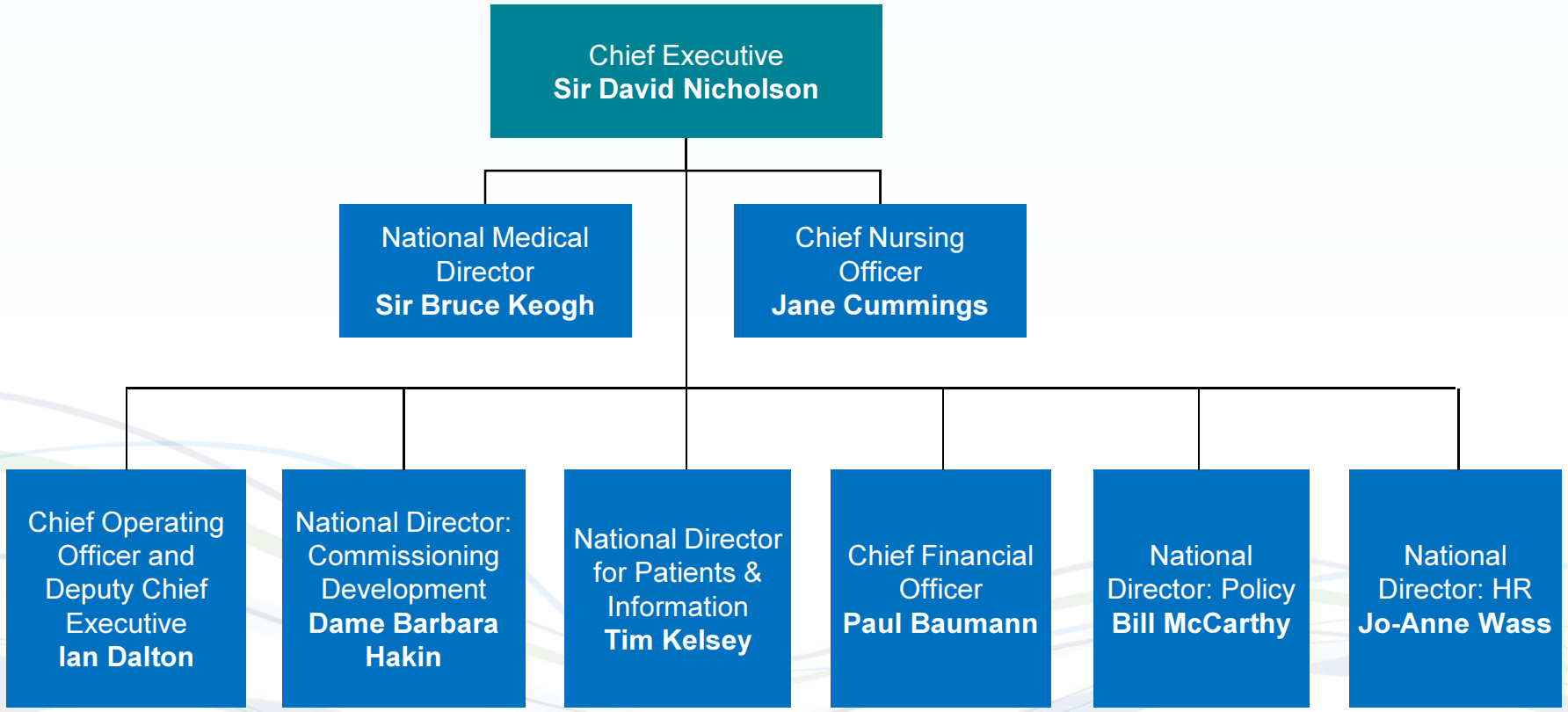
NHS England Outcomes

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long term conditions
- Helping people recover from episodes of ill-health or injury
- Ensuring people have a positive experience of care
- Caring for people in a safe environment and protecting them from avoidable harm

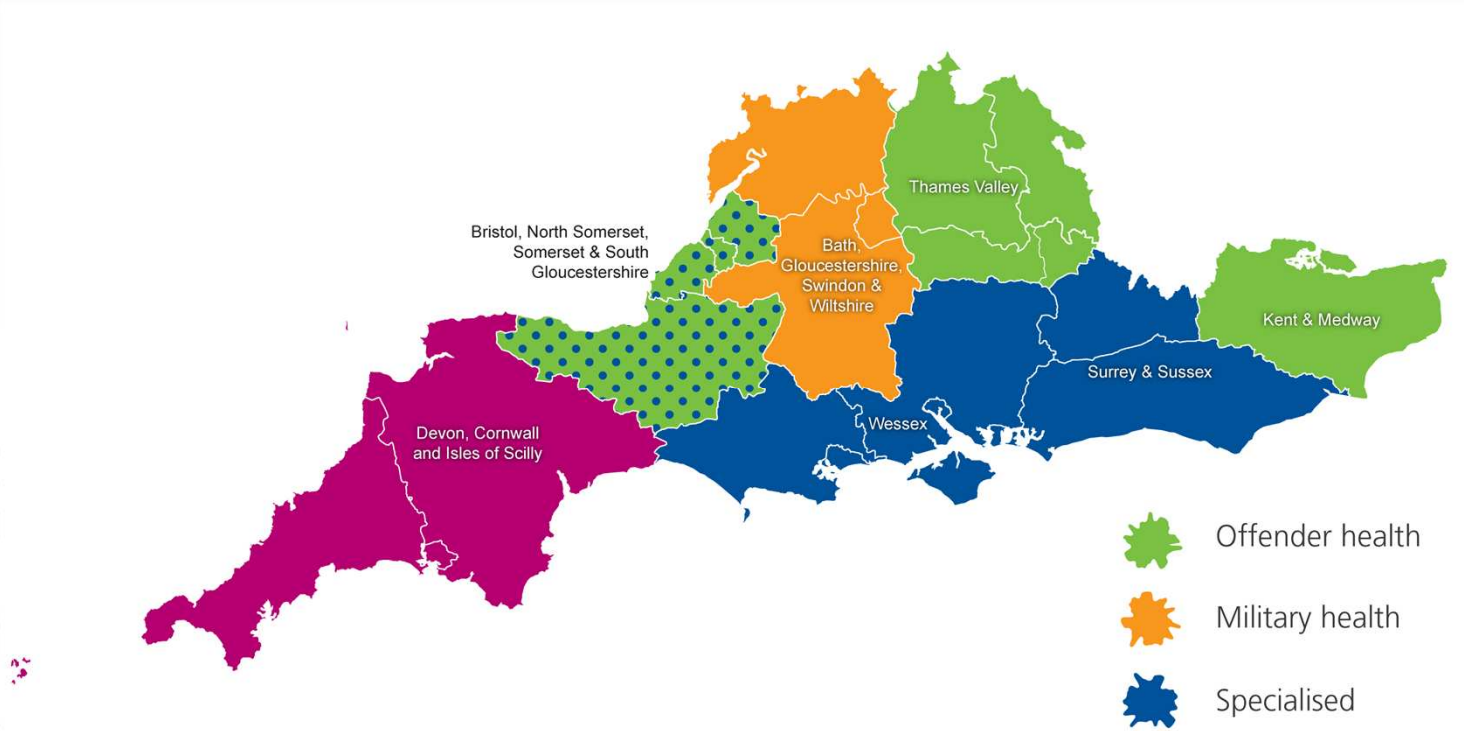
NHS England - Facts and Figures

- Approximately 4000 employees, working across 8 Directorates
- Majority of functions carried out at a local level
  - through 4 regional teams (750) and
  - 27 Area teams (2700)
- 720 people at national support centre in Leeds
- 3200 staff employed across the country
- The 4 Regions are:
    - North of England
    - Midlands and East of England
    - London and
    - the South of England

NHS England Structure



NHS England – South:
Additional responsibilities



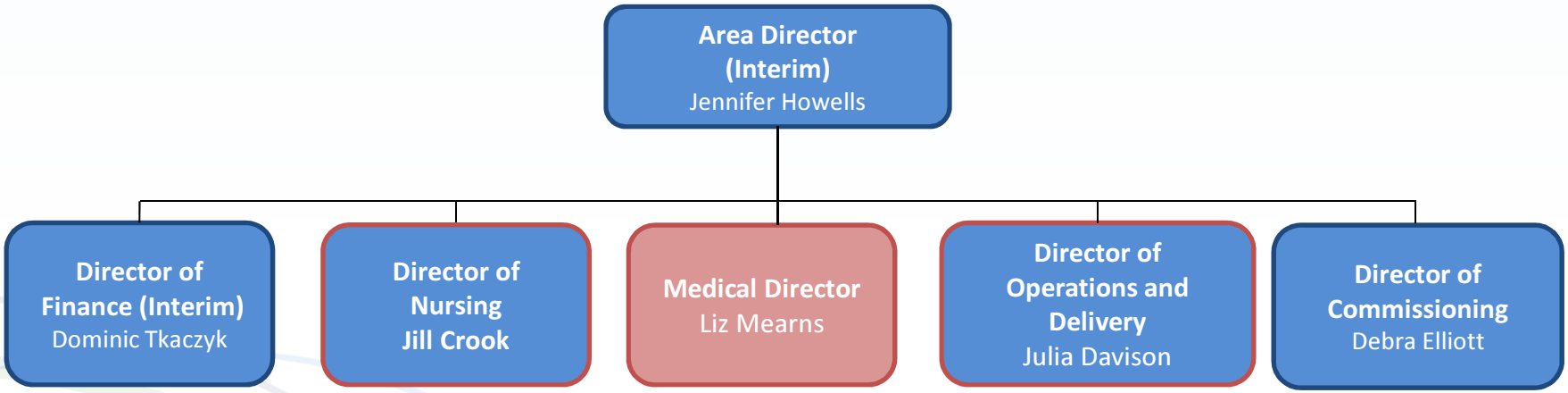
BGSW

1.5 million population
2586 square miles
Budget £405m (BGSW)
£255m (other ATs)
£1609m (CCGs)

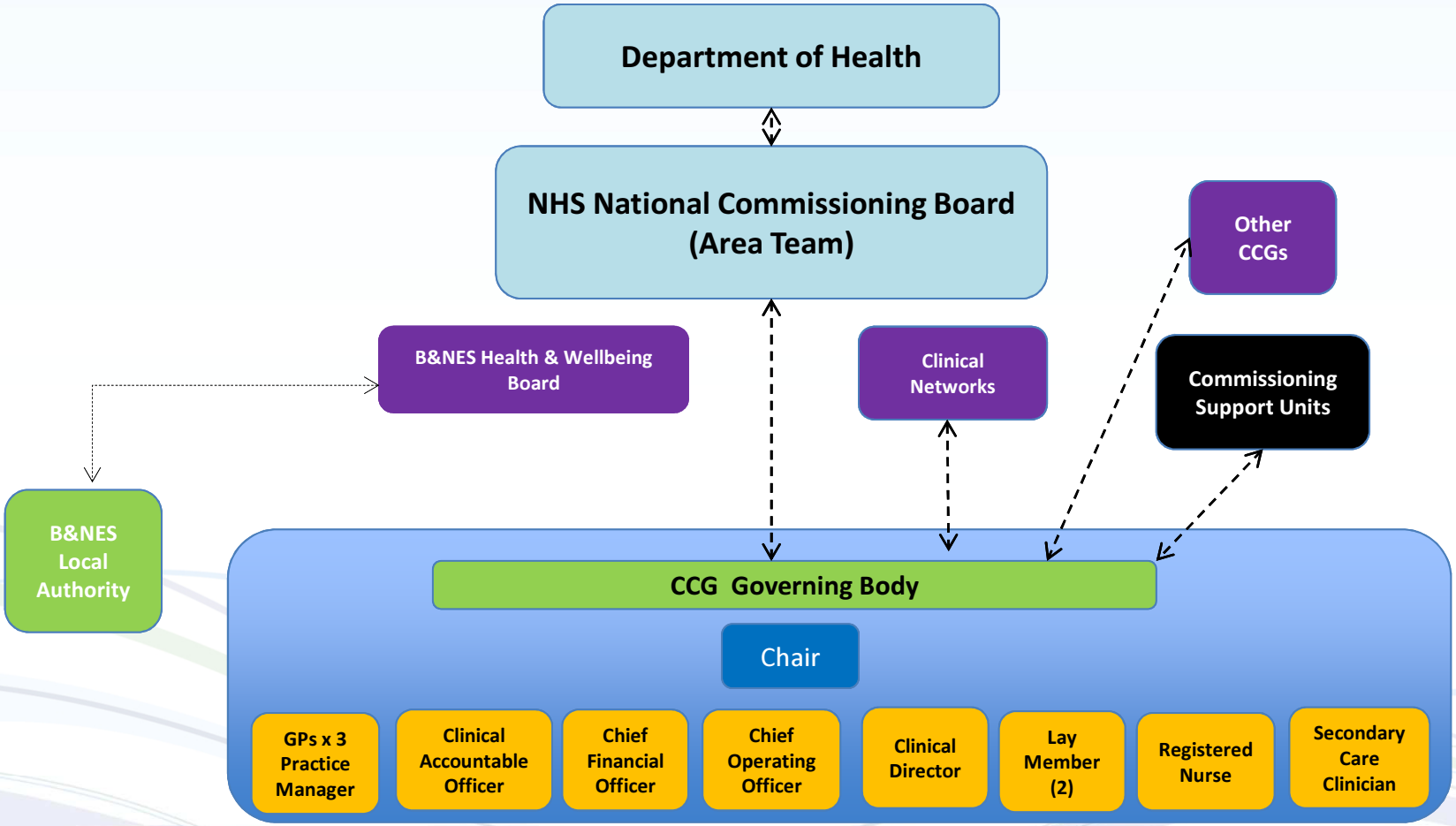
4 Clinical Commissioning Groups
4 Local Authorities plus district councils
4 Health and Wellbeing Boards
3 Local Resilience Forums

206 GP Contracts
238 Dental Contracts
267 Pharmacy Contracts
181 Optometry Contracts
2 Prisons 1xCat B and 1xCat C
2 SARCs
4 Acute Providers & 1 Spec. Provider
4 Community Care Providers
2 Mental Health Providers

BGSW Area Team

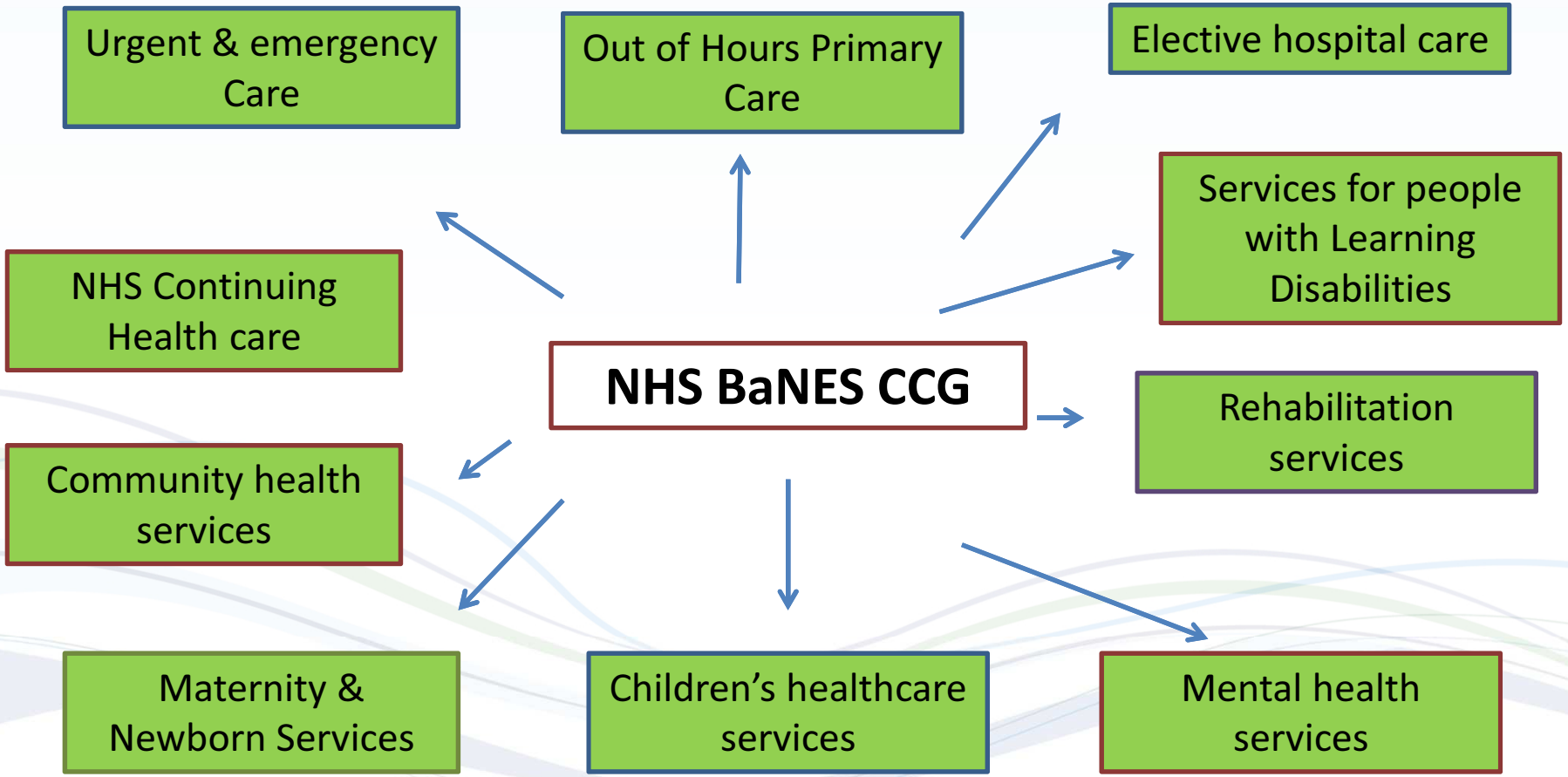


The Local Structure



NHS
Bath & North East Somerset
Clinical Commissioning Group

What are CCGs responsible for?

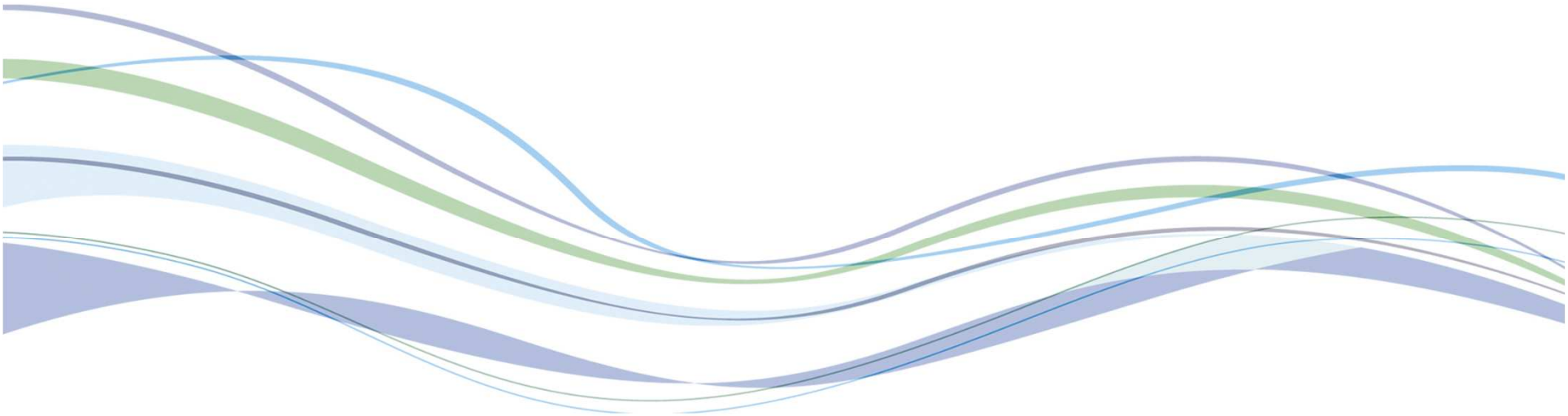


NHS
Bath and North East Somerset
Clinical Commissioning Group

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Thank you



Healthier, Stronger, Together

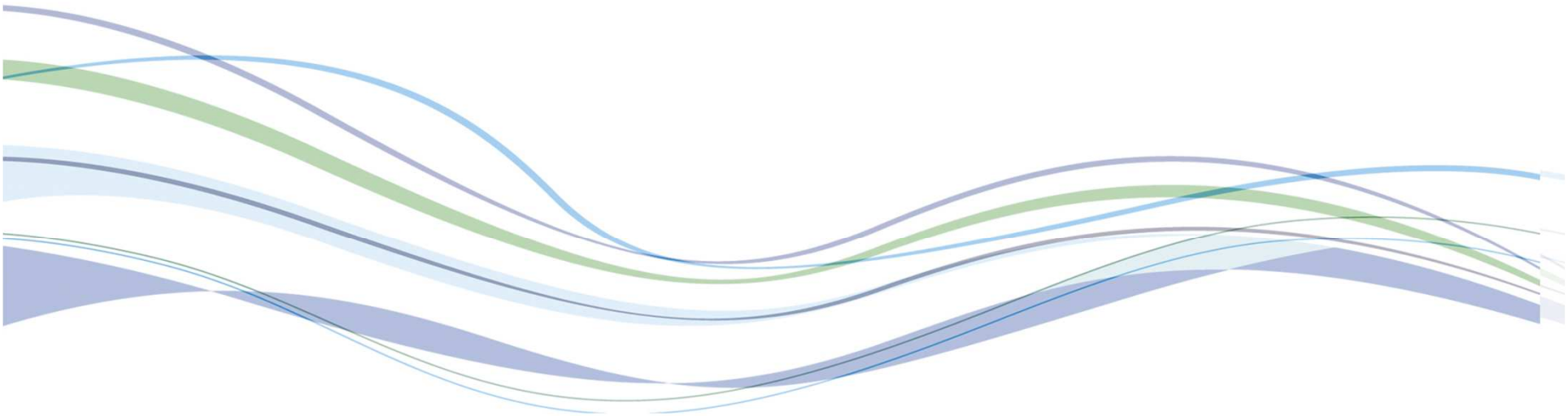
Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

NHS 111 Service Update

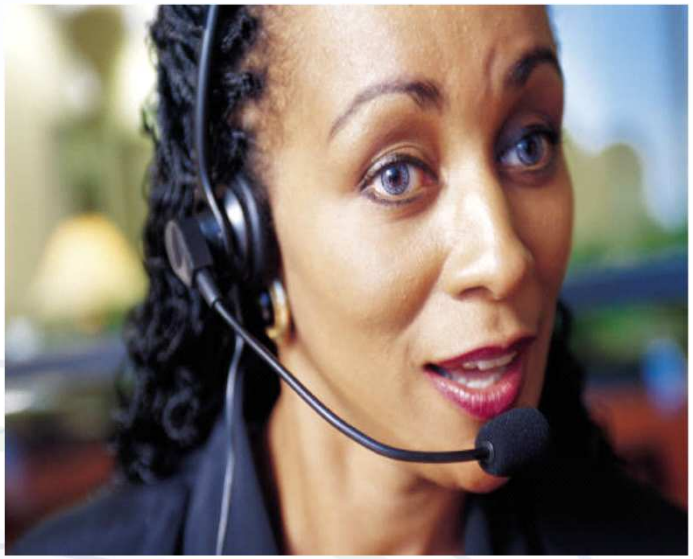
Date: 17 May 2013

Dr Elizabeth Hersch (NHS 111 B&NES and Wiltshire Clinical Governance Lead)
Dr Russell Kelsey (Regional Medical Director, Harmoni)



Healthier, Stronger, Together

Service Overview



- Memorable 3 digit number when you need help, but it is not a 999 emergency
- Available 24 hours a day, 365 days a year
- Calls are free from landlines and mobile phones
- To provide information and advice on what to do next

Bath and North East Somerset Clinical Commissioning Group

Service Aims

- To provide call handling, clinical assessment and appropriate referral to NHS services
- To improve the efficiency of the urgent care system by connecting patients to the right place, first time
- To provide easy access to more integrated services through a Directory of Services

Local Implementation - Timeline

A)	Soft Launch	19th February 2013 (on time)
B)	Soft Launch Period Extended	19th March 2013 – Ongoing
C)	Original Public Launch	19th March 2013 (delayed)
D)	Initial Rectification Period	6 weeks–ends 31st May 2013
E)	Harmoni's Rectification Period Complete	End of June 2013
F)	New Public Launch Date	To be confirmed

Soft Launch – Key Issues

- Poor response times in terms of call handling and calls abandoned at weekends
- Pressures on Ambulance and Out of Hours Providers
- Issues with use of NHS Care Pathways and time to complete a triage call

Intense Six Week Period of Rectification - Key Highlights

- Harmoni has committed to improve service performance in line with Rectification Plan
- Recruitment of further Healthcare Advisers and Clinical Advisers
- Harmoni has committed more management resource to Bristol Call Centre
- Commissioners monitoring performance against Rectification Plan via weekly Remedial Taskforce Meetings

Current Performance

Date	Target %	Mon 06/05/13	Tues 07/05/13	Wed 08/05/13	Thur 09/05/13	Fri 10/05/13	Sat 11/05/13	Sun 12/05/13
% of Calls answered within 60 seconds	95%	78.55%	96.79%	94.79%	98.48%	99.60%	70.11%	85.89%
% Calls abandoned after 30 seconds	5%	7.15%	0.79%	0.00%	0.50%	0.40%	5.85%	3.61%
% Warm transferred	98%	32.26%	42.86%	34.29%	48.28%	56.52%	32.39%	44.05%
Longest Wait for Answer	00:01:00	00:10:57	00:03:41	00:05:09	00:02:17	00:01:54	00:08:17	00:11:00
Longest Wait for Call Back	00:10:00	00:09:05	00:03:42	00:12:18	00:05:54	00:02:38	00:05:31	00:06:22
Ambulance Dispatch as a % of total	10%	7.79%	12.44%	12.24%	8.44%	6.64%	4.85%	10.63%
% Callers referred to A&E	5%	6.12%	7.96%	5.61%	8.44%	4.42%	6.07%	4.75%

Bath and North East Somerset Clinical Commissioning Group

Patient Quality & Safety Processes

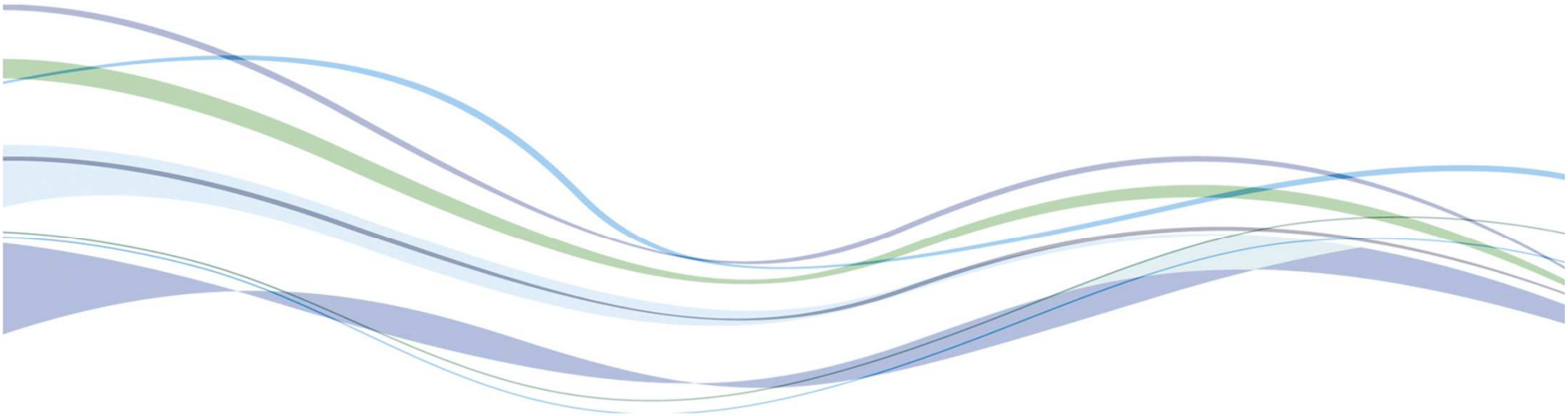
- Complaints Process
- Health Care Professional Feedback forms
- Local Clinical Governance Group
- Regional Clinical Governance Group

Bath and North East Somerset
Clinical Commissioning Group

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Any questions?



Healthier, Stronger, Together

This page is intentionally left blank

Bath & North East Somerset Council

NHS Bath and North East Somerset

Working together for health & wellbeing

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

Wellbeing Policy Development & Scrutiny Panel – May 2013

1. PUBLIC ISSUES

Health and Wellbeing Strategy – Public Consultation

The Bath and North East Somerset Health and Wellbeing Board is welcoming feedback on its draft Health and Wellbeing Strategy from any interested group, organisation, service user or local resident. An online consultation can be found on the Council's webpages: www.bathnes.gov.uk/health-wellbeing-board. Comments on the draft strategy are welcome up until 7 June 2013.

The finished strategy will be the overarching plan for improving health and wellbeing and reducing inequalities across Bath and North East Somerset. It outlines the Health and Wellbeing Board's key areas of focus in the coming years around:

Helping people to stay healthy

- Reduced rates of childhood obesity
- Improved support for families with complex needs
- Reduced rates of alcohol misuse
- Create healthy and sustainable places

Improving the quality of people's lives

- Improved support for people with long term conditions
- Reduced rates of mental ill-health
- Enhanced quality of life for people with dementia
- Improved services for older people which support and encourage independent living and dying well

Fairer life chances

- Improve skills, education and employment
- Reduce the health and wellbeing consequences of domestic violence
- Increase the resilience of people and communities including action on loneliness.

Report of the Director of Public Health 2012

This report can be found on the Council's website by following the link: www.bathnes.gov.uk/services/adult-social-care-and-health/public-health

The report highlights the impressive improvements in local public health over the last 10 years. Some of the successes include the reductions in infant mortality across our area, the significant decreases in the numbers of smokers and the continued reduction in crime. Areas for further improvements are also highlighted and include the rising hospital admissions for alcohol misuse, increases in childhood obesity and high levels of hospital admissions for self-harm.

This report has been deliberately built around the key principles of the Marmot review 'Fair Society Healthy Lives' which demonstrates how to improve health and wellbeing for all of us, by reducing unfair and unjust inequalities in health across our communities. These principles will guide the Public Health contribution to the delivery of the Joint Health and Wellbeing Strategy for Bath and North East Somerset, building on the achievements of recent years and using new opportunities from across the Council to achieve even better health for all of our communities.

The aim of this report is to provide an overview of some of the key public health issues in Bath and North East Somerset. For more detailed information about the populations' health visit www.bathnes.gov.uk/jsna

2. PERFORMANCE

Adult Safeguarding

An internal audit undertaken by the Council's Audit & Risk team has found the overall framework of control for adult safeguarding to be "excellent" (an Audit Rating Level 5, which is the maximum available on a range 1 (poor) to 5 (excellent)).

The audit focused on the following six key objectives:

- An up to date Safeguarding Policy is in place with clear procedures documented and disseminated to the appropriate agencies/organisations.
- Assurance is obtained from organisations commissioned by the Council to support and protect vulnerable adults, which confirms appropriate safeguarding training is provided.
- The role and responsibilities of the Local Safeguarding Adults Board is clearly defined.
- Procedures are in place to ensure all alerts are correctly recorded and the 'Procedure for Safeguarding Adults' is effectively and accurately applied in all cases.
- Procedures are in place to identify reoccurring alerts/ themes by service user and agency/ organisation, and action taken where appropriate.
- Procedures are in place to monitor alerts in respect of clients who are receiving services commissioned outside the authority.

3. SERVICE DEVELOPMENT UPDATES

Extension of the Hospital Social Work Service

The Hospital Social Work service based at the Royal United Hospital and provided by Sirona Care & Health is to be extended to 7-days a week working. The extension of this service plays an important role in facilitating timely discharge from hospital and is, therefore, being funded from the 2013/14 Department of Health "reablement and winter pressures" funding allocation. This funding is allocated to the Clinical Commissioning Group (CCG) by the Department of Health and is transferred from the Clinical Commissioning Group to the Council under a "Section 256" Agreement and is commonly referred to as "Section 245" funding.

Department of Health guidance on the use of this funding is that it should be used to reduce pressures in the health and social care system by investing in services that prevent hospital admission; reduce the length of a stay in hospital; or facilitate discharge from hospital and, also, by investing in personal social care services that maintain independence and enable people to continue to live in the community rather than being admitted to nursing care.

This page is intentionally left blank

Royal United Hospital Bath NHS
NHS Trust

RUH RUH Status

Wellbeing Policy Development and Scrutiny Panel
17th May 2013

Royal United Hospital Bath NHS
NHS Trust

RUH Care Quality Commission

Our job is to check whether hospitals, care homes and care services are meeting essential standards

Reach one of the following judgements for each essential standard inspected:

Met Action Needed Enforced Action

A judgement is also made on the level of impact on people who use the service:

Minor Moderate Major

Healthcare you can Trust

RUH RUH Compliance

RUH Compliance

November 2012: Routine unannounced inspection
Fully Compliant

February 2013: Responsive inspection undertaken in relation to concerns raised by stakeholder partners in relation to discharge processes www.cqc.org.uk

Outcome: Action needed for the following;

- Respecting & involving people who use services: Minor impact
- Care & welfare of people who use services: Moderate impact
- Cooperating with providers: Moderate impact
- Records: Moderate impact

RUH CQC Inspection (February 2013)

- Action Plan developed to address findings
- Steering Group set up to monitor implementation of action plan
  - Meets fortnightly
  - Chaired by Acting Director of Nursing and attended by action plan leads
- Quality Board monitor completion of the action plan & monthly progress report submitted
- Action plan progressing in line with identified timescales and scheduled for completion by 31 May 2013

RUH Monitor Outcome

Application deferred due to:

1. Compliance actions resulting from the CQC visit in February 2013

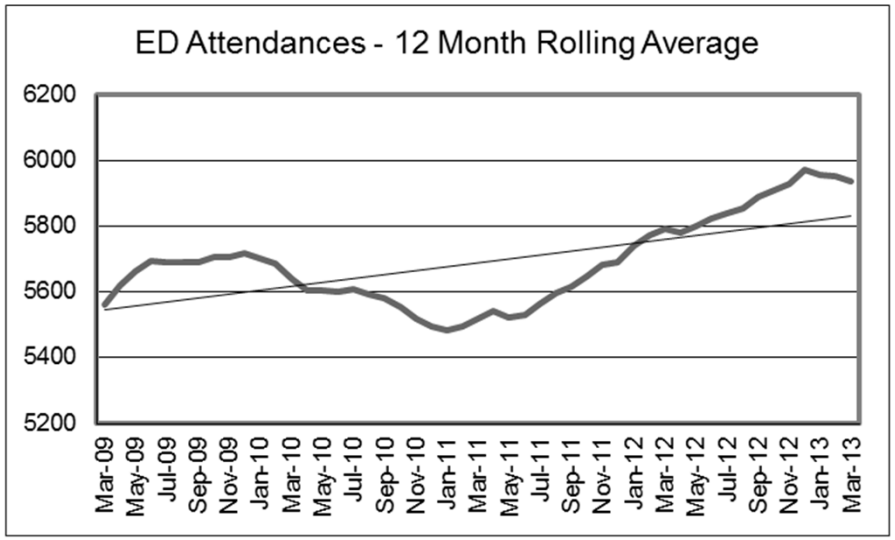
2. Concerns around A&E performance

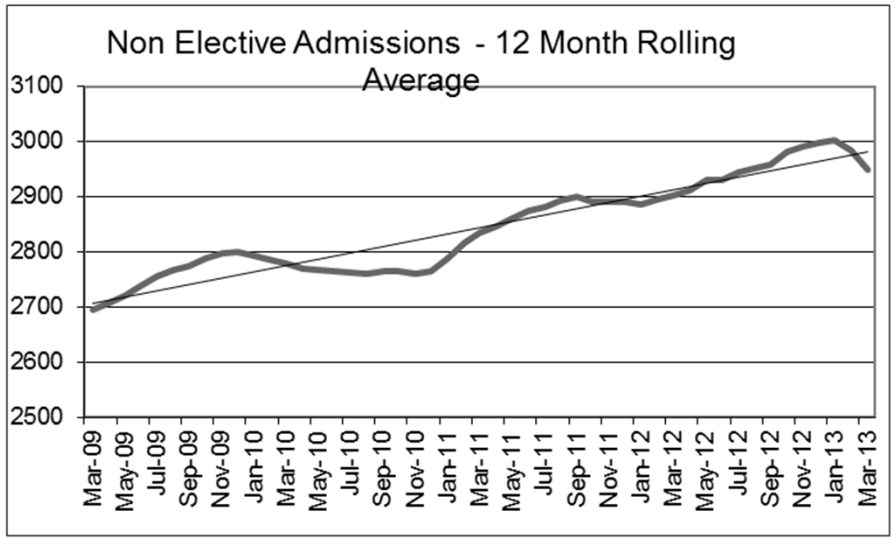
Royal United Hospital Bath NHS
NHS Trust

RUH Black Escalation Jan, Feb & March 2013

Definition:	Unsafe Emergency Department; All operations cancelled; All escalation areas open; Ambulances unable to offload
RUH Perspective:	Insufficient senior/medical decision making prior to admission Insufficient pull from the hospital; over reliance on community hospitals Insufficient social care/blend of health and social care packages 24hr/7day Packages of care cancelled at point of Emergency Department attendance Other acute providers unable to support
Diagnosis:	Community response – busy doing more but more of the same rather than a different response

RUH ED Attendances and Non-Elective Admissions - Trend

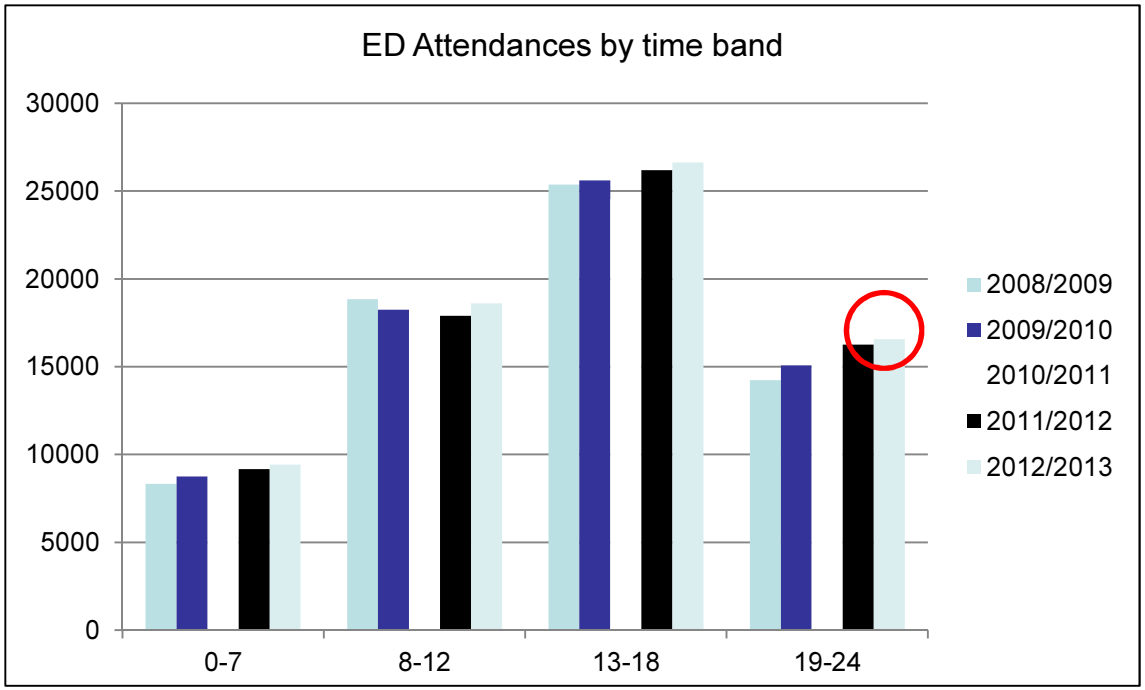




Both ED attendances and non-elective are consistently increasing year on year by ~300 actual attendances and ~270 admissions

Royal United Hospital Bath NHS
NHS Trust

RUH ED Attendances by Time of Day



Over the last 5 years the ED attendance have increased year on year out of hours from 19.00 in the evening until 7.00 in the morning.

Healthcare you can Trust

RUH ED Attendances and Non-Elective Admissions – by PCT

Non Elective Inpatient Growth by PCT:

PCT	2012/13 FOT	Growth
BaNES PCT	14211	1.3%
WILTSHIRE PCT	14397	2.0%
SOMERSET PCT	5519	10.2%
S GLOS PCT	825	0.8%
BRISTOL PCT	197	0.9%
GLOUCESTERSHIRE PCT	68	19.4%
NORTH SOMERSET PCT	51	1.2%
SWINDON PCT	24	-3.0%
OTHER PCT	1029	9.0%
Total	**36321**	**2.4%**

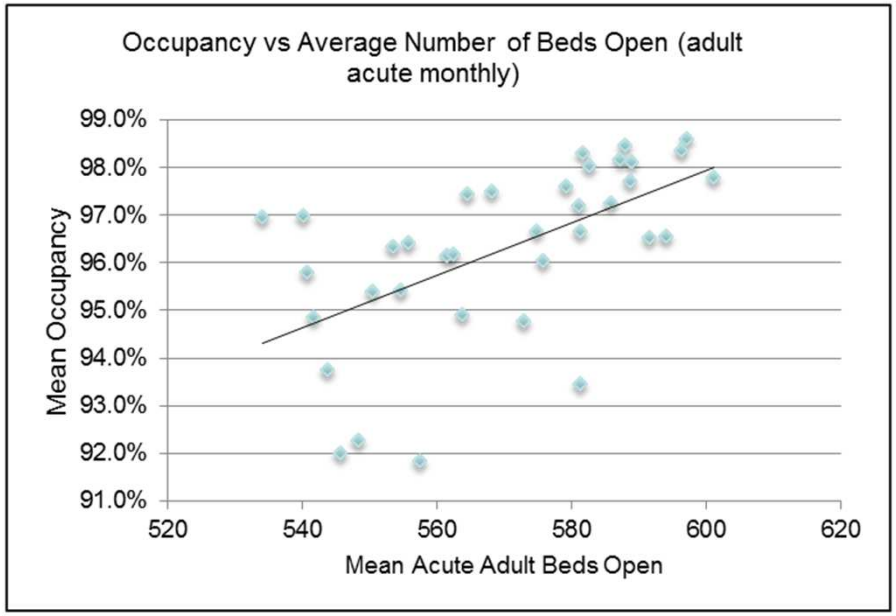
ED Attendances Growth by PCT:

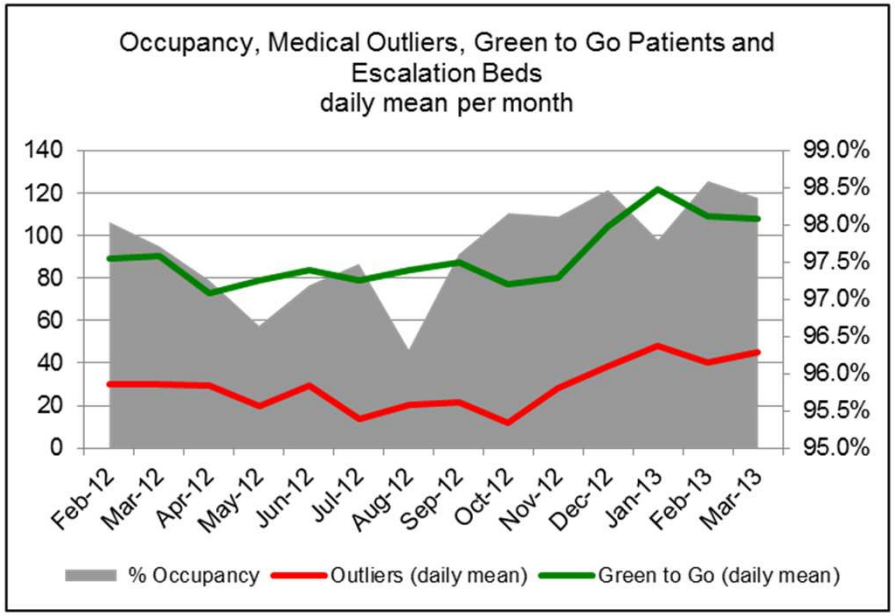
PCT	2012/13 FOT	Growth
BaNES PCT	35228	0.6%
WILTSHIRE PCT	21930	1.7%
SOMERSET PCT	8306	10.6%
S GLOS PCT	2294	2.2%
BRISTOL PCT	749	3.6%
GLOUCESTERSHIRE PCT	194	8.3%
NORTH SOMERSET PCT	131	0.6%
SWINDON PCT	72	-3.5%
OTHER PCT	3254	5.9%
Total	**72158**	**1.6%**

PCT analysis shows that all PCTs have had consistent growth over the last 5 years. The key exception is NHS Somerset, which has grown at a far higher rate (+10%)

It is worth noting that, whilst the percentage growth for Gloucestershire PCT is high, the actual number of patients is small. Swindon PCT has reduced its activity over the period, although again numbers are small.

RUH Hospital Flow: Open Beds, Occupancy, Outliers and Green to Go Patients

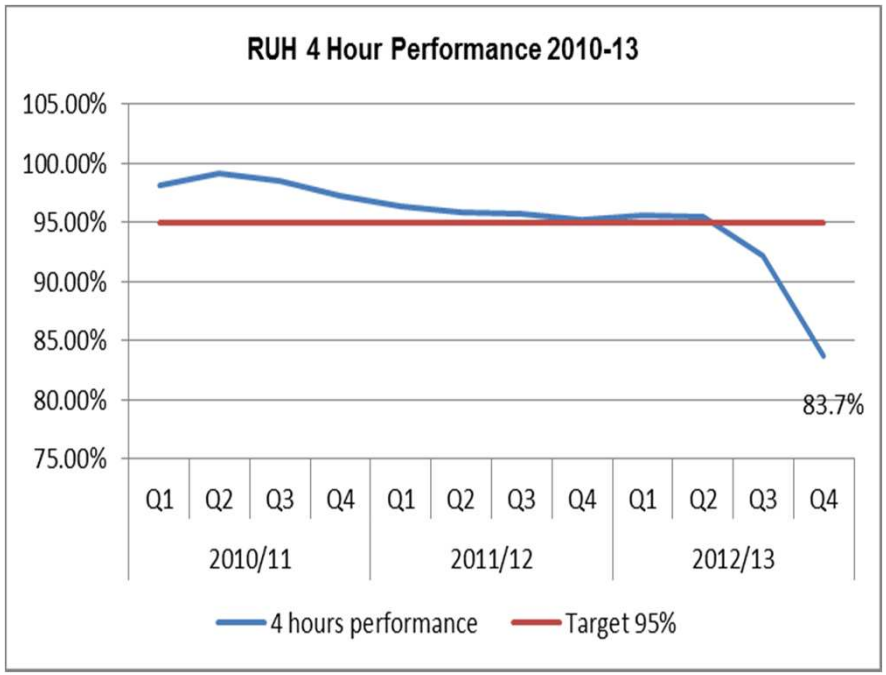


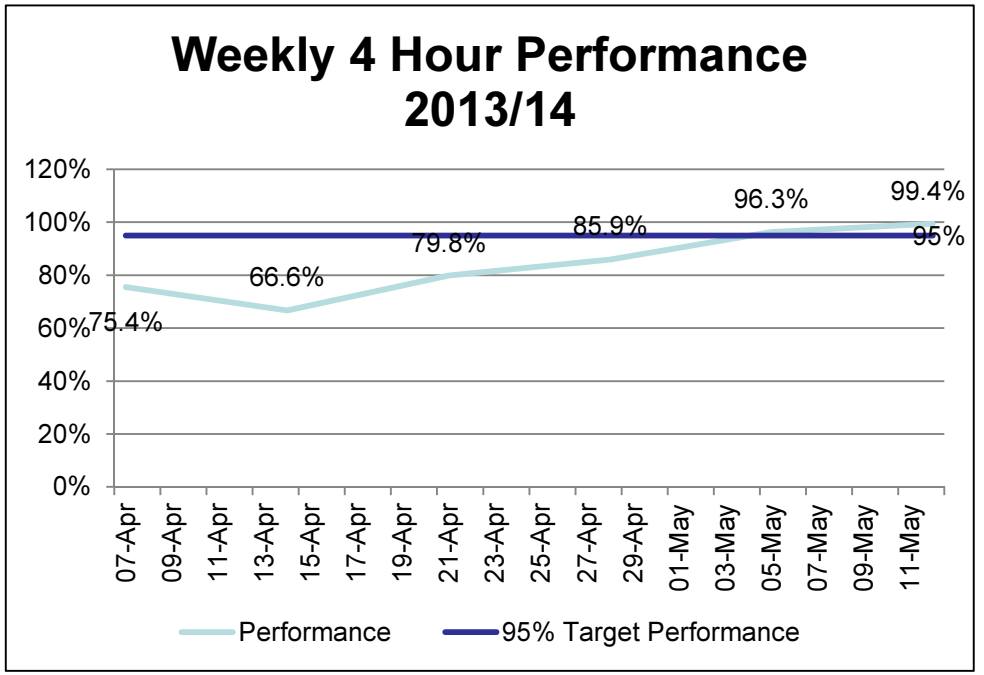


Increasing bed numbers correlates with increased occupancy rates. Increasing occupancy also correlates with increasing numbers of outliers and green to go patients

Royal United Hospital Bath NHS
NHS Trust

RUH 4 hour Performance





Healthcare you can Trust

RUH RUH Focus

- Rapid assessment at front door (Emergency Department and Assessment Units)
- Rehabilitation for home
- Reducing length of stay
- Facilitating safe and timely discharge
- CQC compliance
- Urgent care Task and Finish Group between providers and commissioners

RUH Solutions

- Care provided closer to home
- Better demand management in primary care
- Improved patient education on self care
- Better understanding on how and where to access the right services

RUH Thank you

Questions?